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# Medicare Documentation Checklist & Guidelines for Chiropractic Doctors

**What's Changed?**

- Comprehensive Error Rate Testing (CERT) data for chiropractic claims (page 1)
- Claims must specify pain location and vertebra (page 2)
- Symptom details for the patient's history added (page 2)
- Updated spinal exam requirements for subsequent visits (page 3)
- Clarified definitions of subluxation types, coverage, and treatment duration (pages 3-4)
- Underscored use of the AT modifier for Medicare-covered CPT codes (page 4)
- Signed ABN required for non-covered services; added ABN resources (page 4)
- Added claim denial reasons, usage guidelines, and billing guidance (pages 4-5)

Substantive content changes are in dark red.

Did you get a request from a Medicare contractor for chiropractic documentation? This checklist will help you respond effectively. Check the box after completing each item.

**Important:** Insufficient documentation is a common issue. A Comprehensive Error Rate Testing (CERT) Program review in 2024 found errors in 33.6% of chiropractic claims. Complete records help prevent denials.

## Documentation Basics

Your documentation should include:

### Patient Information

☐ Patient's name and date of service



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## Subluxation Documentation Requirements

☐ Subluxation shown by imaging:

- X-ray taken within 12 months before or 3 months after the start of treatment
  - Exception: In some cases of chronic subluxation, like scoliosis, Medicare may accept an older x-ray if the patient's health record shows the condition existed longer than 12 months and is reasonably permanent
- CT scan, MRI, or both showing subluxation of spine
- Your review of the x-ray, CT, or MRI, noting level of subluxation

**Or**

☐ Subluxation shown by physical exam, with at least 2 elements of the following 4 criteria, 1 of which must be asymmetry/misalignment or range of motion abnormality, based on the "PART" system:

- P: Pain
- A: Asymmetry or misalignment
- R: Range of motion abnormality
- T: Tissue tone changes

☐ Dated documentation of first evaluation

☐ Primary diagnosis of subluxation, including the level

☐ Documentation supporting medical necessity

## Initial Evaluation

☐ History

- Date of initial treatment
- Description of current illness
- Symptoms related to level of subluxation causing patient to seek treatment
  - **Note:** A claim that only says a patient is feeling pain isn't enough. Include the pain's location and the vertebra that could cause pain in that area.
- Past health history and family history (recommended)
- Mechanism of trauma (recommended)
- Quality and character of symptoms or problem (recommended)
- Onset, duration, intensity (sharp, dull, or throbbing), frequency, location, and radiation (spread to other parts of the body) of symptoms (recommended)
- Aggravating or relieving factors (recommended)
- Past interventions, treatments, medication, and secondary complaints (recommended)

- ☐ Contraindications like risk of injury to patient from dynamic thrust or discussion of risk with patient (recommended)
- ☐ Evaluation of musculoskeletal/nervous system through physical exam
- ☐ Treatment given on day of visit, if relevant
  - Specific manipulated areas and levels of the spine
  - Hand-held devices may be covered, but Medicare doesn't offer more payment or extra charges for use of the device

### Treatment Plan

- ☐ Frequency and duration of visits (recommended)
- ☐ Specific treatment goals (recommended)
- ☐ Objective measures to evaluate treatment effectiveness (recommended)

### Subsequent Visits

- ☐ History
  - Review of chief complaint
  - Changes since last visit
  - System review, if relevant
- ☐ Physical exam with at least 2 elements of PART
  - Exam of the part of the spine involved in diagnosis
  - Assessment of change in patient's condition since last visit
  - Evaluation of treatment effectiveness addressing objective measures included in the treatment plan
- ☐ Treatment given on day of visit, including specific manipulated areas and levels of spine

## General Guidelines

- Make sure medical records show that the service is corrective treatment, not maintenance.
- Most spinal joint problems fall into 2 categories:
  - **Acute subluxation:** A new injury, for example, strains or sprains, confirmed by x-ray or exam. Medicare covers treatment if you document active care and expect improvement. Care may last up to 3 months, with visits decreasing over time.

  - **Chronic subluxation:** A long-term condition where treatment can improve function but won't fully resolve the issue. Medicare covers care as long as the patient is improving. When further clinical improvement isn't expected and chiropractic treatment becomes supportive rather than corrective, it's considered **maintenance therapy**. Once the injury is stable, more treatment is maintenance therapy and isn't covered. Maintenance therapy includes services to prevent disease, promote health, or prevent deterioration of a chronic condition.

- Use the Active Treatment (AT) modifier on a claim for active or corrective treatment of acute or chronic subluxation because Medicare requires it to pay for CPT codes 98940, 98941, and 98942. Don't use it for maintenance therapy.
  - **Note:** Medicare developed the AT modifier to clearly define the difference between active treatment and maintenance treatment. Medicare only pays for active or corrective treatment to correct acute or chronic subluxation. Medicare doesn't pay for maintenance therapy.
  - Only use an AT modifier when chiropractic manipulation is reasonable and necessary as defined by national and local policy.
  - **Note:** An AT modifier doesn't prove the service is reasonable and necessary. As always, contractors can deny a claim if a medical review determines that the medical record doesn't support active or corrective treatment.
  - Make sure you know these policies along with Local Coverage Determinations (LCDs) in your area, to understand Medicare's coverage for active or corrective chiropractic services.
- Include records for all service dates on a claim.
- Include an abbreviation key and a copy of the Advance Beneficiary Notice of Noncoverage (ABN), if applicable.
  - Consider getting a signed ABN from patients for services that Medicare may not cover.
  - The ABN should include:
    - An explanation of why Medicare may not pay
    - The patient's acknowledgement of financial responsibility if Medicare denies the claim
  - Download ABN forms at: FFS ABN.
  - Refer to the Medicare Claims Processing Manual, Chapter 23, Section 20.9.1.1, pages 49 and 50, for information about ABN-related claim modifiers.
- Include any other documentation to support medical necessity of services billed and documentation specifically asked for in an additional documentation request (ADR) letter. Failure to respond is a major reason for claim denials.
- Other common claim denial reasons include:
  - Missing or inadequate treatment plans
  - Unclear chief complaint
  - Failure to document **all** treated spinal regions

## Usage Guidelines

- Refer to the specific LCD for your jurisdiction, as coverage and requirements may vary.
- Medicare typically reimburses only 1 chiropractic manipulation for a patient each day. In some cases, more than 1 treatment may be covered if it's medically necessary.
- You must base treatment on your patient's condition and response.
- Prolonged or repeated treatment is more likely to undergo medical review.

## Billing & Claim Submission Guidelines

- You must enroll in Medicare to submit claims and meet your state's licensure requirements.
- You can't opt out of Medicare and provide services under a private contract.
- Medical records must support the services you bill.
- Chiropractic LCDs from Medicare Administrative Contractors (MACs) include ICD-10 coding information to support medical necessity.
- For more information on chiropractor billing, see the following sections in the Medicare Claims Processing Manual, Chapter 1:
  - Carrier Annual Participation Program, Section 30.3.12
  - Annual Open Participation Enrollment Process, Section 30.3.12.1
  - Annual Medicare Physician Fee Schedule File Information, Section 30.3.12.1.2
  - A/B MAC (B) Specific Requirements for Certain Specialties/Services, Section 80.3.2.1.3

## Resources

- Chiropractic Services Compliance Tips
- Complying with Medicare Signature Requirements fact sheet
- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220