Evolent Clinical Guideline 1509 for Record Keeping and Documentation Standards: Chiropractic Care

Guideline Number: Evolent_CG_1509		
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
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STATEMENT

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.

Purpose

This guideline will assist the chiropractor in creating and maintaining complete and appropriate clinical records and documentation.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

MEDICAL RECORD CONTENT REQUIREMENTS

General Guidelines [1,2]

- Documentation should clearly reflect why the skills of a licensed chiropractor are needed/the care is **medically necessary**
- All records (both digital and handwritten) must be legible.
  - 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 must also contain:
  - The patient's name or ID number
  - The subjective complaint(s)
  - Objective findings, assessment
  - Diagnosis, treatment/ancillary diagnostic studies performed.
  - Any recommendations, instructions, or patient education
- All chart entries must be dated with the month, day, and year.
- Handwritten records
  - In chronological order and in permanent ink with original signatures
- Electronic entries
  - Use appropriate security and confidentiality provisions.
- Patient demographics including all of the following:
  - Name
  - Address
  - Telephone numbers (home and work)

- Gender
- Date of birth
- Occupation
- Marital status

- Working diagnosis(es) or condition description similar to the appropriate ICD code
  - If the ICD code is not applicable/allowed, it must be documented and consistent with the associated findings.
- Reason for the encounter or referral (i.e., presenting complaint(s))
- 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
    - Diagnostic studies
    - Laboratory findings
    - Consultations
  - Reports and correspondence related to treating chiropractor's diagnostic studies
    - Laboratory findings
    - Consultations including
      - Rationale for the service
      - Rationale for consult and findings
      - Conclusions
      - Recommendations
- Copy of discharge 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.
- 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 [1,2]

The evaluation documentation must include:

- Support the medical need for a course of treatment through:

- Objective findings
- Detailed clinical observations
- Subjective self-reporting

- Patient's prior medical, familial, and social history
- Baseline evaluation
  - Current and prior functional status (functional mobility and ADL deficits)
- Systems review consistent with the nature of the complaint(s) and relevant historical information
- Objective measures and/or standardized orthopedic and neurological testing demonstrating a decline in functional status
  - 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
- 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
  - Medical need for skilled services
  - The reason formal testing could not be completed
- Functional outcome assessment and/or standardized test results with:
  - Raw scores
  - Standardized scores
  - Score interpretations
- Prognosis and rehab potential

Treatment Plan/Plan of Care [2,3]

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

NOTE: Treatment must not be focused on returning to activities beyond normal daily living.

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. 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.

Plan of care elements

- The patient's age and date of birth
- Date of evaluation
- Medical history and background
- All diagnoses related to the patient's condition
- Contraindications to treatment
- 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
- Patient's response to the evaluation process and interpretation of the evaluation results
- Prognosis for improvement
- Recommendations for the amount, frequency, and duration of services must:
    - Include what is required to achieve targeted outcomes
    - Be commensurate with the patient's level of disability
    - Demonstrate accepted standards of practice
    - Reflect clinical reasoning and current evidence
    - Not request visits that exceed the frequency and duration supported in the plan of care
        - Initial plan of care for a musculoskeletal condition should not exceed 4 weeks
- Patient-specific functional goals that are measurable, attainable, time-specific and sustainable
- Specific therapeutic interventions
- Predicted level of improvement in function (prognosis)
- Specific discharge plan

The plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements. If a plan of care must be updated or altered, documentation must list all changes/updates, including but not limited to:

- New time frame for current treatment period
- Total number of visits from start of care
- Change in objective outcome measures and standardized testing compared to baseline and/or most recent re-assessment
- 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
- 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
- Updated intervention and modality selections
    - Evidence-based and chosen to address the targeted goals
- Educational plan to include
    - Home exercises
    - ADL modifications
    - Self-management teaching
- Changed discharge recommendations (including education of the member in a home program)
- Date and signature of treating chiropractor

Daily Treatment Note [3]

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
- Changes in clinical status (significant, unusual, or unexpected)

Re-evaluation

Re-evaluations should not be routine or recurring; an established patient evaluation is indicated if any of the following apply:

- Patient presents with a new condition
- 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
- 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)

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
- Reported condition was acute, sub-acute, or chronic at the onset of care
- Exacerbation or significant flare-up (if applicable)
- Condition is trauma-related, insidious onset, or repetitive/overuse injuries as a result of activities of daily living
- Date of onset and mechanism of onset is specified
- History of the condition
- Interim history for recurrent episodes
- Pain (level, intensity, and frequency)
- Measurable and functional treatment goals are:
    - Appropriate
    - Time-specific
    - Monitored
- Outcome Assessment Tools
    - Utilized at pre-determined intervals
    - 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 and supported by:

- Subjective complaints
- Objective findings
- Diagnoses
- Treatment performed
- Meet the requirements according to this organization's Clinical Guidelines

- Demonstrated 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 to patient on an "as needed" 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

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.

CODING AND STANDARDS

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Medical Necessity

Medically necessary services are 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
  - Simply 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.
    - The unavailability of a competent person to provide a non-skilled service resulting in the non-skilled service being rendered by a chiropractor does not make the service provided a skilled service
  - They 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
  - They are activities for general fitness, flexibility, sports-specific training enhancement or general tutoring for improvement in academic performance

Medically necessary care must be:

- **Contractual** – all health care services are determined by the practitioner's contract with the payer and individual health plan benefits.
- **Within Scope of Practice** – all health care services are limited to the scope of practice under all applicable state and national health care boards.
- **Within Standard of Practice** – all health care services must be within the practitioner's generally accepted standard of practice.
- **Considerate of Patient Safety** – all health care services must be delivered in the safest possible manner
- **A 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
- **Considerate of Setting** – all health care services must be delivered in the least intensive setting
- **Considerate of 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

- **Supported by Clinical Guidelines**– health care services meet all of the Clinical Guidelines of this organization.

Medical History

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)
  - 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
  - includes marital status, living conditions, education/occupation, alcohol/drug use, sexual history

Definitions

Physical Examination (PE): 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.

POLICY HISTORY

Date	Summary
November 2024	• This guideline replaces Evolent Clinical Guideline 606-02 for Record Keeping and Documentation Standards: Chiropractic Care • Updated references • Removed section on E&M Coding • Removed Scope
December 2023	• No content changes

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

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3. Mootz R. Maximizing the Effectiveness and Efficiency of Clinical Documentation. Topics in Clinical Chiropractic. 1994; 1: Accessed: August 27, 2024. https://chiro.org/documentation/ABSTRACTS/Maximizing_the_Effectiveness.shtml.