Basic Chiropractic Documentation

Use of chart notes (SOAP, Travel card etc.) are used essentially for the following 4 factors

1. Document the specific elements of the history, examination, diagnosis and care of your patient and too track your patients’ progress

2. Requirement based on professional standards and practices

3. Justify your charges in a third-party payer audit

4. Defend yourself against a malpractice suit

**HISTORY:**

- Symptoms causing patient to seek treatment.
- Quality and character of symptoms/problem.
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors. Mechanism of trauma.
- Prior interventions, treatments, medication and secondary complaints
- Past health history as well as family history if relevant.

- Onset
- Location
- Duration
- CHaracter (sharp, dull, etc.)
- Alleviating/Aggravating factors
- Radiation
- Temporal pattern (every morning, all day, etc.)
- Symptoms associated

**INITIAL VISITS:**

a. History as noted above with the symptoms bearing a direct causal relationship to the diagnosis.

b. Evaluation of the musculoskeletal/ nervous system through physical examination. Use outcome assessment forms (pain and functional to establish a baseline and later allow comparison of improvement. Emphasis towards “functional change”)
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c. Diagnosis: Primary, secondary, tertiary, etc. diagnosis with any associated conditions and complicating factors. (Note for Medicare claims subluxation is required as a primary diagnosis)

d. Treatment plan: recommended duration and frequency of visits. Specific treatment goals. Objective measures to evaluate treatment effectiveness. (ROM, ortho tests, functional scales etc.)

e. Date of the initial treatment for the present diagnosis and condition.

SUBSEQUENT VISITS:

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► Review of chief complaint (quantify when possible and avoid simple statements of “I feel better” with “I feel better and I can sit longer, bend further etc.”) Emphasis should be applied to the specific statements that can demonstrate – *functional change*

► System review if relevant.

O

► Evaluation of area involved in diagnosis. (Palpation, ROM, Leg Check, Ortho tests etc.) Do so in a manner that offers some objective or measured values. (This should not be a full re-exam but evaluation a few key elements)

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► This is your diagnosis, as well as your assessment of progress. Assessment likely will include change(s) since last visit or period of time visits, which demonstrates and evaluates the effectiveness of treatment.
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P

► This is your plan of care. It includes not only the initial treatment plan (expected duration and frequency of care along with recommended services, including any possible additional testing, etc.) but on subsequent visits, the treatment rendered on that encounter, home recommendations, referrals to other providers, etc. It should also include the patient’s response to the treatment (i.e., patient tolerated manipulation well and reports pain has reduced from a 6/10 to a 3/10).

► All services that involve time elements must have time documented on each visit. Particular attention should be paid to documenting the types and methods of services such as exercise 97110, manual therapy 97140, neuromuscular reeducation 97112, therapeutic activities 97530, and massage 97124.

All visits must have signature (Medicare) or the initials of the provider on each visit. Any services done by staff should also be indicated as such. The daily SOAP should be a record of how the patient is progressing in care and the specifics of the services applied. Unless it is written in the notes the service, per law, will be considered, not performed.

The goal of any care plan is improve the patient for reduction of pain and improvement of function. The chart notes are there to demonstrate that this has occurred. Exams should have all elements quantified in some fashion to allow comparison. An easy way to see if care is effective (medically necessary) is to compare the same elements of evaluation over time.

The American Chiropractic Association recommends that these basic requirements be considered as appropriate clinical (medical) documentation in patient record keeping. A concerted effort by the chiropractic profession to standardize clinical (medical) documentation will improve the frustration level and reimbursement experience exponentially.

1. The nationally accepted billing 1500 form must be completed in detail. This means all required fields must be completed.

2. Subjective, objective, and treatment (if rendered) components should be incorporated into patient records on each visit. A customized format is not needed but these elements must exist consistently. Any significant changes in the clinical picture (e.g. significant patient improvement or regression) should be noted.
3. All ICD-9-CM diagnosis codes and CPT treatment and procedure codes must be validated in the patient chart and coordinated as to the diagnoses and treatment code descriptors.

4. Uniform chiropractic language should be used within the profession for describing care and treatment. Non-standard abbreviations and indexes should be defined.

5. Documentation for the initial (new patient) visit, new injury or exacerbation should consist of the history and physical and the anticipated patient treatment plan. The initial treatment plan, except in chronic cases, should not extend beyond a 30-45 day interval. Subsequent patient visits should include significant patient improvement or regression if demonstrated by the patient on each visit. As the patient progresses, the treatment plan needs to be reevaluated and appropriately modified by the treating doctor of chiropractic (chiropractic physician) until the patient can be released from care, if appropriate.

6. If the patient is disabled, a statement(s) on the extent of disability and activity restriction is needed at initial and subsequent visits as appropriate over the course of care.

7. Records can be attached to each billing to pre-empt requests; however, it is not mandatory. Local insurers should be contacted for preferences (i.e., No fault PIP, workers’ compensation insurers may require records every visit while health insurers may not).

8. All records must be legible and understandable, released within the authority given by the patients, in a secure, confidential manner and in compliance with existing state (or federal) statutes.

9. The patient name and initials of the person making the chart notation (especially in multi-practitioner offices) should appear on each page of the medical record.

10. If the above recommendations have been met, then the answers as to why the necessity for continuing treatment are answered.