



DOCUMENTATION

Treat ... or Refer?

DOCUMENTING MEDICAL NECESSITY: ANOTHER CASE

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Let's take another look at properly documenting patient findings in a SOAP note in order to demonstrate medical necessity. This process should tell the story of your encounter with the patient. Your documentation of the subjective and objective data acquired with the history of present illness and physical examination is an essential process. During the history taking, you should be considering the different diagnoses you intend to rule in or rule out with your physical examination.

Once the subjective and objective data have been recorded, you should be able to list your assessment including the working diagnosis, followed by the treatment plan.

This process should be properly recorded in the medical record. The data should help you to determine if chiropractic treatment is indicated. If yes, then medical necessity has been demonstrated and you should move forward with the treatment plan.

Today's Case Study

This is a putative case involving a patient with chronic, post-traumatic neck pain, but with a recent change in symptoms. This presentation should challenge you to determine if chiropractic treatment is medically necessary. Possibly, you have seen this type of patient presentation. If not, the following will prepare you to properly care for a future patient.

Subjective Examination

Chief concern: "My hands are numb, my neck hurts, and I cannot button my shirt."

The patient has been coming in for chiropractic treatment for more than 30 years following a whiplash-type injury at age 40. Usually, this 70-year-old male describes his neck pain as a dull ache that bothers him daily. For the past five years, he has experienced 2-3 episodes of severe neck pain with sharp shooting pain down his right (dominant) hand to the thumb and index finger. Normally,

the painful episode resolves with 1-3 cervical manipulations.

However, since a recent fall, which occurred two weeks ago, the patient has noticed a change in symptoms. Now, he has numbness in both hands and feet. He relates that his wife must button his shirts for him. His neck is really stiff now. He notices dizziness when he looks up. When he looks down, he experiences a sharp electrical sensation that shoots down his spine and both arms and legs.

He also admits that his balance does not seem good anymore, and that he has been falling during the past three months. When drinking his morning coffee, he has dropped the cup on occasion; and also complains that he is having bladder problems.

Objective Examination

Gait is a wide-based ataxia upon entering the exam room. Tandem gait testing demonstrates an inability to walk heel to toe.

Active cervical range of motion is limited in all directions. Extension does produce dizziness and flexion produces a sharp electrical sensation that shoots down his spine and into all four extremities.

Palpation of the cervical spine produces pain at the level of C1-2 in the paravertebral muscles bilaterally and over the C 4-6 ligamentum nuchae.

Posterior joint dysfunction is present at C1-2 with pain, reduced range of motion, and hypertonicity of the paravertebral muscles bilaterally.

Myofascial trigger points located in the scalene, upper trapezius, levator scapular, and posterior cervical muscles bilaterally.

Neurological examination: sensory deficits: hypesthesia for light touch, vibratory sensation, and position sense for the upper and lower extremities bilaterally; motor deficits: 1+ bilaterally lower extremities; unable to button or unbutton his shirt. (decreased hand dexterity); deep tendon reflexes: loss of reflexes at biceps (C5) and brachioradialis (C6) bilaterally and hyperreflexia of the triceps (C7) bilaterally; ankle clonus sustained bilaterally; pathological reflexes: Babinski's and Hoffman's signs present bilaterally.

Imaging Findings

MRI demonstrated cervical spinal stenosis and cord compression at C 5-6. Radiographic examination demonstrated disc space narrowing and osteophytic formations at posterior margins of the vertebral bodies of C4-5-6.

Assessment / Plan

- Degenerative cervical myelopathy
- Refer patient for neurosurgical consultation

Discussion

The loss of C5 and C6 reflexes with an increased C7 reflex bilaterally is almost a pathognomonic physical examination finding for spinal cord compression at C5-C6.

It is prudent to consider spinal manipulation to be an absolute contraindication prior to the

neurosurgical consultation. If neurosurgical intervention takes place and relieves the pressure on the cervical spinal cord, any type of cervical manipulation should be avoided for at least six months post-surgical.

Surgical decompression of the cervical spinal cord will not cure the chronic pain syndrome, but hopefully will reduce the progressive neurological damage to the spinal cord.

Once this patient heals from the surgical procedure, it is recommended that the chiropractic provider confer with the surgeon and the patient to determine the type of co-management that best meets the needs of the patient.

The chronic pain syndrome will include a myofascial pain syndrome and cervical joint dysfunction above and below the surgical region. There will be a need for motion (exercises), manual medicine (mobilization and soft-tissue treatments), modalities (shockwave or other modalities), mind/body therapy (cognitive behavioral), and possibly medications.

Hence, the evidence demonstrates medical necessity for chiropractic co-management, but with relative contraindications. You will need to modify the chiropractic interventions in order to prevent injury to the patient. *Primum non nocere.*

Quiz Time

1. The loss of the C5 and C6 reflexes with a hyperreflexia of the C7 deep tendon reflexes is an almost pathognomonic physical examination finding for spinal cord compression at C5-C6. *True or False*
2. Upper motor neuron lesion signs including clonus, hyperreflexia, and pathological reflexes are present with cervical spinal cord compression. *True or False*
3. Lower motor neuron lesion signs include hyporeflexia and ataxic gait. *True or False*

Quiz Answers: 1. True. 2. True. 3. False.

Reference

1. Young WF. Cervical spondylotic myelopathy: a common cause of spinal cord dysfunction in older persons. *Am Fam Physician*, 2000;62(5):1064-1070. Published correction appears in *Am Fam Physician*, 2001;63(10):1916.

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