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Documentation 101 – Part 1 of 10

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BIO ON DR. PAUL R. SHERMAN:
Dr. Paul R. Sherman received his Bachelor of Science Degree in Nutrition from Park College in Parkville, Missouri and his Doctor of Chiropractic Degree from Cleveland Chiropractic College Kansas City, Missouri. He also completed a one year clinical internship at the Cleveland Chiropractic Clinic and a one year clerkship with Michael Sherman, D.C. Dr. Paul Sherman has been with the University of Bridgeport since 1998. Presently, Dr. Sherman is serving as Associate Dean of Academic Affairs and Associate Professor of Clinical Sciences at the University of Bridgeport, College of Chiropractic in Bridgeport, Connecticut. Dr. Sherman has also served as the Interim Dean and Coordinator of Academic Affairs for the College of Chiropractic. In addition, he is a postgraduate faculty member for the University of Bridgeport, College of Chiropractic. Dr. Sherman has been published and is an author, writer and instructor for ChiroCredit.com, a continuing education website for chiropractic. He is licensed to practice chiropractic by the Connecticut State Board of Chiropractic Examiners and the New Jersey State Board of Medical Examiners and was in private practice in New Jersey for 16 years. Dr. Sherman earned the distinction of receiving the National Deans Certificate of Merit when he was a student at Cleveland Chiropractic College Kansas City, Missouri. In addition, he has earned postgraduate certificates in Scoliosis Determination Procedures, Interesting and Challenging Chiropractic Case Studies, Musculoskeletal Applications of MRI and Hospital Protocol. Dr. Sherman holds an active membership with the American Chiropractic Association.

MANUAL CONTENT:
1. How to avoid legal malpractice key components.
2. Four elements comprising the legal definition of malpractice.
3. Legal requirements of informed consent.
4. Two basic types of malpractice insurance coverage.
5. Dos and Don’ts of record keeping.
6. Meeting the 21 NCQA guidelines.
7. Medicare coverage for chiropractic services.
8. Understanding Medicare’s policy regarding x-ray/diagnostic reimbursement when
performed by a chiropractic physician.


10. Three categories of conditions that Medicare covers and one category that Medicare does not cover.

11. Medicare guidelines with reference to X-rays and/or physical examination (P.A.R.T.) system.

12. Medicare documentation requirements for initial visit.

13. Medicare documentation requirements for subsequent visits.

14. Medical documentation for progress notes.

15. Understanding coding i.e.: CMT, CMT descriptors, ICD-10, CPT, E/M codes, E/M descriptors and modifiers.

16. Basic understanding of Medicare appeals process.

17. Basic understanding of participating vs. non-participating provider for Medicare.

18. Determining when diagnostic testing is appropriate as well as commonly used diagnostic procedures in chiropractic practice.

19. Things to consider when interpreting plain film X-rays of the spine and/or extremities.

20. Important clinical laboratory tests to aid in the differential diagnosis of musculoskeletal disorders.


22. Introduction to evidence-based care and overview of CCGPP.

23. Contraindications for chiropractic manipulation.

24. General contraindications to most physiotherapy modalities.

25. General contraindications to myofascial release technique and soft tissue mobilization.

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**COURSE DISCLAIMER:**
The information contained in this Documentation Manual was prepared by Dr. Paul R. Sherman and is being sponsored by the postgraduate department of the University of Bridgeport, College of Chiropractic and does not constitute legal advice. The documentation for medical information being discussed in this Manual generally applies to all forms of insurance i.e.: Medicare, major medical (managed care and traditional plans), auto and workers’ compensation. In addition, these guidelines should be utilized for non-insured patients (cash patients). Special emphasis will be given to the National Federal Medicare guidelines because many plans have been utilizing Medicare as their medical model. Dr. Sherman has attempted to meet all requirements with regard to the National Federal Medicare guidelines for documenting medical necessity for chiropractic care as well as the requirements needed for record keeping from the NCQA guidelines. The information contained in this Manual is believed to be the most current information available on this topic. Dr. Sherman makes no guarantee or warranty with regard to this information as this information is subject to change as guidelines continue to develop. It should be noted that prior to administering any treatment a complete case history, past medical history, family history and physical examination should be performed. In addition, if medically indicated radiographic and/or other diagnostic studies should be performed on all patients to determine if chiropractic care and/or adjunct therapies would be appropriate. If indicated referral to other healthcare providers for consultation/evaluation should be considered.
DOCUMENTING MEDICAL INFORMATION TO MEET INSURANCE GUIDELINES, AVOID MALPRACTICE AND ENHANCE YOUR CLINICAL KNOWLEDGE

HOW TO AVOID LEGAL MALPRACTICE KEY COMPONENTS:

- Practice with a high degree of technical competence in the skills of clinical interviewing, clinician-patient interaction, and in your scope of professional practice.
- Become a doctor who is empathic, respectful and who listens well and responds appropriately to the patient. This will help generate trust and satisfaction among your patients.
- Listen to what the patient does and doesn’t say.
- Avoid trivializing or demeaning the patient.
- Acknowledge the patient’s level of concern.
- Strive for the patient to visualize or understand your reasoning and recommendations.
- Be clear about what you know and what you don’t know.
- Never make promises you can’t keep.
- Be available to the patient.
- Pay careful attention to informed consent.
- Pay attention to your communication with other health professionals involved in the patient’s care. Make sure they know what you are doing and you know what they are doing. Obtain this information by letter, phone, e-mail, or fax.
- Remember that documentation is essential. Make your progress notes clear, comprehensible, concise, and complete.
- Document your attempts to follow-up on missed appointments or tests.
- If a mistake is made in the patient’s record, correct the mistake carefully and indicate enough information so that others can understand what you are doing and when you are doing it. Mark in the patient’s chart addendum, indicate the date and record the new information then sign or initial entry.

FOUR ELEMENTS COMPRISING THE LEGAL DEFINITION OF MALPRACTICE:

1. There must be a duty between the two parties i.e.: Doctor/patient relationship.
2. There must be a breach of that duty (something wrong has to have occurred between the doctor and patient) i.e.:
   - Fractures
   - Failure to diagnose i.e.: cancer, aneurysm (AAA), infections, fractures etc.
   - Failure to refer
   - Sexual harassment (usually attached to claim)
   - Pure negligence (part of failure to diagnose)
   - Lack of informed consent (usually attached to claim)
3. Harm or injury must result from that breach of duty.
4. There has to be proximate cause (there must be a relationship in time between the
bureach and the injury).

Note: If one of these 4 elements is not there the malpractice action fails.

INFORM CONSENT:
The doctor of chiropractic must understand that informed consent is a process of communication between the doctor and the patient. The doctor must realize if there is a risk of harm or injury from a particular treatment he or she is proposing to the patient, it is the doctor’s responsibility to tell the patient about such risks. In addition, the patient should be fully informed of the risks involved and be willing to accept such risks. Keep in mind, the doctor has no legal obligation to disclose or discuss risks that are considered immaterial. This means the less serious the risk and the less chance of the risk then the less likelihood that the legal system would require such disclosure.

LEGAL REQUIREMENTS OF INFORM CONSENT:
1. Information: The patient should be provided with information that a “reasonable person” would want to know about the nature of the procedure, benefits, and risks (in non-technical terms), of all significant potential consequences of a proposed service so that the patient’s consent is given with full knowledge of any inherent dangers involved. Also, the doctor should explain alternative options available.
2. Understanding: The patient must understand the information provided.
3. Voluntariness: The patient’s decision must be freely made, without evidence of coercion. Remember it is the patient, not the doctor, who makes the decision whether to proceed or not in view of the possible consequences and alternatives. This is called “gaining informed consent”.
4. Competency: The patient should be capable of making an autonomous (independent) medical decision in the particular setting.

TWO TYPES OF MALPRACTICE INSURANCE COVERAGE:
1. Claims made policy-doctor is covered provided he/she has insurance.
2. Occurrence policy-doctor is covered even if a claim is brought against the doctor after coverage ends i.e.: retired.

Note: Doctor should have occurrence policy to make sure he/she is fully protected.

DOS AND DON'T OF RECORD KEEPING:

DOS:
- Maintain records in ink (preferably black or blue), never use pencil
- Make additions and changes appropriately (If you forget to say something than make a new entry, date it and mark addendum and make it clear in the entry that the information you are now writing is pertaining to the previous visit and initial or sign entry).
- If you make a mistake just put one line through it and initial correction. Many doctors have lost malpractice suits, even if they did nothing wrong, because of panicking when they were served a summons and then trying to change/alter their records. This is usually detectable and would cause any jury to lose faith in the doctor’s integrity.
- Identify patient name, date and year of service
- Document unusual events
• Record all patient contacts including telephone calls
• Identify the record keeper if more than 1 doctor office
• Maintain legibility
• Maintain a legend for any codes/abbreviations used
• Fill in all blanks or make a line through blank spaces
• Initial and/or sign all documents
• Keep financial and clinical records separate
• Document patient non-compliance
• Proof read correspondence and reports and document in chart
• Take the time to do quality documentation for every patient and entry

DON'T:
• Don't erase
• Don't skip lines or leave spaces
• Don't squeeze in notes
• Don't use correction fluid (white-out)
• Don't back date or alter records
• Don't say anything disparaging about the patient
• Don't ever enter data prematurely
• Don't use 2 different pens on the same day's entry
• Don't use computer-generated notes unless individualized. Make sure computer software being used allows patient records to be “locked” on a daily basis to prevent the possibility of tempering with the records. This will help to secure the authenticity of the records.
• Don't criticize other providers

MEETING THE 21 NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE) GUIDELINES:
The NCQA is a nationally known organization, which establishes guidelines for accrediting health care organizations nationwide. In addition, they establish guidelines and parameters for appropriate record keeping.

THE 21 NCQA GUIDELINES CONSIST OF THE FOLLOWING:

1. Each and every page in the record contains the patient's name or ID #.
2. Personal/biographical data includes address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain author identification.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated in record.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this should be appropriately noted in record.
8. Is there an appropriate past medical history in the record i.e.: serious accidents and/or injuries, operations, hospitalizations, tumors, review of systems and any illnesses. Note: For children and adolescents (18 years and younger), past medical history specifically deals with prenatal care, birth, operations and childhood illnesses.
9. Is there documentation of social history i.e.: smoking, drinking, substance abuse, sexual and dietary habits, typical activities of daily living (ADL) and occupational history.
10. The history and physical examination documents appropriate subjective and objective information for presenting complaints.
11. Are lab and other diagnostic studies ordered as appropriate?
12. Are working diagnoses consistent with findings?
13. Are plans of action/treatment consistent with diagnoses?
14. Is there a date for return visit or other follow-up plan for each encounter?
15. Are unresolved problems from previous office visits addressed in subsequent visits?
16. Is there evidence of appropriate use of consultants?
17. If a consultation is requested, is there a note from the consultant in the record and is there evidence of continuity and coordination of care between primary and specialty physicians.
18. Consultations, lab and imaging reports filed in patients chart initialed or is some other method used to signify review. Is there some kind of explicit notation in the record indicating follow-up plans.
19. Does the care appear to be medically appropriate?
20. Is there a completed immunization record for children, or an appropriate history has been made in the record for adults.
21. Are preventive services appropriately used if medically necessary?