Chiropractor Compliance Summary

Documentation Compliance Criteria for Chiropractic Claims Submitted to the Funds

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Source Information: Medicare Policy

Purpose

The United Mine Workers of America Health and Retirement Funds (the Funds) processes and pays Medicare claims as a Health Care Prepayment Plan contracted through the Centers for Medicare and Medicaid Services (CMS). The purpose of this summary is to provide education about Medicare documentation guidelines to improve the quality of records needed to support the payment of Medicare claims paid by the Funds on behalf of CMS.

Requirement & Retrospective Audits

Medicare requires documentation which is legible, complete, appropriately authenticated and supports medical necessity for services reported on the insurance claim form. You may be audited retrospectively by the Funds or CMS to ensure that you have complied with all Medicare payment policies.

Medicare Enrollment

Chiropractors must be actively participating with Medicare to receive payment from the Funds. Medicare requires that a Chiropractor be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished.

Chiropractic Coverage

- Medicare 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 services are furnished. All other services furnished or ordered by chiropractors are not covered by Medicare.

- If a chiropractor orders, takes, or interprets an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the x-ray can be used for documentation. However, there is no Medicare coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

- In performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.
Some chiropractors have been identified as using an “intensive care” concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered by Medicare and reimbursement under Medicare is limited to not more than one treatment per day.

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.

Legibility of the Record

- Upon a request for records or for authorization purposes, if hand-written records are not legible, please also submit a typed or printed version of the record reflecting its contents word-for-word.
- All notes, orders and entries made in the patient's record should be dated, time stamped and signed by the author.
- Each note stands alone and should include sufficient information to support the level of service, medical necessity and codes reported on the claim form.
- Generally, the medical record should not be altered. However, errors should be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions should be dated, timed, and legibly signed or initialed. You should not add signatures at a later date or alter the record in any way not permitted by applicable Medicare requirements. Delayed entries within a reasonable time frame (24-48 hrs.) may be acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- Medicare generally requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature (stamp signatures are not acceptable). Please see additional directives provided below under “Authentication of Records, Orders, and Notes.”
- To avoid an error for signature reasons, we recommend that you make certain your documentation contains a LEGIBLE IDENTIFIER (signature) or valid electronic signature of the person performing the service and include a signature sample when responding to a request for records.
- The authentication requirement (i.e., legible signature, signature log or signature attestation statement) applies to various documents for many Medicare-covered services. The Funds follows applicable Medicare authentication guidelines.

Authentication of Records, Orders, and Notes

The Funds recommends the following to properly authenticate your documents related to Medicare claims:

Disclaimer: This information is provided by the UMWA Funds as an educational summary and may not include all Medicare requirements for coverage and payment. This summary does not supersede the official policies of the Centers for Medicare & Medicaid Services, and compliance with the guidance in this summary will not necessarily ensure payment. It is each health care provider’s responsibility to understand and to stay current with all coding & billing guidelines, Local and National Coverage Determinations, and any other legal requirements of the Medicare program.
ALWAYS sign your notes, and document and sign all orders. Notes and/or orders submitted with just a typed signature/signature line with no handwritten or electronic signature may not be acceptable.

Notes that have been transcribed should always be reviewed and signed – either electronically or with a hand-written signature - by the author of the note.

Do not sign a typed note without proof reading and making corrections to the note prior to signing.

You should print your name along with your written signature for clarification.

Initials should also have a printed name for clarification. When a note is from an inpatient setting, a full signature is preferred along with a printed name.

Signatures should be legible. A signature for which no letters can be established or that does not contain a typed/printed name for clarification may not be acceptable. Signature logs should be submitted when the signature is not legible. Signature logs should contain a sample signature with a typed or printed name, credentials, and when employment began and terminated (if applicable). Please use the sample signature log accompanying this summary.

When a signature is not present and the record has been requested for review or audit by the Funds, please use the attached Medicare attestation statement. Please provide the appropriate information on the attestation statement, sign it legibly, and submit the attestation statement with the unsigned records to the Funds.

The following are acceptable forms of signature for Medicare claims:

- Legible handwritten signatures
- Illegible signatures over a typed/printed name
- Illegible signatures where the letterhead, addressograph or other information on the page indicates the identity of the individual signing the document
- Illegible signatures accompanied by a signature log or an attestation statement
- A legible first initial and last name
- Initials over a typed/printed name or accompanied by a signature log or an attestation statement

**Documentation Requirements for the Initial Visit**

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

1. The history recorded in the patient record should include the following:
   - Symptoms causing patient to seek treatment;
   - Family history if relevant;
   - Past health history (general health, prior illness, injuries, or hospitalizations; 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; and
Prior interventions, treatments, medications, secondary complaints.

2. Description of the present illness including:

- 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; and
- Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such.

The subluxation must be causal, i.e., the symptoms must be related to the level of the 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.

3. Evaluation of musculoskeletal/nervous system through physical examination to identify:

- 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 resulting in an increase or a decrease of sectional or segmental mobility); and
- Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the immediately preceding four criteria, above, are required, one of which must be asymmetry/misalignment or range of motion abnormality.

The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.
There are two ways in which the level of the subluxation may be specified:
- The exact bones may be listed, for example: C5, C6, etc.
- The area may suffice if it implies only certain bones such as: Occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum), sacro-iliac (sacrum and ilium).

Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:
- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis – antero, postero, retro, lateral, spondylo
- Motion – limited, lost, restricted, flexion, extension, hyper mobility, hypomobility, aberrant

4. Diagnosis:

- The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation.
- Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. Treatment Plan: The treatment plan should include the following:

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

6. Date of the initial treatment.

**Documentation Requirements of Subsequent Visits**

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

1. History
   - Review of chief complaint;
   - Changes since last visit;
   - System review if relevant.

2. Physical exam
- Exam of area of spine involved in diagnosis;
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

**Necessity for Treatment**

- 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, as described above.

- Most spinal joint problems fall into the following categories:
  - **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.
  - **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.*

**Documentation Requirements for Maintenance Therapy**

Maintenance therapy 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.

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.

- The **AT modifier must not be placed on the claim** when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied.
Coding Guidelines

- **AT Modifier**: For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary.
- Applicable HCPCS level 2 guidelines should be followed.
- Applicable guidelines found in ICD-9-CM volumes 1 and 2 to report the diagnosis on the claim should be followed.
- Applicable coding guidelines and applicable Medicare medical necessity guidelines found in your Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) should be followed. Applicable Medicare National Correct Coding Initiative (NCCI) bundling guidelines, applicable Medically Unlikely Edits (MUEs) as well as any other applicable Medicare documentation guidelines should be followed.

**Medicare Resources & References**

Authentication: Program Integrity Manual 100-08 Chapter 3, Section 3.4.1.1

Medicare Benefit Policy Manual, Pub 100-2 Chapter 15, Sections 30.5, 240.1.2-240.1.5