

Chiropractic Coding & Compliance Alert

Reader Questions: Know the Documentation Requirements of an Initial Visit

Question: Do we have any guidelines regarding the documentation requirements for an initial visit that help us prove the medical necessity?

Rhode Island Subscriber

Answer: Definitely, yes. According to CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2, which most of the LCDs also refer to, CMS requires appropriate documentation of patient's initial visit examination proceedings.

Starting from penning the patient's history, which should include symptoms, relevant family history, past medical and surgical history, mechanism of injury, if any, which has caused the presenting symptoms, record a detailed description of symptoms including onset, duration, intensity, frequency, location and radiation, aggravating or relieving factors; and details of prior treatment and medications taken, if any. Make sure that the symptoms the patient narrates have a direct bearing on the level of spinal subluxation that you would identify.

What's more, the symptoms must refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal), or joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. While describing pain, be specific to indicate the location and its probable relation to the particular vertebral level said to have been affected.

You then do evaluation of musculoskeletal/nervous system through physical examination. As for the diagnosis, your first or 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.

You treatment plan must include specific objectively measurable treatment goals, and the frequency of visits that you recommend. Lastly, remember to mention the date of the initial treatment.