

Proper Documentation Can Increase and Expedite Reimbursement

What do the insurance companies look for when they are reviewing for “Medically Necessity”? This is a question that all doctors ask when requested to justify the care they are rendered to their patients in a managed care environment. It is always important to keep several simple points in mind when documenting the clinical care of your patients: make sure that your documentation is:

1. legible;
2. follows a logical flow of clinical decision making; and,
3. complete and that you have provided all requested information.

Most managed care companies utilize peer reviewers (doctors who review medical records) to determine the medical necessity of care rendered to their members. Peer reviewers can only rely on the notation provided by the attending doctor to paint a clear picture of the patient’s condition.

When documentation is presented to the peer reviewer in a format that is either unclear, or incomplete, the peer reviewer will have a difficult time supporting the need for any additional care. This article provides an in-depth view of what a peer reviewer is looking for in clinical documentation in order to provide further authorization of care.

Doctors must remember that what is written in the patient’s chart should provide ongoing snapshots of the patient’s condition. Proper documentation provides the peer reviewer with a logical progression, starting from the patient’s prior health history and continuing all the way through to the point where they reach maximum therapeutic benefit. More specifically, the snapshots should provide insight into the doctor’s evaluation and decision-making regarding this patient’s treatment. Snapshots that are clear and detailed will allow for more informed decision-making by the treating doctor. An analogy is the drawing of a stick figure versus a detailed three-dimensional statue and the amounts of information that they each provide regarding the person depicted. Clear concise and detailed office notes will assist the treating doctor in their decision- making throughout the course of treatment. Additionally, clear, concise and detailed notes will provide subsequent doctors, whether treating or reviewing, with a movie regarding this patient’s health and response to treatment thus far.

When evaluating a patient, there is a classic and time-honored method that remains unchanged. The doctor obtains a history not only of the current complaint but also of the patient’s overall health. This history guides the doctor in determining the level of examination necessary, the necessity of diagnostic imaging, laboratory testing, etc. The combination of the history and the results from the various exams allows the doctor to arrive at a diagnosis, analysis or clinical impression. This diagnosis/clinical impression will then dictate the type of treatment required for the patient. The doctor then monitors the

patient's response to this treatment and determines the patient's prognosis for recovery and improvement.

The methods of recording this information have evolved over time. They have progressed from cryptic, illegible handwritten notes to the most current state-of-the-art voice recognition software.

However, all office notes should contain certain basics:

1. They must be legible, not only to the author of the notes but also to anyone else.
2. They must contain basic demographic information regarding the patient. These bits of information provide cross references to identify the patient's chart.
3. They should contain financial information appropriate to this patient.
4. The office record should contain the patient's responses to various questionnaires such as: case history forms; pain questionnaires; personal injury questionnaires and workers compensation questionnaires.
5. It is necessary for there to be an analysis of the patient's written responses on these questionnaires, as well as the doctor's discovery during the consultation with the patient. This analysis is generally contained in an initial dictation or office note and should be a brief narrative as opposed to a simple listing of the complaints.
6. The doctor must record patient responses to various examinations, testing, etc. by way of a narrative or standard office form.
7. The doctor must then record their assessment of the patient including a diagnosis, analysis or clinical impression by way of a narrative or standard office form.
8. Finally, the doctor must record what their plan for the patient is by way of a narrative or standard office form.

These general but very basic pieces of information correspond to the well accepted format of S. O. A. P. which stands for Subjective, Objective, Assessment and Plan. On subsequent patient encounters, the doctor should record the patient's history including the last encounter with subjective complaints, pain levels, the patient's perception of how they responded to treatment, etc.

It is also necessary to record the objective findings for that encounter including palpation findings, orthopedic testing, etc. The doctor should then record the assessment of the patient including a reaffirmation of or alteration of the diagnosis, and the doctor's interpretation of how the patient is responding.

Finally, the doctor must record what treatment is rendered to the patient including: segments adjusted; techniques used; types of therapies applied and their setting; instructions to the patient for home care in addition to what the doctor plans for subsequent treatment, referral or dismissal.

The actual logistics of performing these tasks varies from doctor to doctor. However, the basic information is the same and must be communicated in a reasonable, legible and logical format. The doctor may wish to dictate all the above bits of information and then have them transcribed. This approach provides for an ongoing narrative format for patient encounters.

An alternative is the use of forms to record information which will not change drastically on each visit. These forms can include examination forms, long - term treatment plans, listings of diagnoses, etc. However, it is essential that on daily office notes that the doctor record information which varies such as subjective complaints, palpation findings, etc.

The American Chiropractic Association in conjunction with the Health Care Financing Administration (HCFA) recommends the acronym P.A.R.T. for recording objective findings associated with a subluxation.

Two of the following four criteria are required; one of which must be an "A" or "R":

- "P" = Pain/Tenderness
- "A" = Asymmetry/Misalignment
- "R" = Range Of Motion Abnormality
- "T" = Tissue, Tone, Texture, Temperature Abnormality

The following is a list of the most common errors seen in office notes:

1. No documentation provided by the doctor on the patient's past history regarding either the chief complaint or other general health history. Generally the doctor will record, in a very cryptic manner, information regarding the chief complaint only.
2. No diagnosis or clinical impression is recorded
3. No treatment plan including frequency of treatment, type of treatment, etc. is present. A long-term treatment plan should also include any coordination of care with other doctors which may be appropriate.
4. There is no record of review of outside records, x-rays, laboratory findings, etc.
5. No written x-ray report is present.
6. The doctor's name and/or the patient's name are not present on all forms/pages.

7. The doctor does not record what specific treatments were rendered to the patient during each visit including: segments adjusted, therapies applied and their settings. The note generally says "adjustment."
8. There are no reevaluations or reexaminations.
9. Finally, the notes are usually illegible.

These commonly identified errors can reflect poorly on the doctor that does not meet the standards for the National Committee of Quality Assurance (NCQA) and can place the doctor at significant risk in the medical and legal arenas.

ActivHealthCare, Inc. recommends that the doctor review the current literature regarding documentation including, but not limited to:

- the Mercy Center Guidelines;
- NCQA standards;
- HCFA recommendations for evaluation and management codes;
- topics in clinical chiropractic J. M. P. T.; and,
- additional journals associated with the chiropractic profession.

ActivHealthCare, Inc. will be happy to assist its doctors interested in obtaining more information on the subject of clinical notation. For more information, you may call our office at (770) 455-0040 or (888) 635-0459.