



## 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 guidance includes, 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
  - 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

## 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 (recommended)
- Specific treatment goals (recommended)
- Objective measures to evaluate treatment effectiveness (recommended)

## 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.  
Be aware of these policies along with any local coverage determination in your area to better understand how active/corrective chiropractic services are covered.
- 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)

**NOTE:****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](#)

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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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