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Part B Insider (Multispecialty) Coding Alert

Avoid This Common Chiropractic Documentation Mistake

Treatment plans are a must, experts say.

You've treated your chiropractic patient, you've selected the correct codes, and you've submitted your claim. All set, right? Not quite. Check out this common mistake that chiropractors make.

"Many chiropractors do not create written chiropractic treatment plans for every new patient," says **Marty Kotlar, DC, CHCC, CBCS**, president of Target Coding, a chiropractic coding and billing consulting firm. "Medicare would like to see chiropractors include the following information with every new patient plan of care,"

Kotlar says:

1. The history

2. Present illness

3. Family history

4. The past health history

5. The physical examination

6. The diagnosis

7. The plan -- This should include:

    - Therapeutic modalities to effect cure or relief (patient education and exercise training)
    - The level of care that is recommended (the duration and frequency of visits)
    - Specific goals that are to be achieved with treatment
    - The objective measures that will be used to evaluate the effectiveness of treatment
    - Date of initial treatment.

8. Signature/initials to authenticate the records.