Functional Outcome Assessment Tools for Documentation Compliance

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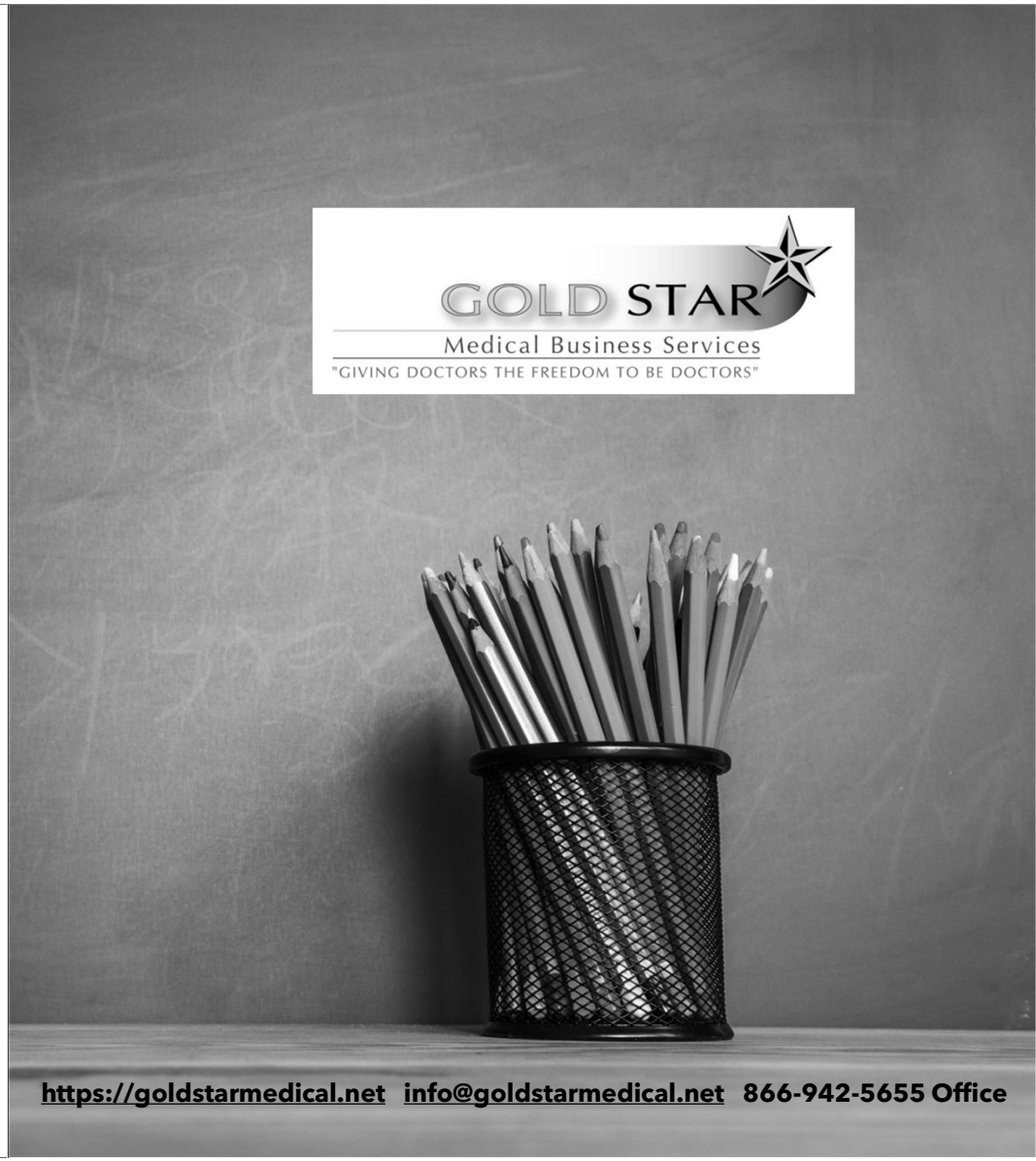

GOLD STAR

Medical Business Services

"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"

LISA MACIEJEWSKI-WEST: CMC, CMOM, CMIS CPMA-I, CPCO-I

- Owner/Founder Gold Star Medical Business Services
- 43 years in Chiropractic
- Certified Professional Medical Auditor (CPMA-AAPC)
- Certified Professional Compliance Officer (CPCO-AAPC)
- Certified AAPC Instructor
- UVCA/ChiroCongress Insurance Helpdesk
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- Member Chiropractic Future Strategic Plan Technical and Reimbursement Committees
- Member TX Chiropractic Association Insurance Reimbursement Committee

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The antitrust laws seek to preserve a free competitive economy and trade in the United States and in commerce with foreign countries. Competitors may not restrain competition among themselves with reference to the price, the quality or the distribution and outputs of their products, and they may not act in concert to restrict the competitive capabilities or opportunities of their competitors, their suppliers or their customers.

Since you have an important responsibility in ensuring antitrust compliance in your healthcare activities, you should comply with the following guidelines:

Don't discuss with other providers your own or competitors' prices, or anything that might affect prices such as costs, discounts, terms of sale, or profit margins.

2. Don't make public announcements or statements about your own prices or those of competitors.
3. Don't make derogatory statements relating to the incompetence, fees or policies of insurance companies or companies providing ancillary services
4. Don't threaten or recommend an embargo of a certain company. This includes statements relating to recommendation of withdrawing from certain insurance plans
5. Don’t stay present where any of the above discussions are taking place.
6. Remember that meetings with government officials may not provide a shield against antitrust liability.
7. Remember that the antitrust guidelines apply to all communications, whether in person, by telephone, email, or any other means.
8. **Confer with counsel before bringing up any topic or making any statement which may implicate any of the above guidelines, or which may otherwise have competitive ramifications.**

How Medical Policy Dictates Patient Care and Documentation

MEDICAL POLICIES

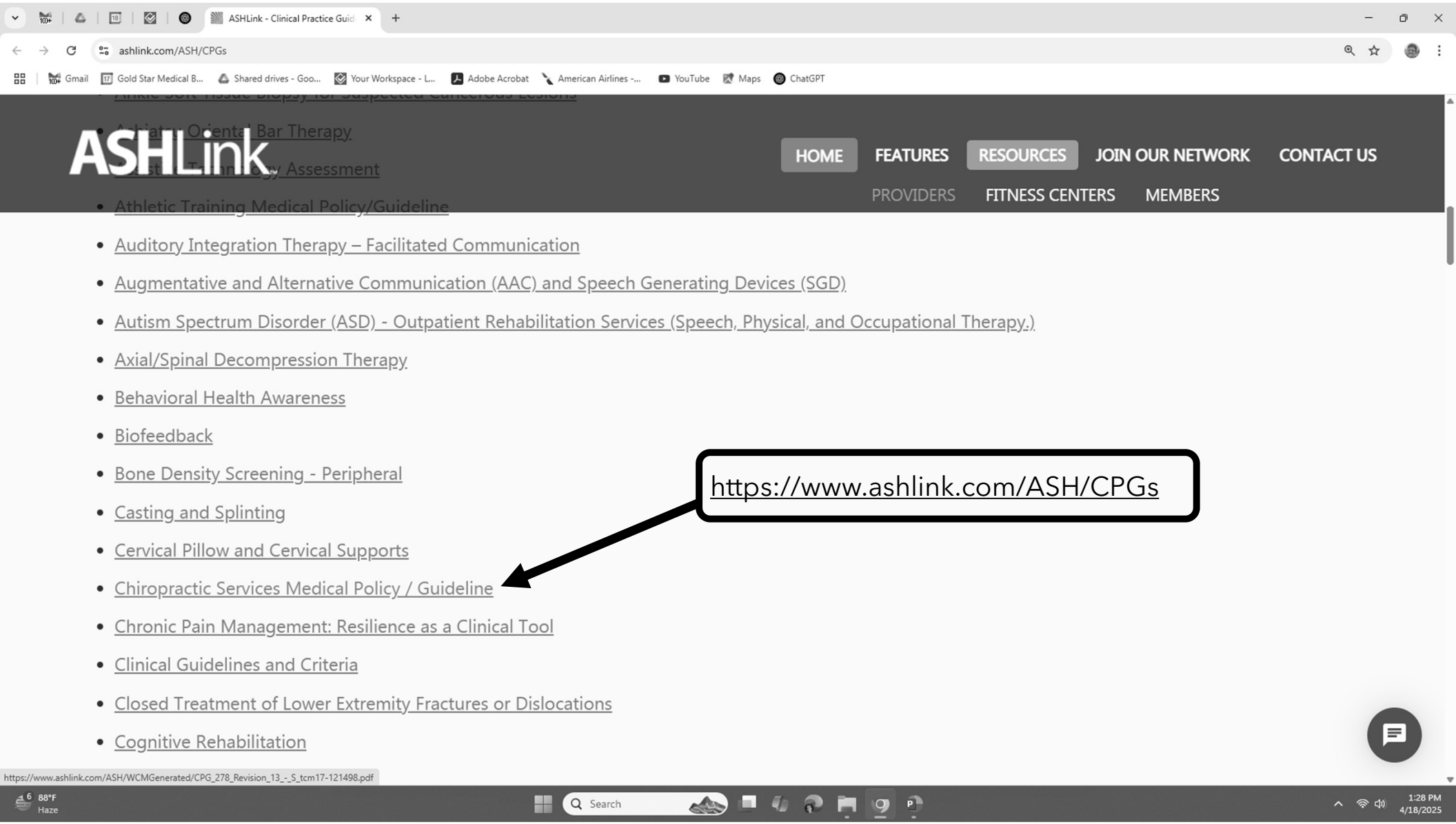
- Developed by Payers, not standardized
- Outlines the PAYER's rules for utilization and documentation
- Used by Payers as a template for Audits
- Treatments that fall outside the payer's guidelines may be denied for Medical Necessity
- Treatments that fall outside the payer's guidelines may be considered to be Experimental/Investigational

How to Find a Policy

Payers may develop their own policies, but most of them "Adopt" policies from Medicare and other organizations designed to create them.

Start at the Payer site. You may be redirected to another Website.

Example, Anthem VA will redirect the Chiropractic Policy Guidelines to ASHN or Carelon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ChatGPT
ASHLink
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FEATURES
RESOURCES
JOIN OUR NETWORK
CONTACT US
PROVIDERS
FITNESS CENTERS
MEMBERS
Athletic Training Medical Policy/Guideline
Auditory Integration Therapy – Facilitated Communication
Augmentative and Alternative Communication (AAC) and Speech Generating Devices (SGD)
Autism Spectrum Disorder (ASD) - Outpatient Rehabilitation Services (Speech, Physical, and Occupational Therapy.)
Axial/Spinal Decompression Therapy
Behavioral Health Awareness
Biofeedback
Bone Density Screening - Peripheral
Casting and Splinting
Cervical Pillow and Cervical Supports
Chiropractic Services Medical Policy / Guideline
Chronic Pain Management: Resilience as a Clinical Tool
Clinical Guidelines and Criteria
Closed Treatment of Lower Extremity Fractures or Dislocations
Cognitive Rehabilitation
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HIGHLIGHTS OF THE ASHN MEDICAL POLICY

- ASHN Policy is 62 pages long. **The words "Function", "Functional" are used 79 times.**
- Provides a comprehensive guideline for documentation and medical necessity criteria for all types of Chiropractic treatments and modalities
- Provides a guideline for exams and re-exams
- Discusses conditions (diagnoses) in which Chiropractic Treatment is considered to be experimental/investigational
- Provides guidelines for referral for additional diagnostics and/or treatment
- Full Transcript of the ASHN policy is available on Request.

3. REHABILITATIVE CHIROPRACTIC SERVICES

Medically Necessary

Rehabilitative chiropractic services are considered **medically necessary** when **ALL** the following criteria are met:

1. The services are delivered by a qualified practitioner of chiropractic services; and
2. The services require the judgment, knowledge, and skills of a qualified practitioner of chiropractic services due to the complexity and sophistication of the therapy and the medical condition of the individual; and
3. The service is aimed at diagnosis, treatment, and/or prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health; and
4. The service is for conditions that require the unique knowledge, skills, and judgment of a Chiropractor for education and training of the patient that is part of an active skilled plan of treatment; and
5. There is a clinically supported expectation that the service will result in a clinically significant level of functional improvement within a **reasonable and predictable period of time***; and
    - Improvement or restoration of function could not be reasonably expected as the individual gradually resumes normal activities without the provision of skilled therapy services; and
    - The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation of continuation of rehabilitative services.

Reasonable and predictable period of time: The specific time frames for which one would expect practical functional improvement is dependent on various factors including whether the services are Rehabilitative or Habilitative services. A reasonable trial of care for rehabilitative services to determine the patient's potential for improvement in or restoration of function is generally up to 4 weeks and is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors). Habilitative services may be prolonged and are primarily influenced by the type of ADLs or IADLs which have not developed, or which are at risk of being lost.

WHAT DOES THIS TELL YOU?

1. The guidelines provide expectation of "clinically significant level of **Functional Improvement**"
2. The guidelines provide a time frame for these expectations to be met "A reasonable trial of care…..**for improvement in or restoration of function** is generally **up to 4 weeks**"

(2) Rehabilitative chiropractic services are considered **not** medically necessary if **any** of the following is determined:

1. The service is **not** aimed at diagnosis, treatment, and prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health.
2. The service is for conditions for which therapy would be considered routine educational, training, conditioning, or fitness. This includes treatments or activities that require only routine supervision.
3. The expectation does **not** exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (up to 4 weeks).
    - If, absent supervised care, function could reasonably be expected to improve at the same / similar rate as the individual gradually resumes normal activities, then the service is considered **not** medically necessary.
    - If an individual's expected restoration potential would not produce a meaningful improvement in relation to the extent and duration of the service required to achieve such potential, the service(s) would be considered **not** medically necessary.
    - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks).
    - The patient has reached maximum therapeutic benefit.

6. CLINICAL DOCUMENTATION

Medical record keeping an essential component of patient evaluation and management. Medical records should be legible and should contain, at a minimum sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Good medical record keeping improves the likelihood of a positive outcome and reduces the risk of treatment errors. It also provides a resource to review cases for opportunities to improve care, provides evidence for legal records, and offers necessary information for third parties who need to review and understand the rationale and type of services rendered (e.g., medical billers and auditors/reviewers).

Outcome measures are important in determining effectiveness of a patient's care. The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures provide information about whether predicted outcomes are being realized. When comparison of follow-up with baseline outcome metrics does not demonstrate minimal clinically important difference (MCID) (minimal amount of change in a score of a valid outcome assessment tool) the treatment plan should be changed or be discontinued. Failure to use Functional Outcome Measures (FOMs) / Outcome Assessment Tools (OATs) may result in insufficient documentation of patient progress and may result in an adverse determination (partial approval or denial) of continued care.

6.1 Evaluation and Re-evaluations

As a best practice, all the following should be clearly described in the submitted records:

- Historical information including a clear description of the current complaint(s)
- Prior and current levels of function
- Tests performed and the results (e.g., evaluation findings)
- Valid diagnosis(es)
- Therapeutic goals and treatment plan (e.g., specific treatments, number of office visits)
- Response to care, progress, and prognosis
- Self – Care advice, including home exercise program

A reevaluation is considered medically necessary following a trial of care to determine whether that care resulted in significant clinical improvement documenting the need to continue a course of therapy, if modification of the approach to care is warranted, if there is need for referral to other healthcare practitioner(s)/specialist(s), or that discontinuance of treatment is warranted.

A reevaluation (an Established Patient E/M service) is considered medically necessary when **all** of the following conditions are met:

- The reevaluation exceeds the recurring routine assessment of patient status included in the work value of the Chiropractic Manipulation CPT® codes work-value; and
- The documentation of the reevaluation includes **all** of the following elements:
  - An evaluation of progress toward current goals; and
  - Making a professional judgment about continued care; and
  - Making a professional judgment about revising goals and/or treatment or terminating services; and
- Any **one** of the following indications is documented:

  - The patient presents with an exacerbation, a new condition(s), or new clinical findings.
  - There is a significant change in the patient's condition(s).
  - The patient has failed to respond to the therapeutic interventions outlined in the current plan of care.

In order to reflect that continued chiropractic services are medically necessary, intermittent progress reports must demonstrate that the patient is making functional progress. Progress reports should be maintained in the medical record and may be required for approval of coverage of services.

A reevaluation is considered **not** medically necessary once it has been determined that the patient has reached maximum therapeutic benefit from the services provided unless there is/are medically necessary reason(s) documented for the reevaluation service.

7.3 Critical Factors during Clinical Reviews

The complexity and/or severity of historical factors, symptoms, examination findings, and functional deficits play an essential role to help quantify the patient's clinical status and assess the effectiveness of planned interventions over time. CQEs consider patient-specific variables as part of the medical necessity verification process. The entire clinical picture must be taken into consideration with each case evaluated based upon unique patient and condition characteristics.

Such variables may include, but not be limited to co-morbid conditions and other barriers to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the symptoms, functional deficits, and exam findings, as well as social and psychological status of the patient and the available support systems for self-care. In addition, the patient's age, symptom severity, and the extent of positive clinical findings may influence duration, intensity, and frequency of services approved as medically necessary. For example:

What does Medicare Say about “Functional Performance”?

Medicare coverage of chiropractic

30.5 - Chiropractor's Services
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)
B3-2020.26

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet the following uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

CONDITIONS THAT WARRANT ACTIVE TREATMENT

- 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.

CONDITIONS THAT WARRANT ACTIVE TREATMENT

- 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.

MAINTENANCE THERAPY

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.

HOW TO DOCUMENT FUNCTIONAL DEFICITS AND FUNCTIONAL IMPROVEMENT

DOCUMENTING PAIN VS. FUNCTION

PAIN

Patient-reported symptoms: Pain is documented based on the patient's subjective description, often using a scale (e.g., 0–10), or descriptors like sharp, dull, throbbing, etc.

Location and radiation: Documentation should include where the pain is, whether it radiates, and whether it's aggravated or relieved by certain movements.

Changes over time: Improvement or worsening of pain is used to justify continuation or discontinuation of care.

FUNCTION

The patient's ability to perform **activities of daily living (ADLs)** or **range of motion/mobility**, such as:

•Walking, bending, lifting, dressing, bathing, or sleeping.

•Range of motion or flexibility of the spine or extremities.

•Muscle strength and coordination.

•Work or recreational activity capabilities.

How to document and monitor function

OATS! **O**utcome **A**ssessment **T**ool**S**

- **Use standardized tools whenever possible.**

FINDING YOUR OATS

- Check with your EMR to see if OATS templates are available
- Online Tool: https://orthopaedicscore.com
  - Use this tool to have patient fill out online. Automatically grades the assessment.
  - Create a PDF and upload to patient's chart or print (if still using paper charts)
  - Available for multiple anatomical areas/extremities

COMMON OATS

STANDARD TOOLS (not all inclusive)

- **Oswestry Low Back Pain Disability Questionnaire**
- **Neck Disability Index - Vernon and Mior Cervical Spine Questionnaire**
- **Arm/Shoulder/Hand – DASH (D**isabilities of **A**rm, **S**houlder, **H**and**)**
- **Hips – WOMAC (W**estern **O**ntario and **Mc**Master Universities Osteoarthritis Index)
- **Knees – KOOS (K**nee Injury and **O**steoarthritis **O**utcome **S**core)
- **Shoulder - ASES Shoulder Score** (**A**merican **S**houlder and **E**lbow **S**urgeons Standardized Shoulder Assessment)
- **General Pain** – **VAS** (**V**isual **A**nalog **S**cale) Not an outcome assessment tool to rate Function, but to monitor pain levels throughout a patient's treatment plan

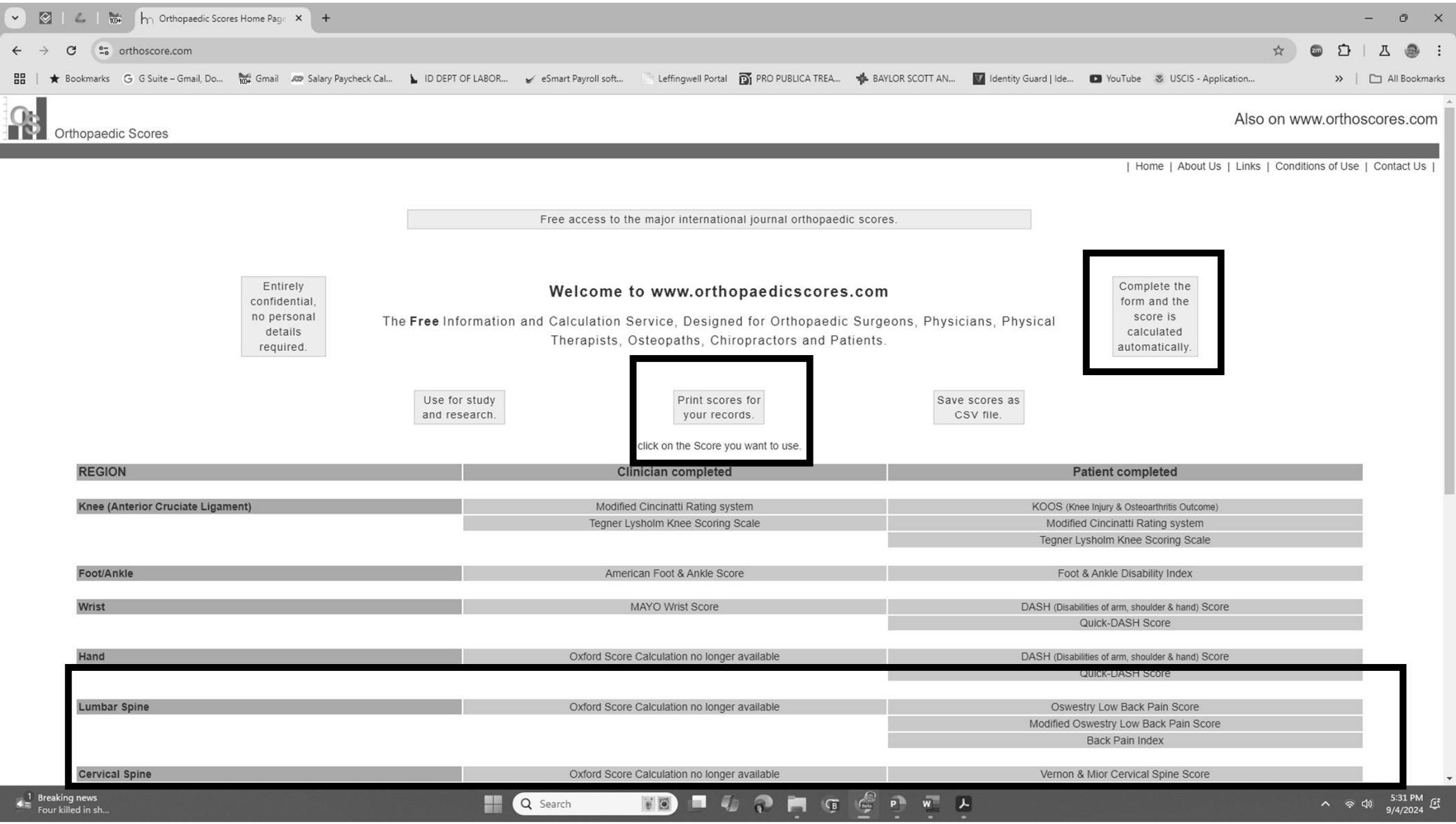
FREQUENCY OF OATS

New Patient Initial Intake

New Injury/ Re-Injury

At the Re-Exam

At the Final Eval prior to patient Release from Care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Complete the form and the score is calculated automatically.
Use for study and research.
Print scores for your records.
Save scores as CSV file.
click on the Score you want to use.
REGION
Clinician completed
Patient completed
Knee (Anterior Cruciate Ligament)
Modified Cincinatti Rating system
Tegner Lysholm Knee Scoring Scale
KOOS (Knee Injury & Osteoarthritis Outcome)
Modified Cincinatti Rating system
Tegner Lysholm Knee Scoring Scale
Foot/Ankle
American Foot & Ankle Score
Foot & Ankle Disability Index
Wrist
MAYO Wrist Score
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Hand
Oxford Score Calculation no longer available
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Lumbar Spine
Oxford Score Calculation no longer available
Oswestry Low Back Pain Score
Modified Oswestry Low Back Pain Score
Back Pain Index
Cervical Spine
Oxford Score Calculation no longer available
Vernon & Mior Cervical Spine Score
Breaking news
Four killed in sh...
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Wrist	MAYO Wrist Score	DASH (Disabilities of arm, shoulder & hand) Score
		Quick-DASH Score
Hand	Oxford Score Calculation no longer available	DASH (Disabilities of arm, shoulder & hand) Score
		Quick-DASH Score
Lumbar Spine	Oxford Score Calculation no longer available	Oswestry Low Back Pain Score
		Modified Oswestry Low Back Pain Score
		Back Pain Index
Cervical Spine	Oxford Score Calculation no longer available	Vernon & Mior Cervical Spine Score
Psychological	Oxford Score Calculation no longer available	DRAM (Distress and Risk Assessment Method)
Hip	Harris Hip Score	Oxford Hip Score
		HOOS (Hip disability and Osteoarthritis Outcome)
		WOMAC Score
Knee (Osteo Arthritis)	Knee Society Score (KSS)	Oxford Knee Score
		KOOS (Knee Injury & Osteoarthritis Outcome)
		WOMAC Score
		IKDC
Shoulder	Constant Shoulder Score	Oxford Shoulder Score
		ASES
	UCLA Shoulder rating scale	DASH (Disabilities of arm, shoulder & hand) Score
		Quick-DASH Score
Shoulder (Instability)	Rowe Score for Instability	Oxford Instability Score
		WOSI (Western Ontario Shoulder Instability Index)
Elbow	MAYO Elbow Score	Oxford Elbow Score
		DASH (Disabilities of arm, shoulder & hand) Score
		Quick-DASH Score
VAS	VAS Score	VAS Score

If you have any suggestions or recommendations, please contact us at suggestions@orthopaedicscores.com

www.orthopaedicscores.com

Date of completion
September 4, 2024

Oswestry Low Back Pain Disability Questionnaire

Clinician's name (or ref) Curtis Dearmont, DC

Patient's name (or ref)
Lisa Maciejewski-West

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition today.

During the past 4 weeks.....

Section 1 - Pain Intensity
- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ◉ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

Section 2 - Personal Care (e.g., Washing, Dressing)
- ○ I can look after myself normally without causing extra pain
- ◉ I can look after myself normally but it is very painful
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help but manage most of my personal care
- ○ I need help every day in most aspects of self care
- ○ I do not get dressed, wash with difficulty and stay in bed

Section 3 - Lifting
- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights but it gives extra pain
- ◉ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ○ I can lift only very light weights.
- ○ I cannot lift or carry anything at all.

Section 4 - Walking
- ○ Pain does not prevent me from walking any distance.
- ◉ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ○ Pain prevents me from walking more than 1/4 mile.
- ○ Pain prevents me from walking more than 100 yards.
- ○ I can walk only with crutches or a stick.
- ○ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ○ I can sit in any chair as long as I like

Section 6 - Standing
- ○ I can stand as long as I want without extra pain.
- ○ I can stand as long as I want but it extra my pain.
- ◉ Pain prevents me from standing for more than 1 hour.
- ○ Pain prevents me from standing for more than ½ an hour.
- ○ Pain prevents me from standing for more than 10 minutes.
- ○ Pain prevents me from standing at all.

Section 7 - Sleeping
- ○ My sleep is never disturbed by pain.
- ○ My sleep is occasionally disturbed by pain.
- ◉ Because of pain I have less than 6 hours sleep.
- ○ Because of pain I have less than 4 hours sleep.
- ○ Because of pain I have less than 2 hours sleep.
- ○ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)
- ○ My sex life is normal and causes no extra pain.
- ◉ My sex life is normal but causes some extra pain.
- ○ My sex life is nearly normal but is very painful.
- ○ My sex life is severely restricted by pain.
- ○ My sex life is nearly absent because of pain.
- ○ Pain prevents any sex life at all

Section 9 - Social Life
- ○ My social life is normal and causes me no extra pain.
- ○ My social life is normal, but increases the degree of pain.
- ◉ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, dancing).
- ○ Painhas restricted my social life and I do not go out as often.
- ○ Pain has restricted my social life to my home.
- ○ I have no social life because of my pain.

Section 10 - Traveling
- ○ I can travel anywhere without pain.

- ○ I can sit in my favourite chair for as long as I like
- ◉ Pain prevents me from sitting for more than 1 hour.
- ○ Pain prevents me from sitting for more than ½ an hour
- ○ Pain prevents me from sitting for more that 10 minutes
- ○ Pain prevents me from sitting at all.

- ○ I can travel anywhere, but it gives extra pain.
- ○ Pain is bad but I mangage journeys of over 2 hours.
- ◉ Pain restricts me to journeys of less than 1 hour.
- ○ Pain restricts me to short necessary journeys under 30 minutes
- ○ Pain prevents me from travelling except to recieve treatment

Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? (Please tick the appropriate box.)
- ◉ Yes
- ○ No

.....if yes, please state the type of treatment you have received)

day)

Print page | Close Window | Reset

To save this data please print or Save As CSV

Nb: This page cannot be saved due to patient data protection so please print the filled in form before closing the window.

Reference for Score: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy. 1980 Aug;66(8):271-3. link

The Oswestry Low back pain Score is:
36 %

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Patient should fill out OATS at initial exam, re-eval and/or any time patient is returning for care to treat a Chronic Condition or a New Condition.

RECOMMEND: Review the entries and score from previous OATS to determine if the patient has had a decrease in function or ADLs.

ELEMENTS OF A COMPLETE MEDICAL RECORD (PATIENT/ADMIN FORMS)

*Most payers will require that you send these forms/documents if/when you are subject to a pre or post payment audit.

- *Patient Intake Forms
- *** OATS**
- Copies of Patient's insurance cards (front and back)
- *NSA Forms (Notice of Non-Participation in patient's plan, Good Faith Estimate)
- Insurance Questionnaire/Verification of Benefits
- *ABN's
- *Copies of PA's/Referrals, if applicable
- *Accident Questionnaire/Copies of Police or Employer Reports (for PI or WC cases)

ELEMENTS OF A COMPLETE MEDICAL RECORD (PROVIDER FORMS)

- Initial/Subsequent Exam notes
- Daily Procedure notes
- Exam forms (PART, Record of Ortho/Neuro Tests performed)
- Written Plan Of Care
- Copies of Prior Medical Records, if relevant
- Imaging reports/studies
- Therapy/rehab flow sheets, if applicable

ELEMENTS OF A GOOD SOAP NOTE TEMPLATE

S = SUBJECTIVE (PATIENT REPORT)

S – Subjective:

Pain description:
Patient reports [type of pain] at [location], rated [0–10 scale]. Pain is [constant/intermittent], worsens with [activity], relieved by [rest/activity/ice/etc.].

Pain change:
Compared to last visit, pain has [improved/stayed the same/worsened] from [previous rating] to [current rating].

****Functional impact**:**
Patient reports/previously reported difficulty with [ADL or functional activity], such as [e.g., walking, sitting, bending, lifting]. Since last visit, reports [improvement/worsening/no change] in ability to [specific functional task].

O = OBJECTIVE FINDINGS (PROVIDER)

O – Objective:

Observation/Posture/Gait:
Posture is [normal/antalgic/etc.]. Gait is [steady/unsteady/etc.].

Palpation findings:
[Tenderness/muscle spasm] noted at [spinal levels].

Range of motion (ROM):
Lumbar/Cervical ROM: [List degrees and changes from previous visit].

Orthopedic/Neurologic tests:
[Test name]: [Results]. Compare to previous visit.

A = ASSESSMENT (PROVIDER)

A – Assessment:

[Spinal region] segmental dysfunction/subluxation identified at [levels].

Patient is demonstrating [objective/subjective] improvement in [pain/function].

Condition is [acute/subacute/chronic], and care remains [medically necessary/supportive/maintenance (not covered)]

P = PLAN OF CARE (PROVIDER)

P – Plan:

Treatment Given that Day (LIST ALL TREATMENTS AND MODALITIES):
Continue spinal manipulation [frequency] for [duration].

Re-evaluation:
Reassess outcomes after [#] visits.

Home care/exercises:
Patient instructed to [exercise/stretch/ergonomic change/etc.].

PRO TIPS

- Be sure to document Chief Complaint **at each visit**

  "Patient here today for ongoing treatment of pain/dysfunction of the low back due to spinal stenosis"

  "New Patient presents today with Severe neck pain and complaint of chronic headaches"

- Always link subjective pain reports with functional impact.
- Show progress over time or justify why care continues if progress is slow.
- Make sure you are adhering to the healthcare industry's STANDARD DOCUMENTATION PRACTICES

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

1. The medical record should be complete and legible.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

2. The documentation of each patient encounter should include: the **date**; **reason for the encounter**; **appropriate history and physical exam**; **review of** lab, **X-ray data and other ancillary services and**, when appropriate, **assessment; and a plan of care** (including discharge plan, if appropriate)

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

3. **Past and present** diagnoses should be accessible to the treating and/or consulting physician

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

4. **The reasons for** and **results of X-rays**, lab tests and **other ancillary services** should be documented or included in the medical record. In many records, **the order and/or intent for the service to be performed is missing.**

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

5. Relevant health risk factors should be identified

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

6. The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance should be documented.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

7. The written plan of care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals; patient/family education; and specific instructions for follow-up.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

8. The documentation should support the medical necessity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

9. All entries to the medical record should be dated and authenticated by physician/provider signature. Medical documentation with missing or invalid signatures fails to meet the CMS signature requirements and may result in claim denial.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

10. The CPT/HCPCS/ICD-10-CM codes reported on the claim should reflect the documentation in the medical record.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

FORMS FROM YOUR EMR

Check with your EMR software vendor to find out what patient forms and/or templates are available for your, or your patient's use. Many software programs designed for chiropractic have templates of relevant forms, including OATS, consult forms, intake forms, etc. Save time by having patient fill out online forms that save directly to their chart.

FORMS EXAMPLES

Copies of these forms are available on request. May be used to create your own fillable documents or templates. Request copies of forms by emailing Lisa Maciejewski-West at info@goldstarmedical.net

Refer to the Forms Disclaimer for more information.

NAME OF CLINIC

NEW PATIENT INTAKE FORM

Date:_____ Patient #_____ **Doctor/Provider:_____**

Name:_____ Primary Phone: _____ (circle) Home Cell Work

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Alternate Phone: _____

MAY WE: (circle all that apply) CALL CELL CALL HOME CALL WORK EMAIL MAIL **you about**

APPOINTMENT REMINDERS ACCOUNT UPDATES CLINIC EVENTS BIRTHDAYS/ANNIVERSARIES

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other/Non-Insured/Cash

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ PATIENT DOB _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

WHEN DID SYMPTOMS APPEAR? _____ Are they getting worse? ☐ YES ☐ NO

IF VISIT IS DUE TO ACCIDENT Date accident happened (if applicable): _____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Do you have any Congenital Condition? ☐Yes ☐ No If YES, Describe _____

_____

Women: Are you pregnant?_____ Date of last Menstrual Period _____

HEALTH ISSUES AND CONDITIONS: Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

HEALTH ISSUES AND CONDITIONS (Continued)

Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use - Daily Occasionally Never

_____ Drug Use - Daily Occasionally Never

_____ Tobacco Use - Daily Occasionally Never

_____ Caffeine - Daily Occasionally Never

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

REVIEWED BY:
DATE:
PRINT NAME:

CONSULTATION QUESTIONNAIRE-HISTORY OF PRESENT ILLNESS

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS ——— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Patient/Guardian Signature_____ Date _____

Provider Signature _____ Date _____

CONSULTATION QUESTIONNAIRE

ACCORDING TO E/M CODING GUIDELINES, THIS PART OF THE PATIENT'S HISTORY CAN BE RECORDED BY ANCILLARY STAFF AND REVIEWED/CONFIRMED BY PROVIDER DURING THE EXAM.

SAVE PROVIDER TIME. TRAIN YOUR BACK OFFICE CA/MA ON HOW TO DO THE INITIAL CONSULT.

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

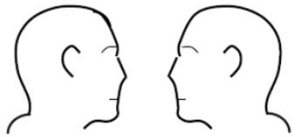
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

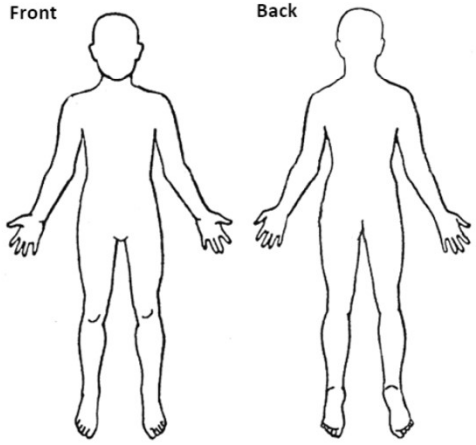
1

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

Example of Medicare PART Exam Form

Page 1 of this form can be used as a daily Subjective Assessment that is filled out by the patient before each treatment.

By modifying the text slightly (at the top of the form) you can use this for the patient to indicate chief pain complaint for that day.

DOCTOR_____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

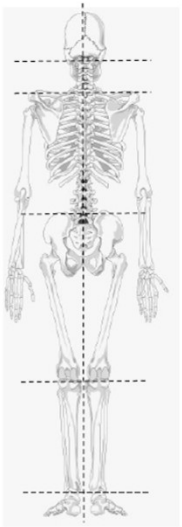
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

C0
C1
C2
C3
C4
C5
C6
C7
L1
L2
L3
L4
L5
SAC
L-IL
R-IL

ASYMMETRY

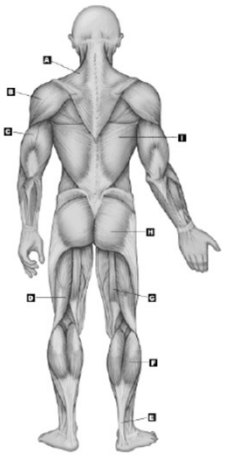
USING ARROWS ↑ ↓ → ←

Mark the Misaligned Vertebrae



T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

TISSUE ABNORMALITIES



A _____
B _____
C _____
D _____
E _____
F _____
G _____
H _____
I _____

Mark Tissue Abnormalities: **TP**=Trigger Points, **LG**=Ligaments (Swollen/Tender), **TN**=Tendons, **SK**=Skin, **FS**=Fascial Restrictions, **SP**=Spasm, **TI**=Tightness

RANGE OF MOTION ASSESSMENT

CERVICAL	NORMAL		PAIN
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		

LUMBAR	NORMAL		PAIN
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

DOCTOR SIGNATURE **DATE**

DOCTOR_____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

EXAMINATION

B/P: _____ PULSE: _____ RESP: _____ HT: _____WT: _____ GRIP: (L)_____ (R)_____

REFLEXES (Wexler Scale)

Biceps _____

Triceps _____

Brac/rad _____

Patella _____

Achilles _____

SENSORY: C5:_____ C6:_____ C7:_____ C8:_____ T1:_____ L3:_____

L4:_____L5:_____ S1:_____ **D=Deficit N=Normal (L) or (R)**

GENERAL ORTHO/NEURO EXAMINATION: (+) or (-), (L) or (R)

Spinous Percus: _____ Babinski _____ Brudzinski _____

Dejerine Triad _____ Rhomberg_____ Valsalva_____

TEST	(+)	(-)	L	R	INDICATION
Distraction					Nerve Root Compression
Jackson					Nerve Root Compression
Max Cerv Root Compression					Nerve Root Compression
Cervical Compression					Nerve Root Compression
Soto Hall					(cerv) (thor) Vertebral Trauma
Spurling's					Nerve Root Irritation
Shoulder Depression					Nerve Root Compression
Libman's					(low) (normal) (high) Pain Threshold
Burn's Bench					(hysteria) (Malingering)
Hoover's					(hysterical paralysis) (Malingering)
Bechterew					Sciatic Disc Compression
Beevor's					Abdominal Muscle Weakness
Minor's Sign					Radicular Disc Pain
Ely					Upper Lumbar Lesion
Fajersztajn					Intervertebral Disc Syndrome
Nachlas					Upper Lumbar Lesion
Gluteal Punch					Spinal Lesion
Goldthwaite					Lumbar Differentiation
Heel-toe Walk					5th Lumbar Motor Deficit
Kemps					Intervetebral Disc Rupture
Lasague					(Muscle) (Disc) (Nerve) Irritation
Braggards					Lumbar Antalgic Spasm
Supported Adam's					Lumbosacral Differentiation

MUSCLE TESTS

LEVEL	Muscle	Muscle Grade L:	Muscle Grade R:
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist Extensors	L:	R:
C7	Triceps	L:	R:
	Wrist Flexors	L:	R:
	Finger Extensors	L:	R:
C8	Finger Flexors	L:	R:

LEVEL	Muscle	Muscle Grade L:	Muscle Grade R:
T1	Finger Abductors	L:	R:
L2-L3	Hip Flexors	L:	R:
L4-L5	Hip Extensors	L:	R:
L3-L4	Knee Extensors	L:	R:
L5-S1	KneeFlexors	L:	R:
L4-L5	Ankle Extensors	L:	R:
S1-S2	Ankle Flexors	L:	R:

DIAGNOSIS: _____

_____

DOCTOR SIGNATURE **DATE**

NAME OF CLINIC/PROVIDER

IMAGING/RADIOLOGY REPORT

DATE OF STUDY _____ **PATIENT**_____

LOCATION STUDY PERFORMED _____ **PATIENT DOB** _____

IMAGING FINDINGS of VIEWS_____

VIEW	NORMAL FINDINGS
	( ) No fractures, pathologies or severe dislocations are displayed
	( ) The boney structures of the Cervical ___ Thoracic ___ Lumbar ___ spine are essentially normal
	( ) The disc spaces appear well maintained (except as noted).
	( ) The A-P Cervical ____ Thoracic ____ Lumbar ____ spine is generally in good alignment.
	( ) The diaphragm is at a normal vertebral level.
	( ) The heart and lung fields appear within normal limits.
	( ) The Lateral Cervical ___ Thoracic ___ Lumbar ___ spine is generally in normal alignment with a proper lordosis _____ kyphosis _____
	ABNORMAL FINDINGS
	( ) Curve Reversal: A reversal of the _____ curve is noted.
	( ) Scoliosis: A _____ scoliosis is displayed in the _____ spine.
	( ) Transitional Vertebrae: Transitional lumbarization/sacralization is displayed.
	( ) Cervical Rib: A Cervical Rib is noted on the right/left.
	( ) Spinous Rotation: A left/right spinous rotation is noted at the _____spinal level(s).
	( ) Diaphragm Level: The left/right diaphragm level appears to be at an abnormal level.
	( ) Spinabifida: A spinabifida is noted at the _____ level.
	( ) DJD: Mild/Moderate/Severe degenerative joint disease is displayed at the _____ vertebrae levels.
	( ) Disc Wedging is noticed at the _____ vertebrae levels.
	( ) Disc Thinning: Mild/Moderate/Severe disc thinning is noted at the _____ vertebrae level(s)
	( ) Osteoporosis: Mild/Moderate/Severe osteoporosis is displayed.
	( ) Compression Fracture: A compression fracture of _____ is displayed.
	( ) Foraminal Encroachment: Foraminal Encroachment is displayed at _____ level(s).
	( ) Fracture: A fracture of the _____ is displayed
	( ) Schmorl's nodes: Schmorl's nodes are seen at the _____ vertebral level(s).
	( ) Spondylothesis: A spondylothesis of the _____ vertebra is noted.
	( ) Other findings: _____
	( ) _____
	( ) _____
	( ) _____
	( ) _____
	( ) _____

Reviewed by _____
Date of Review_____
NAME OF INTERPRETING PHYSICIAN
(PRINT)

NAME OF CLINIC/PROVIDER

DATE OF STUDY _____ **PATIENT**_____

LOCATION STUDY PERFORMED _____ **PATIENT DOB** _____

IMAGING FINDINGS OF VIEWS_____

CLINICAL IMPRESSIONS

Reason for Any Abnormal Finding

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

RECOMMENDATIONS

Additional and/or Follow-up Studies

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewed by _____
Date of Review_____
NAME OF INTERPRETING PHYSICIAN
(PRINT)

Imaging Report

NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

Date_____ **Patient** _____ **Patient DOB**_____

Diagnosis/Clinical Impression #1:

_____

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD Codes:

_____

Diagnosis/Clinical Impression #2:

_____

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD Codes:

_____

Recommended Spinal Manipulation Frequency:

Daily _____ 2 x wk _____ 1 x mo _____

3 x wk _____ 1 x wk _____

Therapy:

Type _____ Location _____ Frequency _____ Time _____

Type _____ Location _____ Frequency _____ Time _____

Type_____ Location _____ Frequency _____ Time _____

Rehab:

Cervical: Passive _____ Active _____ General _____

Lumbar: Passive _____ Active _____ General _____

Structural Support:

Cervical Pillow _____ Cervical Collar Soft _____ Firm _____

Lumbar Cushion _____ Lumbar Belt Soft _____ Firm _____

Extremity: Shoulder ____ Elbow ____ Wrist ____ Knee ____ Ankle _____ Other_____

Short Term Goals:

Reassessment _____ week(s)/month(s)

_____ % Improvement within _____ weeks.

Long Term Goals:

_____ % Improvement Other_____

Reports: Yes No Due Date _____ Type: PI WC IME Interim Insurance Special

Follow Up Procedures: Lab _____ Nutrition _____ Supports _____ Exercises_____

X-ray _____

RESTRICTIONS

Bed Rest _____ Guarded Movement _____ Athletic Activity _____

Cervical: Flexion _____ Extension _____ Lateral Flexion _____ Sleeping _____

Lumbar: Sitting _____ Bending _____ Stooping _____ Lifting _____ Other _____

Other Restrictions: _____

Reviewed/Prepared by: Print Name of Provider

Provider Signature _____

NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

Date_____ **Patient** _____ **Patient DOB**_____

SPECIAL INSTRUCTIONS

Home Instructions: Ice_____ Heat_____ Hot Soaking _____ Lying On Back, Legs Up _____

Sleeping Position _____ Cervical Pillow _____ Wearing Supports _____ Auto position _____ Lifting____

Changing Positions: Bed_____ Auto _____ Seated Position _____ Other _____

Pamphlets: Speedy Recovery ____ After Neck Injury _____ Bad Back _____ Other _____

Patient Education: Back School _____ Other _____

PATIENT EMPLOYMENT

Off Work: From _____ To _____ Home: Rest _____ Bed Rest _____ Guarded _____

Light Duty: From _____ To _____ Description _____

Lifting Restrictions: _____ Special _____

Other _____

_____

LIFESTYLE/DIET MODIFICATION/NUTRITIONAL SUPPORT

_____ None Recommended

_____ Recommendations:_____

_____

CONSULTATION

_____ None recommended at this time.

_____ Referral to _____

For:

_____

_____

Scheduled / / Time: : AM/PM

Provider_____

Confirmed with Patient

By _____

ADDITIONAL DIAGNOSTIC TESTING

_____ None recommended at this time

_____ Following additional studies recommended

Diagnostic Imaging

_____ Arthography
_____ Computer Tomography (CT)
_____ Contrast Enhanced CT
_____ Contrast Enhanced MRI
_____ Diagnostic Ultrasound
_____ Discography
_____ Fluoroscopy
_____ Magnetic Resonance Imaging (MRI)
_____ Positive Emission Tomography (PET)
_____ Radionuclide Bone Scan
_____ Thermography
_____ Videofluorography
_____ Other_____
_____ Other_____

Scheduled / / Time: : AM/PM
Provider_____
Confirmed with Patient / /
By_____

Electrodiagnostics

_____ Brain Electrical Activity Mapping
_____ Brain Stem Auditory Evoked Response
_____ Electroencephalography
_____ Electronystagmography
_____ EMG (Needle)
_____ Magnetoencephalography
_____ Nerve Conduction Velocity
_____ Peripheral Electrodiagnostics
_____ Somatosensory Evoked Potential
_____ Surface Electrode EMG
_____ Visual Evoked Response
_____ Other

Rehabilitation

____ Evaluation
____ Referral

Laboratory

_____CBS
_____ESR
_____SMAC12
_____SMAC24
_____Urinalysis (DS)
_____ Urinalysis (Micr)

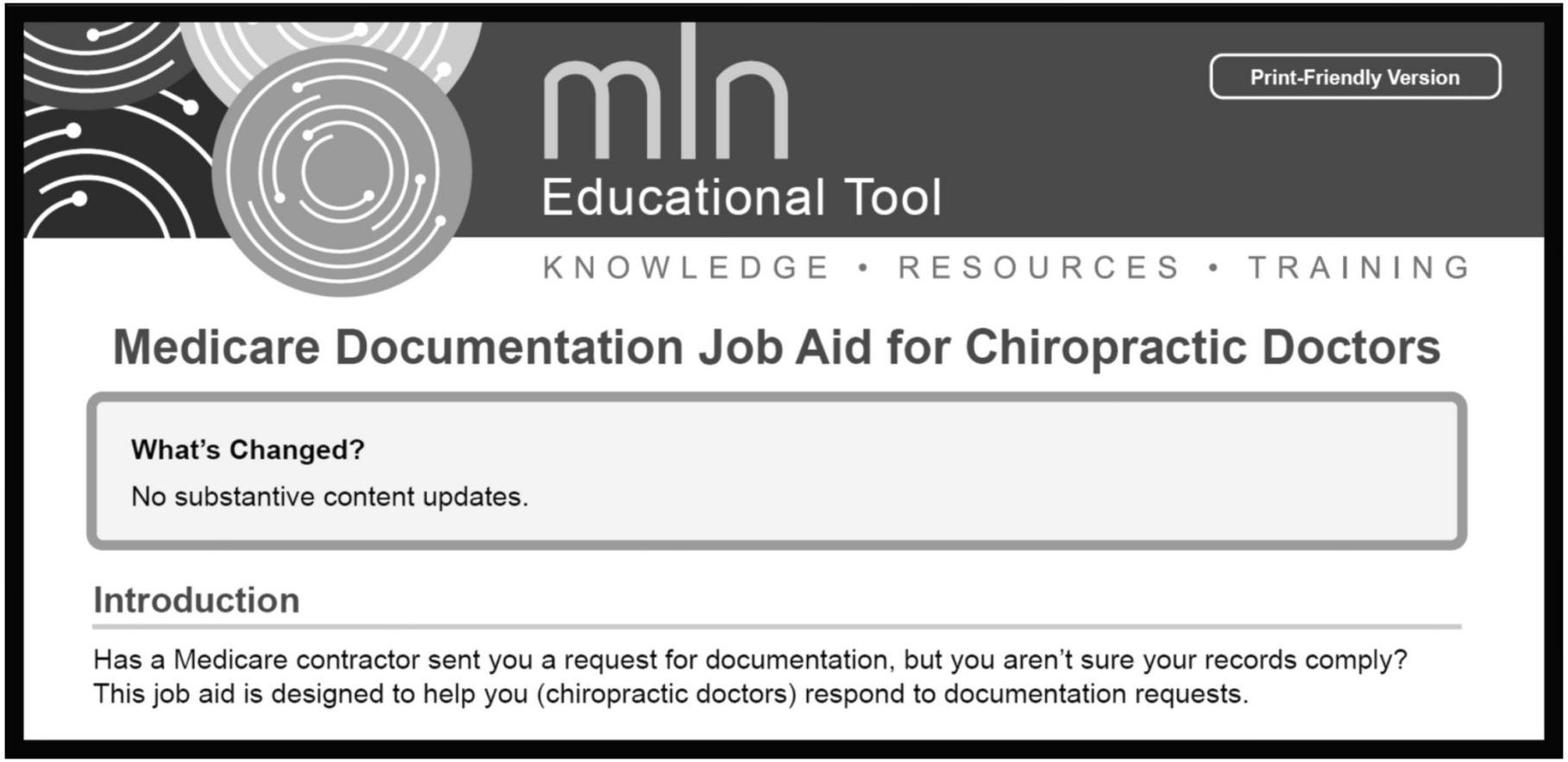
Profiles

_____Anemia
_____Cardiac
_____Hypertension
_____Joint
_____Lipid
_____ Liver
_____Metabolic Bone
_____Pancreas
_____Pregnancy
_____Skeletal Mus
_____Thyroid
_____Urinary Tract
_____Other

Reviewed/Prepared by: Print Name of Provider

Provider Signature _____

SOAP TEMPLATE FOR MEDICARE PATIENTS



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Medicare Documentation Job Aid for Chiropractic Doctors

What's Changed?

No substantive content updates.

Introduction

Has a Medicare contractor sent you a request for documentation, but you aren't sure your records comply? This job aid is designed to help you (chiropractic doctors) respond to documentation requests.

Documentation Guidance

Documentation guidance includes, but is not limited to:

Patient Information

- □ Include the patient's name and date of service on all documentation

Subluxation

- □ Include documentation of subluxation demonstrated by x-ray, date of x-ray: _____
  - o Include a CT scan and or MRI demonstrating subluxation of spine.
  - o Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation.
  - o Include x-rays taken within 12 months before or 3 months following the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record indicates the condition existed longer than 12 months and it is reasonable to conclude the condition is permanent.

Or

- □ Include documentation of subluxation demonstrated 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 initial evaluation
  - □ Include primary diagnosis of subluxation (including level of subluxation)
- □ Include documentation of presence or absence of subluxation for every visit
- □ Include any documentation supporting medical necessity

Initial Evaluation

- History
  - Date of initial treatment
  - Description of current illness
  - Symptoms directly related 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 or 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 (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
- Documentation of presence or absence of subluxation for every visit
- Treatment given on day of visit (if applicable)
  - Include specific areas and levels of the spine where manipulation was performed.
  - Medicare may cover treatment performed using hand-held devices; however, Medicare does not offer additional 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 Visit

- ☐ History
  - ☐ Review of chief complaint
  - ☐ Changes since last visit
  - ☐ System review, if relevant
- ☐ Physical examination (P.A.R.T.)
  - ☐ Assessment of change in patient condition since last visit
  - ☐ Evaluation of treatment effectiveness
- ☐ Documentation of presence or absence of subluxation for every visit
- ☐ Treatment given on day of visit (include specific areas and levels of spine where manipulation was performed)

General Guidelines

- □ Make sure medical records submitted show that the service is a corrective treatment, rather than maintenance
  - o For Medicare purposes, place an AT modifier on a claim when you provide active or corrective treatment to treat acute or chronic subluxation
    - Do not use Modifier AT when you perform maintenance therapy
    - Only use modifier AT when chiropractic manipulation is reasonable and necessary as defined by national and local policy
    - **Note:** Presence of the AT modifier may not indicate the service is reasonable and necessary. As always, contractors may deny 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.
- □ Submit records for all dates of service on a claim
- □ Make sure documentation is legible and complete, including signatures
- □ Include legible signatures and credentials of professionals providing services
  - o If signatures are missing or illegible, include a completed signature attestation statement.
  - o For illegible signatures, include a signature log.
  - o 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.
- □ Include abbreviation key (if applicable)
- □ Include any other documentation to support medical necessity of services billed, as well as documentation specifically requested in an additional documentation request (ADR) letter
- □ Include a copy of the Advance Beneficiary Notice of Noncoverage (if applicable)

DOCUMENTATION MYTHS

There is a different standard of documentation if the patient pays cash

There is a different standard of documentation if I'm Out of Network

I can submit claims before I've completed my notes, and finish them at a later time

I can leave my notes unsigned in case I need to make changes or updates

DOCUMENTATION MYTHS

If I learn the Medicare documentation standard, it will work for all payers

If I under-code, I won't be audited (billing 98940 on all claims)

I have a CASH Practice. I DON'T DEAL WITH THE FEDERAL GOVERNMENT

The Feds established the Framework for Corporate Compliance and Ethics

Most States and Regulatory Boards have Adopted these rules:

*"Compliance regulations do overlap as more laws that **protect the public interest** are established. For instance, data protection and identity verification are continuously moving to the forefront of conversations….. In this case, the FTC uses law enforcement and policy initiatives to protect consumers [in the private sector]"*

https://www.thebidlab.com/learning-center/public-vs-private-compliance/#Private_Sector_Transparency

MALPRACTICE SUITS ON THE RISE

Medical documentation issues play a role in 10–20% of medical malpractice lawsuits. Inaccurate, incomplete, or generic records undermine a physician's defense and make a plaintiff's lawyer more likely to take on a case.

Previous studies of malpractice claims involving documentation indicate that these cases most commonly revolve around missing documentation (70%), inaccurate content (22%), or poor mechanics (18%).[3] Poor mechanics includes errors in transcribed order, illegible entries, and delays in documentation.[3] Physicians often focus on documentation as a means of communicating with other physicians and billing for their services, but it is also crucial to communicate with the patient and **provide a legal record of the care provided**

SOURCE: NATIONAL LIBRARY OF MEDICINE https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9183775/

DENIALS ON THE RISE

It's very likely that at some point, you will have to fight an "unrighteous" denial.

Some payer's denial rates are in excess of 50%, yet only 11% of these denials are ever appealed

82% of claims that are initially denied and appealed will be overturned.

The cost of appealing a denial may be more than the reimbursement on the claim.

https://www.pbs.org/newshour/health/analysis-health-insurance-claim-denials-are-on-the-rise-to-the-detriment-of-patients

AUDITS ON THE RISE

- *1980 Less than 3% of all claims were audited
- *1990 13% of claims are audited
- *2010 22% of claims are audited
- **2024 100% of claims are audited**

*SOURCE: https://www.bea.gov/index.php/system/files/papers/WP2015-4.pdf (Bureau of Economic Analysis)

100% of Claims are Audited
PRE PAYMENT AUDITS

- ✓ Automated: In your software (edits and templates)
- ✓ Automated: At your clearinghouse (Smart Edits, NCCI Edits)
- ✓ Automated: At the payer level (NCCI Edits, Subscriber Information, Payer Policy Edits)
- ✓ Manually: Your coder/biller/billing team (Provider Queries)
- ✓ Manually: The Payer. Claims may be "pulled" from the Automated System for a more in-depth look by a claims adjuster. (Records Requests)

100% of Claims are Audited
POST PAYMENT AUDITS

- ✓ Automated: Random/Lottery
- ✓ Automated: Based on Historical Data derived from data mining programs
- ✓ Automated: Based on Provider Type (OIG Workplan, CERT Audits)
- ✓ Manually: Based on Individual/Provider Error rates and trends
  - ✓ Claims Errors that exceed a certain threshold
  - ✓ Excessive Timely Filing issues
  - ✓ Dx and Coding patterns that may indicate cloning of services and records
  - ✓ Upcoding (billing 98942 on the majority of your claims)

LOOKING TO THE FUTURE

- Rapid expansion in technology and AI is making the possibility of ALL claims being subject to a pre-payment audit a reality in the near future (next 5-10 years).
- Providers will send their documentation as a claim attachment so the document can be scanned for claim accuracy before payment is issued
- The push toward ratifying the Chiropractic Medicare Modernization Act, expanding covered services performed and/or ordered by a DC is nearing its fulfillment. This will most likely result in Medicare increasing audits to make sure that DC's know how to properly document for these expanded services.

LOOKING TO THE FUTURE

Administrative Simplification: Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard

(Article Published Dec. 19, 2022)

Summary (Overview)

The Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard (CMS-0053-P), if finalized, would adopt standards for "health care attachments" transactions, which would support health care claims and prior authorization transactions; adopt standards for electronic signatures to be used in conjunction with health care attachments transactions; and adopt a modification to the standard for the referral certification and authorization transaction.

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

The proposed health care attachments standards cover **three general use cases**, illustrated below, whereby a provider would submit electronic documentation to a health plan:

Prior Authorization: In this case, a provider must obtain a health plan's approval for a service before it is rendered to the patient. The provider will send a request for approval along with supporting information to the health plan. The plan will then review the information, decide whether this service would be covered, and return a response to the provider indicating the coverage decision. **Although there is currently an adopted HIPAA transaction for the prior authorization request and response, there is no way for a provider to submit documentation to support a prior authorization electronically using HIPAA standards.**

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

The proposed health care attachments standards cover three general use cases, illustrated below, whereby a provider would submit electronic documentation to a health plan:

Solicited Documents: In this use case, a provider has submitted a claim for a rendered service and the health plan decides that more information is required to make a payment determination. The health plan requests more information from the provider and the provider responds.

Unsolicited Documents: In this use case, a health care provider submits a claims attachment along with their initial submission of a health care claim transaction for a service they have rendered. This usually occurs when a provider is in a full claims review program with the health plan or the health plan's payment policies require documents with each claim submission for service.

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

Health Care Savings

Based on industry research performed by the Council for Affordable Quality Healthcare (CAQH), significant savings could result from the adoption of automated electronic processing of attachments. The 2019 CAQH report indicates that a fully electronic system for prior authorization with health care attachments could result in as much as $454 million in annual savings to the health care industry.[1] Similar savings can be expected for the industry with a switch to health care attachments for claims. **The 2019 CAQH report further estimates the industry could expect as much as $374 million in savings per year with the full adoption of health care attachments for claims. This results in a total expected industry savings, for prior authorization and claims, of $828 million per year.**

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

RISK ANALYSIS

Conduct a Risk Analysis on your Documentation/SOAP Notes. Use the elements in the next slides to determine if you are deficient or missing key information in your notes that could trigger an adverse determination on a claim or put you at risk for malpractice.

RISKY DOCUMENTATION PRACTICE

- Missing Chief Complaint
- Failure to refer back to exam/xray findings in relation to the treatment given that day
- Failure to establish and write a Plan of Care (verbal ROF's don't cut it)
- Failure to use the POC to assess and document the patient's response to ongoing treatment

RISKY DOCUMENTATION PRACTICE

- Failure to carry the patient's problem list forward to the next date of service
- Failure to adjust diagnoses in the medical record (and claims) as patients respond to care
  - Example, primary dx day 1 of treatment is M54.50 (Low back pain). Patient's pain scale is 8 of 10
  - Day 8, patient's pain scale is 1 of 10 (and has been for the last 3 visits), but M54.50 is still listed as the primary dx for that day's treatment
- Placing dx codes on a claim that do not represent the patient's condition on that day's treatment.

RISKY DOCUMENTATION PRACTICE

- Missing Radiology report if x-ray was used to diagnose the patient
- X-rays being taken on all patients with no documented justification. "Rule Out" reasons are not valid
- Therapy/Rehab services that are not properly documented (time/frequency/supervision)
- Therapy/Rehab services that were not included in the patient's original POC or updated with a new POC
- Other ancillary services not documented (ie: Acupuncture treatment notes, dispensing of Nutritional supplements)

RISKY DOCUMENTATION PRACTICE

- Failure to document and/or refer to patient's lifestyle issues that could contribute to their health problems (ie: Job that requires heavy lifting/repetitive motion, sports activities that may contribute to injury)
- Failure to document co-morbidities (ie: Obesity, High Blood Pressure, Previous Stroke, Osteoporosis, etc)
- Failure to document counseling on co-morbidities (ie: recommendation that patient go on a weight loss program, lose xxx pounds, etc)

RISKY DOCUMENTATION PRACTICE

- Failure to identify and counsel patients about social determinants preventing good health (smoking, recreational drug use)
- Other ancillary services not documented (ie: Acupuncture treatment notes, dispensing of Nutritional supplements)
- No Outcome Assessment tools (OATS) such as Ostwestry, Midas, VAS, WOMAC, KOOS, etc

RISKY DOCUMENTATION PRACTICE

- Failure to write a Plan of Care
- Failure to use the POC as a guideline for future visits
- Writing an incomplete POC (not indicating what interventions will be used throughout the course of treatment, no short or long-term treatment goals)
- If patient's condition may warrant referral for MRI, Surgical intervention, this should be documented as to when you will be assessing the effectiveness of conservative treatments)
- Failure to indicate recommendations for home/self care instructions in the POC

RISKY DOCUMENTATION PRACTICE

- Failure to use the POC to document whether the patient is responding to treatment as expected, better or worse than expected
- Failure to remove dx codes that no longer apply to the patient's current condition
- Failure to document a change in the patient's POC
- Failure to document missed appointments/cancellations

RISKY DOCUMENTATION PRACTICE

- Failure to establish a reason for care (chief complaint/co-morbidities, etc)
- MDM is fairly complex, but not documented as such. Claim supports complex MDM, but documentation does not.
- Same POC for EVERY PATIENT (common when working with a Practice Management Consultant).
- Failure to review the Payer's Medical Policy guidelines for **their** documentation and coding standards

RISKY DOCUMENTATION PRACTICE

- **Unsigned notes**
- Illegible Signature with no accompanying signature log
- **Missing provider credentials (ie: DC**, DPT, APRN, etc)
- **One provider rendering services for another and signing the note as if it is the other provider (locum tenens providers should sign their own note, "acting as a covering/locum provider for Dr _____")**
- **Notes not signed in a timely manner**

WHAT IS CONSIDERED A TIMELY NOTE?

Medicare providers must comply with documentation requirements, including the timeliness of documentation in connection with the provider signature. Unless the documentation for a service is completed; including signature; a provider cannot submit the service to Medicare. **Medicare states if the service was not documented, then it was not done.**

Providers are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record." This statement is from the Centers for Medicare & Medicare Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 12, (PDF) Section 30.6.1. **CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.**

SOURCE:
https://www.palmettogba.com/palmetto/jma.nsf/DIDC/9VTLBC1017~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Documentation#:~:text=CMS%20does%20not%20provide%20any,away%20from%20the%20service%20itself.

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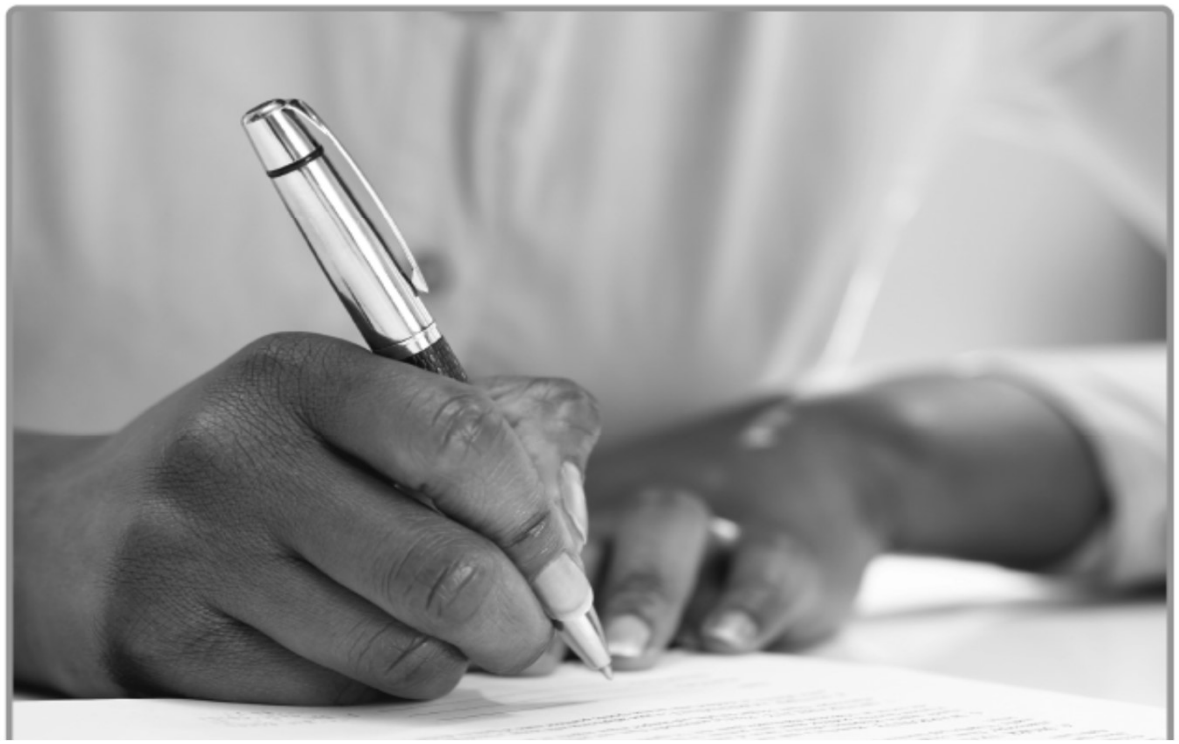
Complying with Medicare Signature Requirements



Medicare Signature Requirements

Documentation must meet Medicare's signature requirements. Medicare claims reviewers look for signed and dated medical documentation meeting Medicare signature requirements. If entries aren't signed and dated, they may deny the associated claims.

FAQs

How do we define a handwritten signature?

A mark or sign the ordering or prescribing physician or Non-Physician Practitioner (NPP) makes on a document signifies knowledge, approval, acceptance, or obligation.

What if I use a scribe when documenting medical record entries?

Even if a scribe dictates the entry on your behalf, you must sign the entry to effectively authenticate the documents and care you provided or ordered. It's unnecessary to document who transcribed the entry.

What is required for a valid signature?

A valid signature must be:

- For services you provided or ordered
- Handwritten or electronic
  - We allow stamped signatures if you have a physical disability and can prove to a CMS contractor you're unable to sign due to that disability
- Legible or can be confirmed by comparing to a signature log or attestation statement

Can I avoid delays in claim reviews by sending a signature log or signature attestation with my documentation?

We encourage you to send a complete medical record with proper signature documentation first to avoid medical review delays. This includes a signature log or attestation if needed.

Must I date my signatures?

Documentation must have enough information to show the date you ordered or performed the services. If you dated the entries immediately above and below an undated entry, medical review may reasonably assume the entry date in question.

What are the medical review guidelines for using an electronic signature?

The medical review guidelines for using an electronic signature are:

- Systems and software products must include protections against modification, and you should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.

RISKY DOCUMENTATION PRACTICES

- CPT/HCPCS Codes on the claim do not match the information in the medical record
- Dx/ICD10 codes on the claim that are irrelevant to the treatment given that day and documented in the medical record
- Procedures that are billed on a claim not represented in the note or Plan of Care
- SALTING NOTES

YOUR CLAIM SHOULD BE AN EXACT MIRROR OF YOUR DOCUMENTATION

OTHER CHIROPRACTIC DOCUMENTATION RISKS

TOO MUCH S.A.L.T. IS BAD FOR YOU

S.A.L.T. = Same as last time

Most Chiropractic EMR systems have the ability for you to SALT your note from one visit to the next

Allows for quicker notes, but has inherent risks

TOO MUCH S.A.L.T. IS BAD FOR YOU

- **Risks of SALTed notes**
  - Not making necessary written modifications to the note for that day's treatment
  - Not removing codes that are irrelevant/not applicable to that day's treatment
  - Not responding to changes in patient's condition in the note
  - Failure to modify and update the POC when needed

QUESTIONS?

CONCERNS?

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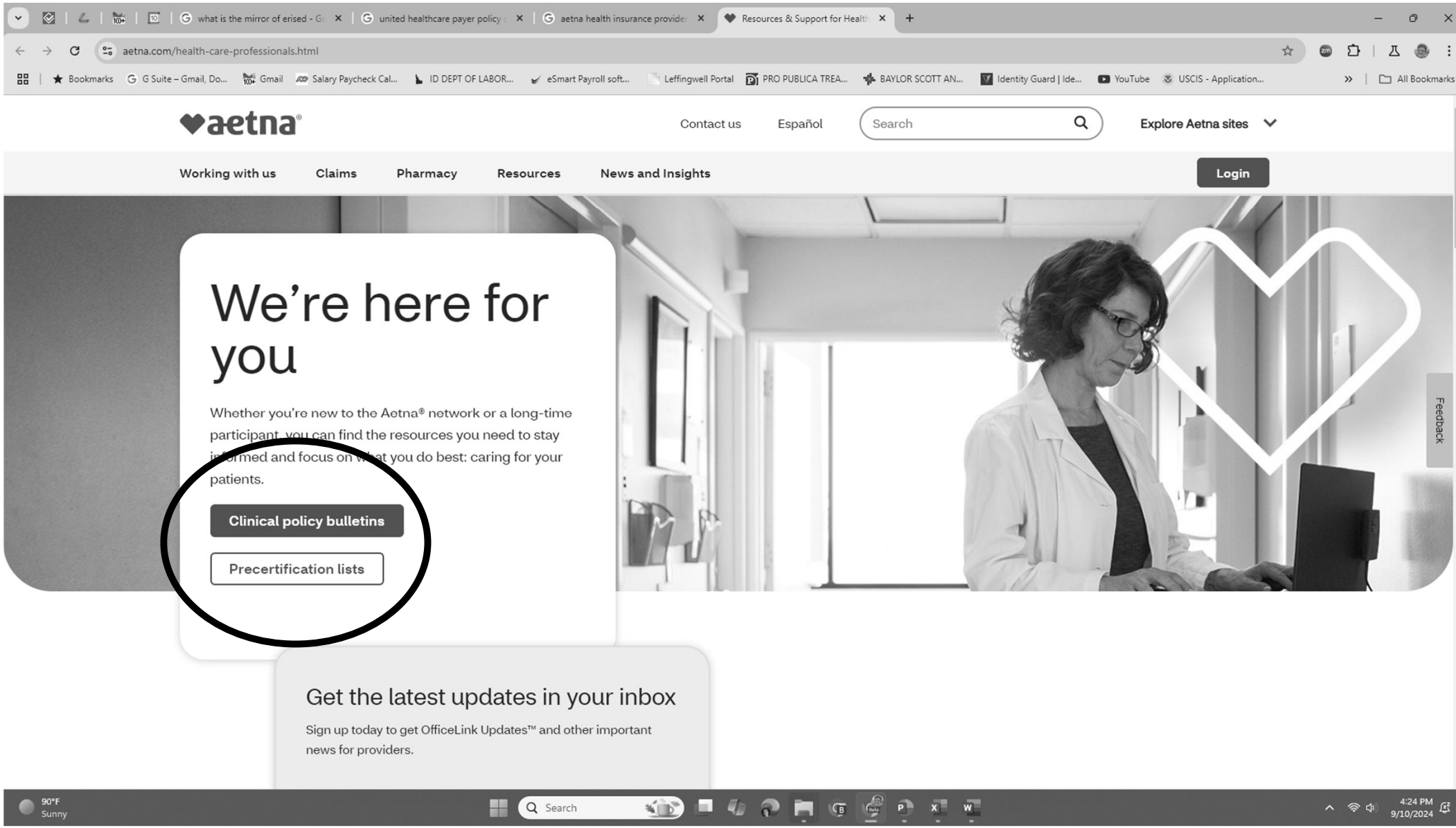
THANK YOU FOR YOUR ATTENDANCE!

SUPPLEMENTAL INFORMATION

1. EXAMPLE OF AETNA MEDICAL POLICY
2. EXAMPLE OF CHIROPRACTIC ABN (PART B) – TEMPLATE AVAILABLE ON REQUEST
3. EXAMPLE OF CHART AUDIT WORKSHEETS - TEMPLATE AVAILABLE ON REQUEST
4. MEDICARE DOCUMENTATION TEMPLATE: CHIROPRACTIC JOB AID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eSmart Payroll soft...
Leffingwell Portal
PRO PUBLICA TREA...
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Identity Guard | Ide...
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Policy

Scope of Policy

This Clinical Policy Bulletin addresses chiropractic services.

I. Medical Necessity

A. Aetna considers chiropractic services medically necessary when *all* of the following criteria are met:

1. The member has a neuromusculoskeletal disorder; *and*
2. The medical necessity for treatment is clearly documented; *and*
3. Improvement is documented within the initial 2 weeks of chiropractic care.

If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.

If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.

Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

Additional Information

Clinical Policy Bulletin Notes >

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B. Home-based chiropractic service is considered medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound). This may be considered medically necessary in the transition of the member from hospital to home, and may be an extension of case management services.
C. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
D. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

II. **Experimental, Investigational, or Unproven**

A. Aetna considers the following procedures experimental, investigational, or Unproven:

1. *Manipulation when it is rendered for non-neuromusculoskeletal conditions (see examples below, not an all-inclusive list):*

- Attention-deficit hyperactivity disorder
- Asthma
- Autism spectrum disorder
- Depression
- Dizziness / vertigo

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II. **Experimental, Investigational, or Unproven**

A. Aetna considers the following procedures experimental, investigational, or Unproven:

1. *Manipulation when it is rendered for non-neuromusculoskeletal conditions (see examples below, not an all-inclusive list):*

   - Attention-deficit hyperactivity disorder
   - Asthma
   - Autism spectrum disorder
   - Depression
   - Dizziness / vertigo
   - Dysmenorrhea
   - Epilepsy
   - Female infertility
   - Gastro-intestinal disorders
   - Improvement of brain function
   - Menopause-associated vasomotor symptoms
   - Prevention of falls
   - Treatment of post-concussion syndrome;

2. *Manipulation of infants for non-neuromusculoskeletal indications (see examples below, not an all-inclusive list):*

   - Infants with gastro-intestinal disorders including constipation

Top

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CPT Codes / HCPCS Codes / ICD-10 Codes

CPT codes covered if selection criteria are met:

Code	Code Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	spinal, three to four regions
98942	spinal, five regions
98943	extraspinal, one or more regions
CPT codes not covered for indications listed in the CPB:	
ConnecTX, inertial traction, positional release therapy, IntraDiscNutrosis program, Origin insertion release technique, Ultralign adjusting device **- no specific code:**	
22505	Manipulation of spine requiring anesthesia, any region
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes [not covered for FAKTR]
Other CPT codes related to the CPB:	
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553	single or multiple trigger point(s), three or more muscle(s)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	3 or more muscles
95836 - 95857	Muscle and range of motion testing
95860 - 95887	Electromyography and nerve conduction tests

AUDIT TEMPLATES

- Auditors may use various templates when reviewing medical records.
- Auditor will first check documents against the records request.
  - Did you send them everything they requested?
  - Did you send them more than they needed (irrelevant or not applicable to the audit)
- Auditor will check records against “Standard Documentation Requirements” first
- Auditor will check records against Industry Specific Requirements (ie: Medicare NCD/LCD/LCA)
- Auditor will confirm that the medical record supports the claim that was submitted

GENERAL AUDIT TEMPLATE

CHART AUDITING WORKSHEET

GENERAL DOCUMENTATION STANDARDS

GENERAL DOCUMENTATION STANDARD		PRESENT	NOT PRESENT	NOT APPLICABLE	NOTE
The medical record should be complete and legible					
The documentation of each patient encounter should include: the date; reason for the encounter; appropriate history and physical exam; review of lab, X-ray data and other ancillary services and, when appropriate, assessment; and a plan of care (including discharge plan, if appropriate)					
DATE					
REASON FOR THE ENCOUNTER					
APPROPRIATE HX AND EXAM					
REVIEW OF LABS					
REVIEW OF XRAY					
DOCUMENTED ANCILLARY SERVICES					
ASSESSMENT/DIAGNOSIS					
PLAN OF CARE					
Past and present diagnoses should be accessible to the treating and/or consulting physician					
The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record. In many records, the order and/or intent for the service to be performed is missing.					
Relevant health risk factors should be identified					

CHART AUDITING WORKSHEET
GENERAL DOCUMENTATION STANDARDS

GENERAL DOCUMENTATION STANDARD		PRESENT	NOT PRESENT	NOT APPLICABLE	NOTE
The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance should be documented.					
The written plan of care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals; patient/family education; and specific instructions for follow-up					
The documentation should support the medical necessity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making					
All entries to the medical record should be dated and authenticated by physician/provider signature. Medical documentation with missing or invalid signatures fails to meet the CMS signature requirements and may result in claim denial.					
The CPT/HCPCS/ICD-10-CM codes reported on the Medicare claim should reflect the documentation in the medical record					

MEDICARE AUDIT TEMPLATE

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)	☐	☐	☐	_____

A. **Notifier:** <NAME OF CLINIC>
B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Treatment(s) below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Treatment(s) below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
98940: 1-2 Region Spinal Manipulation **98941**: 3-4 Region Spinal Manipulation **98942**: 5 Region Manipulation	**Medicare only covers chiropractic treatment to correct a spinal misalignment (subluxation). Maintenance treatment is not a covered service.**	98940 - $40.00 98941 - $55.00 98942 - $70.00 (your fees here)

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Treatment(s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** Treatment(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. ☐ **OPTION 2.** I want the **D.** Treatment(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. ☐ **OPTION 3.** I don't want the **D.** Treatment(s) listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

MEDICARE PART B ABN TEMPLATE

CHIROPRACTIC

PAR PROVIDER

A. **Notifier:** <NAME OF CLINIC>
B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Treatment(s) below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Treatment(s) below.

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WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Treatment(s) listed above.

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☐ **OPTION 1.** I want the **D.** Treatment(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~
☐ **OPTION 2.** I want the **D.** Treatment(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.** Treatment(s) listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information: This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

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MEDICARE PART B ABN TEMPLATE

CHIROPRACTIC

NON-PAR PROVIDER

A. **Notifier:** <NAME OF CLINIC>
B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Treatment(s) below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Treatment(s) below.

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G. OPTIONS: Check only one box. We cannot choose a box for you.
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H. Additional Information: Dually Eligible beneficiaries must be instructed to check Option Box 1 on the ABN in order for a claim to be submitted for Medicare adjudication.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

MEDICARE PART B ABN TEMPLATE

CHIROPRACTIC

DUAL ELIGIBLE PATIENTS (PATIENTS WITH MEDICARE AND MEDICAID)

Medicare Documentation Job Aid for Chiropractic Doctors

GOLD STAR MEDICAL BUSINESS SERVICES HTTPS://GOLDSTARMEDICAL.NET INFO@GOLDSTARMEDICAL.NET 866-942-5655

Documentation Basics

Chiropractic documentation should include:

Patient Information

- ☐ Include the patient's name and date of service on all 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
    - 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

When you print a chart for audits, make sure **EVERY PAGE** contains the name of the Patient, their DOB, and the name of the practice/provider

This section is a **MEDICARE SPECIFIC Standard**, which may or may not be the same for commercial payers.

In the absence of a specific commercial payer's guideline, the Medicare standard can be used to show the payer you have documented according to a well defined and industry accepted standard

DOCUMENTATION ELEMENTS THAT JUSTIFY YOUR E/M CODE

Initial Evaluation

- ☐ 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) ⇦ **OATS!**

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)

General Guidelines

- ☐ Make sure medical records show that the service is a corrective treatment, not a maintenance treatment.
  - ☐ For Medicare purposes, place an AT modifier on a claim when you give active or corrective treatment for acute or chronic subluxation.
    - Don't use an AT modifier 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.

General Documentation Guidelines for All Disciplines

- ☐ Include records for all dates of service on a claim.
- ☐ Make sure documentation is legible and complete, including signatures.
- ☐ Include legible signatures and 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 getting this information.
- ☐ Include abbreviation key (if relevant).
- ☐ Include any other documentation to support medical necessity of services billed, as well as documentation specifically asked for in an additional documentation request (ADR) letter.
- ☐ Include a copy of the Advance Beneficiary Notice of Noncoverage (if relevant).

www.orthopaedicscores.com

Date of completion
April 21, 2025

Neck Disability Index - Vernon and Mior **Cervical Spine** Questionnaire

Clinician's name (or ref) _____

Patient's name (or ref)
_____

This questionnaire has been designed to give your therapist information as to how your neck pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition today.

During the past 4 weeks.....

Section 1 - Pain Intensity

- ◯ I have no pain at the moment
- ◯ The pain is very mild at the moment
- ◯ The pain is moderate at the moment
- ◯ The pain is fairly severe at the moment
- ◯ The pain is very severe at the moment
- ◯ The pain is the worst imaginable at the moment

Section 2 - Personal Care (e.g., Washing, Dressing)

- ◯ I can look after myself normally without causing extra pain
- ◯ I can look after myself normally, but it causes extra pain
- ◯ It is painful to take care of myself, and I am slow and careful
- ◯ I need some help, but I am able to manage most of my personal care
- ◯ I need help every day in most aspects of my care
- ◯ I do not get dressed, I wash with difficulty, and stay in bed

Section 3 - Lifting

- ◯ I can lift heavy weights without extra pain
- ◯ I can lift heavy weights, but it gives extra pain
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ◯ I can lift only very light weights
- ◯ I cannot lift or carry anything at all

Section 4 - Reading

- ◯ I can read as much as I want to with no pain in my neck
- ◯ I can read as much as I want to with slight pain in my neck
- ◯ I can read as much as I want with moderate pain in my neck
- ◯ I cannot read as much as I want because of moderate pain in my neck
- ◯ I can hardly read at all because of severe pain in my neck
- ◯ I cannot read at all

Section 6 - **Concentration**

- ◯ I can concentrate fully when I want to with no difficulty
- ◯ I can concentrate fully when I want to with slight difficulty
- ◯ I have a fair degree of difficulty in concentrating when I want to
- ◯ I have a lot of difficulty in concentrating when I want to
- ◯ I have a great deal of difficulty in concentrating when I want to
- ◯ I cannot concentrate at all

Section 7 - **Work**

- ◯ I can do as much work as I want to
- ◯ I can only do my usual work but no more
- ◯ I can do most of my usual work but no more
- ◯ I cannot do my usual work
- ◯ I can hardly do any work at all
- ◯ I cannot do any work at all

Section 8 - **Driving**

- ◯ I can drive my car without any neck pain
- ◯ I can drive my car as long as I want with slight pain in my neck
- ◯ I can drive my car as long as I want with moderate pain in my neck
- ◯ I cannot drive my car as long as I want because of moderate pain in my neck
- ◯ I can hardly drive at all because of severe pain in my neck
- ◯ I cannot drive my car at all

Section 9 - **Sleeping**

- ◯ I have no trouble in sleeping
- ◯ My sleep is slightly disturbed (less than 1 hour sleepless)
- ◯ My sleep is mildly disturbed (1-2 hours sleepless)
- ◯ My sleep is moderately disturbed (2-3 hours sleepless)
- ◯ My sleep is greatly disturbed (3-5 hours sleepless)
- ◯ My sleep is completely disturbed (5-7 hours sleepless)

Section 5 - Headaches

- ◯ I have no headaches at all
- ◯ I have slight headaches which come infrequently
- ◯ I have moderate headaches which come infrequently
- ◯ I have moderate headaches which come frequently
- ◯ I have severe headaches which come frequently
- ◯ I have headaches most of the time

Section 10 - Recreation

- ◯ I am able to engage in all my recreational activities with no neck pain at all
- ◯ I am able to engage in all my recreational activities with some neck pain
- ◯ I am able to engage in most, but not all, of my usual recreational activities because pain in my neck
- ◯ I am able to engage in a few of my usual recreational activities because of pain in my neck
- ◯ I can hardly do any recreational activities because of pain in my neck
- ◯ I cannot do any recreation activities at all

Print page | Close Window | Reset

To save this data please print or Save As CSV

Nb: This page cannot be saved due to patient data protection so please print the filled in form before closing the window.

The Vernon and Mior Cervical Spine Score is

0 %

Reference for Score: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther. 1991 Sep;14(7):409-15. Erratum in: J Manipulative Physiol Ther 1992 Jan;15(1):followi. link to pubmed

Web Design London - James Blake Internet

Oswestry Disability Index (ODI) Scoring Instructions

🔢 Step-by-Step Scoring:

1. **Each of the 10 sections** is scored from **0 to 5**, where:
    - **0 = least disability**
    - **5 = most disability**
    - Only **one statement** per section is selected by the patient.
2. **Add up the scores** for each of the 10 sections.
3. **If all 10 sections are completed**, total score is out of **50**.
4. If a patient **skips a section**, adjust the total possible score accordingly (e.g., if only 9 sections completed, score is out of 45).

🧮 Disability % Formula:

Disability %=(Total ScoreTotal Possible Score)×100\text{Disability \%} = \left(\frac{\text{Total Score}}{\text{Total Possible Score}} \right) \times 100Disability %=(Total Possible ScoreTotal Score)×100

📊 Interpreting the Score:

Disability %	Level of Disability	Interpretation
0% – 20%	Minimal disability	Can cope with most activities; no treatment indicated.
21% – 40%	Moderate disability	May need conservative treatment.
41% – 60%	Severe disability	Pain significantly impacts daily life.
61% – 80%	Crippled	May require intensive treatment.
81% – 100%	Bed-bound or exaggerating symptoms	Possibly over-reporting or requires immediate intervention.

Chiropractic SOAP Note Template

S – Subjective:

Pain description:
Patient reports [type of pain] at [location], rated [0–10 scale]. Pain is [constant/intermittent], worsens with [activity], relieved by [rest/activity/ice/etc.].

Pain change:
Compared to last visit, pain has [improved/stayed the same/worsened] from [previous rating] to [current rating].

Functional impact:
Patient reports difficulty with [ADL or functional activity], such as [e.g., walking, sitting, bending, lifting]. Since last visit, reports [improvement/worsening/no change] in ability to [specific functional task].

O – Objective:

Observation/Posture/Gait:
Posture is [normal/antalgic/etc.]. Gait is [steady/unsteady/etc.].

Palpation findings:
[Tenderness/muscle spasm] noted at [spinal levels].

Range of motion (ROM):
Lumbar/Cervical ROM: [List degrees and changes from previous visit].

Orthopedic/Neurologic tests:
[Test name]: [Results]. Compare to previous visit.

A – Assessment:

[Spinal region] segmental dysfunction/subluxation identified at [levels].

Patient is demonstrating [objective/subjective] improvement in [pain/function].

Condition is [acute/subacute/chronic], and care remains [medically necessary/supportive/maintenance (not covered)].

P – Plan:

Treatment Given that Day (LIST ALL TREATMENTS AND MODALITIES):
Continue spinal manipulation [frequency] for [duration].

Re-evaluation:
Reassess outcomes after [#] visits.

Home care/exercises:
Patient instructed to [exercise/stretch/ergonomic change/etc.].

Pro Tips

Always link subjective pain reports with functional impact.

Show progress over time or justify why care continues if progress is slow.

Clinical Practice Guideline: **Chiropractic Services Medical Policy/Guideline**

Date of Implementation: **October 20, 2016**

Product: **Specialty**

Related Policies:
CPG 1: X-ray Guidelines
CPG 3: Quality Patient Management
CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care
CPG 110: Medical Record Maintenance and Documentation Practices
CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations, Re-evaluations and Consultations
CPG 119: Spinal Manipulative Therapy for Non-Musculoskeletal and Related Disorders
CPG 120: Spinal Manipulative Therapy for Treatment of Children
CPG 121: Passive Physiotherapy (Therapeutic) Modalities
CPG 129: Electrodiagnostic Testing
CPG 133: Techniques and Procedures Not Widely Supported as Evidence-Based
CPG 135: Physical Therapy Medical Policy / Guidelines
CPG 142: Supports and Appliances
CPG 175: Extra-Spinal Joint Manipulation / Mobilization for the Treatment of Upper Extremity Musculoskeletal Conditions
CPG 177: Extra-Spinal Joint Manipulation / Mobilization for the Treatment of Lower Extremity Musculoskeletal Conditions
CPG 275: Mechanical Traction (Provided in a Clinical Setting)
CPG 285: Spinal Manipulative Therapy (SMT) for Musculoskeletal and Related Disorders

CPG 278 Revision 13 - S
Chiropractic Services Medical Policy/Guideline
Revised – October 17, 2024
To CQT for review 08/19/2024
CQT reviewed 08/19/2024
To MA-UMC for review 09/30/2024
MA-UMC reviewed 09/30/2024
To QIC for review and approval 10/01/2024
QIC reviewed and approved 10/01/2024
To QOC for review and approval 10/17/2024
QOC reviewed and approved 10/17/2024

Table of Contents

DESCRIPTION

This document addresses Chiropractic skilled services which may be delivered by a Chiropractor/Doctor of Chiropractic acting within the scope of a professional license. This document also addresses the processes associated with Medical Necessity Determinations performed by American Specialty Health (ASH) Clinical Quality Evaluators (CQEs) on Chiropractic services submitted for review. For information about Medicare (CMS) medical necessity, please see Section 8.4.

The determination of medically necessary care, as outlined in this guideline, protects against inappropriate care that may be wasteful, unsafe, and harmful to the patient, while assuring approved care is safe, appropriate, curative, and improves the patient's function and quality of life. To protect the health and safety of patients, American Specialty Health (ASH) has implemented medical necessity review strategies to educate practitioners of the need to implement methods to reduce clinical errors and improve patient safety. These medical necessity review strategies include encouraging practitioners to adopt evidence-based health care approaches to patient care, implement professional standards of care, and follow applicable care management guidelines. Conducting risk management procedures via medical necessity review minimizes potential adverse outcomes and harm to the patient and prevents wasteful, unsafe and inappropriate care.

Medical necessity review protects the safety of patients. The application of rehabilitative spinal manipulative care to a patient must be appropriate and safe. Cases where it is not safe to administer spinal manipulative care may pose significant health and safety risk to a patient, for example:

- A patient with atlantoaxial instability secondary to chronic rheumatoid arthritis would be put at significant risk of harm, possibly life threatening, if spinal manipulative procedures were administered to the cervical spine.
- A patient that had received a trial of spinal manipulative care but is now showing signs of progressive neurological deficits should not receive ongoing care but should be referred for further studies and possible alternative consultations to determine if more aggressive care is needed (e.g., surgical spinal decompression) to prevent permanent neurological damage.
- A patient reports acute low back pain, loss of sensory perception in the lower extremities and bladder dysfunction. Failure to recognize and diagnose classic signs

of Cauda Equina syndrome would have serious harmful effects including permanent neurological dysfunction as this condition requires immediate surgical intervention.

Care approved through medical necessity review is safe, appropriate, curative in nature, and directed at specific treatment goal resolution to ensure clinical benefit and improvement to the patient's quality of life.

- For risk-reduction and the protection of patients, the review process does not approve treatment when a condition should be referred to a medical physician, the treatment is unsafe, or when treatment is not providing measurable health improvement.
- For the benefit of patients, the review process approves services when the evidence and practitioner treatment plan supports the use of conservative treatment for conditions known to be amenable to the services provided so that patients may recover from conditions without the need for more costly or high-risk treatments such as prescription opioids, injections, or surgery.

The availability of coverage for rehabilitative and/or habilitative services will vary by benefit design as well as by State and Federal regulatory requirements. Benefit plans may include a maximum allowable chiropractic benefit, either in duration of treatment or in number of visits or in the conditions covered or type of services covered. When the maximum allowable benefit is exhausted or if the condition or service are not covered, coverage will no longer be provided even if the medical necessity criteria described below are met.

GUIDELINES

1. PROVIDERS OF CHIROPRACTIC SERVICES

Covered, medically necessary chiropractic services must be delivered by a qualified Chiropractor acting within the scope of their license as regulated by the Federal and State governments. Some services may be performed by ancillary providers (e.g., licensed massage therapist, physical therapist) under the direction and supervision of a licensed Chiropractor; however, generally, only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide such services. Benefits for services provided by these ancillary healthcare providers may also be dependent upon the patient's benefit contract language.

Aides and other nonqualified personnel are limited to provision of non-skilled services such as preparing the individual, treatment area, equipment, or supplies; assisting a qualified therapist or assistant; and transporting individuals.

2. HABILITATIVE SERVICES

Chiropractic Manipulative Therapy (CMT) is not generally considered to be a medically necessary habilitative service. Medically necessary habilitative services refer to therapeutic modalities and procedures necessary to maintain, develop or improve skills needed to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs) which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Such services are generally performed by physical therapists, occupational therapists, and speech therapists. However, Chiropractors may provide therapeutic modalities and procedures that meet the definition of medically necessary habilitative services when allowed by state scope of practice; however, joint manipulation (chiropractic manipulation/osteopathic manipulation) is not generally considered to be medically necessary as a Habilitative service.

3. REHABILITATIVE CHIROPRACTIC SERVICES

Medically Necessary

Rehabilitative chiropractic services are considered **medically necessary** when **ALL** the following criteria are met:

1. The services are delivered by a qualified practitioner of chiropractic services; and
2. The services require the judgment, knowledge, and skills of a qualified practitioner of chiropractic services due to the complexity and sophistication of the therapy and the medical condition of the individual; and
3. The service is aimed at diagnosis, treatment, and/or prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health; and
4. The service is for conditions that require the unique knowledge, skills, and judgment of a Chiropractor for education and training of the patient that is part of an active skilled plan of treatment; and
5. There is a clinically supported expectation that the service will result in a clinically significant level of functional improvement within a **reasonable and predictable period of time***; and
    - Improvement or restoration of function could not be reasonably expected as the individual gradually resumes normal activities without the provision of skilled therapy services; and
    - The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation of continuation of rehabilitative services.

Reasonable and predictable period of time: The specific time frames for which one would expect practical functional improvement is dependent on various factors including whether the services are Rehabilitative or Habilitative services. A reasonable trial of care for rehabilitative services to determine the patient's potential

for improvement in or restoration of function is generally up to 4 weeks and is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors). Habilitative services may be prolonged and are primarily influenced by the type of ADLs or IADLs which have not developed, or which are at risk of being lost.

Not Medically Necessary

(1) Maintenance care (e.g., elective care, wellness care) is considered **not** medically necessary as a rehabilitative service; and is often a specific benefit exclusion.

(2) Rehabilitative chiropractic services are considered **not** medically necessary if **any** of the following is determined:

1. The service is **not** aimed at diagnosis, treatment, and prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health.
2. The service is for conditions for which therapy would be considered routine educational, training, conditioning, or fitness. This includes treatments or activities that require only routine supervision.
3. The expectation does **not** exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (up to 4 weeks).
    - If, absent supervised care, function could reasonably be expected to improve at the same / similar rate as the individual gradually resumes normal activities, then the service is considered **not** medically necessary.
    - If an individual's expected restoration potential would not produce a meaningful improvement in relation to the extent and duration of the service required to achieve such potential, the service(s) would be considered **not** medically necessary.
    - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks).
    - The patient has reached maximum therapeutic benefit.
4. A passive modality is **not** preparatory to other skilled treatment procedures or is not necessary in order to provide other skilled treatment procedures safely and effectively.
5. A passive modality has insufficient published evidence to support a clinically meaningful physiologic effect on the target tissue or improve the potential for a positive response to care for the condition being treated.
6. Services do **not** require the skills of a qualified practitioner of chiropractic services. Examples include but not limited to:
    - Practitioner recommended activities and services that can be practiced independently and can be self-administered safely and effectively.

- Home exercise programs that can be performed safely and independently to continue therapy without skilled supervision.
- Activities for the general health and welfare of the individual such as:
  - General exercises (basic aerobic, strength, flexibility, or aquatic programs) to promote overall fitness/conditioning.
  - Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports.
  - Massages and whirlpools for relaxation.
  - General public education/instruction sessions.

7. Re-evaluations or assessments of a patient's status that are not a significant, separately identifiable E/M service above and beyond the usual preservice and post service work components included within the chiropractic manipulative services.
8. Re-evaluations or assessments of a patient's status that are not necessary to continue a course of therapy nor related to a new condition, new or changed health status for which the evaluation will likely result in a change in the treatment plan.
9. The treatments/services are **not** supported by and are **not** performed in accordance with nationally recognized clinical standards or with peer-reviewed literature as documented in appliable ASH CPGs or other literature accepted by ASH Clinical Quality committee.

(3) The following treatments are considered **not** medically necessary because they are non-medical, educational, or training in nature. In addition, these treatments/programs may be specifically excluded under benefit plans:

- Back school
- Group therapy (because it is not one-on-one, individualized to the specific patient's needs)
- Vocational rehabilitation programs and any program or evaluation with the primary goal of returning a patient to work
- Work hardening programs
- Nutrition wellness education or similar wellness interventions

4. CHIROPRACTIC MANIPULATION / MOBILIZATION

Chiropractic Manipulative Therapy (CMT) is a specific therapeutic procedure characterized by controlled force, leverage, direction, amplitude, and velocity intended to correct or improve spinal subluxation (altered joint alignment, motion, or physiologic function in an intact motion segment). This is distinguished from the use of the term manipulation by other professions which may include a spectrum of manual therapies such as mobilization, soft tissue manipulation, and muscle-energy techniques. For more information, see the *Spinal Manipulative Therapy for Musculoskeletal and Related Disorders (CPG 285 - S)* clinical practice guideline.

The CMT service includes an appropriate review of medical records, a brief pre-treatment evaluation of the patient's condition(s), as well as documentation of the patient's response post-treatment. These brief evaluations are essential to determine if:

- The treatment provided significant clinical improvement
- Further care is warranted
- A change in treatment plan is indicated
- A referral is indicated
- The treatment should be discontinued

Failure to appropriately perform and adequately document these brief evaluations may result in an adverse determination (partial approval or denial) of those CMT services.

4.1 Guidelines for Chiropractic Spinal Manipulation

In accordance with the current version of the American Medical Association's (AMA) Current Procedural Terminology (CPT) codebook, the five spinal regions are:

- Cervical region (includes the atlanto-occipital joint)
- Thoracic region (includes the costovertebral and costotransverse joints)
- Lumbar region
- Sacral region
- Pelvic region (includes the sacro-iliac joints)

The CPT® codes for reporting spinal manipulation/mobilization are as follows:

- 98940 CMT; Spinal, 1-2 regions
- 98941 CMT; Spinal, 3-4 regions
- 98942 CMT; Spinal, 5 regions

Medical Necessity Criteria

ASH considers chiropractic spinal manipulation (or grade V mobilization) to be medically necessary when both of the following criteria are met:

- There is adequate documentation that the patient has a symptomatic (acute, subacute, or chronic; with or without radicular components) musculoskeletal or related disorder attributable to a mechanical, structural, or functional disorder of the sacroiliac, lumbosacral; lumbar, thoracic and/or cervical spine or headache disorders including tension-type and migraine headaches; and
- There is an absence of contraindications to manipulation/mobilization or diagnostic red flags suggesting a possible organic disorder in the area of treatment, including but not limited to:
  - Malignancy or infection
  - Metabolic bone disease
  - Fusion or ankylosis

- Acute fracture or ligament rupture
- Joint hypermobility/instability

Documentation Requirements to Substantiate Medical Necessity of Chiropractic Spinal Manipulation/Mobilization

Proper patient specific evaluation and sufficient documentation is essential to establish the clinical necessity and effectiveness of spinal manipulation/mobilization, aid in the determination of patient outcomes management, and support continuity of patient care. At a minimum, documentation is required for every treatment day and for each area or spinal segment treated. Each daily record should include: the date of service, the procedure performed, area of treatment, and the identity of the person(s) providing the manipulation/mobilization services. Failure to properly identify and sufficiently document the practitioner's clinical findings that substantiate the clinical rationale to support spinal manipulation/mobilization on a daily progress note may result in an adverse determination (partial approval or denial).

Documentation should include:

(1) Absence of contraindications to spinal manipulation/mobilization in the area of treatment.

(2) Physical exam findings that correlate with the patient's subjective complaint(s) and support the diagnosis and treatment plan. Such findings may include:

- Pain (e.g., bone, muscle, joint)
- Tenderness/achiness (e.g., muscles, joints)
- Stiffness and/or limited motion
- Tone or texture changes in the adjacent muscles and soft tissues including muscle tightness or weakness
- Asymmetry or misalignment between adjacent spinal segments
- Acute inflammation (e.g., redness, heat, swelling, pain, impaired function, tenderness)
- Headache disorders (including tension-type and migraine headaches)
- Impaired function (e.g., functional deficits, ADL restrictions)
- Muscle disorders (e.g., spasms, cramps, injuries, trigger points)
- Numbness/tingling or other paresthesia, weakness, loss of deep tendon reflexes, or other signs of nerve or nerve root compression or irritation
- Other exam findings related and/or specific to the patient's condition(s) or complaint(s)

(3) A valid musculoskeletal diagnosis for a spinal complaint for which there is sufficient clinical evidence that spinal manipulation/mobilization is both safe and efficacious. Spinal manipulation/mobilization for non-musculoskeletal conditions is not medically necessary.

(4) Documentation that identifies against valid criteria (x-ray findings or physical exam findings) the presence and location of spinal dysfunctions / subluxation. Failure to appropriately document the spinal subluxation(s) may result in an adverse determination (partial approval or denial) of CMT services.

(5) An assessment of clinically significant change(s) in the patient's condition(s) if documenting the need for continued care.

4.2 Guidelines for Chiropractic Extra-Spinal Joint Manipulation/Mobilization

In accordance with the current version of the CPT® codebook, the five extraspinal regions are:

- Head region (including the temporomandibular joint, excluding the atlanto-occipital)
- Upper extremities
- Lower extremities
- Rib cage (excluding the costotransverse and costovertebral joints)
- Abdomen

The CPT® code for reporting extra-spinal manipulation/mobilization is:

- 98943 CMT; Extraspinal, 1 or more regions

Medically Necessary Extra-Spinal Joint Manipulation/Mobilization

In the absence of contraindications, the use of Extra-Spinal Joint Manipulation/Mobilization may be considered medically necessary when subjective complaint(s) and objective findings demonstrate a reasonable expectation of achieving a clinically significant level of improvement in the patient's complaint/condition. Examples of such complaints/conditions include, but not limited to:

- Shoulder complaints, dysfunction, disorders, and/or pain
- Restricted joint play of humeroradial joint
- Restricted joint play of radiocarpal joint
- Restricted joint play of iliofemoral joint
- Restricted joint play of proximal tibiofibular joint
- Ankle inversion sprains

Documentation Requirements to Substantiate Medical Necessity of Chiropractic Extra-Spinal Manipulation / Mobilization

The patient's medical records should document the practitioner's clinical rationale to support extra-spinal manipulation/mobilization (98943). In addition to the documentation criteria in section 4.1, documentation for extra spinal manipulation should include, at a minimum, abnormal joint mechanics or a range of motion abnormality that is appropriately documented and correlated with the subjective findings of an extra-spinal complaint and other pertinent exam findings in order to support extra-spinal manipulation/mobilization.

4.3 Use of Chiropractic Spinal Manipulation / Mobilization on Children

ASH considers Chiropractic spinal manipulation or mobilization for the treatment of children to be medically necessary when the documentation establishes a valid diagnosis and symptom pattern and there is a reasonable assumption of a positive benefit versus risk profile. Additional caution should be considered prior to performing Chiropractic spinal manipulation on infants and children. While there is insufficient literature to conclude that CMT is clinically effective or ineffective in children, a limited, short trial of care may be reasonable when the CMT meets all other medical necessity criteria. Monitoring the patient's tolerance for the services provided and response to care is especially important in this population as tolerance and response is highly variable in the pediatric population.

Chiropractic spinal manipulation is considered **not** medically necessary for non-musculoskeletal and related disorders in children, such as:

- Asthma
- Infantile colic
- Nocturnal enuresis
- Otitis media

5. THERAPEUTIC MODALITIES AND PROCEDURES

The CPT® codebook defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." Modalities may be supervised, which means that the application of the modality does not require direct one-on-one patient contact by the Chiropractor; or modalities may involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the Chiropractor.

Supervised modalities are untimed therapies. Untimed therapies are usually reported only once for each date of service regardless of the number of minutes spent providing this service or the number of body areas to which they were applied. Untimed services billed as more than one unit will require significant documentation to justify treatment greater than one session per day. Examples of supervised modalities include:

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation
- Vasopneumatic devices
- Whirlpool
- Paraffin bath
- Diathermy
- Ultraviolet or infrared light

Modalities that require constant attendance, are timed, and reported in 15-minute increments (one unit) regardless of the number of body areas to which they are applied. Examples of modalities that require constant attendance include:

- Contrast baths
- Ultrasound
- Manual, attended electrical stimulation (e.g., NMES)
- Iontophoresis

The CPT® codebook defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function." Except for Group Therapy (97150) and Work Hardening/Conditioning (97545-6), therapeutic procedures require direct one-on-one patient contact (constant attendance) by the Chiropractor, are timed therapies, and must be reported in units of 15-minute increments. Only the actual time that the Chiropractor is directly working with the patient performing exercises/activities, instruction, or assessments is counted as treatment time. The time that the patient spends not being treated because of a need for rest or equipment set up is not considered treatment time. Any exercise/activity that does not require, or no longer requires, the skilled assessment and intervention of a health care practitioner is not considered a medically necessary therapeutic procedure. Exercises often can be taught to the patient or a caregiver as part of a home/self-care program. Examples of therapeutic procedures that require the Chiropractor to have direct (one-on-one) patient contact include:

- Therapeutic exercises
- Neuromuscular re-education
- Gait training
- Manual therapy (e.g., soft tissue mobilization)
- Therapeutic activities
- Sensory integrative techniques
- Wheelchair training

Documentation Requirements to Substantiate Medical Necessity of Therapeutic Modalities and Procedures

Proper patient specific evaluation and sufficient documentation is essential to establish the clinical necessity and effectiveness of each modality and procedure, aid in the determination of patient outcomes management, and support continuity of patient care. At a minimum, documentation is required for every treatment day and for each therapy performed. Each daily record should include: the date of service, the name of each modality and/or procedure performed, the parameters for each modality (e.g., amperage/voltage, location of pads/electrodes), area of treatment, total treatment time spent for each therapy (mandatory for timed services), the total treatment time for each date of service, and the identity of the person(s) providing the services. Failure to properly identify and sufficiently document the parameters for each therapy on a daily progress note may result in an adverse determination (partial approval or denial).

5.1 Passive Care and Active Care

Passive Care

Passive care are those interventions applied to a patient with no active participation on the part of the patient. Passive care includes various skilled therapeutic procedures (e.g., chiropractic manipulation, manual therapy [CPT® 97140], acupuncture) as well as passive therapeutic modalities, such as heat, cold, electrical stimulation, and ultrasound. The following guidelines are relevant to the use of passive therapeutic modalities:

- Generally used to manage the acute inflammatory response, pain, and/or muscle tightness or spasm in the early stages of musculoskeletal and related condition management (e.g., short term and dependent upon patient condition and presentation; a few weeks). When the symptoms that prompted the use of certain passive therapeutic modalities begin to subside (e.g., reduction of pain, inflammation, and muscle tightness) and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms.
- Use in the treatment of sub-acute or chronic conditions beyond the acute inflammatory response time frame requires documentation of the anticipated benefit and condition-specific rationale (e.g., exacerbation, inclusion with active care as an alternative for pharmacological management of chronic pain) to be considered medically necessary. Passive therapeutic modalities can be appropriate in these situations when they are preparatory and essential to the safe and effective delivery of other skilled therapeutic procedures (e.g., chiropractic manipulation, manual therapy [CPT® 97140], therapeutic exercise, acupuncture) that are considered medically necessary.
- Used as a stand-alone treatment is rarely therapeutic, and thus not required or indicated as the sole treatment approach to a patient's condition. Therefore, a

treatment plan should not consist solely of passive therapeutic modalities but should also include skilled therapeutic procedures (e.g., chiropractic manipulation, manual therapy [CPT® 97140], therapeutic exercise, acupuncture).

- Should be based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) passive therapeutic modalities to the same body part during the therapy session. Use of more than two (2) passive therapeutic modalities on a single visit date and for a prolonged period is unusual and should be justified in the documentation for consideration of medical necessity.

Active Care

Active care involves therapeutic interventions that require patients to engage in specific exercises, movements, or activities to improve their health. Unlike passive care, which relies on external treatments (such as passive therapeutic modalities), active care emphasizes patient involvement and responsibility. Examples of active care include

- Therapeutic Exercise Prescription (CPT® Code 97110): This service may be considered when healthcare professionals are present and supervising tailored exercises performed by the patient based on the patient's condition, goals, and limitations. These exercises may be considered medically necessary to restore/develop strength, endurance, range of motion and flexibility which has been lost or limited as a result of a disease or injury. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Neuromuscular Reeducation (NMR) (CPT® Code 97112): This service may be considered when healthcare professionals are present and supervising tailored exercises/movements performed by the patient for the purpose of retraining the connection of the brain and muscles, via the nervous system to improve balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities. This procedure may be considered medically necessary for impairments which affect the neuromuscular system. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Therapeutic Activities Prescription (CPT® code 97530): This service may be considered when healthcare professionals are present and supervising tailored therapeutic activities or functional activities performed by the patient to improve function when there has been a loss or restriction of mobility, strength, balance or coordination. This intervention may be considered necessary when a patient needs to improve function-based activities. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Independent Exercise Programs: Patients are provided with appropriate exercise routines to perform on their own (e.g., home exercise programs [HEPs]).

Supervised skilled care is provided in the development, modification, and progression of the HEPs.

- Education and Self-Management: Patients receive education about their condition, proper body mechanics, and strategies to prevent recurrence. Empowering patients with knowledge helps them actively manage their health.

Use of various forms of active care should be started as soon as treatment is initiated and documented in the medical record, including instructions supporting Independent Exercise, Education and Self-Management. Active therapeutic procedures requiring the supervision of a skilled practitioner (e.g., therapeutic exercise, therapeutic activities, NMR) are initiated as soon as possible to patient tolerance. Patients should progress from active therapeutic procedures requiring the supervision of a skilled practitioner to solely an independent exercise program as soon as reasonably possible.

The goal for active therapeutic procedures requiring the supervision of a skilled practitioner is to provide the necessary skilled care (e.g., exercise technique and movement correction, technique feedback, exercise program modification, and/or exercise progression) to empower patients to successfully adopt and maintain an independent exercise program more efficiently and effectively than if they tried to do it on their own.

The length of time per session and the duration for medically necessary, active therapeutic procedures requiring the supervision of a skilled practitioner will vary depending upon multiple factors including but not limited to the patient's knowledge of exercise techniques and health status of the patient, the diagnosis, co-morbidities, phase of care, chronicity, and exam findings, especially the nature and severity of complaints, orthopedic, neurologic, and functional impairments.

The following guidelines are relevant to supervised therapeutic exercise (97110) and other active therapeutic procedures (e.g., 97112 and 97530) requiring the supervision of a skilled practitioner:

- For most patients, the length of time per visit for medically necessary active therapeutic procedures typically doesn't exceed two (2) timed units of CPT® Codes such as: 97110, 97112 or 97530. This includes some patients with significant impairments that would not be able to tolerate a longer active care time. Initially some individuals may only be able to tolerate the duration covered in one (1) timed unit. A longer time per visit requires documentation to support this level of supervision and activity
- More than two (2) or three (3) supervised active therapeutic procedure (e.g., 97110, 97112, 97530) sessions per week is expected to be a rare occurrence. Frequency of greater than three (3) times per week requires documentation to support this level of supervision.

- The duration of the treatment plan for active therapeutic procedures (e.g., 97110, 97112, 97530) varies based on the patient's condition, progress, treatment goals, and whether skilled services are necessary. It may span a visit or two, or several weeks or months, with periodic sessions to achieve functional improvement and address specific deficits. Certain patient factors may influence this duration (e.g., post-surgical status; significant trauma; significant orthopedic/neurological findings).

5.2 Treatment Interventions

Below are descriptions and medical necessity criteria, as applicable, for different treatment interventions, including specific modalities and therapeutic procedures associated with Chiropractic services. This material is for informational purposes only and is not indicative of coverage, nor is it an exhaustive list of services provided.

Hydrotherapy/Whirlpool/Hubbard Tank

These modalities involve supervised use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, skin conditions. Hydrotherapy may be considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions or for wound care (cleansing and debridement).

Hot/Cold Packs

Hot packs increase blood flow, relieve pain, and increase flexibility. Cold packs decrease blood flow to an area for reduction of pain and swelling. They may be considered medically necessary for musculoskeletal conditions that include significant pain and or swelling.

Paraffin Bath

This modality uses hot wax for application of heat. It is indicated for use to relieve pain and increase range of motion of extremities (typically wrists and hands) in post-surgical patients or patients with chronic joint dysfunction.

Mechanical Traction

This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain, spasm, and nerve root compression. Mechanical traction may be considered medically necessary only when there is no improvement after the application of other evidence-based therapeutic procedures to significantly improve symptoms for 3 weeks; the patient has signs of nerve root compression or radiculopathy; it is used in combination with other evidence-based treatments including therapeutic exercise with extension movements. Mechanical traction applied to the thoracic spine is unproven.

ASH considers using a table or chair with moving roller(s) against the spine or paraspinal tissue (e.g., Spinalator) a type of passive mobilization modality (often referred to as "intersegmental traction") that may have limited value in reducing spinal stiffness and muscle tension and is only appropriate as preparatory or adjunctive to spinal manipulative procedures. It should not be used as a stand-alone therapy. It should only be used for a short duration (1-2 weeks) to facilitate manipulations and to transition into an active therapy program.

Axial Decompression Therapy (AKA Decompression Therapy or Spinal Decompression Therapy) is considered unproven and not medically necessary.

Infrared Light Therapy

Infrared light therapy is a form of heat therapy used to increase circulation to relieve muscle spasm. Other heating modalities are considered superior to infrared lamps and should be considered unless there is a contraindication to those other forms of heat. Utilization of the Infrared light therapy CPT® code is not appropriate for low level laser treatment.

Electrical Stimulation

Various types and frequencies of electrical stimulation is used to relieve pain, reduce swelling, heal wounds, and improve muscle function. Functional electric stimulation may be considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation.

Iontophoresis

Electric current used to transfer certain chemicals (medications) into body tissues. Use of iontophoresis may be considered medically necessary for the treatment of inflammatory conditions, such as plantar fasciitis and lateral epicondylitis.

Contrast Baths

This modality is the application of alternative hot and cold baths and is typically used to treat extremities with subacute swelling or chronic regional pain syndrome (CRPS). Contrast baths may be considered medically necessary to reduce hypersensitivity reduction and swelling.

Ultrasound

This modality provides deep heating through high frequency sound wave application. Non-thermal applications are also possible using the pulsed option. Ultrasound is commonly used to treat many soft tissue conditions that require deep heating or micromassage to a localized area to relieve pain and improve healing. Ultrasound may be considered medically necessary to relieve pain and improve healing.

Diathermy

Shortwave diathermy utilizes high frequency magnetic and electrical current to provide deep heating to larger joints and soft tissue, and may be considered medically necessary for pain relief, increased circulation, and muscle spasm reduction. Microwave diathermy presents an unacceptable risk profile and is considered not medically necessary.

Therapeutic Exercises

Therapeutic exercise includes instruction, feedback, and supervision of a person in an exercise program specific to their condition. Therapeutic exercise may be considered medically necessary to restore/develop strength, endurance, range of motion and flexibility which has been lost or limited as a result of a disease or injury. Exercise performed by the patient within a clinic facility or other location (e.g., home, gym) without a physician or therapist present and supervising would be considered not medically necessary.

Neuromuscular Reeducation (NMR)

NMR generally refers to a treatment technique performed for the purpose of retraining the connection of the brain and muscles, via the nervous system, the level of communication to improve balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities.. The goal of NMR is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident, and systemic neurological disease. Example techniques may include proprioceptive neuromuscular facilitation (PNF), quadriceps activation methods, activities that engage balance and core control, and desensitization techniques. This does not include contract/relax or other soft tissue massage techniques. NMR is typically used as the precursor to the implementation of Therapeutic Activities.

Aquatic Therapy

Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or neurologically impaired individuals. (The term is not intended to refer to relatively normal functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.) The goal is to develop and/or maintain muscle strength and range of motion by reducing forces of gravity through total or partial body immersion (except for head). Aquatic therapy may be considered medically necessary to develop and/or maintain muscle strength and range of motion when it is necessary to reduce the force of gravity through partial body immersion.

Gait Training

This procedure involves teaching patients with neurological or musculoskeletal disorders how to ambulate given their disability or to ambulate with an assistive device. Assessment of muscle function and joint position during ambulation is considered a necessary component of this procedure, including direct visual observation and may include video, various measurements, and progressive training in ambulation and stairs. Gait training may be considered medically necessary for patients whose walking abilities have been impaired by neurological, integumentary, muscular or skeletal abnormalities, surgery, or trauma. This also includes crutch/cane ambulation training and re-education.

Therapeutic Massage

Therapeutic Massage involves the application of fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands and may be considered medically necessary when performed to restore muscle function, reduce edema, improve joint motion, or relieve muscle spasm caused by a specific condition or injury.

Soft Tissue Mobilization

Soft tissue mobilization techniques are more specific in nature and include, but are not limited to, myofascial release techniques, friction massage, and trigger point techniques. Specifically, myofascial release is a soft tissue manual technique that involves manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue. This procedure is considered medically necessary for treatment of pain and restricted motion of soft tissues resulting in functional deficits.

Therapeutic Activities

Therapeutic activities or functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities may be considered medically necessary) to improve function when there has been a loss or restriction of mobility, strength, balance or coordination. These dynamic activities must be part of an active treatment plan and directed at a specific outcome. This intervention may be considered medically necessary after a patient has completed exercises focused on strengthening and range of motion but needs to improve function-based activities.

Activities of Daily Living (ADL) Training

This procedure is considered medically necessary to enable the patient to perform essential activities of daily living, instrumental activities of daily living and self-care including bathing, feeding, preparing meals, toileting, dressing, walking, making a bed, and transferring from bed to chair, wheelchair, or walker.

Self-Care/Home Management Training

Self-Care/Home Management Training involves instructing and training patients with impairments in essential activities of daily living (ADL) and self-care activities (e.g., bathing, feeding, dressing, preparing meals, toileting, walking, making bed, and transferring from bed to chair, wheelchair or walker). This also includes compensatory training for ADLs, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment. Self-Care/Home Management Training may be considered medically necessary only when training is designed to address specific needs and goals of the patient for self-management skill development.

Orthotic Management and Training

Orthotic management and training may be considered medically necessary when the documentation specifically demonstrates that the specific knowledge, skills, and judgment of a Chiropractor are required to train the patient in the proper us of braces and/or splints (orthotics). Many braces or splints do not require specific training by the Chiropractor in their use and can be safely procured and applied by the patient. Patients with cognitive, dexterity, or other significant deficits may need specific training where other patients do not.

Prosthetic Training

Prosthetic training may be considered medically necessary when the professional skills of the practitioner are required to train the patient in the proper fitting and use of a prosthetic (an artificial body part, such as a limb). Periodic return visits beyond the third month may be necessary.

Wheelchair Management Training

This procedure is considered medically necessary only when it is part of a broader active treatment plan directed at a specific goal. The patient must have the capacity to learn from instructions. Typically, three (3) sessions are adequate.

5.3 Precautions and Contraindications to Therapeutic Modalities and Procedures

Thermotherapy:

The use of thermotherapy is contraindicated for the following:

- Recent or potential hemorrhage
- Thrombophlebitis
- Impaired sensation
- Impaired mentation
- Local malignant tumor
- IR irradiation of the eyes
- Infected areas

Precautions for use of thermotherapy include:

- Acute injury or inflammation
- Pregnancy
- Impaired circulation
- Poor thermal regulation
- Edema
- Cardiac insufficiency
- Metal in the area
- Over an open wound
- Large scars
- Over areas where topical counterirritants have recently been applied
- Demyelinated nerve

Cryotherapy:

The use of cryotherapy is contraindicated for the following:

- Cold hypersensitivity
- Cold intolerance
- Cryoglobulinemia
- Paroxysmal cold hemoglobinuria
- Raynaud disease or phenomenon
- Over regenerating peripheral nerves
- Over an area with circulatory compromise or peripheral vascular disease

Precautions for cryotherapy include:

- Over the superficial branch of a nerve
- Neuropathy
- Over an open wound
- Hypertension
- Poor sensation or mentation

Hydrotherapy:

The use of immersion hydrotherapy is contraindicated for the following:

- Cardiac instability
- Confusion or impaired cognition
- Maceration around a wound
- Bleeding
- Infection in the area to be immersed
- Bowel incontinence

- Severe epilepsy
- Patients with suicidal ideation
- Impaired mentation

Precautions for full body immersion in hot or very warm water include:

- Pregnancy
- Multiple Sclerosis
- Poor thermal regulation

Mechanical Traction:

Contraindications for mechanical traction include:

- Where motion is contraindicated
- Acute injury or inflammation
- Joint hypermobility or instability
- Peripheralization of symptoms with traction
- Uncontrolled hypertension
- Congenital spinal deformity
- Fractures
- Impaired mentation

Precautions for mechanical traction include:

- Structural diseases or conditions affecting the tissues in the area to be treated (e.g., tumor, infection, osteoporosis, RA, prolonged systemic steroid use, local radiation therapy)
- When pressure of the belts may be hazardous (e.g., with pregnancy, hiatal hernia, vascular compromise, osteoporosis)
- Cardiovascular disease
- Displaced annular fragment
- Medial disc protrusion
- Cord compression
- When severe pain fully resolves with traction
- Claustrophobia or other psychological aversion to traction
- Inability to tolerate prone or supine position
- Disorientation

Additional precautions for *cervical* traction:

- TMJ problems
- Dentures

Shortwave Diathermy:
The use of thermal shortwave diathermy (SWD) is contraindicated for the following

- Any metal in the treatment area or on/in the body.
- Malignancy
- Eyes
- Testes
- Growing epiphyses
- Recent or potential hemorrhage
- Thrombophlebitis

Contraindications for all forms of SWD:

- Implanted or transcutaneous neural stimulators including cardiac pacemakers
- Pregnancy
- Impaired sensation
- Impaired mentation
- Infected areas

Precautions for all forms of SWD:

- Near electronic or magnetic equipment
- Obesity
- Copper-bearing intrauterine contraceptive devices

Electrical Currents:
Contraindications for use of electrical currents:

- Demand pacemakers, implantable defibrillator, or unstable arrhythmia
- Placement of electrodes over carotid sinus and heart
- Areas where venous or arterial thrombosis or thrombophlebitis is present
- Pregnancy – over or around the abdomen or low back
- Infected areas

Precautions for electrical current use:

- Cardiac disease
- Impaired mentation
- Impaired sensation
- Malignant tumors
- Areas of skin irritation or open wounds

Ultrasound:
Contraindications to the use of ultrasound include:

- Malignant tumor
- Pregnant uterus
- Central Nervous Tissue
- Joint cement
- Plastic components
- Pacemaker or implantable cardiac rhythm device
- Thrombophlebitis
- Eyes
- Reproductive organs
- Impaired sensation
- Impaired mentation
- Infected areas

Precautions for ultrasound include:

- Acute inflammation
- Epiphyseal plates
- Fractures
- Breast implants

Pediatric Patients:
The use of electrical muscle stimulation, SWD, thermotherapy, cryotherapy, ultrasound, laser/light therapy, immersion hydrotherapy, and mechanical traction is contraindicated if the patient cannot provide the proper feedback necessary for safe application.

Unproven:
In addition to the contraindications listed above, there are a wide range of services which are considered unproven, pose a significant health and safety risk, are scientifically implausible and/or are not widely supported as evidence based. Such services would be considered not medically necessary and include, but are not limited to:

- Axial/Spinal decompression
- Dry needling
- Laser therapy
- Manual muscle testing to diagnosis non-neuromusculoskeletal conditions
- Microcurrent Electrical Nerve Stimulation (MENS)
- Other unproven procedures (see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for complete list)

5.4 Redundant Therapeutic Effects and Duplicative Rehabilitative or Habilitative Services

(1) Certain therapeutic modalities and procedures are considered redundant in nature, and it would be inappropriate to provide these services to the same body region during the same treatment session. This includes treatments, such as but not limited to:

- More than one heating modality
- Massage therapy and myofascial release
- Orthotics training and prosthetic training
- Whirlpool and Hubbard tank
- CMT and manual therapy techniques applied for same physiological purpose

(2) Duplicative (same or similar) rehabilitative services provided by different healthcare practitioners/specialties for the same condition(s) are considered **not** medically necessary. When patients receive chiropractic services, physical therapy services, occupational therapy services, or other healthcare specialty services for the same condition(s), the healthcare practitioners should provide different treatments that reflect each healthcare discipline's unique perspective on the patient's impairments and functional deficits and not duplicate the same treatment therapeutic goals. Each healthcare specialty practitioner must also have separate and distinct evaluations, treatment plans, and goals.

6. CLINICAL DOCUMENTATION

Medical record keeping an essential component of patient evaluation and management. Medical records should be legible and should contain, at a minimum sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Good medical record keeping improves the likelihood of a positive outcome and reduces the risk of treatment errors. It also provides a resource to review cases for opportunities to improve care, provides evidence for legal records, and offers necessary information for third parties who need to review and understand the rationale and type of services rendered (e.g., medical billers and auditors/reviewers).

Outcome measures are important in determining effectiveness of a patient's care. The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures provide information about whether predicted outcomes are being realized. When comparison of follow-up with baseline outcome metrics does not demonstrate minimal clinically important difference (MCID) (minimal amount of change in a score of a valid outcome assessment tool) the treatment plan should be changed or be discontinued. Failure to use Functional Outcome Measures (FOMs) / Outcome Assessment Tools (OATs) may

result in insufficient documentation of patient progress and may result in an adverse determination (partial approval or denial) of continued care.

6.1 Evaluation and Re-evaluations

As a best practice, all the following should be clearly described in the submitted records:

- Historical information including a clear description of the current complaint(s)
- Prior and current levels of function
- Tests performed and the results (e.g., evaluation findings)
- Valid diagnosis(es)
- Therapeutic goals and treatment plan (e.g., specific treatments, number of office visits)
- Response to care, progress, and prognosis
- Self – Care advice, including home exercise program

The initial evaluation is usually completed in a single session. An evaluation is mandatory before implementing any chiropractic treatment in order to determine if the patient needs skilled chiropractic care. Initial evaluations (New or Established Patient) include an Evaluation and Management (E/M) history and physical examination service and may be supported by, as necessary, imaging, laboratory studies, and/or other diagnostic tests and measures. An initial evaluation is essential to determine whether any services that may be recommended by the evaluating practitioner are medically necessary, to determine if referral to another clinical setting or another type of evaluation is necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data.

A reevaluation is considered medically necessary following a trial of care to determine whether that care resulted in significant clinical improvement documenting the need to continue a course of therapy, if modification of the approach to care is warranted, if there is need for referral to other healthcare practitioner(s)/specialist(s), or that discontinuance of treatment is warranted.

A reevaluation (an Established Patient E/M service) is considered medically necessary when **all** of the following conditions are met:

- The reevaluation exceeds the recurring routine assessment of patient status included in the work value of the Chiropractic Manipulation CPT® codes work-value; and
- The documentation of the reevaluation includes **all** of the following elements:
  - An evaluation of progress toward current goals; and
  - Making a professional judgment about continued care; and
  - Making a professional judgment about revising goals and/or treatment or terminating services; and
- Any **one** of the following indications is documented:

- The patient presents with an exacerbation, a new condition(s), or new clinical findings.
- There is a significant change in the patient's condition(s).
- The patient has failed to respond to the therapeutic interventions outlined in the current plan of care.

In order to reflect that continued chiropractic services are medically necessary, intermittent progress reports must demonstrate that the patient is making functional progress. Progress reports should be maintained in the medical record and may be required for approval of coverage of services.

A reevaluation is considered **not** medically necessary once it has been determined that the patient has reached maximum therapeutic benefit from the services provided unless there is/are medically necessary reason(s) documented for the reevaluation service.

The CPT® codebook provides the following definitions:

New Patient: Is one who **has not** received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same special and subspecialty who belongs to the same group practice, within the past three (3) years.

Established Patient: Is one who **has** received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three (3) years.

6.2 Treatment Sessions

Chiropractic treatment can vary from performing CMT alone to using a variety of therapeutic modalities and procedures depending on the patient's condition(s), response to care, and treatment tolerance. All services must be supported in the treatment plan and be based on the patient's medical condition(s)

A chiropractic treatment session may include:

- Chiropractic Manipulation.
- Passive modalities such as electrotherapeutic, mechanical modalities, and manual therapies such as soft tissue mobilization preparatory to other skilled services.
- Active therapeutic procedures such as therapeutic exercise, or functional activities
- Functional training in self-care and home management or modification of environments (e.g., home, work, school, community) including biomechanics and ergonomics.

- Reevaluation, if there is a significant change in the patient's condition, the patient has a new complaint(s), or there is a need to update and modify the treatment plan and goals.

Documentation of treatment should include:

- Date of treatment
- Subjective complaints and current status (including functional deficits and ADL restrictions)
- Description/name of each specific treatment intervention provided, including:
    - The type and specific location of CMT including segment(s) adjusted, subluxation listings/dynamic restrictions, direction(s) of corrective thrust(s), and specific technique(s) used;
    - The parameters for each therapy provided (e.g., voltage/amperage, pad/electrode placement, area of treatment, types of exercises/activities, and intended goal of each therapy)
    - Treatment time for each therapy and total treatment time per date of service
- The patient's response to each service and to the entire treatment session
- Any progress toward the goals in objective, measurable terms using consistent and comparable methods
- Any changes to the plan of care
- Recommendations for follow-up visit(s)
- Signature/electronic identifier, name and credentials of the treating clinician

The CMT service includes a brief pre-treatment evaluation of the patient's condition(s), as well as documentation of the patient's response post-treatment. Failure to appropriately perform and document these brief evaluations may result in an adverse determination (partial approval or denial) of those services.

6.3 Discharge/Discontinuation of Intervention

The chiropractor discharges the patient from chiropractic services when the anticipated goals or expected outcomes for the patient have been achieved. The chiropractor discontinues intervention when the patient is unable to continue to progress toward goals or when they determine that the patient will no longer benefit from care.

The discharge documentation includes:

- The status of the patient at discharge and the goals and outcomes attained.
- Appropriate date and authentication by the chiropractor who performed the discharge.
- When a patient is discharged prior to attainment of goals and outcomes, the status of the patient and the rationale for discontinuation.

- Final functional status.
- Proposed self-care recommendations, if applicable.
- Referrals to other health care practitioners/referring physicians, as appropriate.

6.4 Duplicated / Insufficient Information

(1) Entries in the medical record should be contemporaneous, individualized, appropriately comprehensive, and made in a chronological, systematic, and organized manner. Duplicated/nearly duplicated medical records (AKA cloned records) are not acceptable. It is not clinically reasonable or physiologically feasible that a patient's condition will be identical on multiple encounters. (Should the findings be identical for multiple encounters, it would be expected that treatment would end because the patient is not making progress toward current goals.)

This includes, but not limited to:

- Duplication of information from one treatment session to another (for the same or different patient[s])
- Duplication of information from one evaluation to another (for the same or different patient[s])

Duplicated medical records do not meet professional standards of medical record keeping and may result in an adverse determination (partial approval or denial) of those services.

(2) The use of a system of record keeping that does not provide sufficient information (e.g., checking boxes, circling items from lists, arrows, travel cards with only dates of visit and listings). These types of medical record keeping may result in an adverse determination (partial approval or denial) of those services.

Effective and appropriate records keeping that meet professional standards of medical record keeping document with adequate detail a proper assessment of the patient's status, the nature and severity of his/her complaint(s) or condition(s), and/or other relevant clinical information (e.g., history, parameters of each therapy performed, objective findings, progress towards treatment goals, response to care, prognosis).

7. CLINICAL REVIEW PROCESS

Medical necessity evaluations require approaching the clinical data and scientific evidence from a global perspective and synthesizing the various elements into a congruent picture of the patient's condition and need for skilled treatment intervention. Clinical review decisions made by the CQEs are based upon the information provided by the treating practitioner in the submitted documentation and other related findings and information. Failure to appropriately document pertinent clinical information may result in adverse determinations (partial approval or denial) of those services. Therefore, thorough

documentation of all clinical information that established the diagnosis/diagnoses and supports the intended treatment is essential.

7.1 Definition of Key Terminology used in Clinical Reviews

Chiropractic Maintenance Therapy Services

Chiropractic maintenance therapy services is defined as a treatment plan that seeks to prevent disease, promote health, correct subluxations unrelated to a diagnosed illness or injury, and prolong and enhance the quality of life and is not directed toward a specific condition that is expected to improve or resolve in a reasonable period of time (corrective care). Medicare also includes chiropractic supportive care as maintenance care and considers all forms of chiropractic maintenance care as not covered. (Chiropractic maintenance therapy services are not generally covered under commercial benefits.)

Chiropractic Supportive Care Services

Chiropractic supportive care is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic withdrawals of treatment. Chiropractic supportive care follows appropriate application of passive and active care including rehabilitation and lifestyle modifications. Chiropractic supportive care cannot be scheduled and should be rendered on an "as needed" basis (PRN) for up to 4 months in duration. Detailed and adequate documentation of each aspect and phase of intervention and patient's response to care is necessary to document the medical necessity of chiropractic supportive care. Chiropractic supportive care may be covered under some commercial benefits.

Elective/Convenience Services

Examples of elective/convenience services include: (a) preventive services; (b) wellness services; (c) services not necessary to return the patient to pre-illness/pre-injury functional status and level of activity; (d) services provided after the patient has reached MTB. (Elective/convenience services may not be covered through specific client or ASH benefits.)

Minimal Clinically Important Difference (MCID)

The MCID is the minimal amount of change in a score of a valid outcome assessment tool that indicates an actual improvement in the patient's function or pain. Actual significance of outcome assessment tool findings requires correlation with the overall clinical presentation, including updated subjective and objective examination/evaluation findings.

Maximum Therapeutic Benefit (MTB)

MTB is the patient's health status when the application of skilled therapeutic services has achieved its full potential (which may or may not be the complete resolution of the patient's condition.) At the point of MTB, continuation of the same or similar skilled treatment

approach will not significantly improve the patient's impairments and function during this episode of care.

If the patient continues to have significant complaints, impairments, and documented functional limitations, one should consider the following:

- Altering the treatment regimen such as utilizing a different physiological approach to the treatment of the condition, or decreasing the use of passive care (modalities, massage etc.) and increasing the active care (therapeutic exercise) aspects of treatment to attain greater functional gains;
- Reviewing self-management program including home exercise programs; and/or
- Referring the patient for consultation by another health care practitioner for possible co-management or a different therapeutic approach.

Preventive Services

Preventive services are designed to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimal health, wellness, and function. These services are not designed or performed to treat or manage a specific health condition. (Preventive services may or may not be covered under specific clients or through ASH benefits).

Acute

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is less than 6 weeks in duration, typically characterized by the presence of one or more signs of inflammation or other adaptive response.

Sub-Acute

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than 6 weeks, but not greater than 12 weeks in duration.

Chronic

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than 12 weeks in duration.

Red Flag(s)

Signs and symptoms presented through history or examination/assessment that warrant more detailed and immediate medical assessment and/or intervention.

Yellow Flag(s)

Adverse prognostic indicators with a psychosocial predominance associated with chronic pain and disability. Yellow flags signal the potential need for more intensive and complex treatment and/or earlier specialist referral.

Co-Morbid Condition(s)
The presence of a concomitant condition, that may inhibit, lengthen, or alter in some way the expected response or approach to care.

Health Equity (HE)
The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Centers for Medicare & Medicaid Services, 2024).

Social Determinants of Health (SDoH)
The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Five domains: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

7.2 Clinical Review for Medical Necessity

The goal of the CQEs during the review and decision-making process is to approve, as appropriate, those clinical services necessary to return the patient to pre-clinical/pre-morbid health status, stabilize, or functionally improve a chronic condition, as supported by the documentation presented. The CQE is to evaluate if the documentation and other clinical information presented by the practitioner has appropriately substantiated the patient's condition and appropriately justifies the treatment plan that is presented.

Approval

ASH CQEs have the responsibility to approve appropriate care for all services that are medically necessary. The CQEs assess the clinical data supplied by the practitioner in order to determine whether submitted services and/or the initiation or continuation of care has been documented as medically necessary. The practitioner is accountable to document the medical necessity of all services submitted/provided. It is the responsibility of the peer CQE to evaluate the documentation in accordance with their training, understanding of practice parameters, and review criteria adopted by ASH through its clinical committees.

The following items influence clinical service approvals:

- No evidence of contraindication(s) to services submitted for review
- Complaints, exam findings, and diagnoses correlate with each other
- Treatment plan is supported by the nature and severity of complaints
- Treatment plan is supported by exam findings

- Treatment plan is expected to improve symptoms (e.g., pain, function) within a reasonable period of time
- Maximum therapeutic benefit has not been reached
- Treatment plan requires the skills of the practitioner
- Demonstration of progression toward active home/self-care and discharge

Partial Approval

Occurs when only a portion of the submitted services are determined to be medically necessary services. The partial approval may refer to a decrease in treatment frequency, treatment duration, number of Durable Medical Equipment (DME)/supplies/appliances, number of therapies, or other services from the original amount/length submitted for review. This decision may be due to any number of reasons, such as:

- The practitioner's documentation of the history and exam findings are inconsistent with the clinical conclusion(s)
- The treatment dosage (frequency/duration) submitted for review is not supported by the underlying diagnostic or clinical features
- The need to initiate only a limited episode of care in order to monitor the patient's response to care

Additional services may be submitted and reviewed for evaluation of the patient's response to the initial trial of care. If the practitioner or patient disagrees with the partial approval of services, they may contact the CQE listed on their response form to discuss the case, submit additional documentation through the Reopen process, or submit additional documentation to appeal the decision through the Provider Appeals and Member Grievances process.

Non-approval / Denial

Occurs when none of the services submitted for review are determined to be medically necessary services. The most common causes for a non-approval/denial of all services are administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's condition(s) are not, or are no longer, responding favorably to the services being rendered by the treating practitioner, or the patient has reached maximum therapeutic benefit.

Additional / Continued Care

Approval of an additional treatment/services requires submission of additional information, including the patient's response to care and updated clinical findings. In cases where an additional course of care is submitted, the decision to approve additional treatment/services will be based upon the following criteria:

- The patient has made clinically significant progress under the initial treatment plan/program based on a reliable and valid outcome tool or updated subjective, functional and objective examination findings.
- Additional clinically significant progress can be reasonably expected by continued treatment. (The patient has not reached MTB or maximum medical improvement.)
- There is no indication that immediate care/evaluation is required by other health care professionals.

Any exacerbation or flare-up of the condition that contributes to the need for additional treatment/services must be clearly documented.

Ancillary diagnostic procedures should be selected based on clinical history and examination findings that suggest the necessity to rule out underlying pathology or to confirm a diagnosis that cannot be verified through less invasive methods.

- Information is expected to directly impact the treatment/services and course of care
- The benefit of the procedure outweighs the risk to the patient's health (short and long term)
- The procedure is sensitive and specific for the condition being evaluated (e.g., an appropriate procedure is utilized to evaluate for pathology)

The clinical information that the CQE expects to see when evaluating the documentation in support of the medical necessity of submitted treatment/services should be commensurate with the nature and severity of the presenting complaint(s), the scope of the services being requested, the scope of practice of the practitioner performing the services, and may include but is not limited to:

- History
- Physical examination/evaluation
- Documented treatment plan and goals
- Estimated time of discharge

In general, the initiation of care is warranted if there are no contraindications to prescribed care, there is reasonable evidence to suggest the efficacy of the prescribed intervention, and the intervention is within the scope of services permitted by State or Federal law. The treatment submission for a disorder is typically structured in time-limited increments depending on clinical presentation. Dosage (frequency and duration of service) should be appropriately correlated with clinical findings, potential complications/barriers to recovery and clinical evidence. When the practitioner discovers that a patient is nonresponsive to the applied interventions within a reasonable time frame, re-assessment and treatment modification should be implemented and documented. If the patient's condition(s) worsen,

the practitioner should take immediate and appropriate action to discontinue or modify care and/or make an appropriate healthcare referral.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary. If a patient's recovery can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

7.3 Critical Factors during Clinical Reviews

The complexity and/or severity of historical factors, symptoms, examination findings, and functional deficits play an essential role to help quantify the patient's clinical status and assess the effectiveness of planned interventions over time. CQEs consider patient-specific variables as part of the medical necessity verification process. The entire clinical picture must be taken into consideration with each case evaluated based upon unique patient and condition characteristics.

Such variables may include, but not be limited to co-morbid conditions and other barriers to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the symptoms, functional deficits, and exam findings, as well as social and psychological status of the patient and the available support systems for self-care. In addition, the patient's age, symptom severity, and the extent of positive clinical findings may influence duration, intensity, and frequency of services approved as medically necessary. For example:

- Severe symptomatology, exam findings, and/or functional deficits may require more care overall (e.g., longer duration, more services per encounter than the average); these patients may require a higher frequency of care; but may require short-term trials of care initially to assess the patient response to care.
- Less severe symptomatology, exam findings and/or functional deficits usually require less care overall (e.g., shorter duration, fewer services per encounter, and frequency of encounters than the average); but may allow for less oversight and a longer initial trial of care.
- As patients age they may have a slower response to care and this may affect the approval of a trial of care.
- Because pediatric patients (under the age of 12) have not reached musculoskeletal maturity, it may be necessary to modify the types of therapies approved as well as shorten the initial trial of care.
- Complicating and/or co-morbid condition factors vary depending upon individual patient characteristics, the nature of the condition/complaints, historical and examination elements, and may require appropriate coordination of care and/or more timely re-evaluation.

Health equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health. Factors that can impede health equity include, but are not limited to, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, and preferred language. Social Determinants of Health (SDoH) are important influences on health equity status. SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. There are typically five domains of SDoH: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context. These barriers to health equity may impact health care access, the patient presentation, clinical evaluations, treatment planning, and patient outcomes which may in turn influence medical necessity considerations.

The following are examples of the factors CQEs consider when verifying the medical necessity of rehabilitative services for musculoskeletal conditions and pain disorders.

7.3.1 General Factors

Multiple patient-specific historical and clinical findings may influence clinical decisions, such as but not limited to:

- Red flags
- Yellow flags (psychosocial factors)
- Co-morbid conditions (e.g., diabetes, inflammatory conditions, joint instability)
- Age (older or younger)
- Non-compliance with treatment and/or self-care recommendations
- Lack of response to appropriate care
- Lifestyle factors (e.g., smoking, diet, stress, deconditioning)
- Work and recreational activities
- Pre-operative/post-operative care
- Medication use (type and compliance)

Nature of Complaint(s)

- Acute and severe symptoms
- Functional testing results that display severe disability/dysfunction
- Pain that radiates below the knee or elbow (for spinal conditions)

History

- Trauma resulting in significant injury or functional deficits
- Pre-existing pathologies/surgery(ies)
- Congenital anomalies (e.g., severe scoliosis)
- Recurring exacerbations

- Prior episodes (e.g., >3 for spinal conditions)
- Multiple new conditions which introduce concerns regarding the cause of these conditions

Examination

- Severe signs/findings
- Results from diagnostic testing that are likely to impact coordination of care and response to care (e.g., fracture, joint instability, neurological deficits)

Assessment of Red Flags

At any time, the patient is under care, the practitioner is responsible for seeking and recognizing signs and symptoms that require additional diagnostics, treatment/service, and/or referral. A careful and adequately comprehensive history and evaluation in addition to ongoing monitoring during the course of treatment is necessary to discover potential serious underlying conditions that may need urgent attention. Red flags can present themselves at several points during the patient encounter and can appear in many different forms. If a red flag is identified during a medical necessity review, the CQE should communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods. When a red flag is identified, the CQE may inquire whether such red flag was identified and addressed by the practitioner, not approve services and recommend returning the patient back to the referring healthcare practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings.

Due to the rarity of actual red flag diagnoses in clinical practice, it is emphasized that the practitioner does not need to perform expensive or invasive diagnostic procedures (e.g., x-ray, advanced imaging, laboratory studies) in the absence of suspicious clinical characteristics. Important red flags and events as well as the points during the clinical encounter at which they are likely to appear include but may not be limited to:

Past or Current History

- Personal or family history of cancer
- Current or recent urinary tract, respiratory tract, or other infection
- Anticoagulant therapy or blood clotting disorder
- Metabolic bone disorder (osteopenia and osteoporosis)
- Unintended weight loss
- Significant trauma sufficient to cause fracture or internal injury
- Unexplained dizziness or hearing loss
- Trauma with skin penetration
- Immunosuppression (AIDS/HIV/ARC)

- Intravenous drug abuse, alcoholism
- Prolonged corticosteroid use
- Previous adverse reaction to substances or other treatment modalities
- Use of substances or treatment which may contraindicate proposed services
- Uncontrolled health condition (e.g., diabetes, hypertension, asthma)

Present Complaint

- Writhing or cramping pain
- Precipitation by significant trauma
- Pain that is worse at night or not relieved by any position
- Suspicion of vascular/cerebrovascular compromise
- Symptom's indicative of progressive neurological disorder
- Unexplained dizziness or hearing loss
- Complaint inconsistent with reported mechanism of injury and/or evaluation findings
- Signs of psychological distress

Physical Examination/Assessment

- Inability to reproduce symptoms of musculoskeletal diagnosis or complaints
-
- Fever, chills, or sweats without other obvious source
- New or recent neurologic deficit (e.g., special senses, peripheral sensory, motor, language, and cognitive)
- Positive vascular screening tests (e.g., carotid stenosis, vertebrobasilar insufficiency, abdominal aortic aneurysm)
- Abnormal vital signs.
- Uncontrolled hypertension
- Signs of nutritional deficiency
- Signs of allergic reaction requiring immediate attention
- Surface lesions or infections in area to be treated
- Widespread or multiple contusions
- Unexplained severe tenderness or pain
- Signs of abuse/neglect
- Signs of psychological distress

Pattern of Symptoms Not Consistent with Benign Disorder

- Chest tightness, difficulty breathing, chest pain
- Headache of morbid proportion
- Rapidly progressive neurological deficit

- Significant, unexplained extremity weakness or clumsiness
- Change in bladder or bowel function
- New or worsening numbness or paresthesia
- Saddle anesthesia
- New or recent bilateral radiculopathy

Lack of Response to Appropriate Care

- History of consultation/care from a series of practitioners or a variety of health care approaches without resolving the patient's complaint
- Unsatisfactory clinical progress, especially when compared to apparently similar cases or natural progression of the condition
- Signs and symptoms that do not fit the normal pattern and are not resolving

Assessment of Yellow Flags

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness and recovery. Examples of yellow flags include depressive symptoms, injuries still in litigation, signs, and symptoms not consistent with pain severity, and behaviors incongruent with underlying anatomic and physiologic principles.

If a yellow flag is identified during a medical necessity review, the reviewer should communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods. The CQE may inquire if the yellow flag was identified, and, if so, how it was addressed. They may recommend returning the patient back to the referring healthcare practitioner or referring the patient to other health care practitioner/specialist as appropriate.

Assessment of Historical Information

The following factors are assessed in review and determination if the services are medically necessary:

- The mechanism of onset and date of onset are congruent with the stated condition's etiology.
- The patient's past medical history and response to care do not pose contraindication(s) for the services submitted for review.
- The patient's past medical history of pertinent related and unrelated conditions does not pose contraindication(s) for the services submitted for review.
- The patient's complaint(s) have component(s) that are likely to respond favorably to services submitted for review.
- Provocative and palliative factors identified on examination indicate the presence of a musculoskeletal condition as expected per diagnosis(es) or complaints, or as consistent with other type of diagnosis(es).

- The patient's severity of limitations to activities of daily living (ADLs) are appropriate and commensurate for the presence of the condition(s) or disorder(s).
- The quality, radiation, severity, and timing of pain are congruent with the documented condition(s) or disorder(s).
- The patient's past medical history of having the same or similar condition(s) indicates a favorable response to care.
- The absence or presence of co-morbid condition(s) may or may not present absolute or relative contraindications to care.

Assessment of Examination Findings

- The exam procedures, level of complexity, and intensity are appropriate for the patient's complaint(s) and historical findings.
- Objective palpatory, orthopedic, neurologic, and other physical examination findings are current, clearly defined, qualified, and quantified, including the nature, extent, severity, character, professional interpretation, and significance of the finding(s) in relation to the patient's complaint(s) and differential diagnosis(es).
- Exam findings provide evidence justifying the condition(s) is/are likely to respond favorably to services submitted for review.
- Exam findings provide a reasonable and reliable basis for the stated diagnosis(es).
- Exam findings provide a reasonable and reliable basis for treatment planning; accounting for variables such as age, sex, physical condition, occupational and recreational activities, co-morbid conditions, etc.
- The patient's progress is being appropriately monitored each visit (as noted within daily chart notes and during periodic re-exams) to ensure that acceptable clinical progress is realized.

Assessment of Treatment / Treatment Planning

- Treatment dosage (frequency and duration of service) is appropriately correlated with the nature and severity of the subjective complaints, potential complications/barriers to recovery, and objective clinical evidence.
- Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary, even if they are performed or supervised by a Chiropractor. Therefore, if the continuation of a patient's care can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.
- The use of passive modalities in the treatment of subacute or chronic conditions beyond the acute inflammatory response phase requires documentation of the anticipated benefit and condition-specific rationale in order to be considered medically necessary.

- The treatment plan includes the use of therapeutic procedures to address functional deficits and ADL restrictions.
- The set therapeutic goals are functionally oriented, realistic, measurable, and evidence based.
- The proposed/estimated date of release/discharge from treatment is noted.
- The treatment/therapies are appropriately correlated with the nature and severity of the patient's condition(s) and set treatment goals.
- Functional Outcome Measures (FOM) demonstrate minimal clinically important difference (MCID) from baseline results through periodic reevaluations during the course of care. This is important in order to determine the need for continued care, the appropriate frequency of visits, estimated date of release from care, and if a change in the treatment plan or a referral to an appropriate health care practitioners/specialist is indicated.
- Home care, self-care, and active-care instructions are documented.

Durable Medical Equipment (DME), supplies, appliances, and supports are provided when medically necessary and appropriately correlated with clinical findings and clinical evidence.

Assessment of Diagnostic Imaging / Special Studies

- Laboratory tests are performed only when medically necessary to improve diagnostic accuracy and treatment planning. Abnormal values are professionally interpreted as they relate to the patient's complaint(s) or to unrelated co-morbid conditions that may or may not impact the patient's prognosis and proposed treatment.
- X-ray procedures are performed only when medically necessary to improve diagnostic accuracy and treatment planning. (Indicators from history and physical examination indicating the need for x-ray procedures are described in the *X-Ray Guidelines (CPG 1 - S)* clinical practice guideline).
- Advanced imaging studies, when medically necessary and/or available, are evaluated for structural integrity and to rule out osseous, related soft tissue pathology, or other pathology.
- Imaging or special studies' findings are appropriate given the nature and severity of the patient's condition(s) and the findings obtained are likely to influence the basis for the proposed treatment.
- EMG and NCV studies, when medically necessary and/or available, are evaluated for objective evidence of neural deficit. For more information, see the *Electrodiagnostic Testing (CPG 129 - S)* clinical practice guideline.
- According to the CPT® codebook "Needle electromyographic procedures include the interpretation of electrical waveforms measured by equipment that produces

both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode." For nerve conduction testing, "motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested" (AMA, current year). Waveforms must be reviewed on site in real-time. Reports must be prepared on site by the examiner and consist of the work product of the interpretation of numerous test results. EMG and NCV testing are only covered if provided by a qualified health care professional or physician. State licensure rules and regulations apply. For more information, see the *Electrodiagnostic Testing (CPG 129 – S)* clinical practice guideline

7.3.2 Factors that Influence Adverse Determinations of Clinical Services (Partial Approvals/Denials)

Factors that influence adverse determinations of clinical services may include but are not limited to these specific considerations and other guidelines and factors identified elsewhere in this policy. Topics/factors covered elsewhere in this guideline are also applicable in this section and may result in an adverse determination on medical necessity review. To avoid redundancy, many of those factors have not been listed below.

Additional Factors Considered in Determination of Medical Necessity
History / Complaints / Patient Reported Outcome Measures

- The patient's complaint(s) and/or symptom(s) are not clearly described.
- There is poor correlation and/or a significant discrepancy between the complaint(s) and/or symptom(s) as documented by the treating practitioner and as described by the patient.
- The patient's complaint(s) and/or symptom(s) have not demonstrated clinically significant improvement.
- The nature and severity of the patient's complaint(s) and/or symptom(s) are insufficient to substantiate the medical necessity of any/all submitted services.
- The patient has little or no pain as measured on a valid pain scale.
- The patient has little or no functional deficits using a valid functional outcome measure or as otherwise documented by the practitioner.

Evaluation Findings

- There is poor - correlation and/or a significant discrepancy in any of the following:
  - Patient's history
  - Subjective complaints
  - Objective findings
  - Diagnosis

    - Treatment plan
- The application of various exam findings to diagnostic or treatment decisions are not clearly described or measured. (e.g., severity, intensity, professional interpretation of results, significance).
- The patient's objective findings have not demonstrated clinically significant improvement.
- The objective findings are essentially normal or are insufficient to support the medical necessity of any/all submitted services.
- The submitted objective findings are insufficient due to any of, but not limited to, the following reasons:
    - Old or outdated relative to the requested dates of service
    - Do not properly describe the patient's current status
    - Do not substantiate the medical necessity of the current treatment plan
    - Do not support the patient's diagnosis/diagnoses
    - Do not correlate with the patient's subjective complaint(s) and/or symptom(s)
- Not all of the patient's presenting complaints were properly examined.
- The patient does not have any demonstrable functional deficits or impairments.
- The patient has not made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services.
- Clinically significant therapeutic progress is not evident through a review of the submitted records. This may indicate that the patient has reached maximum therapeutic benefit.
- The patient is approaching or has reached maximum therapeutic benefit.
- The patient's exam findings have returned to pre-injury status or prior level of function.
- There is inaccurate reporting of clinical findings.
- The exam performed is for any of the following:
    - Wellness
    - Pre-employment
    - Sports pre-participation
- The exam performed is non-standard and solely technique/protocol based.
- The procedure(s) used to validate subluxation(s) are considered not-evidence based, not widely accepted, and/or not medically necessary (e.g., functional leg length assessment, surface electromyographic study).

Diagnosis

- The diagnosis is not supported by one or more of the following:
    - Patient's history (e.g., date/mechanism of onset)
    - Subjective complaints (e.g., nature and severity, location)

- Objective findings (e.g., not clearly defined and/or quantified, not professionally interpreted, significance not noted)

Submitted Medical Records

- The submitted records are insufficient to reliably verify pertinent clinical information, such as (but not limited to):
  - Patient's clinical health status
  - The nature and severity of the patient's complaint(s) and/or symptom(s)
  - Date/mechanism of onset
  - Objective findings
  - Diagnosis/diagnoses
  - Response to care
  - Functional deficits/limitations
- There are daily notes submitted for the same dates of service with different/altered findings without an explanation.
- There is evidence of duplicated or nearly duplicated records for the same patient for different dates of service, or for different patients.
- There is poor correlation and/or a significant discrepancy between the information presented in the submitted records with the information presented during a verbal communication between the reviewing CQE and treating practitioner.
- The treatment time (in minutes) and/or the number of units used in the performance of a timed service (e.g., modality, procedure) during each encounter/office visit was not documented.
- Some or all of the service(s) submitted for review are not documented as having been performed in the daily treatment notes.

Treatment / Treatment Planning

- The submitted records show that the nature and severity of the patient's complaint(s) and/or symptom(s) require a limited, short trial of care in order to monitor the patient's response to care and determine the efficacy of the current treatment plan. This may include, but not limited to, any of the following:
  - Significant trauma affecting function
  - Acute/sub-acute stage of condition
  - Moderate-to-severe or severe subjective and objective findings
  - Possible neurological involvement
  - Presence of co-morbidities that may significantly affect the treatment plan and/or the patient's response to care
- There is poor correlation of the treatment plan with the nature and severity of the patient's complaint(s) and/or symptom(s), such as (but not limited to):
  - Use of acute care protocols for chronic condition(s)

  - Prolonged reliance on passive care
  - Active care and reduction of passive care are not included in the treatment plan
  - Inappropriate use of passive modalities in the plan of care
  - Use of passive modalities as stand-alone treatments (which is rarely therapeutic) or as the sole treatment approach to the patient's condition(s)
- There is evidence from the submitted records that the patient's treatment can proceed safely and effectively through a home exercise program or self-management program.
- The patient's function has improved, complaints and symptoms have decreased, and patient requires less treatment (e.g., lesser units of services per office visit, lesser frequency, and/or shorter total duration to discharge).
- The patient's symptoms and/or exam findings are mild and the patient's treatment plan requires a lesser frequency (e.g., units of services, office visits per week) and/or total duration.
- Therapeutic goals have not been documented. Goals should be measurable and written in terms of function and include specific parameters.
- Therapeutic goals have not been reassessed in a timely manner to determine if the patient is making expected progress.
- Failure to make progress or respond to care as documented within subjective complaints, objective findings and/or functional outcome measures.
- The patient's condition(s) is/are not amenable to the proposed treatment plan.
- Additional significant improvement cannot be reasonably expected by continued treatment, therefore treatment must be changed or discontinued.
- The patient has had ongoing care without any documented lasting therapeutic benefits.
- The condition requires an appropriate referral and/or coordination with other appropriate health care services.
- The patient is not complying with the treatment plan that includes lifestyle changes to help reduce frequency and intensity of symptoms
- The patient is not adhering to treatment plan that includes medically necessary frequency and intensity of services without documented extenuating circumstances.
- The use of multiple passive modalities with the same or similar physiologic effects to the identical region is considered redundant and not reasonable or medically necessary.
- Home care, self-care, and active-care instructions are not implemented or documented in the submitted records.
- Uncomplicated diagnoses do not require services beyond the initial treatment plan before discharging the patient to active home/self-care (e.g., mild knee pain that can be managed with a home exercise program).

- As symptoms and clinical findings improve the frequency of services (e.g., visits per week/month) did not decrease.
- The submitted services do not or no longer require the professional skills of the treating practitioner.
- The treatment plan is for any of the following:
    - Chiropractic maintenance therapy
    - Preventive care
    - Elective/convenience/wellness care
    - Back school
    - Group therapy (not one-on-one; 2 + patients)
    - Vocational rehabilitation or return to work programs
    - Work hardening programs
    - Routine educational, training, conditioning, return to sport, or fitness.
    - Non-covered condition
- There is duplication of services with other healthcare practitioners/specialties.
- The treatment plan is not supported due to, but not limited to, any of the following reasons:
    - Technique-/protocol-based instead of individualized and evidence based
    - Generic and not individualized for the patient's specific needs
    - Does not correlate with the set therapeutic goals
    - Not supported in the clinical literature (e.g., proprietary, unproven)
    - Not considered evidence-based and/or professionally accepted
- The treatment plan includes services that are considered not evidence-based, not widely accepted, unproven and/or not medically necessary, or inappropriate or unrelated to the patient's complaint(s) and/or diagnosis/diagnoses. (e.g., Low level laser therapy, axial/spinal decompression, select forms of EMS such as microcurrent, H-wave. Also see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S*) clinical practice guideline for complete list).

Health and Safety

- There are signs, symptoms and/or other pertinent information presented through the patient's history, exam findings, and/or response to care that require urgent attention, further testing, and/or referral to and/or coordination with other healthcare practitioners/specialists.
- There is evidence of the presence of Yellow and/or Red Flags. (See section on Red and Yellow Flags above.)
- There are historical, subjective, and/or objective findings which present as contraindications for the plan of care.

7.3.3 Referral / Coordination of Services

When a potential health and safety issue is identified, the CQE must communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods to recommend returning the patient back to the referring health care practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings. Such referral does not preclude coordinated cotreatment if / when applicable and medically necessary.

Clinical factors that may require referral or coordination of services include, but not limited to:

- Symptoms worsening following treatment
- Deteriorating condition (e.g., orthopedic or neurologic findings, function, etc.)
- Reoccurring exacerbations despite continued treatment
- No progress despite treatment
- Unexplained diagnostic findings (e.g., suspicion of fracture)
- Identification of red flags
- Identification of co-morbid conditions that don't appear to have been addressed previously that represent absolute contraindications to services
- Constitutional signs and symptoms indicative of systemic condition (e.g., unintended weight loss of greater than 4.5 kg/10 lbs. over 6-month period)
- Inability to provoke symptoms with standard exam
- Treatment needed outside of scope of practice

8. CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

ASH manages CMS Required and Supplemental benefits for Medicare Advantage Plans. Required (Traditional) Medicare benefits are covered based on CMS guidelines and regulations, CMS approved ICD defined conditions and CPT® defined services. ASH practitioners are required to follow CMS clinical requirements for the appropriate delivery and documentation of services rendered to Medicare beneficiaries who are served by ASH Medicare Advantage health plan clients.

8.1 Covered Conditions

Required Medicare Benefits

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.

To demonstrate a subluxation by physical examination, evaluation of the musculoskeletal/nervous system should include:

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

Two of the four criteria identified above are required, one of which must be asymmetry/misalignment or range of motion abnormality.

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably to 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.

The five spinal regions are:

- Neck (Occiput, C1 – C7)
- Back (T1 – T12)
- Low Back (L1 – L5)
- Pelvis (Ilium, SI)
- Sacrum (Sacrum, Coccyx)

The patient's symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine, muscle, bone, rib, and joint and be reported as pain, inflammation, or signs such as swelling, spasticity, etc. The subluxation must be causal, (i.e., the symptoms must be related to the level of 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.

The precise level of subluxation must be specified to substantiate a claim for manipulation of the spine. There are two ways in which the level of subluxation may be specified:

- The exact bones may be listed (e.g., C5, C6)

- The area may suffice if it implies only certain bones are involved (e.g., Occipito-atlantal [occiput and C1], lumbo-sacral [L5 and sacrum], sacro-iliac [sacrum and ilium])

Supplemental Medicare Benefits

ASH Medicare Advantage health plan clients may include additional covered musculoskeletal conditions beyond those included in the Required Medicare Benefit as described in a client specific benefit design.

8.2 Covered and Non-Covered Services

Required Medicare Benefits

Required Medicare benefits only cover manual manipulation of the spine by use of the hands. Additionally, manual devices may be used in performing manipulation of the spine, however, no additional payment is available for the use of a device. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

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 result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition. 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.

Non-Covered

Maintenance Care

Maintenance care includes services that seek to prevent disease, promote health, and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. Medicare includes chiropractic supportive care as maintenance care and considers all forms of chiropractic maintenance care as not covered. Medicare defines chiropractic maintenance care as: *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.*

8.3 Documentation

For Medicare and Medicaid services, medical records keeping must follow and be in accordance with Medicare and any additional state Medicaid required documentation guidelines.

The patient's history should include the following:

- Symptoms causing patient to seek treatment

- Family history, if relevant
- Past health history (general health, prior illness, injuries or hospitalization, 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
- Prior interventions, treatments, medications, secondary complaints

The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

8.4 Medical Necessity

CMS provides guidance for medical necessity determination based on the Medicare Benefit Policy Manual, Chapter 15, and limited Local Coverage Determinations (LCD). There is no National Coverage Determination (NCD) for chiropractic. Local Coverage Articles (LCA) may include language regarding medical necessity. When Medicare policy guidance for medical necessity is sufficient and clear to guide medical necessity decisions, the applicable Medicare guidance should be used in medical necessity review determinations. If the Medicare guidance for medical necessity review determinations is not clear or is insufficient in providing adequate guidance for a medical necessity determination for chiropractic services, the next policy in line used in making medical necessity review decisions would be the ASH *Chiropractic Services Medical Policy Guideline (CPG 278 – S)* clinical practice guideline. If applicable this policy will provide guidance for medical necessity review determinations of the Medicare covered service of chiropractic manipulative therapy for subluxation of the spine. The determination of medically necessary care as outlined in this guideline protects against inappropriate care that may be wasteful, unsafe, and harmful to the patient. The clinical benefit of insuring services are medically necessary highly outweighs the risk from clinical harms, including the possibility of limitations from delayed or decreased access to services. These additional criteria are implemented by clinical quality evaluators to determine medical necessity consistently to ensure all appropriate care is provided to MA beneficiaries.

The clinical evidence to support the delivery of services for covered conditions is supported by the guidelines and primary research references noted below. In summary, the evidence supports the use of chiropractic manipulative therapy for the treatment of spinal subluxation when the patient is correctly diagnosed with those conditions, there are not

contraindications for the treatment, and the course of care produces a favorable outcome following an appropriate frequency of treatment encounters.

This Clinical Policy is reviewed and approved by the ASH Clinical Quality committees that are comprised of contracted network practitioners including practitioners of the same clinical discipline as the practitioners for whom compliance with the practices articulated in this document is required. Guidelines are updated at least annually, or as new information is identified that result in material changes to one or more of these policies.

9. EVIDENCE REVIEW

There are several guidelines, systematic reviews, meta-analyses, and randomized controlled trials (RCTs) published that examine chiropractic manipulative therapy for various spinal conditions and other procedures (e.g., physical rehabilitation, exercise, education, manual therapies (e.g., mobilization, soft tissue mobilization) and note effectiveness (Qaseem et al., 2020; Bricca et al., 2020; Raghava Neelapala et al., 2020; Taylor et al., 2007; Chou et al., 2016; Qaseem et al., 2017; Byström et al., 2013; Macedo et al., 2016; Saragiotto et al., 2016; Steffens et al., 2016; van Middelkoop et al., 2011; Hurwitz et al., 2009; Delitto et al., 2012; Blanpied et al., 2017; BiDonde et al., 2019; Yousefi-Nooraie et al., 2008; Chou et al., 2020; Skelly et al., 2018; Skelly et al., 2020; Wheden et al., 2022; Jenks et al., 2022). Passive modalities, such as ultrasound, electric stimulation, traction, laser, and hot and cold packs, are often used in combination with manual therapies and exercise despite insufficient and/or inconclusive evidence for many conditions. Often methodologic flaws and heterogeneity of studies result in an inability to draw confirmatory conclusions.

Therapeutic Massage: Few clinical trials have been undertaken to assess the effect of this modality alone in the treatment of specific medical conditions. Rehabilitation programs frequently combine massage therapy with one or more other treatment interventions. While there is scant literature regarding the efficacy of this treatment when used as the sole modality, massage therapy has been a part of physical therapy or chiropractic treatment plans for the management of musculoskeletal pain. As an example, for mechanical low back pain, the greatest effects of massage therapy are seen in short term relief of pain. The effects on function were less clear. These therapeutic effects tend to diminish in the longer term (Chou et al., 2016). Massage therapy was also noted as an effective treatment of acute post-operative pain (Chou et al., 2020) and chronic low back pain in the intermediate term (Skelly et al., 2018). Slight functional improvements were noted in the intermediate term for fibromyalgia using myofascial release massage (Skelly et al., 2018; Kundakci et al., 2022).

9.1 Conditions Considered Unproven

Scoliosis

Scoliosis, lateral curvature of the spine, is a structural alteration that occurs in a variety of conditions. Progression of the curvature during periods of rapid growth can result in significant deformity, which may be accompanied by cardiopulmonary compromise (Schreiber et al., 2019; Scherl, 2016). Options for treatment of scoliosis include observation, bracing, and surgery. Evidence is insufficient to demonstrate effectiveness of physical therapy (scoliosis-specific exercises, (including the Schroth Method), chiropractic treatment, electrical stimulation, or biofeedback to correct, improve or prevent further curvature (Seleviciene et al., 2022; Santos et al., 2022; Fan et al., 2020; Schreiber et al., 2019; Scherl, 2016; National Institutes of Health [NIH]/National Institute of Arthritis and Musculoskeletal and Skin Disease [NIAMS], 2019; American Academy of Orthopedic Surgeons [AAOS], 2019; Mehlman, 2020; Romano, et al., 2012). Evidence is insufficient to demonstrate effectiveness of this treatment method to correct, improve or prevent further curvature

Scoliosis in itself is generally not predictive of pain or dysfunction. The clinical presentation of scoliosis can vary greatly, ranging from minimal or no symptoms, to severe pain and disability. The presence of scoliosis can result in chronic pain, radicular symptoms and even restriction of lung capacity. However, most patients with scoliosis do not have symptoms. Practitioners should focus on treating the symptoms of the patient with scoliosis as they would any other patient with back pain.

9.2 Specific Treatments Considered Unproven

Dry Hydrotherapy

Dry hydrotherapy, also referred to as aquamassage, water massage, or hydromassage, is a treatment that incorporates water with the intent of providing therapeutic massage. The treatment is generally provided in chiropractor or physical therapy offices. There are several dry hydrotherapy devices available that provide this treatment, including the following:

- Aqua Massage® (AMI Inc., Mystic, CT)
- AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- H2OMassage System™ (H2OMassage Systems, Winnipeg, MB, Canada)
- Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

Proponents of dry hydrotherapy maintain that it can be used in lieu of certain conventional physical medicine therapeutic modalities and procedures, such as heat packs, wet hydrotherapy, massage, and soft tissue manipulation. The assertions that have been made

by manufacturers of this device at their websites have not yet been proven. No published studies or information regarding dry hydrotherapy devices or dry hydrotherapy treatment were identified in the peer-reviewed scientific literature. In the absence of peer- reviewed literature demonstrating the effectiveness of dry hydrotherapy and in the absence of comparison to currently accepted treatment modalities, no definitive conclusions can be drawn regarding the clinical benefits of this treatment.

Non-invasive Interactive Neurostimulation (e.g., InterX ®)

Refer to *Non-invasive Interactive Neurostimulation (InterX®) (CPG 277 – S) clinical practice guideline* for more information.

Microcurrent Electrical Nerve Stimulation (MENS)

For more information, see Electric Stimulation for Pain, Swelling and Function in the Clinic Setting (CPG 272 – S) clinical practice guideline.

H-WAVE ®

Refer to *H-WAVE® Electrical Stimulation (CPG 269 – S) clinical practice guideline* for more information.

Spinal Manipulation for the Treatment of Non-Musculoskeletal Conditions and Related Disorders

Refer to *Spinal Manipulative Therapy for Non-Musculoskeletal Conditions and Related Disorders (CPG 119 – S) clinical practice guideline* for more information.

Taping/Elastic therapeutic tape (e.g., Kinesio™ tape, Spidertech™ tape)

Refer to *Strapping and Taping (CPG 143 – S) clinical practice guideline* for more information.

Dry Needling

Refer to *Dry Needling (CPG 178 – S) clinical practice guideline* for more information.

Laser Therapy (LT)

Refer to *Laser Therapy (LT) (CPG 30 – S) clinical practice guideline* for more information.

Vertebral Axial Decompression Therapy and Devices

Refer to Axial/Spinal Decompression Therapy (CPG 83 – S) clinical practice guideline for more information.

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NAME OF PRACTICE/PROVIDER

PATIENT NAME_____

PATIENT DOB_____

DATE COMPLETED_____

Neck Disability Index (NDI)

Instructions: For each section, select the one statement that best describes your condition today.

1. Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

2. Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

3. Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

4. Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can't read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

5. Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

6. Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want.
- ☐ I have a lot of difficulty in concentrating when I want.
- ☐ I have a great deal of difficulty in concentrating when I want.
- ☐ I cannot concentrate at all.

7. Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

8. Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I can't drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my car at all.

9. Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1–2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2–3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3–5 hrs sleepless).
- ☐ My sleep is completely disturbed (5–7 hrs sleepless).

10. Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I can't do any recreation activities at all.

Oswestry Low Back Disability Index (ODI)

Instructions: This questionnaire is designed to help understand how your back pain affects your ability to manage everyday life. Please check one box in each section that most closely describes your condition today.

1. Pain Intensity

- ☐ I can tolerate the pain I have without having to use painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

2. Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

3. Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

4. Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 1/2 mile.
- ☐ Pain prevents me walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than 1/2 hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

6. Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me standing for more than 1 hour.
- ☐ Pain prevents me standing for more than 1/2 hour.
- ☐ Pain prevents me standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

7. Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than 6 hours sleep.
- ☐ Even when I take tablets, I have less than 4 hours sleep.
- ☐ Even when I take tablets, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

8. Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

9. Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting more energetic interests (e.g., dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.

- ☐ I have no social life because of pain.

10. Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.