Medicare Documentation Checklist for Chiropractic Doctors

What's Changed?

No substantive content updates.

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

Documentation Basics

Chiropractic documentation should include:

Patient Information

☐ Patient's name and date of service on all documentation

Subluxation Documentation Requirements

☐ Documentation of subluxation shown by x-ray:

- CT scan, MRI, or both showing subluxation of spine
- Documentation of your review of the x-ray, MRI, or CT, noting level of subluxation
- X-ray taken within 12 months before or 3 months after the start of treatment
  - 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.

Or

☐ Documentation of subluxation shown by physical exam, with at least 2 elements of the following (otherwise known as the "PART" system):

- P: Pain
- A: Asymmetry or misalignment
- R: Range of motion abnormality
- T: Tissue tone changes with 1 falling under asymmetry or misalignment or range of motion abnormality

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- ☐ Dated documentation of first evaluation
- ☐ Primary diagnosis of subluxation, including the level
- ☐ Any 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
- Past health history; family history (recommended)
- Mechanism of trauma (recommended)
- Quality and character of symptoms or problem (recommended)
- Onset, duration, intensity, frequency, location, and radiation 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

- 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, include specific manipulated areas and levels of spine

General Guidelines

- Make sure medical records show that the service is corrective treatment, not maintenance.
- Use the AT modifier on a claim for active or corrective treatment of acute or chronic subluxation but not 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 after medical review.

    Make sure you know these policies, along with any local coverage determination in your area, to better understand how active or corrective chiropractic services are covered.
- Include records for all service dates on a claim.
- Make sure documentation is legible and complete, including signatures.
- Include legible signatures and credentials of professionals giving 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 getting this information.
- Include an abbreviation key and a copy of the Advance Beneficiary Notice of Noncoverage (if applicable).
- Include any other documentation to support medical necessity of services billed and documentation specifically asked for in an additional documentation request (ADR) letter.

Resources

- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220
- MLN Matters® 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