Medicare Documentation Requirements Explained

The documentation requirements for an initial and a subsequent visit may vary from one payor to the next and should be followed per the Medical Review Policy of that payor. In the absence of any other guidelines, use the Medicare guidelines. Medicare's documentation requirements aid in proving medical necessity. These standards are published in most Chiropractic Local Coverage Determinations (LCDs) or Local Coverage Articles (LCAs) from your Medicare Administrative Contractor (MAC). Just as no two patients are the same, documentation varies, too—it must be appropriate for the conditions being treated. This tool strives to clarify the stated requirements.

Initial Visit

Initial visit notes tend to be more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented in an initial visit and lays the groundwork for the entire course of treatment. An initial visit is any visit that kicks off a new episode of care, whether for a new or returning patient. **Note:** This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.

Medicare's Stated Requirement	What It Means
A **detailed patient history** that includes: • Symptoms that caused the patient to seek treatment and when the problem started • Description/mechanism of the current injury • Quality, character, frequency, and location of the symptoms • His/her relevant family history and past health history	• Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, beyond simple "subjective" • Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs). • With multiple complaints, outline each complaint with details as noted • The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care • There is a clear mechanism of injury, or comments regarding when the condition started. If no clear injury has occurred, rule out accidents, slips, trips and falls and indicate when the pain started. • Update any changes in family and health history, and social history or habits on returning patients, as appropriate
An **evaluation** of the musculoskeletal & nervous system determined through a physical exam	• The components of PART should be present for all spinal regions in which there is a complaint. If using x-ray to identify the subluxation, include the findings and date of the study. • Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis • Specific segments for primary areas to be treated are clearly indicated • Secondary compensations, or asymptomatic findings are clearly indicated • Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.
A **diagnosis** (**Note:** the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation.	• The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes • Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.
A **plan for treatment** including recommended level of care (duration and frequency of visits); the specific functional treatment goals related to the impacted activities of daily living; and objective measures to evaluate the effectiveness of the treatment.	• Include the expected duration in days/weeks/month for this active episode of care • Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month. • List short-term and long-term goals related to the functional deficits collected in the history section of the note. Ensure they can be easily measured on a visit-to-visit basis. • Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcomes Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals.

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