Medicare - Chiropractic Documentation

CMS DOCUMENTATION REQUIREMENTS

Chiropractic must document subluxation and it is the primary diagnosis. The subluxation must be determined by x-ray or physical examination via the PART format.

Documentation of the Subluxation: The P.A.R.T. System

When an x-ray is not used the physical exam must contain the following specifics of physical examination. **This protocol requires that at least two of the four components must be documented, and at least one of A or R.** Specific vertebrae must be identified not just a region. (i.e. must be C5 not cervical).

P: PAIN AND TENDERNESS – Location, Quality and Intensity

Observation: You can document, by personal observation, the pain that the patient exhibits during the course of the examination.

Percussion, Palpation, or Provocation: When examining the patient, ask them if pain is reproduced, such as, “Let me know if any of this causes discomfort.”

Visual Analog Type Scale: The patient is asked to grade the pain on a visual analog type scale from 0-10.

Audio Confirmation: Like the visual analog scale, the patient is asked to verbally grade their pain from 0-10.

Pain Questionnaires: Patient questionnaires, such as the McGill pain questionnaire or an in-office patient history form can be used for the patient to describe their pain.

A: ASYMMETRY/MISALIGNMENT Identify on a sectional or segmental level by using one or more of the following:

Observation: You can observe patient posture, analyze gait or plumb line. Static and Dynamic Palpation: Describe the spinal misaligned vertebrae, and symmetry.

Diagnostic Imaging: You can use x-ray, CAT scan and MRI to identify misalignments.

R: RANGE OF MOTION ABNORMALITY Identify an increase or decrease in segmental mobility using one or more of the following:

Observation: You can observe an increase or decrease in the patient’s range of motion.

Motion Palpation: You can record your palpation findings, including listing(s). Be sure to record the various areas that are involved and related to the regions manipulated. Stress Diagnostic Imaging: You can x-ray the patient using bending views. Range of Motion Measuring Devices: Devices such as goniometers or inclinometers can be used to record specific measurements.

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T: TISSUE, TONE CHANGES Identify using one or more of the following:

Observation: Visible changes such as signs of spasm, inflammation, swelling, rigidity, etc.

Palpation: Palpated changes in the tissue, such as hypertonicity, hypotonicity, spasm, inflammation, tautness, rigidity, flaccidity, etc. can be found on palpation.

Use of Instrumentation: Document the instrument used and findings. Tests for Length and Strength: Document leg length, scoliosis contracture, and strength of muscles that relate.

Examples of proper documentation of PART

Tenderness and pain on palpation C5, C6, & C7

ROM restricted on flexion C5, C6, and C7

This would indicate subluxation at those levels as pain and range of motion were noted in the specific segments. Note not all 4 components were used but two, with one being the requirement of range of motion or asymmetry.

HISTORY

This protocol should be followed for every new injury/illness or flare up

- Symptoms causing patient to seek treatment.
- Quality and character of symptoms/problem.
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors. Mechanism of trauma.
- Prior interventions, treatments, medication and secondary complaints
- Past health history as well as family history if relevant.

INITIAL VISITS:

A. History as noted above with the symptoms bearing a direct causal relationship to the diagnosis.

B. Evaluation of the musculoskeletal/ nervous system through physical examination.

C. Diagnosis: Primary, secondary, tertiary, etc. diagnosis with any associated conditions and complicating factors. (Note for Medicare claims subluxation is required as a primary diagnosis)

D. Treatment plan: recommended duration and frequency of visits. This should include specific and expected goals and the response to care. Objective measures to evaluate treatment effectiveness.

E. Date of the initial treatment for the present diagnosis and condition

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Subsequent Visit-SOAP Note requirements:

S ►Review of chief complaint (objectify not only with statements of "I feel better" but "I feel better and I can sit longer, bend further etc.") Emphasis should be applied to the specific statements that can demonstrate – *functional change*

►System review if relevant.

- **How is your pain today? A pain scale is useful (1-10)**
- **Because it is better or worse what can you do now or not do now as a consequence?**
- **Try to relate to "functional" activities as much as possible.**
- **Medicare does not expect improvement on each visit but the overall progress should be realized over a period of visits**
- **If there is a new complaint there is where it is addressed and if there is a need for a system review this is also where it would be addressed.**

Examples:

Pain increased by 50%

Neck less stiff

Felt better for __ days following last visit

Exercises helping to improve mobility

O ►Evaluation of area involved in diagnosis. (Palpation, ROM, Leg Check, Ortho tests etc.) Do so in a manner that offers some objective or measured values. (This should not be a full re-exam but evaluation a few key elements)

- **Evaluate the spine region of diagnosis (region(s) of subluxation in particular if Medicare)**
- **Leg check, palpatory findings, orthopedic tests etc., done in a manner that allows for some level of measurement for comparison over time.**

Examples:

ROM motion for flexion is now full

Straight leg raise positive at 70 degrees bilaterally

Muscle spasm decreased 25% in the trapezius bilaterally

Reminder: Subsequent visits are synonymous with any face-to-face encounter following the initial visit.

* Objective measures consist of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to

quantify progress and support justifications for continued treatment. Therefore, treatment effectiveness must be assessed during every subsequent visit (objective measurable goals).

Some providers use forms (Oswestry, etc.) to measure treatment effectiveness. If this is the case, then a patient would need to complete the form on every visit.

Reminder: Some forms, including the Oswestry, may not contain answers/responses that are objective (actual measures/values). The Chiropractor or patient may need to add additional information. For example, the form may use the term 'severe' for the evaluation of pain. 'Severe' is not an objective measure. The pain would need an actual value.

Examples of objective measures to evaluate goals include:

- Pain
  - Baseline: '9' on a scale of '1-10'
  - Goal: Decrease pain to '1'
- Standing:
  - Baseline: Only able to stand for 20 minutes
  - Goal: Able to stand for more than 1 hour
- Range of Motion (ROM):
  - Baseline: Lumbar spine flexion of 53 degrees and extension 11 degrees
  - Goal: Increase lumbar flexion to 80 and extension to 25

A ►Assessment of change since last visit, if any, which allows evaluation of treatment effectiveness. This element is essentially done by following the protocol in the S and O parameters

- **Comparison of the changes noted above however if the S and O already made reference to changes there is not a need to repeat them.**
- **If there is a new diagnosis or a change of assessment it should be highlighted**

Examples:

Cervical segmental dysfunction resolved but continued pain in the lumbar spine associated with spasm and subluxation

P ► Documentation of treatment given on day of visit.

- **Treatment provided with the specific manipulation to the subluxated vertebrae (the specific vertebrae must be listed such as C4 etc.)**

- **Other treatment should also be noted. If a treatment plan is written at the start of care for the current episode that can be referenced. The plan should have frequency and intensity (2 x a week for 4 weeks etc.) as well as the specific services. If it is a timed service time must be noted. Exercises or similar procedures should note the type, sets, reps etc.**

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- **Signature of the provider. This should clearly be evident at the end of the chart note.**

Signature Requirements:
Medicare requires the individual who ordered/provided services be clearly identified in the medical records. The signature for each entry must be legible and should include the practitioner's first and last name and applicable credentials, e.g., P.A., D.C., D.O., or M.D.

The daily SOAP should be a record of how the patient is progressing in care and the specifics of the services applied. Unless it is written in the notes the service, per law, will be considered, not performed.

The goal of any care plan is to improve the patient for reduction of pain and improvement of function. The chart notes are there to demonstrate how this has occurred. Exams should have all elements quantified in some fashion, to allow comparison. An easy way to see if care is effective (medically necessary) is to compare the same elements of evaluation, over time, and compare the results. When the progress of the patient levels off further care will be considered maintenance.