

Medicare Article: Part II

Essentials of Documentation

This article is the second of a series of articles that have been prepared by the **Association of Chiropractic Colleges Post-graduate Subcommittee** to serve doctors in the field and to address the concerns outlined in the 2005 OIG report which stated that 94% of claims submitted by chiropractors are missing required elements in the documentation.

Essentials of Documentation

(Adapted from “Medicare Made Simple” notes as presented by Susan A. McClelland, BS, CCA, FICC for the Association of Chiropractic Colleges May 3, 2007).

Medicare has specific requirements for documentation, but nothing extraordinary. Whether a patient is covered by Medicare, or not, all chiropractic encounters should be represented with appropriate, specific record-keeping that adheres to a basic standard. Documentation should contain required elements and should be consistent, accurate, legible, indelible, chronological, dated, signed/initialed, and contemporaneous.

Quick Tips:

- If you use medical shorthand, be sure to use and understand standard abbreviations and symbols. Never ‘make up’ abbreviations.
- Appropriate documentation on file should include intake forms/questionnaires, initial exam report, daily visit SOAPs that include identification of subluxation via x-ray or PART, follow up exams, and waivers. Documentation must be able to support ‘medical’ necessity for chiropractic care.
- Be careful of computer-generated notes. Notes must be thorough and specific to each patient and each encounter.

Identifying the subluxation.

Subluxation must be demonstrated by x-ray or by PART in all of your initial and subsequent notes. Technically, this is not true... If you utilize x-ray, the films must be reasonably proximate (within 12 months prior to or three months after the initiation of care). Exceptions may be made if the condition is chronic/permanent. A CT/MRI may be accepted. If you utilize the PART method, you must demonstrate a subluxation based on physical examination. Two of the four criteria are required, and one of them must be asymmetry/misalignment or range of motion abnormality.

Pain/tenderness (Include location, quality, intensity. Findings can be identified via: observation, percussion, palpation, provocation, pain scales, algometers, pain questionnaires, etc.)

Asymmetry/misalignment (Sectional or segmental level. Findings can be identified via: observation of posture/gait, static palpation, imaging, etc.)

Range of motion abnormality (Changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility. ROM findings can be identified via: motion palpation, observation, stress diagnostic imaging, ROM measurements, etc.)

Tissue/tone changes (Changes in the soft tissues including skin, fascia, muscle, and ligament. Findings may be identified via: observation, palpation, use of instrumentation, tests for length and strength, etc.)

Always back up findings with objective data. And remember that no one will complain if you utilize both x-ray and PART to demonstrate your case!

Initial Visit Must-Have's

The initial visit should include no less than a patient history, description of the presenting complaint, evaluation findings, diagnosis, treatment plan, and date of initial visit.

History: Statement of health, past health history, social/family history, description of the presenting complaints and any secondary complaints.

Presenting complaint: Symptoms, mechanism of trauma, quality and character of the pain, onset, duration, intensity, frequency, location, and radiation of symptoms, aggravating/relieving factors, prior interventions, treatments, and medications.

Evaluation: Physical examination and evaluation of the musculoskeletal/nervous system. Document everything you do and detail your findings.

Diagnosis: The primary diagnosis must be subluxation, including the level. The description must include reference to the condition of the spinal joint involved or to the direction/position assumed by the named joint. The secondary diagnosis would refer to the NMS condition and should be directly/causally related to the subluxation noted.

Treatment plan: Include the recommended level of care with duration and frequency of visits, specific treatment goals, and objective measures to evaluate treatment effectiveness. Always include the date of the initial treatment and sign it!

Sample treatment plan: 05-05-06 CMT and adjunctive modalities daily for 1 week and 3x/wk for the following 2 weeks. Re-eval at that time; L MRI may be indicated. Off work 2 wks. Home care: Cryo q 2 hrs x 15 mints; avoid strenuous activity; LS supports to be worn when standing. Short-term goals: Minimize pain (<3) and spasm; increase pain-free LS flexion (>45 degrees). Long-term goals: restore ability to tie shoes w/o pain, sit/stand for prolonged periods (>2 hrs.), and get in/out vehicles w/o difficulty; return normal sleep patterns. *Dr. SIGNATURE.*

Subsequent Visits

Subsequent visits should be documented and should include no less than the following: subjective comment on patient's progress and changes since last visit, physical exam findings including changes since last visit, and documentation of the treatment given on the day of the visit (don't just refer back to the plan from the initial visit without also giving today's findings!)

- S: Review of chief complaint, note any changes since the last visits, system review if relevant (any surgeries, illness, trauma, or medications since last visit?)
- O/A: Physical/regional exam. Examine the area of the spine involved in the diagnosis and note findings. Assess change in the patient's condition since the last visit. Evaluate the treatment for effectiveness. (Note, listings and type of technique are not currently required by CMS or CPT in reporting; however, for the thoroughness of the record we'd recommend these details.)
- P: Document the treatment given on the day of the visit and any adjunctive therapy (if used).

Sample subsequent visit note:

05-15-06: patient notes diminished intensity/frequency of LBP. VAS decreased to 4/10. Overall lumbar paraspinal spasm/tenderness bilaterally, but decreased since last visit. Joint fixation at L4-L5 and right SI. Condition resolving. L5 and RSI adjusted with side posture. Continue treatment plan as prescribed at initial visit on 05-05-06. Return Tuesday. *Dr. Signature*

Self -Test

As you review your records, ask yourself the following questions, 'Does the record show...':

- ...a significant NMS condition?
- ...precise sublaxation(s) documented by physical exam or x-ray?
- ...a complaint consistent with the sublaxation levels found?
- ...noted vital signs?
- ...a past health history?
- ...a check for contraindications?
- ...noted quality and intensity of chief complaint?
- ...noted aggravating and relieving factors?
- ...the physical exam substantiating the condition and the sublaxation?
- ...a primary diagnosis of sublaxation and a secondary NMS condition caused by the sublaxation?
- ...a treatment plan with specific goals?
- ...notations for subsequent changes?
- ...the adjustment clearly recorded in the record as being accomplished?
- ...notations on the effectiveness of treatment that would qualitatively and quantitatively substantiate the need and frequency of treatment?
- ...the adjustment is for acute, chronic, or maintenance care along with appropriate ABN documentation?