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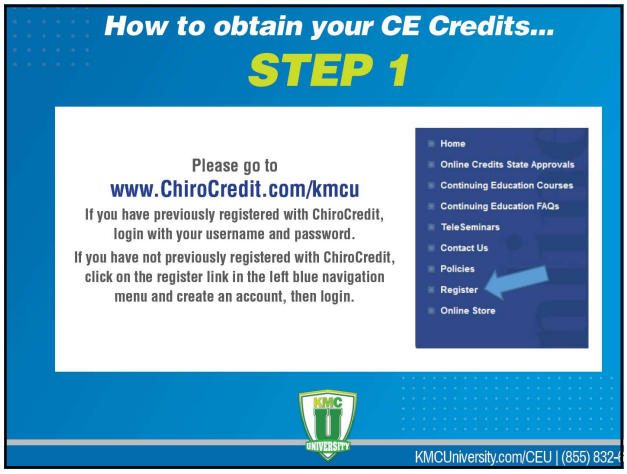
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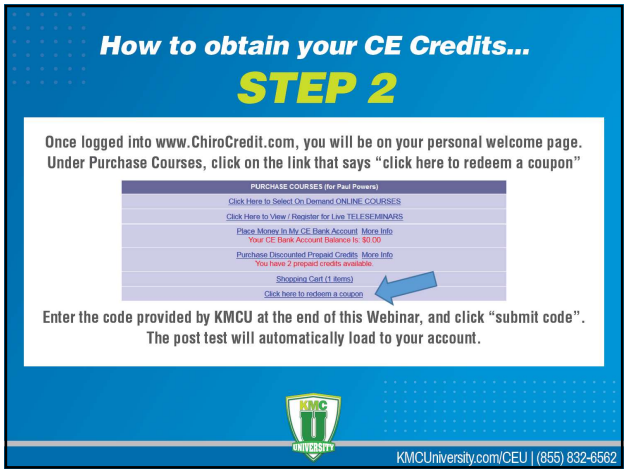
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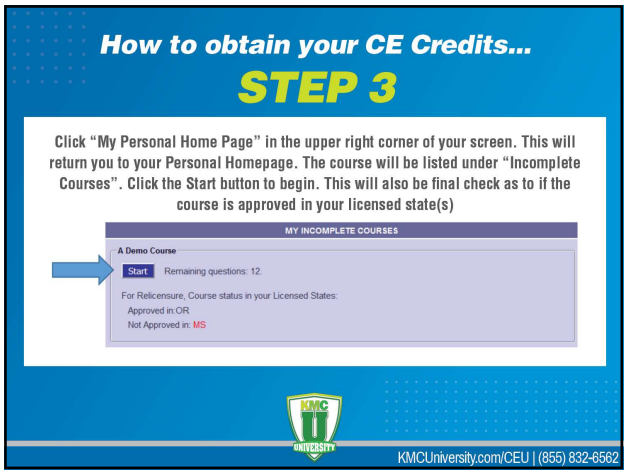
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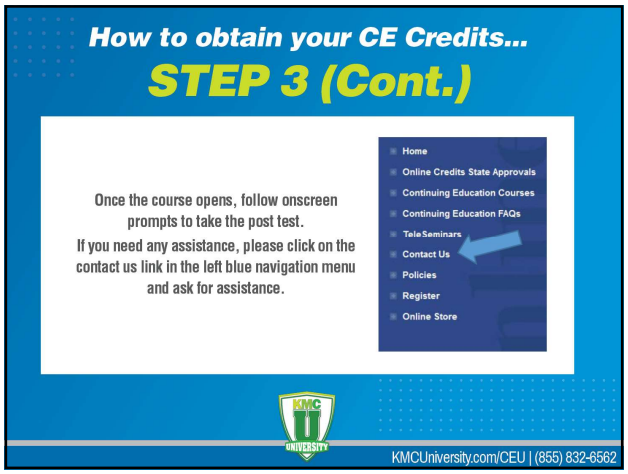
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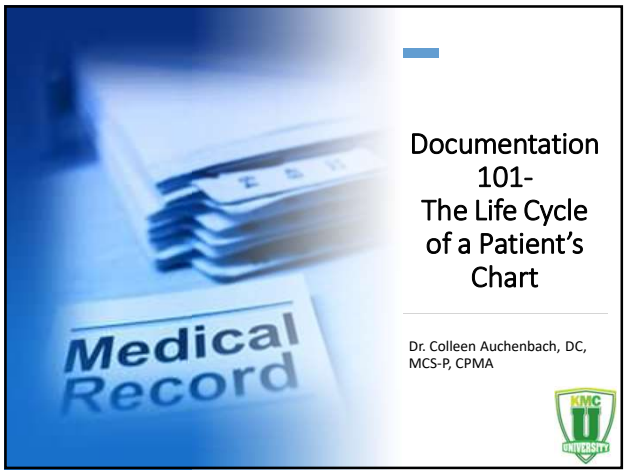

Documentation 101- The Life Cycle of a Patient's Chart

Dr. Colleen Auchenbach, DC, MCS-P, CPMA

7

Outcomes

- Overview of basic documentation requirements
- Communicating medical necessity in the documentation
- Capturing the entire patient's story from initial visit to discharge to wellness care or maintenance
- Best practices for utilizing abbreviations, addressing legibility, and authentication of signatures

8

Good Documentation Tells the Story!

9

How Documentation Tells a Story

Beginning/setting

"a long time ago in an office far, far away, a patient came in …"

Protagonist

"the patient is … year old male/female who has …. (History)"

Conflict

"the patient has … (problem that needed fixed)"

Action

"The patient undergoes … (your treatment) to address the problem"

Resolution

"The patient no longer has the problem (Discharge from Medically Necessary care) and is living happily ever after with maintenance treatment"

10

Know Your Audience

- Another healthcare provider
- Your board
- A malpractice attorney
- Third-party payer's medical necessity auditor
- Each has different but necessary requirements for your documentation

11

Anatomy of a Patient Chart

Every Chart Should Have:

- New Patient Intake
- Copy or scan of Insurance Card(s) (If applicable)
- Patient Consent Authorization
- Record Release Authorization
- Office Financial Policy
- Authorization to treat a minor (if applicable)
- X-ray report form (if applicable)
- Patient Health History
- HIPAA Notification of Privacy Practices Acknowledgment

Initial Documentation Collected

- Record of Fees/Charges/Payments
- Payment Plan (if applicable)
- Diagnosis
- SOAP Note (aka: daily visit notes)
  - **S**ubjective, **O**bjective, **A**ssessment, **P**lan (include DC's signature)
- Initial Exam and re-exams
- Insurance Billing and Remittance data (if applicable)

Ongoing Documentation

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Implement the Basics

- Basic documentation principles
- Proper use of abbreviations
- Addressing legibility
- Authentication of signatures
- Records management

13

Tips for Complete Documentation

- Patient name must be included on both sides of paper charts.
- Date-of-service on both sides of paper charts.
- Writing must be legible.
- If a CA completes any part of treatment, they must sign that section of the note. DC must always authenticate!
- If notes are taken by a scribe, they must sign the notes. DC must always authenticate!
- The DC is responsible for taking a final look at all documentation.
- Signing the notes is the last step in the process.

Reminder

Documentation is considered a LEGAL document!

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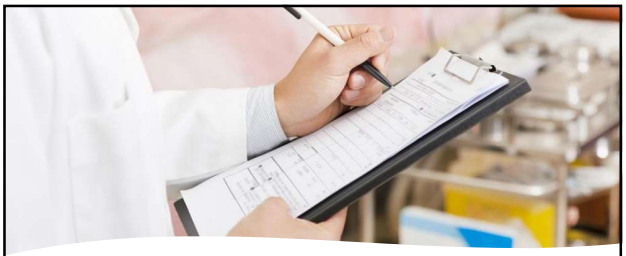

A Sign of Good Documentation

- Provides an accurate timeline of treatment
- Confirms medical necessity
- Ensures quality of patient care
- Clearly reports the actual happenings in the visit
- Secures appropriate reimbursement
- Meets licensure requirements

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The Marks of Bad Electronic Documentation

- Non-standard abbreviations
- Consents not documented
- Referrals not documented (visits to physical therapy or an LMT)
- Lack of Outcome Assessments (OATs)
- Missing components of SOAP
- Identical Notes (all visits look the same)

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The Marks of Bad Paper Documentation

- Pencil or white out
- Illegible
- Non-standard abbreviations
- No signature or dates
- Blank spaces (especially on intake forms)
- No identifying patient information (missing names and date of birth)

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Use Standard Abbreviations

- All abbreviations should be standard
- The easier your charts are to read, the better they will perform under scrutiny
- Supply a legend or key if you use non-standard abbreviations for any reason

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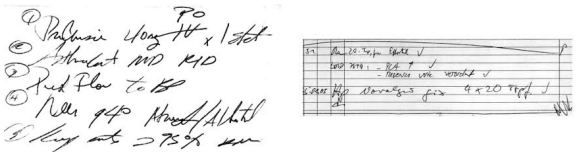
Legibility

- Use blue or black ink
- Never use correction fluid or erase
- Correct errors by putting one line through it, make your correction, and initial and date the change
- Legible to an external auditor or third-party



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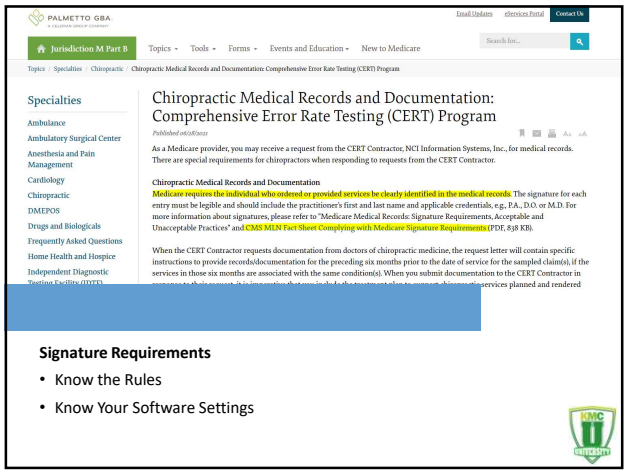

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Q: What is required for a valid signature?

A:
- Services provided or ordered must be authenticated by the ordering practitioner
- Handwritten or electronic signatures (stamped signatures are not acceptable)
- Legible Signatures

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Records Management

- Secure- Locked files or Password Protected
- Authorized Access - Individual Users Assigned
- Limited Permissions- EHR on a need-to-know basis
- Patient's Right of Access – HIPAA rules
- Backed Up – Confirmed data back ups and integrity checks

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The Patient's Story

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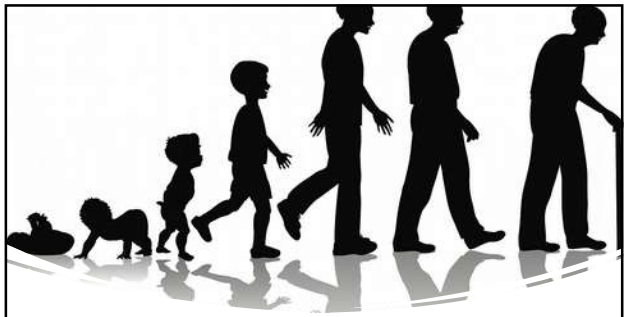

The Life Cycle of the Patient Chart

- A complete history
- Treatments performed
- Rationale for therapy
- Discharge date for maintenance care
- Maintenance treatments
- Everything that relates to how their health is managed by your office

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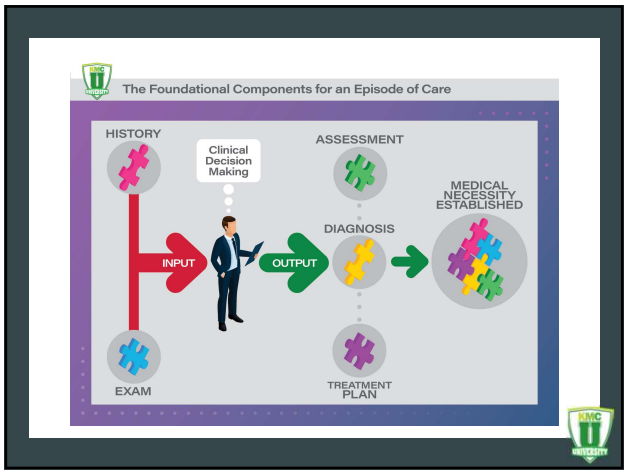

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The Patient's Flow Under Care

27

What 3rd Party Payers Want to See

- Proof of Medical Necessity
- Start date of care with the cause
- End date of care for Episode
- Diagnoses match the patient's complaints
- Procedure codes match the services reported

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Medical Necessity

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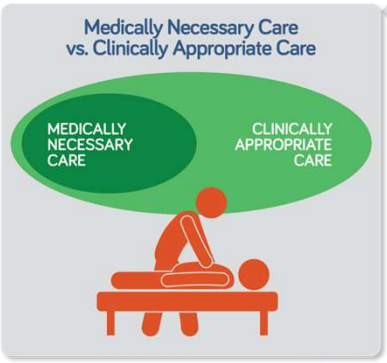
Medically Necessary Care vs. Clinically Appropriate Care



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Is All Care Medically Necessary?

Clinically Appropriate Care

- Enhances life
- Relieves symptoms
- Wellness care
- Supportive care
- Maintenance care

Medically Necessary Care

Yields a significant improvement in patient's clinical findings and FUNCTION

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Medicare Documentation Guidelines in the Absence of Others

Initial Visit

- History
- Description of Present Illness
- Physical Exam
- Diagnosis
- Treatment Plan
- Date of initial treatment

Subsequent Visits

- History
- Review of chief complaint
- Physical Exam
- Document daily treatment
- Progress related to treatment goals/plan

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3rd Party Payers Documentation Expectations

Treatment-related documentation is critical to determine whether 3rd party coverage and payment is warranted. Supporting Medical Necessity is the **key to success**.

- Medical necessity is defined as accepted health care services and supplies provided by health care entities for the evaluation and treatment of a disease, condition, illness, or injury and is consistent with the applicable standard of care.

In chiropractic, this means:

- *The patient must have a significant health problem in the form of a neuromusculoskeletal condition that needs treatment. The manipulative services rendered must have a therapeutic relationship to the patient's condition and provide a reasonable expectation of recovery or functional improvement.*

33

GUIDELINES

Medically Necessary

I. **A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.**

II. **Physical therapy services are considered medically necessary to improve, adapt or restore functions which have been impaired or permanently lost and/or to reduce pain as a result of illness, injury, loss of a body part, or congenital abnormality when ALL the following criteria are met:**

- The individual's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- Improvement is evidenced by successive objective measurements.
- The services are delivered by a qualified provider of physical therapy services (i.e., appropriately trained and licensed by the state to perform physical therapy services).
- Physical therapy occurs when the judgment, knowledge, and skills of a qualified provider of

Payer Requirements

- Potential to improve
- Individualized program with quantifiable, attainable treatment goals
- Improvement is evidenced by successive objective measurements

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The Easy Stuff

Daily Treatment

- What was done for the patient
- This should be supported by the treatment plan which was formulated from the history and examination findings

Maintenance/Wellness treatments

- Document to state/federal standards

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The Not-So-Easy Stuff

- History that relates to Medical Necessity treatment
- Examination
- Rationale for treatments
- Treatment plan
- Assessment
- ALL of these must be written in the documentation

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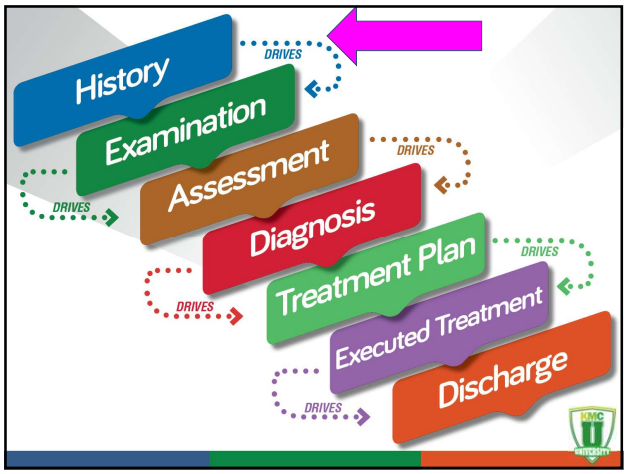

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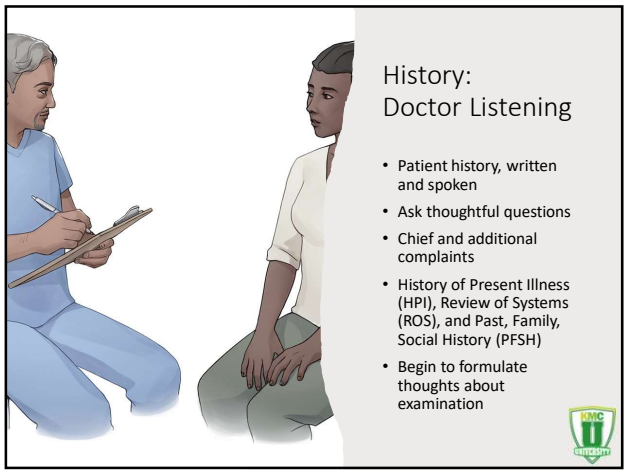

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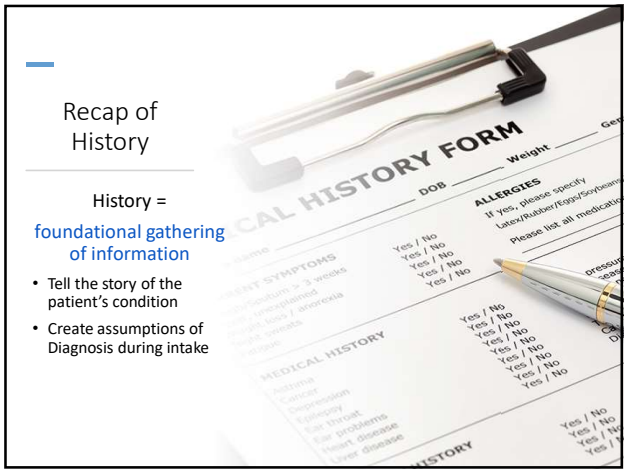

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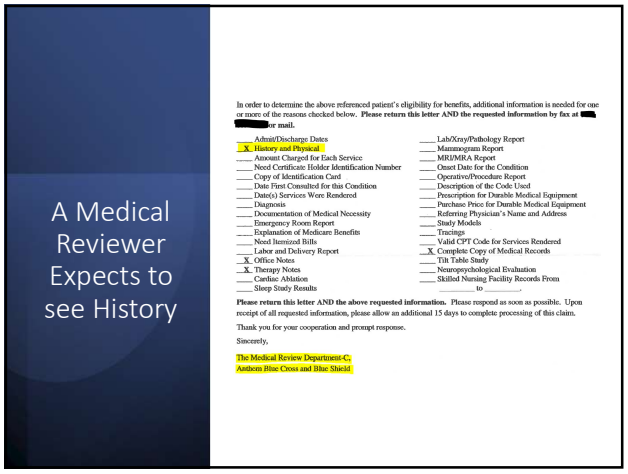

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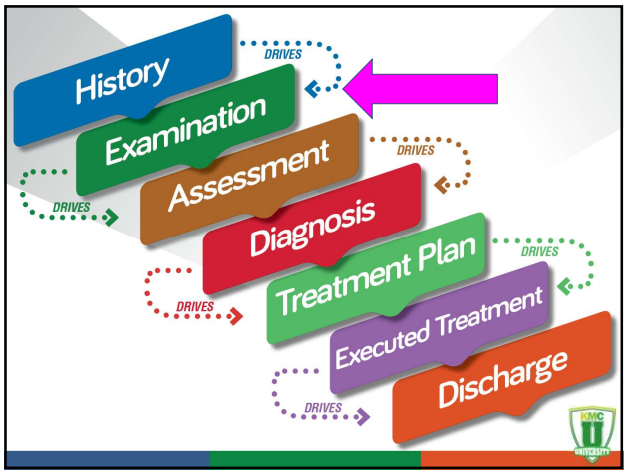

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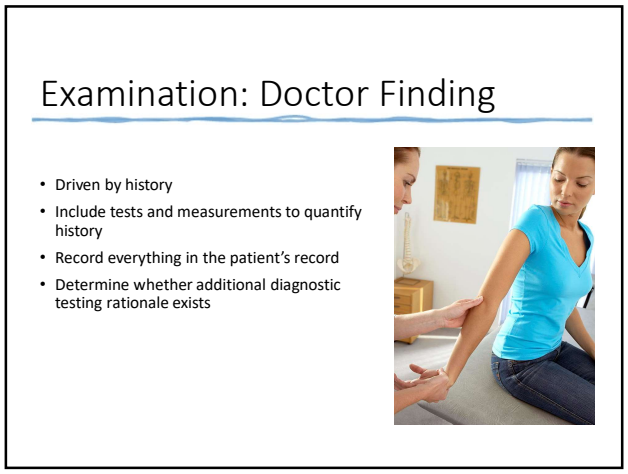

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How History Relates to the Examination

- Examination is needed to substantiate history findings
- Each piece of history has meaning
- Exam objectively supports subjective data from patient

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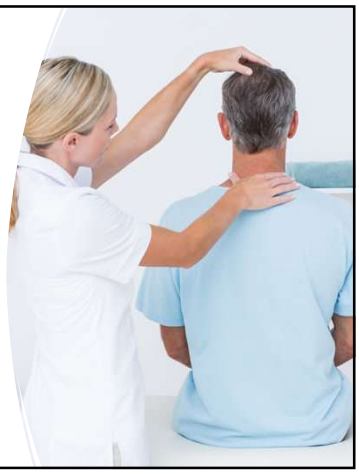
Exam Provides Proof

Positive history components become ortho/neuro/palpation examinations

Physical exam confirms or disproves your assumptions about your Diagnosis



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Confirmation

- Observation
- Inspection
- Selective tissue tension
- Resisted isometric
- Neuromuscular
- Functional assessment
- Special tests

Quantifies condition with objective data
We choose the test to confirm our assumptions from the history

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Tell Us What You're Thinking

- Why are the tests being ordered? X-rays, labs, other diagnostic tests, referrals, and DME
- Why did you decide to do what you did?

What's between your ears must appear in the documentation.

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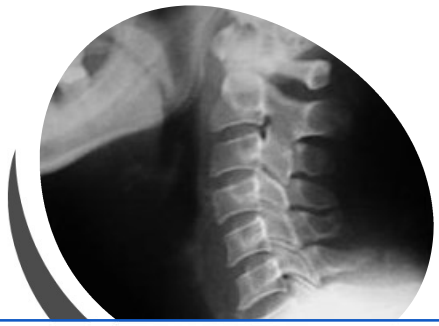

Radiographs:
- Rationale: Based upon the patient's history and examination, this most recent cervical trauma, and a history of prior neck injury, cervical radiographs were ordered. As routine procedure the patient confirmed that there were no contraindications to taking these films, including but not limited to pregnancy, trying to become pregnant, receiving active radiation therapy, or other contraindication for X-ray exposure.

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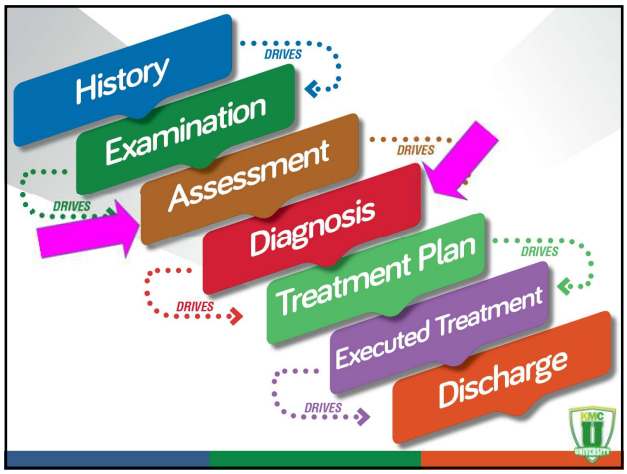

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Assessment: Doctor Thinking

History + Exam = Assessment and Diagnosis => Tx Plan

- Diagnosis for each region you plan to treat
- Treatment plan is based on Assessment and Diagnosis
- Diagnosis and plan for each component service

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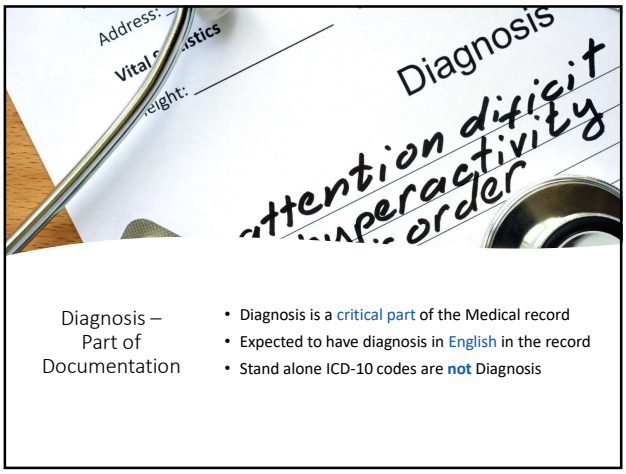

Diagnosis – Part of Documentation

- Diagnosis is a critical part of the Medical record
- Expected to have diagnosis in English in the record
- Stand alone ICD-10 codes are **not** Diagnosis

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Every Episode Needs a Plan

- Whether a couple of visits, a month of care, or a longer episode
- The plan is the **doctor's roadmap** to what treatment will be provided based on findings

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Elements of a Treatment Plan

- Duration, frequency and all recommended services or procedures.
- Specific, measurable and functional treatment goals.
- Objective measures to evaluate effectiveness.

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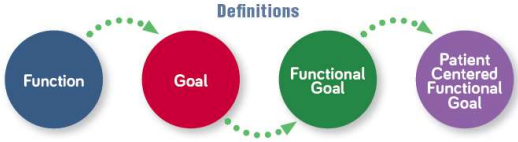
Writing Effective Treatment Goals

Meet the guidelines by including functional short-term goals (STG) and functional long-term goals (LTG) in your compliant treatment plan. Include specific dates the goals are expected to be achieved.



Well-written and clear treatment goals are patient-centered and contain the following elements:

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Be a **SUPER** Doctor-Compliant & Professional

- Every service or treatment provided must have a distinct and separate rationale
- Tell why you are performing the therapies for this specific patient

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Your Medical Records Must Tell the Story

GOALS AND RECOMMENDATIONS

- X-Rays of cervical, thoracic, and lumbar spine and left shoulder.
- Moist Heat/Cold Packs to the mid back, low back, and left shoulder, Electrical Muscle Stimulation to the mid back, low back, and left hip, and Ultrasound therapy to the neck.
- Chiropractic treatment 3 times per week for 4 weeks, with a planned re-evaluation for further care if needed
- Request X-ray/Radiology reports from previous physician.
- Schedule appointment with Medical Doctor ASAP

SUPPORTS

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What Not To Do

Plan:
The patient is in the acute inflammatory stage, the first of three phases of healing. This stage can last between 46-72 hours with associated swelling, redness, warmth and pain. Exercises will target reactivation through proprioception, balance, isometrics within pain free ROM, as well as spinal stabilization exercises within pain free range of motion. Cardio Training can be initiated. I see nothing in her history that indicates this is acute, if anything the history supports a chronic problem.

Goals:
decrease swelling and edema
decrease pain
break up scar tissue and fibrous adhesions
decrease muscle spasms
increase active range of motion
increase passive range of motion
restore biomechanical integrity
prevent re-injury

These will not work for treatment goals. You must have specific short and long term goals for each area of the body you are billing for. You have the intake form where she filled out her ADL limitations so you should use that for your goals. You are completely missing your treatment plan.

Todays treatment included the following; 1-2 region manipulation, examination and consultation. Need to list the specifics of what segments were adjusted and with what technique.

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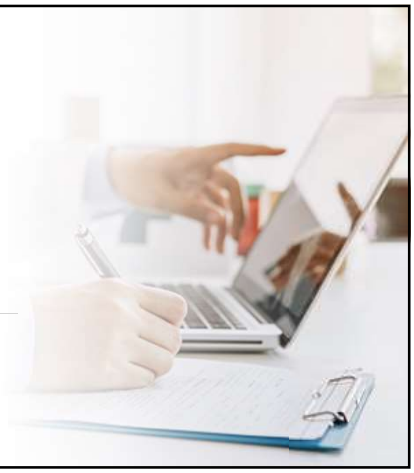
Treatment Plan vs. Executed Treatment

The Documentation Should Show the Difference!



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The Plan

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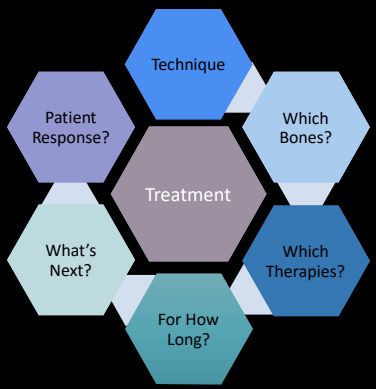
The Treatment



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Execute Treatment: Doctor Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear
- Code the correct treatment that you chose

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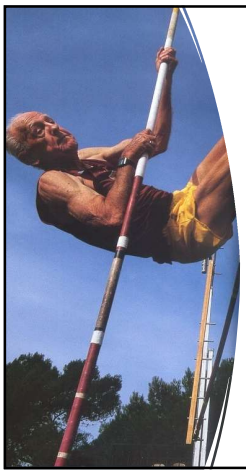

Daily Subjective Documentation Must Include Patients' Self-Appraisals

Examples:

- Better - Ability to brush hair in the morning without thumb and index finger tingling 50% of the time
- Worse - Increased difficulty putting on socks and now requires assistance from a family member
- Same - No change in ability to walk one block without increased pain

62

Include function in the conversation

Know the complaints, functional deficits, and goals so your can focus your conversation on how they have changed.

- Better
- Worse
- Same
- Measurable

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Good Subjective

Patient reports cervical pain that is dull and rated at 3/10. She reports there has been no change in her overall neck pain since the last visit, but she now is able to sleep 7-8 hours a night with 3 hours uninterrupted by pain.

Since the last visit the patient has decreased in sharp low back pain from a 4/10 to 2/10. He says "It didn't hurt to ride my bike here today." When asked how long of a drive that was, he indicated that it was about a 30 minutes.

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Gathering Functional Self-Assessment

"Mrs. Klaus, your walking ability really seems to have improved. When you first came in you were able to walk about 10 feet without that sharp pain… How far are you able to walk today without the pain coming back?"

65

Gathering Functional Self-Assessment

"I understand you feel your back pain is the same as when you first came in. At that time, you could only stand to do dishes for 10 minutes, and spasms would start … How long can you stand to wash dishes now?"

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Subjective

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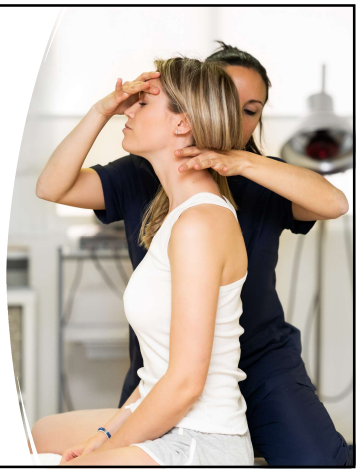
Daily Objective Findings

The Objective section:

- Follows the area(s) of complaint
- Verifies changes since the previous visit
- Documents support for what will be treated on that day's visit



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What We Hope to See

Daily Assessment: showing continued improvement and meeting expectations as indicated in today's subjective and objective evaluation.
- *Current Functional Ability:* Todd currently has the ability to lay down and stay asleep for 2 hours before being awakened by the next pain. He's dressing more easily and finding less difficulty in concentrating. I believe he is on course to meeting his short term goal of sleeping an uninterrupted 4 hours within 30 days.

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(P) If You Treated Today…

Today's Treatment:
- **Primary Treatment (1-2 regions):** Diversified and Drop Table - Chiropractic Manipulative Treatment (CMT) to the C2, C3, C4, C5 and C6 spinal level(s).
- **Supportive Therapy** to optimize treatment effectiveness the following therapy(s) were performed:
  - **As per treatment plan - Hot Pack:** hot moist pack applied to posterior cervical (neck) and upper thoracic region(s) for 15 minutes.
  - **As per treatment plan - EMS Unattended** low volt EMS applied to left side of neck, right side of neck, left trapezius and right posterior trapezius region(s) for 15 minutes.
- **Advised**
  - *Tx Effect:* Examination and treatment performed today without incident

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Tell the FULL Story

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When Should You Refer Out

Certain situations indicate that you should not treat the patient

- Patient's condition is not responding to the treatment rendered, when all reasonable alternative chiropractic methods have been exhausted
- The patient's condition is worsening with treatment
- The patient experiences a medical emergency

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Continue Care or Discharge?

- Assessment findings justify continued care or discharge
- Final exam should verify maximum therapeutic benefits has been achieved
- Clearly documented in the patient's chart
- Communication to patient necessary

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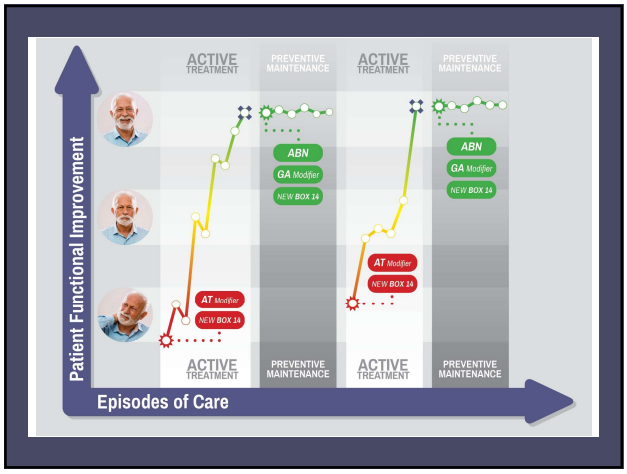

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Take A Closer Look

"Be open to the idea that you can always learn"

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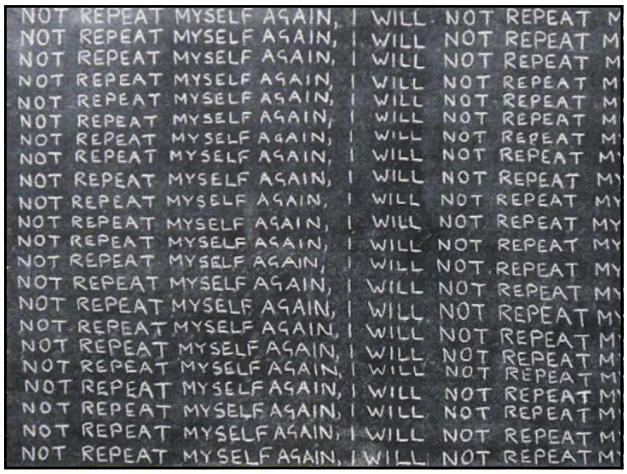

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Auto-Salted Notes

Date 12/21/2020
Provider:
*** continued from previous page ***
neurological complaints.

Date 12/23/2020
Provider:
*** continued from previous page ***
neurological complaints.

Date 12/31/2020
Provider:
*** continued from previous page ***
chance of a need for long-term treatment. It also means that there is a 60 to 80% chance of long-term residuals of primary presenting musculoskeletal, orthopedic and neurological complaints.

She is recovering from radiation and this process will take time.

Spinal adjustment is used to release pinched or irritated nerves and to help restore more normal movement of spinal segments.

Plan:
The patient is in the acute inflammatory stage, the first of three phases of healing. This stage can last between 46-72 hours with associated swelling, redness, warmth and pain. Exercises will target reactivation through proprioception, balance, isometrics within pain free ROM, as well as spinal stabilization exercises within pain free range of motion. Cardio Training can be initiated.

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Streamline the Process

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Master Internal Systems

- Team member driven documentation
- They gather relevant data
- You review out of sight of the patient then…
- You lead the conversation
- Save as much as an hour a day

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Record Standards That Apply to All

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Timely: What Medicare Says*

- CMS expects the documentation to be generated at the time of service or shortly thereafter
- Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service

**Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual. Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6.1.*

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What Medicare Says

A provider can't submit a claim for payment until documentation is completed.

- You can't submit the claim until the note is fully documented and signed
- In other words – "Until you sign off on your notes all of the work you did is unbillable!"

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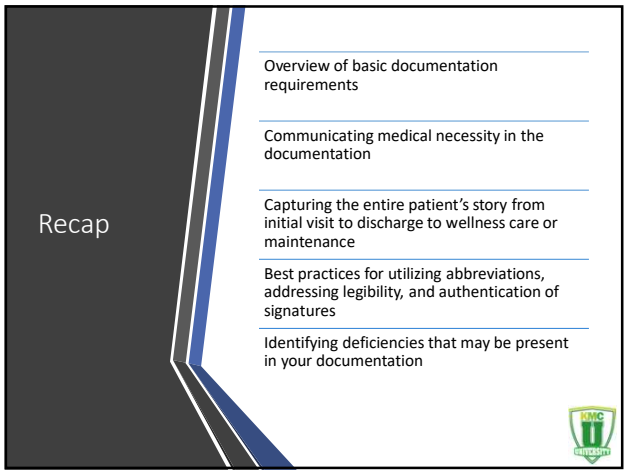

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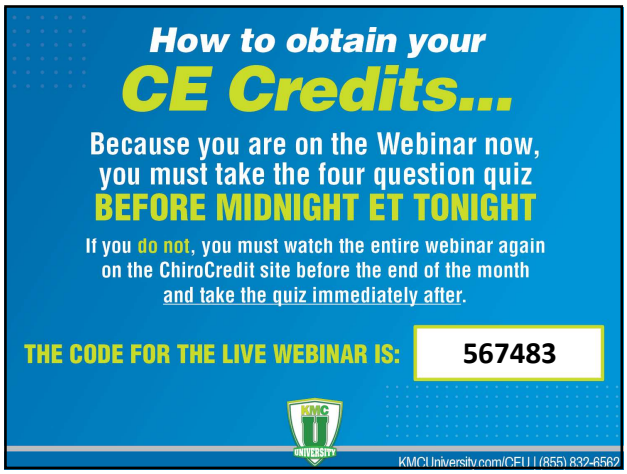
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