ChiroCredit.com Presents:

Coding and Documentation 201

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Got Documentation?

Clinical and Practical Documentation of Chiropractic
Gregg Friedman, DC, CCSP, FIACA

- 2nd Generation Chiropractor
- Practicing Since 1987
- Certified, American Board of Independent Medical Examiners (2004-2009)
- Teaching/Consulting/Expert Testimony

Questions:
What ONE thing can we do to accomplish ALL of the following?
1. Keep your State Board off your back
2. Minimize malpractice exposure
3. Improve patient compliance
4. Improve reimbursement

Answer:
Improve Your Documentation.
Doctors...Start Your Engine!

- Exam Documentation vs. Daily Documentation
- Start the Engine
- Drive the Track

Why Do We Need to Document?

- Protect Our Patients
- Protect Ourselves
- Justify Treatment
- Prove Outcomes

BAD DOCUMENTATION

- Examination
  - Not Performed
  - Not Written
  - Not Specific (i.e. LaSegue's)
  - All Subjective
  - Doesn't Justify Need For Care
BAD DOCUMENTATION

• SOAP Notes (Subjective)
  • Not Documented
  • Illegible
  • Vague and Non-specific
  • Unchanging

BAD DOCUMENTATION

• SOAP Notes (objective)
  • Illegible
  • Not-documented
  • Not Objective

BAD DOCUMENTATION

• SOAP Notes (assessment)
  • Improper
  • Illegible
  • Not-Documented
BAD DOCUMENTATION

• SOAP Notes (plan)
  • Non-specific
  • No times for timed codes
  • Illegible
  • Doesn't match with diagnoses
  • Doesn't match with billing

Great Documentation

• Results in great satisfaction and success in reaching your goals
  • Increase service to your patients
  • Less hassle practice
  • Increase economic position

Documenting Chiropractic

• Problem Oriented Medical Record (POMR)
  • Introduced in 1968 by Lawrence Weed, M.D.
  • Healthcare industry standard for all payers and all providers
Components of POMR

- Complete Problem List
- Diagnoses for each problem being treated
- Specific treatment goals for each condition
- Written treatment plan for each active problem
- SOAP format for ongoing treatment
- Document resolution and/or referral dates for each complaint

The History

- Onset
  - What Happened?
  - When Did it Happen?
    - Sudden
    - Gradual
    - BEWARE: Sudden Onset, No Trauma

More History

- Provocative and Palliative
  - What positions, activities or movements make each symptom better or worse
More History

- What is the Quality of Each Symptom?
  - Sharp
  - Dull
  - Achy
  - Burning
  - Throbbing
  - Etc.

More History

- Do Any of the Symptoms Radiate?
  - Where
  - What Side
  - How Far
  - What Dermatomes

More History

- Site
  - Specific for Each Symptom
  - Intensity
  - Frequency
More History

- Temporal
  - For Each Symptom, Are Certain Times of the Day Worse?

Also Note...

- Prior Interventions and Treatment
- Prior Surgeries
- Prior Injuries/Traumas
- Prior Illness(es)
- Prior Hospitalizations
- Medications

Don’t Forget...

- HIPAA
- Informed Consent
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The Examination

- What To Do
- How To Document It
Examination Form

- Visual ROM noting pain
- Motor Neurologic Exam
  - Muscle tests noting weakness (Grade 0-5)
  - Deep Tendon Reflexes
- Sensory Neurologic Exam
  - Dermatomal sensation
- Palpation Findings
  - Spinal/Extremity Restrictions
  - Muscle tonicity/tenderness
- A few orthopedic tests

Purpose of the E/M Exam

- Screen for NASTY things
  - Fractures
  - Dislocations
  - Disc problems
  - Other issues
  - Determine Other Tests/Physicians
- Determine Other Tests/Physicians
Does the E/M Exam Prove Medical Necessity?

- Initial Exam
- Re-Exams

Proper Coding

- New Patient Evaluation and Management
  - New Patient to You
  - Re-activated patient you haven’t seen in 3 years or more
  - 99201-99205
    - -25 Modifier

Proper Coding

- Established Patient Evaluation and Management
  - Re-exams
  - Initial exam on existing patient with new injury
  - 99211-99215
    - -25 Modifier
Proving Medical Necessity

• If the E/M exam does NOT prove medical necessity, than how DO we prove it?

So How Do We Prove Medical Necessity?

Outcome Assessments

A procedure or method of **measuring** a change in patient status **over time**, primarily to evaluate the **effect of treatment**.

3 Criteria for Objectivity

• Duct Tape
• Handcuffs
• Influence
“For the purposes of determining impairment, greater weight is given to those findings that are more objective.”

Subjective vs. Objective

- **Subjective Complaints**
  - 3 Categories
    - Purely Subjective (very weak documentation)
    - Quantitative Measurement of Subjective Test (better documentation)
    - Valid and Reliable, Quantitative Measurement of Subjective Test (Best Documentation)

Subjective vs. Objective

- **Objective**
  - 3 Categories
    - Objective Test w/Subjective Interpretation (weakest)
    - Quantitative Measurement of Objective Test w/Subjective Interpretation (better)
    - Quantitative Measurement of Objective Test w/Objective Interpretation (the mother lode!)
Outcome Assessments
Subjective vs. Objective

- Range of Motion
- Muscle Testing
- Outcome Questionnaires
- Pain Scale
- Muscle Tonicity
- Radiographic Imaging
- Electro-Diagnostic Testing

The Real International Language is...

Measured Function

P.A.R.T.
- REQUIRED for Medicare
The PART System of Documentation

• For chiropractic, must have these 3 components:

1. Presence of a subluxation that causes a significant neuromusculoskeletal condition
   - the subluxation must be consistent with the complaint/condition

The PART System of Documentation (cont’d)

2. Documentation of the Subluxation
   - by x-ray
   - by physical examination

   If documented by physical examination, the P.A.R.T. system must be used.

The PART System of Documentation (cont’d)

3. Documentation of the Initial and Subsequent Visits
   - specific documentation requirements apply whether the subluxation is demonstrated by x-ray or physical examination
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P = Pain and Tenderness

Identify using one or more of the following:

- Observation: note the location, quality and severity of the pain
- Percussion, Palpation or Provocation
- Visual Analog Type Scale
- Audio Confirmation: verbally from 0-10
- Pain Questionnaires
Documenting Subjective Complaints

- Pain or Discomfort
- Mild, Moderate, Severe
- Intensity
- Frequency

BAD Documentation for PART

- Neck pain, middle back pain, low back pain
- Mild, Moderate, Severe neck pain
- Occasional, Intermittent, Frequent or Constant...
- The patient rated the pain (multiple areas) a 7 out of 10

GOOD Documentation for PART

Mr. Smith presented to the office today with the following symptoms:

Occipital headaches, which he rated a 7 out of 10 on a scale from 0-10, with 10 being the worst, 80% of awake time.

Neck pain, which he rated a 5 out of 10 on a scale from 0-10, with 10 being the worst, 40% of awake time.
Outcome Questionnaires

- Quantitative Measurement of Subjective Test
- Valid and Reliable
- Copyright Protected

General Health Information

- Health Status Questionnaire – RAND 36

Pain Measurement

- Quadruple Visual Analogue Scale
- Pain Disability Questionnaire (now used for spinal impairment ratings, 6th Edition)
Spine Related Condition-Specific Questionnaires
• Oswestry Low Back Pain Disability Questionnaire (revised)
• Roland Morris Disability Questionnaire
• Modified Roland (Sciatica) Questionnaire
• Back Bournemouth Questionnaire
• Neck Bournemouth Questionnaire
• Neck Disability Index Questionnaire
• Copenhagen Neck Functional Disability Scale

More Spine Related Condition-Specific Questionnaires
• Headache Disability Index
• Dizziness Handicap Inventory
• Tinnitus Handicap Inventory
• TMD Disability Index
• Spinal Stenosis Treatment Outcome Questionnaire

Extremity Condition-Specific Questionnaires
• Upper Extremity
  • Shoulder Injury Self-Assessment of Function Questionnaire
  • Shoulder Pain and Disability Index
  • Mayo Elbow Performance Index
  • Carpal Tunnel Syndrome Questionnaire
  • Patient Rated Wrist Evaluation
Extremity Condition-Specific Questionnaires
- Lower Extremity
  - Hip Rating Questionnaire
  - Patellofemoral Function Scale
  - Knee Score Questionnaire
  - Ankle Grading System

Psychometric Questionnaires
- Waddell's Non-Organic Low Back Pain Signs
- Modified Zung Depression Index
- Modified Somatic Perception Questionnaire

Recommendation for “P”
- Intake Form/Consultation: OPQRST for each symptom
- Outcome Questionnaires at initial exam (within first week) and all re-exams - METRIC
- For Daily Visits:
  - Specific site(s)
  - Specific intensity - METRIC
  - Specific frequency - METRIC
A = Asymmetry/Misalignment

Identify on a sectional or segmental level by using one or more of the following:

- Observation: posture or gait
- Static and Dynamic Palpation
- Diagnostic Imaging – must have x-ray report

Observation of Posture or Gait

- Posture
  - Subjective Interpretation of Objective Test
- Gait
  - Structural
  - Functional

Static and Dynamic Palpation

- Subjective Interpretation of Objective Test
Restrictions/Subluxations

- Hypomobile
- Palpation
- Segmental (C1, C3, T4, L5, etc.)
- Sectional
  - Atlanto-occipital, cervico-dorsal, thoraco-lumbar, lumbo-sacral, sacro-iliac

Diagnostic Imaging

- X-Ray
- MRI
- CT

Diagnostic Imaging

- Without Measurements
  - Subjective Interpretation of Objective Test

- With Measurements
  - Quantitative Measurement of Objective Test
  w/Objective Interpretation
MRI’s vs. CT Scans

- MRI’s show soft tissues, such as discs
- CT scans show hard tissues, such as fractures (posterior element, uncinate processes, dens)

GOOD Documentation for PART