MEDICARE DOCUMENTATION JOB AID FOR DOCTORS OF CHIROPRACTIC

Have you received a request for documentation from a Medicare contractor but not sure if your records comply? We understand the challenges Doctors of Chiropractic face when determining what to include in responding to a request for medical records. The A/B Medicare Administrative Contractors (MACs) partnered together to create this job aid to help you properly respond to these requests.

Documentation shall include, but is not limited to:

Patient Information

- ☐ Name of beneficiary and date of service on all documentation

Subluxation

- ☐ Subluxation demonstrated by X-ray, date of X-ray: _____
  - A CT scan and/or MRI is acceptable evidence if subluxation of spine is demonstrated
  - If diagnostic studies were taken in a hospital or outpatient facility, a written report, including interpretation and diagnosis by a physician, must be present in patient's medical record
  - Documentation of chiropractor's review of the X-ray/MRI/CT, noting level of subluxation
  - The X-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

or

- ☐ Subluxation demonstrated by physical examination (Pain, Asymmetry/misalignment, Range of motion abnormality, Tissue tone changes [P.A.R.T.]; at least 2 elements, 1 of which must be A. or R.)
  - ☐ Include dated documentation of initial evaluation
  - ☐ Primary diagnosis of subluxation (including level of subluxation)
- ☐ Documentation of presence or absence of subluxation must be included for every visit
- ☐ Any documentation supporting medical necessity

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Task Force for Error-Free Medicare Claims

Initial Evaluation

- ☐ History
  - ☐ Date of initial treatment
  - ☐ Description of present illness
  - ☐ Symptoms bearing a direct relationship to level of subluxation causing patient to seek treatment
  - ☐ Family history (if relevant) (recommended)
  - ☐ Past health history (recommended)
  - ☐ Mechanism of trauma (recommended)
  - ☐ Quality and character of symptoms/problem (recommended)
  - ☐ Onset, duration, intensity, frequency, location and radiation of symptoms (recommended)
  - ☐ Aggravating or relieving factors (recommended)
  - ☐ Prior interventions, treatments, medication, and secondary complaints (recommended)
- ☐ Contraindications (e.g., risk of injury to patient from dynamic thrust, discussion of risk with patient) (recommended)
- ☐ Physical examination (P.A.R.T.)
  - ☐ Evaluation of musculoskeletal/nervous system through physical examination
- ☐ Documentation of presence or absence of subluxation must be included for every visit
- ☐ Treatment given on day of visit (if applicable)
  - ○ Include specific areas/levels of spine where manipulation was performed
  - ○ Manual devices that are hand-held with the thrust of the force of the device being controlled manually may be covered; however, no additional payment is made nor does Medicare recognize an extra charge for use of the device.

Treatment Plan

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

Subsequent Visit

- ☐ History
- ☐ Review of chief complaint
- ☐ Changes since last visit
- ☐ System (if relevant)
- ☐ Physical examination (P.A.R.T.)
  - ☐ Assessment of change in patient condition since last visit
  - ☐ Evaluation of treatment effectiveness (address objective measures included in treatment plan)
- ☐ Documentation of presence or absence of subluxation must be included for every visit
- ☐ Treatment given on day of visit (include specific areas/levels of spine where manipulation was performed)

General Guidelines

- ☐ Ensure medical records submitted support the service is "corrective treatment," rather than maintenance
  - For Medicare purposes, an AT modifier must be placed on a claim when providing active/corrective treatment to treat acute or chronic subluxation
    - Do not use Modifier AT when maintenance therapy has been performed
    - Modifier AT must only be used when chiropractic manipulation is "reasonable and necessary" as defined by national and local policy
    - **NOTE:** Presence of the AT modifier may not in all instances indicate the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review.
- ☐ Submit records for all dates of service on claim
- ☐ Documentation shall be legible and complete (including signatures)
- ☐ Legible signatures/credentials of professionals providing services
  - If signatures are missing or illegible, include a completed signature attestation statement
  - For illegible signatures, include a signature log
  - For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.
- ☐ Abbreviation key (if applicable)
- ☐ Any other documentation provider deems necessary to support medical necessity of services billed, as well as documentation specifically requested in the additional documentation request (ADR) letter
- ☐ Copy of Advance Beneficiary Notice of Noncoverage (if applicable)

Educational References

For additional information regarding documentation and coverage guidelines, refer to the Centers for Medicare & Medicaid Services' (CMS) internet-only manuals (IOMs) for chiropractic services:

- CMS IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 220
- Medicare Learning Network (MLN) Matters® Special Edition articles SE1601 Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits
- MLN Matters® SE1603 Educational Resources to Assist Chiropractors with Medicare Billing

Disclaimer:

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this document to provide nationally consistent education on topics of interest to health care professionals. The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate. Visit the CMS CERT webpage to learn about the CERT Program and review CERT Improper Payments Reports.

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