

Chiro - Passing Medicare Audit Requires Good Documentation

Passing a Medicare audit is a matter of knowing the Medicare Chiropractic guidelines and following the rules about documentation. If you have the appropriate documentation, passing the audit will be tedious but not impossible. Let's examine the Medicare chiropractic guidelines as they have been written. On the initial visit, the following information should be recorded in the patient's record as part of the patient history. This is subjective – as told to you by the patient.

Patient History

Symptoms causing patient to seek treatment: There should be a portion of your case history form that asks the patient why he/she is seeking treatment. This information should be recorded in the patient's own words.

Family history (if relevant): For many chiropractic patients, the family medical history may not be significant. In an allopathic office, family medical history is important because certain conditions such as cancer or heart problems have a tendency to run in families. For spinal problems, family history information can be gathered but may not have an impact on treatment.

Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history): There are many personal health records that will solicit this information in a very organized fashion as part of the patient history.

Mechanism of trauma: Mechanism of trauma is the area of documentation that is the most contentious at this point in time. Prior to recent developments, chiropractors were recording mechanism of trauma only when there was a specific accident or injury that precipitated the care. Otherwise, if the patient woke up one day with a sore back, there was no documentation on mechanism of trauma. Many of the current Medicare audits have received failing marks because the mechanism of trauma was not recorded in the documentation. It needs to be recorded for every patient. In addition, WPS auditors were requiring that the mechanism of trauma not be related to an activity of daily living. This would leave only a slip and fall or an injury caused by an external force to meet the mechanism of trauma guidelines. More recently, WPS auditors have backed off of the requirement that the mechanism of trauma not be related to activities of daily living (ADLs).

For your documentation, it is best to record a mechanism of trauma for every new patient. If possible, ask leading questions of your patient to elicit a specific incident that precipitated the pain that the patient is experiencing. "Prior to experiencing your low back pain, did you slip or fall? Were you doing any unusual activity? When did you first experience the pain? Can you recall anything unusual that happened prior to experiencing the pain?" Record any incident that the patient can relate that ties to the pain that brought them into your office.

Quality and character of symptoms/ problem: In this scenario, you are trying to elicit information about the type of pain that is being experienced – dull, sharp, tingling, stabbing, ache, burning, numbness. In addition, you might want to ask whether the pain is constant, intermittent or random.

Onset, duration, intensity, frequency, location and radiation of symptoms: If you have recorded mechanism of trauma above, it should have included a date of onset. The intensity and frequency are also addressed in the quality and character of the symptoms or problems. If the patient has a neck pain radiating into the right arm, the radiation must be indicated.

Aggravating or relieving factors and prior interventions, treatments, medications, secondary complaints: As part of your documentation of chief complaint, there should be an indication whether certain activities exacerbate the problem. For example, if the patient presents with neck pain, does sitting, lying down, standing or bending over aggravate or relieve the pain? In addition, where has the patient sought treatment... from their medical doctor or a physical therapist? Remember, this section of documentation is the patient history, the subjective part of the documentation requirements.

PART Examination

After recording the patient history, the objective portion of the examination begins. You can either use x-rays or an orthopedic/neurological examination to justify the need for care. If the patient is presenting with a neck problem, Medicare expects to see a physical examination of the cervical area. If the patient presents with low back pain, Medicare expects to see a physical examination of the lumbar area. Even though neck pain can be related to a misalignment of the lumbar or pelvic area, Medicare does not comprehend or substantiate a problem unless an examination of that problem area occurs.

Thankfully, Medicare stopped short of requiring specific physical examinations in their documentation. The examinations performed are left to the discretion of the chiropractor. In addition to recording positive findings, be sure to also record negative findings. Remember, there are four sections of the PART exam: pain, asymmetry, range of motion and tissue/tone changes. To use the PART exam to justify care, you must have positive findings in either asymmetry or range of motion.

Treatment Plan

In addition to mechanism to trauma documentation, the treatment plan documentation has received the most attention from Medicare auditors. The documentation must include the recommended level of care which is defined as duration and frequency of visits. Again, remember that Medicare determines short, intermediate, and long-range treatment plans based on the neuromusculoskeletal diagnosis codes so your treatment plan should specify the primary and secondary diagnosis codes.

The most critical part of required documentation seems to be the treatment plan - and the part that is gaining the closest scrutiny from Medicare - is specific treatment goals. For example, if the patient's current cervical right rotation is 50°, a specific treatment goal might be to increase the range of motion to 75°. Given that most Medicare patients are older and have some degree of spinal degeneration, the treatment goal must be cognizant of the patient's current condition. A 90-year-old patient will probably not be able to achieve normal cervical right rotation unless they are in exceptional physical condition. If you have not recorded degrees of range of motion, perhaps you have used a scale such as zero to four to indicate restriction. If the patient is currently experiencing a 4, severe restriction, the treatment goal might be to increase the range of motion to a 2, mild restriction. If you are using a rating scale, it is necessary to explain to Medicare the gradients on that scale.

For asymmetry or misalignment, it is much more difficult to establish specific treatment goals. How do you quantify the degree of misalignment? If you have found a good way of quantifying misalignment or subluxation, include specific treatment goals related to correcting the misalignment or asymmetry. If you choose to establish treatment goals related to pain, we suggest that you use the Analog Pain Scale. Using this pain scale, the patients will rate their pain on a scale from zero to 10 with 10 being almost intolerable. If the patient presents with the pain scale of seven, you can establish a goal of reducing the pain 3 or 4. In addition, you can also reference their dependence on prescription painkillers and the possibility of eliminating drugs entirely. With regard to tissue or tone changes, you can substantiate and quantify the severity of muscle spasms. In most cases, doctors are using a rating scale from zero to four.

Adjustments

As the final part of your initial assessment, Medicare requires an indication whether adjustments were performed on the initial visit, what segments were adjusted and how.

Functional Limitations

In addition to establishing treatment goals related to range of motion or asymmetry, you can also establish ancillary treatment goals related to functional assessment and/or limitations. If you use a functional assessment tool that rates the degree of difficulty in performing a task correlated with the level of pain involved in the performance, you can establish very specific treatment goals related to returning the individual to as much a normal functional abilities as possible. In this case, you would have a list of functional activities that can be graded according to difficulty and associated with level of pain.

Re-Exam and Visits

Once you have collected all of the data on the initial visit, Medicare looks at your specific treatment plan and goals to see if you have achieved optimal level of correction during subsequent visits. When it is appropriate, you should review the history and the progress toward resolving the chief complaint. At the time of re-examination, you should focus on all of those areas that were positive it during your initial examination to determine whether changes have occurred.

Each treatment should indicate the treatment performed, the visit number (as part of the visit plan), the date of the initial visit and a treatment plan update if appropriate. Periodically throughout the treatment plan, you should indicate your evaluation of the treatment effectiveness. When you perform a re-examination, you should summarize the progress made toward resolving the treatment goals.

New Injury or Exacerbation

Every chiropractor realizes that the body is not a static organism but a living, breathing and constantly changing collection of cells. If the patient experiences one of these three scenarios during the course of treatment, it should be highly documented and perhaps initiate a new treatment phase:

1. **New Injury:** A new injury – especially to a different area of the spine – should be thoroughly documented. In most cases, especially if you have a new diagnosis, you would change the “date first consulted” or date of initial treatment since this is a new problem that has surfaced. You would have a different treatment plan and different treatment goals.
2. **New Condition:** If the patient originally presented with headaches and is now experiencing low back pain, this is another indication for a complete examination and perhaps a new treatment phase with new diagnosis.
3. **Exacerbation/aggravation of existing condition:** Suppose that you have been treating the patient for three months and they have been making steady but slow progress. As a result of a new daily activity, the patient experiences a return of their symptoms. In this case, the exacerbation should be thoroughly documented in the patient's words and through your physical exam prior to adjustment.

It is Possible to Pass a Medicare Audit

When you accept Medicare patients in your office, it forces you to buy into the rules and guidelines established by Medicare. That is just a fact of life. There is no doubt that the documentation requirements are stringent. Of course, having written guidelines makes it easier to play by the rules. There should be no surprises. With the appropriate documentation and attention to detail, it is possible to pass a Medicare audit at 100%.