Medicare Documentation

By

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Medical Necessity: "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."[1]

In other words, the area(s) of chief complaint must be consistent with the area(s) of examination, which must be consistent with the area(s) of adjustment, which must be consistent with the area(s) billed.

Required Documentation

- Initial Visit[2]
  - History
  - Description of present illness
  - Evaluation of musculoskeletal/nervous system through physical exam
  - Diagnosis
  - Treatment plan
  - Date of initial treatment

- Subsequent visits[3]
  - History
  - Physical exam
  - Documentation of treatment given on day of visit

- **History**[4]
  - The history recorded in the patient record should include the following:
  - Symptoms causing patient to seek treatment
  - Family history, if relevant
  - Past history (general health, prior illness, injuries or hospitalizations, medications, surgical history)
  - Social history (not required, but advisable)
  - Mechanism of trauma
  - Quality and character of symptoms/problem
  - Onset, duration, intensity, frequency, location, and radiation of symptoms
  - Aggravating and relieving factors

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[1] Medicare Benefit Policy Manual Chapter 15, Section 240.1.3
[2] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(A)
[3] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(B)
[4] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2

- Prior interventions, treatments, medications, secondary complaints

- **Description of present illness**[5]
    - The description of present illness should include:
    - Symptom causing patient to seek treatment
    - 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 and secondary complaints

These points can be covered in the History section

Description of present illness[6]

"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 (I), 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 subluxation that has been cited. A statement on the claim that there is "pain" is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined."

X-rays

"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 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."[7]

Certain conditions require an x-ray to establish the diagnosis (e.g., Degenerative Disc Disease)

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[5] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(A)
[6] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(A)
[7] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(1)

If you list one of these diagnoses, you must have an x-ray and an x-ray report on file.

Certain conditions require an MRI to establish the diagnosis (e.g., Displacement of Intervertebral Disc)

If you list one of these diagnoses, you must have an MRI report on file.

Evaluation of Musculoskeletal/Nervous System Through Physical Exam

- Orthopedic Tests
  - Use standard orthopedic tests for the area indicated
  - Diagnosis should be consistent with test results

- Neurological Tests
  - Use standard neurological tests (reflexes and pin-prick sensitivity) for the area indicated
  - Diagnosis should be consistent with test results
  - The orthopedic tests, reflexes, and pin-prick sensitivity tests are primarily for the purpose of ruling out pathological processes.

- Range of Motion Testing
  - The gold standard as defined by the AMA is dual digital inclinometry
  - You should document the measurement technique that you use
  - Range-of motion testing is where changes in sectional mobility are noted for P.A.R.T.

- Muscle Strength Testing
  - You can use either manual muscle testing or mechanically assisted muscle testing (such as Jtech)
  - Document the method used
  - The range-of-motion and muscle strength tests are primarily for functional assessment of the area of the spine tested.

P.A.R.T.

- P.A.R.T. consists of the following:
  - “P = Pain/tenderness evaluated in terms of location, quality, and intensity
  - A = Asymmetry/misalignment identified on a sectional or segmental level
  - R = Range-of-motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility)
  - T = 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 above are required, one of which must be asymmetry/misalignment or range-of-motion abnormality."[8]
- Range-of-motion testing and palpation are where the pain/tenderness, asymmetry/misalignment, changes in segmental mobility, and tissue, tone changes are noted for P.A.R.T.
- A physical (palpitory) exam is used to evaluate the musculo-skeletal/nervous system…

- Palpation
  - Palpation is the manual inspection of the area of the spine indicated in the complaint.
  - This is where the pain/tenderness, asymmetry/misalignment, changes in segmental mobility, and tissue, tone changes are noted for P.A.R.T.

Contributions from common indicators to the P-A-R-T formula.
"Common Indicators of subluxation include examination techniques (visual inspection, palpation, range of motion, strength testing, and chiropractic mechanical function testing) as well as instrumentation techniques. Common contributions from each test to the P-A-R-T formula for subluxation diagnosis are shown below.

1.) Examination

1a. Visual Inspection including postural analysis A

1b. Palpation
i. Muscular spasm A/T
ii. Muscle tenderness P/T
iii. Osseous malposition A
iv. Osseous tenderness P/T
v. Motion, restricted R
vi. Motion, excessive R

1c. Range of motion by spinal region (estimated), including thoracic excursion with respiration R/A

1d. Muscle strength testing
i. Manual T
ii. Mechanical (including computerized) T

1e. Chiropractic Mechanical Function Testing
i. Apparent/functional leg length comparison tests P/A/R/T
ii. Cervical function tests P/A/R/T

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[8] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(2)

iii. Pelvic function tests P/A/R/T
iv. Symmetrical motion testing P/A/R/T
v. Other specialized tests P/A/R/T

1f. Postural Evaluation
i. Antalgic posture P/A/R
ii. Scoliosis A/R/T
iii. Asymmetry of neck, head, shoulders, hips, etc. A/R

2A. Instrumentation
i. Bilateral or four quadrant scales A
ii. Skin temperature reading instruments T
iii. Ranges of motion by spinal region R
iv. Pressure algometry P/T
v. Spirometry R
vi. Surface electromyography T

2B.Imaging
i. Videofluoroscopy A/R/T
ii. Reference to plain film radiographs A/R/T
iii. Reference to Magnetic Resonance Images A/T
iv. Reference to Computerized Tomography images A/T
v. Thermography T"[9]

Outcome Assessment Questionnaires

The outcome assessment questionnaires are utilized to gauge the functional ability of the patient as a whole and to assess progress. This is a key element of the treatment plan and should be utilized with all patients, not just Medicare patients.

- The main outcome assessment questionnaires used are:
- Roland-Morris Questionnaire
- Revised Oswestry Low Back Pain Disability Questionnaire
- Neck Disability Questionnaire

- Some other specialized questionnaires are:
  - Headache Disability Index
  - Shoulder Evaluation Form
  - Carpal Tunnel Questionnaire

    Tinnitus Handicap Inventory

Subsequent Visit Documentation

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

- History

[9] Excerpted from the Local Coverage Determination for Maine (L3172), Jurisdiction 14, Pages 9-10

    - Review of chief complaint
    - Changes since last visit
    - System review if relevant
- Physical Exam
    - Exam of area of spine involved in diagnosis
    - Assessment of change in patient condition since last visit
    - Evaluation of treatment effectiveness
- Documentation of treatment given on day of visit"[10]

In other words:

- The patient is improved HOW?
- The patient needs care WHY?
- The patient was adjusted WHERE?

S.O.A.P

- S = History and chief complaint
- O = Exam and outcome assessment questionnaire
- A = Assessment
    - This is where you get to be the doctor
    - Put you opinion here
- P = Treatment plan

The SOAP note was designed for the practice style of a MD.
We practice a little differently.

Assessment Visit

The record requirements for the assessment visit would be the same as for a medical doctor; we note all subjective findings from the patient, we record all objective test results and observations, we assess the patient's condition and note it in the notes and diagnosis, and we formulate a plan of treatment with measurable goals.

Treatment Visit

The treatment visits are where we put the plan developed during the assessment visit into action.

We would continue to note subjective statements from the patient regarding changes in their condition and objective findings from palpation

The assessment would be limited to determining if the patient is "on course" or not.

During the treatment visit, the treatments and therapies administered to the patient and the patient's response to them should be noted.

To develop an accurate picture of patient care another doctor or a reviewer would need a "block" of records including the records of the assessment visits before and after the

[10] Medicare Benefit Policy Manual Chapter 15, Section 240.1.2(B)

date in question as well as all of the treatment visit records for the visits that occurred between those assessment visits.