**Chiropractic Critical Documentation Requirements Documentation Requirement**

Documentation has become a key issue in the chiropractic office. This is particularly important when it comes to Medicare.

Chiropractic has failed two major documentation checks by the Office of the Inspector General.

2005

2009

2016

Most Medicare payments for chiropractic services did not comply with Medicare requirements. On the basis of our sample results, we estimated that $358.8 million, or approximately 82 percent, of the $438.1 million paid by Medicare for chiropractic services was unallowable. These overpayments occurred because CMS's controls were not effective in preventing payments for medically unnecessary chiropractic services.

Strong controls to prevent improper payments for chiropractic services are important to program integrity. For example, CMS could consider taking appropriate action to limit the number of chiropractic services that Medicare will reimburse to a specified maximum (e.g., 30 per beneficiary per year). If such a limit had been in place during our audit period, it would have prevented chiropractors from billing a high number of medically unnecessary services. Unless CMS implements strong controls, it is likely to continue to make improper payments to chiropractors.

The professions poor performance resulted in the appearance that chiropractic bills excessive amounts of non-covered maintenance care.

According to CMS and the Office of the OIG, chiropractic will continue to be audited and those chiropractors that fail, will be subject to two distinct penalties:

1. They will have to pay the money back to Medicare
2. They will be subject to pre-audit review

This is particularly interesting because Medicare specifically spells out all items required in their documentation.

The purpose of this class is to insure that:

1. You know the Medicare Documentation Requirements
2. You develop a documentation strategy that will result in proper documentation that demonstrates the medical necessity of your care.

The Rules:

According to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15: 30.5 Physician Services – Chiropractor’s Services

**B. Maintenance Therapy**

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

According to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15: 240 Chiropractic Services – General

**240.1.3 - Necessity for Treatment**

**(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)**

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.

Most spinal joint problems fall into the following categories:

* Acute subluxation-A patient’s condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient’s condition.
* Chronic subluxation-A patient’s condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review.

**240.1.5 - Treatment Parameters**

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The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already “set” and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an “intensive care” concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

**240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician’s Exam**

**(Rev. 1, 10-01-03) B3-2251.2**

Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

A subluxation may be demonstrated by an x-ray or by physical examination, as described below.

**1. Demonstrated by X-Ray**

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided 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. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

**2. Demonstrated by Physical Examination**

Evaluation of musculoskeletal/nervous system to identify:

Pain/tenderness evaluated in terms of location, quality, and intensity; Asymmetry/misalignment identified on a sectional or segmental level;

Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and

Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under “physical examination” are required, one of which must be asymmetry/misalignment or range of motion abnormality.

The history recorded in the patient record should include the following: Symptoms causing patient to seek treatment; Family history if relevant;

Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);

Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

Prior interventions, treatments, medications, secondary complaints.

**A. Documentation Requirements: Initial Visit**

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History as stated above.
2. Description of the present illness including: Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location, and radiation of symptoms; Aggravating or relieving factors;

Prior interventions, treatments, medications, secondary complaints; and Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

1. Evaluation of musculoskeletal/nervous system through physical examination.
2. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
3. Treatment Plan: The treatment plan should include the following: Recommended level of care (duration and frequency of visits); Specific treatment goals; and

Objective measures to evaluate treatment effectiveness.

1. Date of the initial treatment.

**B. Documentation Requirements: Subsequent Visits**

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History

Review of chief complaint; Changes since last visit;

System review if relevant.

1. Physical exam

Exam of area of spine involved in diagnosis;

Assessment of change in patient condition since last visit; Evaluation of treatment effectiveness.

1. Documentation of treatment given on day of visit.

When the above steps are completed, your documentation is complete, the necessity of care is proven, and your claim will be paid. And, should you be audited, you can withstand the audit.