National Imaging Associates, Inc.*	
Clinical guidelines RECORD KEEPING AND DOCUMENTATION STANDARDS: CHIROPRACTIC CARE	Original Date: November 2015
Physical Medicine – Clinical Decision Making	Last Revised Date: August 2022
Guideline Number: NIA_CG_606-02	Implementation Date: July 2023

Policy Statement
Recordkeeping is used to document the condition and care of the patient, avoid or defend against a malpractice claim, and support the medical necessity requiring the provision of skilled services. The provider is responsible for documenting the evidence to clearly support the foregoing indices and submitting the documentation for review in a timely manner.

These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans or market-specific health plan. To be covered, services must be skilled as appropriated by the following descriptions and definitions.

INDICATIONS

MEDICAL RECORD CONTENT REQUIREMENTS FOR ALL PATIENTS

GENERAL GUIDELINES

- Documentation should clearly reflect why the skills of a licensed chiropractor are needed. The service is considered a *skilled service* if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the supervision of a licensed chiropractor. The deciding factors are always whether the services are considered reasonable, effective treatments requiring the skills of a chiropractor or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of a licensed chiropractor.
- All records (both digital and handwritten) must be legible, which is defined as the ability of at least two people to read and understand the documents.
- Each date of service must adequately identify the patient and include the treating chiropractor's signature and credentials. Each subsequent page in the record must also contain the patient's name or ID number.

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- All chart entries must be dated with the month, day, and year.
- Records must also be in chronological order and if handwritten they must be in permanent ink with original signatures. Electronic entries should be made with appropriate security and confidentiality provisions.
- Patient demographics including name, address, home and work telephone numbers, gender, date of birth, occupation, and marital status must be provided.
- Any working diagnosis(es) or condition description similar to the appropriate ICD code must be provided. If one is not applicable/allowed, it must be documented and consistent with the associated findings.
- The reason for the encounter or referral (i.e., presenting complaint(s)).
- Each date of service must include the subjective complaint(s), objective findings, assessment, diagnosis, treatment/ancillary diagnostic studies performed, and any recommendations, instructions, or patient education.
- Services must be documented in accordance with Current Procedural Terminology (CPT®) coding criteria (e.g., location (body region), time component, etc.).
- Adverse events associated with treatment should be recorded in the patient chart.
- Copies of relevant reports and correspondence with other skilled practitioners; including, but not limited to diagnostic studies, laboratory findings, and consultations.
- Copies of reports and correspondence related to treating chiropractor's diagnostic studies, laboratory findings, and consultations, including rationale for the service or consult and findings, conclusions, and recommendations.
- Copy of discharge summary must be provided if patient has a current authorization with a different provider and is seeking services with a new provider. Treatment should not duplicate services provided in multiple settings.
- Appropriate consent forms should be included when applicable.
- A key or summary of terms when non-standard abbreviations are used. Another practitioner should be able to read the record and have a clear understanding of the patient's condition and treatment rendered.
- Any corrections to the patient's record must be made legibly in permanent ink (single line through the error), dated, and authenticated by the person making the correction(s). Electronic documentation should include the appropriate mechanism indicating that a change was made without the deletion of the original record.

EVALUATION

The evaluation must include:

- Documentation to support the medical need for a course of treatment through objective findings and subjective self-reporting.
- A list of the conditions and complexities and description of the impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the peer reviewer or other healthcare professionals that the planned services are reasonable and appropriate for the individual.
- The patient's general demographics, prior medical, familial, and social history, including, but not limited to accidents, surgeries, medications, illness, living environment, general

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health status (self, family or caregiver report), medications, co-morbidities and history or identification of any past or current treatment for the same condition.
- All diagnoses related to the patient's condition and contraindications to treatment as well as safety risks must be provided. This may also include impairment, activity limitations, and participation restrictions.
- Baseline evaluation, including current and prior functional status (functional mobility and ADL deficits).
- Systems review consistent with the nature of the complaint(s) and relevant historical information should be included in documentation.
- Objective measures and/or standardized orthopedic and neurological testing demonstrating a decline in functional status must be provided. (Note: Treatment must not be focused on returning to activities beyond normal daily living). Assessment tools used during the evaluation should be valid, reliable, relevant, and supported by appropriate chiropractic best practices guidelines.
- While outcome assessment measures are preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention. Test information must be linked to difficulty with or inability to perform everyday tasks.[1]
- In the absence of objective measures, the evaluation must include detailed clinical observations of current skill sets, patient interview/questionnaire, and/or informal assessment supporting functional mobility/ADL deficits and the medical need for skilled services. The documentation must clearly state the reason formal testing could not be completed.
- Functional outcome assessment and/or standardized test results with raw scores, standardized scores, and score interpretations.
- Detailed clinical observations, as well as prognosis and rehab potential.
- Contraindications to care, with an explanation of their current management.

TREATMENT PLAN OR PLAN OF CARE (POC)

Plan of care must be individualized, goal-oriented, and aimed at restoring specific functional deficits.

Plan of care elements

- The patient's age, date of birth, and date of evaluation
- Medical history and background
- All diagnoses related to the patient's condition and contraindications to treatment as well as safety risks
- Date of onset or current exacerbation of the patient's condition
- Description of baseline functional status/limitations based on standardized testing administered or other assessment tools
- Meaningful clinical observations; the patient's response to the evaluation process; and interpretation of the evaluation results, including prognosis for improvement and recommendations for the amount, frequency, and duration of services

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- The plan of care must include goals detailing type, amount, duration, and frequency of chiropractic services required to achieve targeted outcomes. The frequency and duration must also be commensurate with the patient's level of disability as well as accepted standards of practice while reflecting clinical reasoning and current evidence.[2]
- Visits requested must not exceed the frequency and duration supported in the plan of care
- Treatment diagnosis and specific contraindications to treatment
- Baseline/current functional status/limitations as compared to pre-episode functional status
- Patient-specific functional goals that are measurable, attainable, time-specific and sustainable. The initial plan of care for a musculoskeletal condition should not exceed 4 weeks.
- Proposed frequency and duration of treatment within a reasonable and generally predictable time period
- Specific therapeutic interventions to be provided
- Predicted level of improvement in function (prognosis)
- Specific discharge plan

Updated plan of care elements

- Time frame for current treatment period
- Total visits from start of care
- Change in objective outcome measures and standardized testing compared to baseline and/or most recent re-assessment/updated plan of care
- Measurable overall progress toward each goal including whether goal has been met or not met. Goals should be updated and modified as appropriate
- Modification of treatment interventions in order to meet goals
- Home program and self-management teaching
- Collaboration with other services/professionals
- Measurable short- and long-term functional goals that are achievable within the length of time services are requested
- Individualized targeted outcomes that are linked to functional limitations outlined in the most recent evaluation
- Intervention selections must be evidence-based and chosen to address the targeted goals
- Type of modalities and treatment interventions to be provided
- Educational plan, including home exercises, ADL modifications
- Anticipated discharge recommendations, including education of the member in a home program
- Date and signature of treating chiropractor
- Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements.
- The plan of care should clearly support why the skills of a licensed chiropractor are needed as opposed to discharge to self-management or non-skilled personnel without

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the supervision of a licensed chiropractor. If telehealth is included, the plan of care should clearly support why the skills of a licensed chiropractor are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of a licensed chiropractor.

DAILY TREATMENT NOTE

Daily notes should include:

- Standard type format (i.e., SOAP) and contain the date for return visits or follow-up
- Skilled treatment interventions that cannot be carried out solely by non-skilled personnel. All services and level of services must be supported by the documentation and include the clinical rationale for the treatment intervention, a time component, and goals, if needed.
- Assessment of patient's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates
- Significant, unusual, or unexpected changes in clinical status

RE-EVALUATION

Re-evaluations should not be routine or recurring. While there is broad consensus on the general indications for formal reevaluation of patients, there is less agreement about proposed reasons for reporting patient re-evaluations, i.e., discharge planning, on a routine/prescheduled basis, and/or in meeting regulatory requirements. An established patient evaluation is indicated if any of the following apply:

- The patient presents with a new condition
- There is a significant or unanticipated change in symptoms or decline in functional status
- Assessment of response or non-response to treatment at a point in care when meaningful clinical change can reasonably be detected
- There is a basis for determining the need for change in the treatment plan/goals

The re-evaluation exceeds the parameters of the typical office visit and includes the following:

- Updated history
- Subjective symptoms
- Physical examination findings
- Appropriate standardized outcome tool/measurements as compared to the previous evaluation/reevaluation
- Evidence to support the need for continued skilled care
- Identify appropriate services to achieve new or existing treatment goals
- Revision in Treatment Plan, i.e., updated goals
- Correlation to meaningful change in function
- Evidence of the effectiveness of the interventions provided; progress toward goals

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UTILIZATION REVIEW

Clinical Guidelines have been developed to support medically necessary treatment as part of the peer review process. Clinical documentation is evaluated when making utilization review determinations. The elements evaluated by a clinical reviewer include, but are not limited to:

- Whether treatment involves an initial trial of care or ongoing care
- Proposed services/procedures for initial trial or ongoing treatment
- Whether the reported condition was acute, sub-acute, or chronic at the onset of care
- Documentation of an exacerbation or significant flare-up, if applicable
- Whether a condition is trauma-related, insidious onset, or repetitive/overuse injuries as a result of activities of daily living
- The date of onset and mechanism of onset is specified
- A history of the current condition is documented
- An interim history is provided for recurrent episodes
- The level, intensity, and frequency of pain is recorded
- Measurable and functional treatment goals are recorded, appropriate, time-specific, and monitored
- Outcome Assessment Tools are utilized at pre-determined intervals and treatment does not continue after further meaningful change would be minimal or difficult to measure
- Treatment demonstrates functional improvement that is sustained over time and meets minimum detectable change (MDC) and/or minimum clinically important change (MCIC) requirements
- All services billed meet CPT® coding requirements; are supported by subjective complaints, objective findings, diagnoses, and treatment performed; and meet the requirements according to this organization's Clinical Guidelines
- The record demonstrates the need for skilled services as opposed to home management or unskilled services
- Patients with mild complaints and minimal functional limitations are released to a home exercise program
- Treatment has exceeded 2-3 months for the same or similar condition
- Treatment is provided on patient-directed PRN basis without a treatment plan, functional goals, or sustained improvement

LACK OF INFORMATION

Reviewers determine that claims/requests have insufficient documentation when the medical documentation submitted is inadequate to support a request for services as medically necessary, such as an initial evaluation, recent progress note and/or the most recent daily treatment notes. Incomplete notes (for example, unsigned, undated, insufficient detail) may also result in a denial for lack of sufficient information.

CONFIDENTIALITY OF RECORDS

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All contracted practitioners will treat patient identifiable health information according to HIPAA standards to ensure the confidentiality of the record and provide the minimum necessary information when requested to perform a review of services.

BACKGROUND

Definition

Medical Necessity

Reasonable or necessary services that require the specific training, skills, and knowledge of a chiropractor in order to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a licensed chiropractor.

- Services shall not be considered reasonable and medically necessary if they can be omitted without adversely affecting the member’s condition or their quality of care.
- A service is also not considered a skilled service merely because it is furnished by a licensed chiropractor. If a service can be self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a chiropractor, then it cannot be regarded as a skilled service even though a licensed chiropractor actually rendered the service.
- Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a chiropractor renders the service.
- Services that include repetitive activities (exercises, skill drills) which do not require a licensed chiropractor’s expertise (knowledge, clinical judgment and decision-making abilities) and can be learned and performed by the patient or caregiver are not deemed medically necessary.
- Activities for general fitness and flexibility, sports-specific training enhancement or general tutoring for improvement in educational performance are not considered medically necessary.

All network practitioners will maintain clinical documentation that clearly supports the medical necessity of all health care services. In addition, all network practitioners are required to provide additional clinical documentation and/or explanation regarding medical necessity of services at the request of this organization.

Medically necessary care includes the following elements:

- **Contractual** – all covered medically necessary health care services are determined by the practitioner’s contract with the payer and individual health plan benefits.

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- **Scope of Practice** – medically necessary health care services are limited to the scope of practice under all applicable state and national health care boards.
- **Standard of Practice** – all health care services must be within the practitioner's generally accepted standard of practice and based on creditable, peer-reviewed, published medical literature recognized by the practitioner's relevant medical community.
- **Patient Safety** – all health care services must be delivered in the safest possible manner.
- **Medical Service** – all health care services must be medical, not social or convenient, for the purpose of evaluating, diagnosing, and treating an illness, injury, or disease and its related symptoms and functional deficit. These services must be appropriate and effective regarding type, frequency, level, duration, extent, and location of the enrollee's diagnosis or condition.
- **Setting** – all health care services must be delivered in the least intensive setting.
- **Cost** – the practitioner must deliver all health care services in the most cost-effective manner as determined by this organization, the health plan, and/or employer. No service should be more costly than an alternative diagnostic method or treatment that is at least as likely to provide the same diagnostic or treatment outcome.
- **Clinical Guidelines**– health care services are considered medically necessary if they meet all of the Clinical Guidelines of this organization.

Medical History: **Applicable to all Network Providers**
The Medical History includes all of the following:

- The History of Present Illness (HPI) includes the location, quality, severity, duration, timing, context, modifying factors that are associated with the signs and symptoms
- A Review of Systems (ROS) – 13 systems (musculoskeletal/neurological, etc.) and constitutional symptoms. Should also address communication/language ability, affect, cognition, orientation, consciousness
- Past Medical, Family and Social History (PFSH) that includes the patient's diet, medications, allergies, hospitalizations, surgeries, illness or injury, the family health status, deaths, problem-related diseases, and
- The patient's social status that includes marital status, living conditions, education/occupation, alcohol/drug use, sexual history

Physical Examination (PE): **Applicable to Chiropractors (CHIRO)** Examination of the body areas that includes the head, neck, chest, abdomen, back, and extremities, and the organ systems (11), constitutional, eyes, ENT, CV, GI, GU, musculoskeletal, skin, neurological, psychiatric, lymphatic, immunological, and hematological.

New Patient:
The patient has not been seen at any time by any practitioner within the same group practice, for any purpose, within the last 3 years.

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Starting on January 1st, 2021, providers may select the level of office and outpatient Evaluation and Management (E/M) services based on either Time or Medical Decision Making.

Selecting an E&M Code Based on Medical Decision Making[3]

A new medical decision-making table was created in 2021 to provide guidelines for E/M code level selection. Documentation should support the E/M service chosen.[3]

The medical decision-making elements associated with codes 99202-99215 will consist of three components:

1) Problem: The number and complexity of problems addressed
2) Data: Amount and/or complexity of data to be reviewed and analyzed
3) Risk: Risk of complications and or morbidity or mortality of patient management.

In order to select a level of an E/M service, two of the three elements of medical decision making must be met or exceeded.

Using Time to Select an E&M Code

According to the AMA 2022 CPT® codebook,[4] physician or other qualified healthcare professional time includes the following activities:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Code	Time range	Code	Time range
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

When using time to select an E&M code, a medically appropriate history and examination must still be documented.[5]

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POLICY HISTORY

Date	Summary
August 2022	• No content changes • References Updated

December 2021	• Original Record Keeping and Documentation Standards guideline split into two new separate guidelines to clearly delineate differences between Chiropractic Care and Speech/PT/OT. The two new guidelines are titled as follows:
	  o Record Keeping and Documentation Standards: Chiropractic Care
	  o Record Keeping and Documentation Standards: Physical Medicine
	• Added section on selecting the level of office and outpatient Evaluation and Management (E/M) services based on either Time or Medical Decision Making
	• Removed PT/OT/Speech indications and coding information from Chiropractic Care guideline
	• Added "General Information" statement

October 2020	• Added teletherapy in the policy statement • Added start of care be listed on progress note requirements • Moved CPT codes to background • Added indication of home program compliance for max benefit of therapy as part of updated POC • Added accommodative language to be inclusive of chiropractic care in medical necessity definition • Added support for excessive frequency/duration requests being in accordance with accepted standard of practice • Added parenthetical evaluation section to clarify that treatment should not focus on return to activities beyond normal daily living (sport/recreation/work) • Added that visits requested must not exceed the frequency and duration supported in the plan of care • Added qualifier for proof of skilled treatment for requested frequencies regardless of level of severity of delay
January 2020	• No edits made to guideline in response to the review of the evidence base
July 2019	• Definitions moved to the background so that relevant information is more readily available

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	• Organization of material into subcategories as well as formatting CPT code tables and deleting repetitive information for consistency and readability • Clarification and grammar edits to provide greater detail • Additional caveats for medical necessity/non-skilled interventions included as greater support for lack of skill denials • Updated references

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ADDITIONAL RESOURCES

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Reviewed/Approved by NIA Clinical Guideline Committee

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GENERAL INFORMATION
It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

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