



Policy Information

Policy Title	Auditing and Monitoring of Chiropractic Coding, Billing and Documentation	Current Version Publish Date	11/2025
Policy Manual	Reimbursement	Original Effective Date	11/2025
Policy Number	14	Next Review Date	Annual

Policy Applicability (LOB)

<input checked="" type="checkbox"/> Medicare Inc	<input checked="" type="checkbox"/> Commercial IA	<input checked="" type="checkbox"/> Commercial IL	<input checked="" type="checkbox"/> Health Choices
<input checked="" type="checkbox"/> Medicare WI	<input checked="" type="checkbox"/> Commercial WI	<input checked="" type="checkbox"/> CPPHP (Kansas)	

Policy Statement and Purpose

The purpose of this policy is to ensure accurate, consistent, and compliant coding and documentation for Chiropractic services. Regular chiropractic audits are conducted to validate adherence to ICD-10-CM, and billing requirements, as well as to identify opportunities for education and process improvement.

Policy Definitions

E&M Services: Established Patient Evaluation and Management codes (CPT 99212-99215).

Policy Provisions and Required Procedures

Medical Associates Health Plan is committed to maintaining the highest standards of documentation and coding integrity. Chiropractic services must be:

- Medically Necessary
- Supported by complete and accurate documentation and
- Billed using appropriate CPT, ICD-10, and modifier codes consistent with payer guidelines and federal regulations (Medicare and commercial)

Audits will be performed to confirm compliance, identify risks and guide provider education.

This policy applies to:

- All chiropractic visits billed under CPT® codes 98940–98943 and related services (E/M, therapies, and modalities)
- Billing, coding, and compliance teams involved in documentation or claim submission for chiropractic services

Audit Objectives

The Chiropractic Coding Audit aims to:

1. Verify that clinical documentation supports the services billed.
2. Confirm accurate selection of CPT®, ICD-10-CM, and modifier codes.
3. Ensure compliance with federal, state, and payer regulations.
4. Detect potential overbilling, underbilling, or unbundling.

5. Identify educational opportunities for providers and billing staff.

Audit Frequency and Sampling

- **Routine audits** will be conducted at least **annually** for each chiropractor.
- **Targeted audits** may be performed more frequently if prior results indicate elevated risk.
- A **minimum sample size** of 10 chiropractic encounters per provider

Documentation Standards

Each chiropractic record must include:

- Patient name, Date of Birth, and date of service
- Chief complaint and history
- Objective exam findings (including PART findings for Medicare)
- Diagnosis (ICD-10-CM) consistent with documentation
- Specific spinal regions treated
- Procedures and CPT® codes supported by documentation
- Treatment plan, frequency, duration, and goals
- Signature and credentials of the rendering provider

Audits will be performed using the **Chiropractic Coding Audit Rubric** to assess:

- Documentation integrity and signatures
- Medical necessity and diagnosis coding
- Correct CPT® code selection for manipulation (98940–98943)
- Evaluation & Management (E/M) coding, if billed
- Use of therapy and modality codes (e.g., 97012, 97014, 97110, 97140)
- Plan of care and re-evaluation documentation
- Proper use of modifiers (AT, 25, GA, GY, etc.)
- Compliance with payer and Medicare documentation requirements

Each element will be scored for compliance, and results will be summarized in an audit report.

Scoring and Thresholds

Score Key:

- **3 = Fully Meets Standard**
- **2 = Partially Meets Standard (minor deficiencies)**
- **1 = Does Not Meet Standard (major deficiency or missing documentation)**
- **N/A = Not Applicable**

Score Range	Interpretation	Required Action
90–100%	Fully compliant	Maintain practices
80–89%	Minor deficiencies	Corrective education
70–79%	Moderate deficiencies	Remediation and re-audit in 120 days
<70%	Non-compliant / High risk	Immediate corrective action and compliance review

Reporting

- Audit results will be summarized in an **Audit Findings Report** and shared with the provider and Compliance Department.

- Aggregate results will be reviewed quarterly by the **Compliance Committee** to identify trends, risk areas, and needed training.

Corrective Action & Education

If a provider scores below 80%, corrective action will include:

- Follow-up audits** will be performed within 120 days to validate improvement.
- Education and feedback**

Repeated or intentional noncompliance may result in removal from the MAHP networks and contract termination.

Provider Appeal Rights

Chiropractors may appeal audit findings in writing.

Related Policies	
Related Training/ Job Aids	
NCQA Standard	
References	<ul style="list-style-type: none"> CPT® Professional Edition – Current year ICD-10-CM Official Guidelines for Coding and Reporting CMS Chiropractic Services Documentation Guidelines Medicare Benefit Policy Manual, Chapter 15, Section 240 OIG Compliance Program Guidance for Individual and Small Group Physician Practices Chiropractic Audit Rubric: Summary Audit results:
Exhibits	

Policy Owners / Reviewers

Department Owner	Lisa Kuhls	Date Reviewed	11/2025
Department Reviewer	Network Strategy Committee	Date Reviewed	12/9/2025
Approving Committee if applicable	<input type="checkbox"/> Compliance <input checked="" type="checkbox"/> UMC <input type="checkbox"/> QIC <input checked="" type="checkbox"/> Board of Directors <input type="checkbox"/> Other: _____	Date Approved	2/2026 3/2026

History

Date of revision	<i>Summary of changes</i> <u>Prior Reviews:</u> Revised:
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