Optimizing Chiropractic Documentation for Compliance and Care Quality

A KMC University White Paper
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Executive Summary:

Accurate, complete, and Medicare-compliant documentation is crucial for the sustainability and success of any chiropractic practice. This white paper explores best practices across the entire episode of care, from initial patient history through treatment and discharge. By aligning with Evaluation and Management (E/M) guidelines and Medicare's documentation requirements, chiropractic professionals can enhance patient care, support reimbursement efforts, and reduce audit risks.

1. The Importance of Comprehensive History Documentation:

Medicare audits frequently find missing or incomplete patient history:

- 70% of initial visit documentation lacks a complete history.
- 66% omit a full description of the History of Present Illness (HPI).

Often, missing each area of complaint information, mechanism of injury, previous episode details, and functional deficits.

Pertinent Review of Systems (ROS) should be performed at the initial visit and updated during follow-ups.

Key questions for ROS include:

- Is the condition ongoing?
- Managed by another provider?
- Related to chief complaint?
- Require referral

Past, Family, and Social History (PFSH) should be evaluated for previous surgeries, medications, treatments, family history, and lifestyle factors.

2. Driving the Examination with the HPI:

Use the OPQRST model:

- **O**nset
- **P**rovoking Factors
- **Q**uality
- **R**egion and Radiation
- **S**everity
- **T**ime

Ensure no blanks in the intake forms and use HPI to guide compliant examinations.

3. Performing the Examination:

PART Documentation is required by Medicare:

- **P**ain
- **A**symmetry
- **R**ange of Motion
- **T**issue Changes

Quantify the complaints with appropriate findings.

Radiology rationale should be documented with clear indications such as trauma history or suspected pathology.

4. Accurate Diagnosis and Clinical Assessment:

Use a stepwise process to link findings to diagnosis and justify your plan of care.

Initial assessments should express clinical opinions, acknowledge co-morbidities, complicating factors, and justify treatment plans without restating objective data.

5. Crafting a Compliant Treatment Plan:

Include Recommended care with rationale, frequency/duration, start date, outcome measures (OATs), specific and functional goals.

Use SMART (Specific, Measurable, Achievable, Relevant, Time-bound) or RUMBA (Relevant, Understandable, Measurable, Behavioral, Achievable) models for goal setting.

6. Documenting Routine Daily Visits (SOAP) Notes:

SOAP format: **S**ubjective, **O**bjective, **A**ssessment, **P**lan

For Medicare visits, support the AT modifier by documenting medical necessity and active treatment clearly.

Modifiers Used Only with 98940, 98941, 98942		
Modifier	***Description/Instruction***	***Effect on Medicare Payment***
AT	Reporting Active/Corrective Treatment Indicates service rendered was medically necessary per Medicare guildeline	Medicare will consider for payment.
GA	Waiver of Liability (ABN) on file for mandatory use Indicates maintenance care or visits exceed carrier screen	If patient select ABN Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABN for maintenance care as required	Claim will be denied. Patient will not be deemed responsible for payment.

Modifiers Used with Statutorily Excluded Services		
Modifier	***Description/Instruction***	***Effect on Medicare Payment***
GY	Indicates statutorily non-covered item/service is rendered by a DC	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABN on file for voluntary use	Claim will be denied/patient financially liable; we don't recommend Medicare's official ABN form for voluntary use.
GP	Services delivered under an outpatient physical therapy plan of care	Use on PT modalities and procedures, along with GY to receive proper denial.

7. Discharge and Specialty Visits:

Types of discharge: Maximum Medical Improvement, Therapeutic Withdrawal, Administrative (by doctor or patient).

Discharge summaries must include: Condition treated, Dates, Visits, Treatment, Goals achieved, Final status.

Conduct re-evaluations every 30 days per CCGPP guidelines with updated history, exam, assessment, and plan.

Conclusion:

Don't let documentation gaps put your practice at risk. Our team at KMC University offers a **FREE Discovery Assessment** to help you quickly identify strengths, weaknesses, and immediate opportunities for improvement in your documentation and compliance processes. It's a no-obligation way to gain clarity and take the first step toward better protection, higher reimbursements, and greater confidence in your systems.