Medicare Documentation Job Aid for Chiropractic Doctors

Documentation Basics:
Chiropractic Documentation should include:

	Present	Not Present	N/A	Notes/Comments
Patient Information:				
Include the patient's name and date of service on all pages of documentation	☐	☐	☐	_____
Subluxation Documentation Requirements:				
Include documentation of subluxation shown by x-ray or physical exam	☐	☐	☐	_____
Include a CT scan and or MRI showing subluxation of spine	☐	☐	☐	_____
Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation	☐	☐	☐	_____
Include x-rays taken within 12 months before or 3 months following the beginning of treatment	☐	☐	☐	_____

Note - *In some cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record shows the condition existed longer than 12 months and it's reasonable to conclude the condition is permanent*

OR

Include documentation of subluxation shown by physical examination. Documentation must show at least 2 elements of:

Pain	☐	☐	☐	_____
Asymmetry/misalignment	☐	☐	☐	_____
Range of motion abnormality	☐	☐	☐	_____
Tissue tone changes (P.A.R.T.), including 1 that falls under asymmetry/misalignment or range of motion abnormality	☐	☐	☐	_____
Include dated documentation of the first evaluation	☐	☐	☐	_____
Include primary diagnosis of subluxation (including level of subluxation)	☐	☐	☐	_____
Include any documentation supporting medical necessity	☐	☐	☐	_____

Initial Evaluation:	**Present**	**Not Present**	**N/A**	**Notes/Comments**
History	☐	☐	☐	_____
Date of initial treatment	☐	☐	☐	_____
Description of current illness	☐	☐	☐	_____
Symptoms related to level of subluxation causing patient to seek treatment	☐	☐	☐	_____
Family history (recommended)	☐	☐	☐	_____
Past health 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 issues (recommended)	☐	☐	☐	_____
Past interventions, treatments, medication, and secondary complaints (recommended)	☐	☐	☐	_____
Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended)	☐	☐	☐	_____
Physical examination (P.A.R.T.)	☐	☐	☐	_____
Evaluation of musculoskeletal and nervous system through physical examination	☐	☐	☐	_____
Treatment given on day of visit (if relevant)	☐	☐	☐	_____
Include specific areas and levels of the spine that you manipulated	☐	☐	☐	_____
Medicare may cover treatment using hand-held devices. But Medicare doesn't offer more payment or 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 Visits:				
History	☐	☐	☐	_____
Review of chief complaint	☐	☐	☐	_____
Changes since last visit	☐	☐	☐	_____
System review, if relevant	☐	☐	☐	_____
Physical examination (P.A.R.T.)	☐	☐	☐	_____
Assessment of change in patient's condition since last visit	☐	☐	☐	_____
Evaluation of treatment effectiveness	☐	☐	☐	_____
Treatment given on day of visit (include specific areas and levels of spine that you manipulated)	☐	☐	☐	_____