Chiropractic Record Keeping
(DeskBook Chapter 4.1)

Presented by Evan M. Gwilliam, DC MBA BS
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Vice President

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Education
- Bachelor’s of Science, Accounting - Brigham Young University
- Master’s of Business Administration - Broadview University
- Doctor of Chiropractic, Valedictorian - Palmer College of Chiropractic

Certifications
- Certified Professional Coder (CPC) - AAPP
- Nationally Certified Insurance Coding Specialist (NCICS) - NCCT
- Certified Chiropractic Professional Coder (CCPC) - AAPP
- ChiroCode Certified Chiropractic Professional Coder (CCPC) - ChiroCode
- Certified Professional Coder – Instructor (CPC-I) - AAPP
- Medical Compliance Specialist – Physician (MCS-P) - MCS
- Certified Professional Medical Auditor (CPMA) – AAPP, NAMAS
- Certified ICD-10 Trainer - AAPP
Take-away

• Know what third parties want to see in your records

• Master SOAP and POMR

• Eliminate common documentation errors

Documentation

• Outlines a clear course of care and the patient’s response to treatment

• Provides clear evidence of continuity of care to communicate with other providers

• Acts as a legal record of the care given

• Allows comparisons between differing patient episodes as well as other patients with similar conditions

• Supports the billing for services rendered
Documentation

Is your documentation a weakness to be exploited by those who do not want to pay?

Or, is it a shield that protects you from liability and audits?
Medical Necessity

“Services or items reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member”
Medical Necessity Quick Check

1. Does the patient have a **complaint** that is consistent with an injury or condition?
   - Care given because of provider technique, philosophy, or just routine is not medically necessary.

2. Do the exam findings confirm the existence of the condition which **explains** the complaint?
   - Document a causal chain:

3. Is the **treatment appropriate** for the diagnosis and phase of the condition?
   - Treatment should transition from passive to active. It should vary for patients who are 80 years apart in age. Avoid cookie cutter care.

4. Does the record show **progress** towards measurable goals?
   - Improvement must be noted over time.
The Medical Necessity Recipe

1. Complaint
2. Explanation
3. Appropriate
4. Progress

Chiropractic Services Targeted

• 2014 CERT Improper Payment Report
  o 54.1% of chiropractic claims were paid improperly
  • 92.2% of those improper payments were due to insufficient documentation

<table>
<thead>
<tr>
<th>Documentation Errors by Doctors of Chiropractic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element</td>
</tr>
<tr>
<td>Evaluation: Improper or missing</td>
</tr>
<tr>
<td>Diagnosis: Improper or missing</td>
</tr>
<tr>
<td>Treatment plan: Insufficient</td>
</tr>
<tr>
<td>Medical necessity not shown or miscoded</td>
</tr>
<tr>
<td>Contraindications not checked</td>
</tr>
</tbody>
</table>
Denials

• Payers often believe that services rendered were unnecessary because:
  o There were too many visits
  o There were unnecessary services at each visit
  o Billing does not match documentation

• Good documentation can prove that:
  o The visits were medically necessary
  o The services were needed to help the patient get better
  o The billing is an accurate reflection of the record

Bad Records

Bad records can cause:
• State board action
• Claim payment denial
• Administrative heartburn
• Miscommunication between payers and the doctors
Chiropractic Record Keeping
(DeskBook Chapter 4.2)

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ChiroCode INSTITUTE

A well organized chart

• Intake forms
• Outcomes assessments
• Records from other providers
• Correspondence
• Daily visits
• Discharge
Problem Oriented Medical Record

1. Why did the patient begin care?
2. What did the provider find wrong?
3. What did he/she do about it?
4. How did care end?

Problem Oriented Medical Record

1. Complete problem list
2. Diagnoses for each problem
3. Treatment goals for each problem
4. Written treatment plan for each problem
5. SOAP notes for ongoing treatment of each problem
6. Date of resolution or referral for each problem
SOAP

- Subjective
- Objective
- Assessment
- Plan

- Only 1/6 of a Problem Oriented Medical Record (POMR)
- The following is for a subsequent visit SOAP, not initial

Subjective - Patient’s point of view
- Presenting complaint
- Severity and duration
- New or ongoing
- Changes to symptoms
- Response to last treatment
- Pain scale
- Aggravating or relieving factors
- Patient statement of functional change
Subjective - Patient’s point of view

S: Mary Jane presents today for continued treatment for neck pain that began three days ago after “sleeping wrong.” It worsens throughout the day, but generally rates 4/10 on the verbal numeric rating scale, which is an improvement from 6/10 three days ago. It is dull, achy, and located around the C3-C5 region on the right. It has decreased her quality of sleep, but no other changes are reported.

Objective - Measurable information

- Physical exam findings
- Inspection, palpation
- Range of motion
- Neuro/ortho tests +/-
- Outcomes assessment retest
**Objective** - Measurable information

O: Involuntary muscle contraction is palpated on the right from C3 to C7, with tenderness and restricted left rotation and lateral bending. All other sectional ROM within normal limits. Restricted intersegmental motion is noted at C3, C5, and T4.

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**Assessment** - S+O=A

- Patient risk factors and/or response to treatment
- Diagnostic statement / clinical impression
- Patient compliance, or lack thereof
- Progress towards short and long term goals
Assessment- S+O=A

A: Diagnosis
- M99.01 Segmental dysfunction, cervical region
- M62.838 Other muscle spasm (neck)
- M54.2 Cervicalgia

Treatment tolerated without incident. Patient appears to be responding as anticipated as evidenced by 20% improvement in left cervical rotation.

Plan- Outline of what is next
- Procedures recommended/performed
- Frequency/duration of treatment
- Rationale linking treatment to diagnosis
- Specific and measurable goals
- Home instructions
- Anticipated date of discharge
- Next visit date
Plan- Outline of what is next

P: Interferential current (97014) was administered to the affected region for 10 minutes to reduce pain as outlined in care plan dated 1/29/2017. Diversified Chiropractic Manipulative Treatment (98940) was performed in the cervical region at C3 and C5, as well as T4. Patient will continue with care plan as outlined. She is due to return in two days.

SOAP and CMS

1. History (S)
2. Physical Exam (O)
3. Treatment given (P)
4. Progress (A)
Quality Patient Records

• One chart per patient, regardless of payer
• Name and DOB should be on each page
• Pages should be numbered and chronological
• Missed appointments, displeasure, and negative events should be recorded
• Correspondence with attorneys, insurance companies, and referrals should be recorded
• Handwritten records are not recommended
• Use standardized abbreviations
• Sign, legibly within 24 hours

Common Errors

• Illegible records
• Missing dates
• Missing signature
• Missing informed consent
• Missing re-assessment
• Missing patient identifiers
• Missing metrics/objective
• Blanks used to indicate “WNL”
• Missing legend for abbreviations
• Missing care plan
• Cloned records
• Billing only 98940 or only 98941
• Using travel cards
Cloned records

<table>
<thead>
<tr>
<th>Patient Visit</th>
<th>Subjective Documentation</th>
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<tbody>
<tr>
<td>Day One</td>
<td>&quot;The patient is troubled by a moderate grade of intermittent dull pain with stiffness and soreness in her head on both sides.&quot;</td>
</tr>
<tr>
<td>Day Two</td>
<td>&quot;In both sides of her head she is afflicted by a moderate grade of dull pain with stiffness and soreness which occurs intermittently.&quot;</td>
</tr>
<tr>
<td>Day Three</td>
<td>&quot;The patient is afflicted by an intermittent dull pain with stiffness and soreness of a moderate degree in her head bilaterally.&quot;</td>
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<td>Day One</td>
<td>&quot;Evidence of subluxation is detected coupled with tender deep paraspinal musculatures located at the middle and lower cervical regions on both sides.&quot;</td>
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<tr>
<td>Day Two</td>
<td>&quot;Joint dysfunction is noted coupled with tenderness located in the middle and lower cervical areas on both sides.&quot;</td>
</tr>
<tr>
<td>Day Three</td>
<td>&quot;The presence of subluxation is apparent, plus tender deep paraspinal musculatures overlying the lower and middle cervical region on both sides.&quot;</td>
</tr>
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Avoiding Clones

- Watch out for “text spinners” or “random text generators”
- Consider:
  - Patient age
  - Severity of condition
  - Specific goals that mention actual ROM or OATs score for that patient
  - Diagnoses that are specific. i.e. more than just pain and subluxation
  - Complicating factors
Radiology Reports

1. Demographics including:
   - The facility or location where the study was performed
   - Name of patient and another identifier such as date of birth or record number (this is a HIPAA standard)
   - Name or type of examination
   - Date of the examination
   - Inclusion of the following additional items is encouraged:
     - Date of dictation
     - Date and time of transcription
     - Patient’s date of birth or age
     - Patient’s gender

2. Relevant clinical information such as patient history or exam findings that elicited the need for the imaging

3. Body of the report
   - Findings: use appropriate anatomic, pathologic, and radiologic terminology
   - Potential limitations that may affect the quality of the films, such as patient habitus or expected artifacts
   - Comparison studies and reports if available

4. Impression (conclusion or diagnosis)
   - A specific diagnosis should be given when possible
   - A differential diagnosis should be rendered when appropriate
   - Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate
   - Any significant patient reaction should be reported
Signatures

- Electronic signatures can be
  - Electronic image using a pen tablet
  - Digitized and confirmed by valid software
- Unacceptable signatures include:
  - Illegible signature or initials, not over typed/printed name, not on letterhead, not accompanied by a signature log or attestation statement
  - Unsigned note with provider's printed name
  - "Signature on file"

Acceptable signatures include:
- Legible first initial and last name
- Illegible signature over typed or printed name, or with clear letterhead
- Illegible signature with a signature log or attestation statement
- Initials over a typed or printed name, or accompanied by a log or attestation statement
- Unsigned handwritten note where other entries on the same page in the same handwriting are signed
Take-away

• Know what third parties want to see in your records

• Master SOAP and POMR

• Eliminate common documentation errors
The *ChiroCode DeskBook* is available at ChiroCode.com

This presentation is covered Chapters 4.1 and 4.2