MEDICARE DOCUMENTATION

GENERAL DESCRIPTION

NOTE: The documentation requirements below are not PM&A's. They are Medicare's .
Follow the documentation requirements below to armor yourself in the event of an audit by Medicare and other payers.

OUTCOMES

- Better documentation for clinical records
- Less chance for Medicare audits

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SAMPLE CHECKLIST

Instructions. Make a copy of this checklist below. Review the items on it and make a check mark next to the items that apply to your office. Add, delete, and edit other items and fax or email back to PM&A for your own personalized copy. Review every three months and continue to adjust as needed.

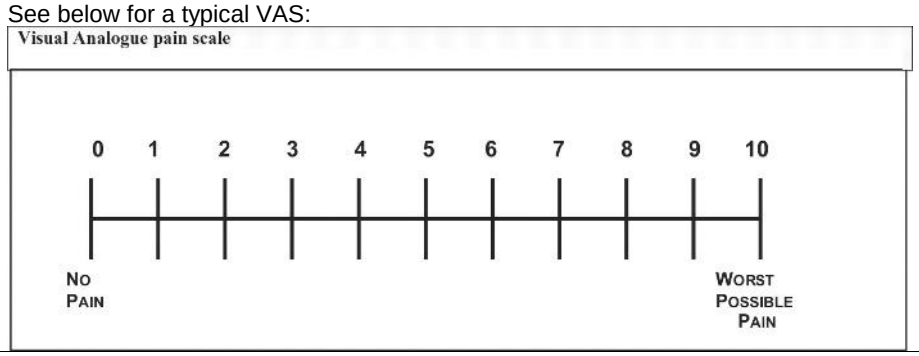
Medicare Documentation Checklist

(Add, delete, edit, and use.)

"Success is the Sum of Detail"

Assessment Date:_____ Assessment Done by: _____

	Fill In → **A** = Always, **M** = Most of the time, **S** = Some of the time, **N** = Not this time	A M S N
	History Obtained at Initial Visit:	○ ⊙ ◉ ⊗
	1. Symptom(s) causing patient to seek care	○ ⊙ ◉ ⊗
	2. Family history if relevant	○ ⊙ ◉ ⊗
	3. Past health history (general health, prior illness, injuries, hospitalizations, surgeries, current medications)	○ ⊙ ◉ ⊗
	4. Mechanism of trauma	○ ⊙ ◉ ⊗
	5. Quality and character of symptoms/problem	○ ⊙ ◉ ⊗
	6. Onset, duration, intensity, frequency, location, radiation of symptoms	○ ⊙ ◉ ⊗
	7. Aggravating or relieving factors	○ ⊙ ◉ ⊗
	8. Prior interventions, treatments, medications, secondary complaints.	○ ⊙ ◉ ⊗
	Initial Visit or New Onset	○ ⊙ ◉ ⊗
	9. History (as stated above)	○ ⊙ ◉ ⊗
	10. Description of the present illness:	○ ⊙ ◉ ⊗
	a. Mechanism of trauma (how did it happen?) For example, getting out of bed, twisting, gardening.	○ ⊙ ◉ ⊗
	b. Quality and character of symptoms/problem	○ ⊙ ◉ ⊗
	c. Onset, duration, intensity, frequency, location, radiation of symptoms	○ ⊙ ◉ ⊗
	d. Aggravating or relieving factors,	○ ⊙ ◉ ⊗
	e. Prior interventions, treatments, medications, secondary complaints	○ ⊙ ◉ ⊗
	f. Symptoms causing patient to seek care. Symptom(s) must be related to the level of the subluxation documented.	○ ⊙ ◉ ⊗
	11. Evaluation of spine/nervous system through physical examination.	○ ⊙ ◉ ⊗
	a. PART: pain and tenderness, asymmetry/misalignment, range of motion abnormality, tissue, tone changes	○ ⊙ ◉ ⊗
	12. Diagnosis: Primary diagnosis must be a subluxation, including the level or identified descriptive term of location, i.e., condition of the spinal joint involved, direction of position assumed by the named bone.	○ ⊙ ◉ ⊗
	13. Treatment plan, to include the following:	○ ⊙ ◉ ⊗
	a. Recommended level of care (duration and frequency of visits), specific goals, objective measures to evaluate treatment effectiveness, date of the initial treatment. Though not a documentation requirement, this is where you will educate the patient face to face, as to their subluxation and what will happen if they don't get it corrected, as well as educate them on their innate intelligence.	○ ⊙ ◉ ⊗
	Subsequent Visits:	○ ⊙ ◉ ⊗
	14. Review of chief complaint, changes since last visit, systems review if relevant	○ ⊙ ◉ ⊗

	15. Physical Exam	○ ⊙ ◉ ⊗
	a. Exam - area of spine involved in diagnosis	○ ⊙ ◉ ⊗
	b. Assessment of change in patient condition since last visit	○ ⊙ ◉ ⊗
	c. Evaluation of treatment effectiveness. Though not a documentation requirement, this is a perfect time to re-educate the patient on chiropractic principles.	○ ⊙ ◉ ⊗
	d. Documentation of the presence or absence of a subluxation	○ ⊙ ◉ ⊗
	e. PART: **p**ain and tenderness, **a**symmetry/misalignment, **r**ange of motion abnormality, **t**issue, tone changes.	○ ⊙ ◉ ⊗
	16. Documentation of treatment given on day of visit (technique(s) used and areas adjusted)	○ ⊙ ◉ ⊗
	17. Progress or lack thereof, related to goals and treatment plan (is the patient meeting goals?)	○ ⊙ ◉ ⊗
	Other Tips:	○ ⊙ ◉ ⊗
	18. Your subjective findings in initial visits/new onsets should tell a story about what happened, how it happened, and when it happened.	○ ⊙ ◉ ⊗
	19. The Visual Analog Scale (VAS) is not sufficient documentation as your sole objective tool. Use additional tools to measure objectives findings, such as x-rays, Oswestry, Neck & Back Disability Index, etc.	○ ⊙ ◉ ⊗
	20. See below for a typical VAS:  	○ ⊙ ◉ ⊗
	21. You should self-audit your documentation on a regular basis.	○ ⊙ ◉ ⊗