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Documentation Challenges in Peer/Utilization Review

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Over the past several months, numerous providers have contacted me with problems and questions regarding peer/utilization review.

The phone calls have come from all over the country, indicative that there is much confusion about this hated insurance mechanism. My last few articles have attempted to clear up some of the misunderstanding, but it is apparent that most practitioners are still uncertain of what is expected of them.

Many doctors are surprised to hear that peer review has little to do with the condition of the patient. Things like patient improvement, diagnoses and documentary literature surrounding treatment efficacy are all secondary to whether the documentation within the file supports the need for the treatment provided. This is the fundamental difference between a paper review (like peer and utilization reviews) and independent medical examinations. While often used interchangeably, IMEs are physical examinations of the patient, while peer/utilization reviews are essentially "audits" of the provider's documentation.

Doctors are often frustrated by these paper reviews because they feel that the patient's well-being is paramount, whether or not the provider can keep good notes. But in this age of claims adjusters "looking over your shoulder," office notes have become (and really always were) legal documents. These documents must support the need for care on an ongoing basis, from the date of your initial consultation through your most recent office visit. Practice parameters which dictate what "most" chiropractors do in their offices take this one step further, creating an accepted standard for what your documentation should provide.

I would like to address some of the complaints which I have heard regarding the denial of claims from inadequate documentation:

"It's impossible to document cases the way reviewers demand."

It is difficult to provide adequate documentation when a doctors has a high volume practice. This was the reason that travel cards were born and continues to be one of the primary reasons cases are denied. That a doctor can't get the appropriate documentation down on paper is no rationale for arguing with a reviewer. I have the answer: dictation! The quality and thoroughness of dictation far outweigh travel cards, check-off systems, computer-generated notes and handwritten entries. It is legible, pertinent and easy to do.

"The medical doctors wouldn't send their notes to me."

You are responsible for having all pertinent documentation. If not how do you know that's what the patient has? What's the position? Is there thecal sac compression? Often peer review organizations do not obtain documentation from other providers, leaving the reviewer with only the chiropractic file. Include all relevant notes when submitting your case!

Have all patients sign a medical release. On a patient's first visit, have your office staff fax the release to the appropriate providers and have them mail or fax you copies of their records. If you still can't obtain the appropriate documentation, then enlist the help of the patient. It is ultimately the patient's responsibility to obtain information that you require. This is essential!

"My notes state that the patient would only be seen on a PRN basis!"

My last article was on supportive care and establishing the need for such care. Supportive care requires specific documentation without which there cannot be a claim for treatment beyond maximum medical improvement. Elements of supportive care include trial withdrawals, a diagnosis which progressively deteriorates without your care, and treatment provided solely on a patient-requested basis.

Too many doctors document the need for PRN or "as needed" care without carefully understanding the parameters for supportive care. Such ongoing treatment requires a concerted effort on the part of the doctor to adequately convey the necessary information.

"I made referrals during the course of the patient's treatment."

That's fine, but the referrals still have to be supported by the documentation and have sufficient clinical rationale. An inappropriate referral would be the doctor who orders a lumbar MRI when the file reflects a negative SLR, symmetrical deep tendon reflexes, no motor weakness and radicular pain to the buttock. With any referral, be it imaging study, electrodiagnostic testing or professional second opinion, there must be appropriate reasoning documented in the notes. (Note: The fact that the patient's attorney needs a referral to "build his case" is not any rationale for any referral.)

Anything done outside of a normal daily routine (SEMG, prescription for durable medical equipment like cervical pillows, lumbar supports, professional referrals, etc.) should be accompanied by a separate, short entry in your file explaining the rational for your decision. This gets you in the good habit of proper documentation and defends your actions in peer review situations.

"The patient has had multiple exacerbations which have prolonged care."

What happened, what effect it had on the injury and the estimated time it would take to bring the patient to pre-exacerbation status. Recognize that many providers use every cough and sneeze as rationale for prolonged treatment. This is not considered appropriate chiropractic management, especially without substantial supporting documentation.

This is especially true for minor or uncomplicated injuries. It is very difficult to support an assertion that the minor soft-tissue trauma will require six months of treatment, regardless of exacerbating factors. When there is documentation reflecting multiple exacerbations over the course of care, questions begin to fly.

There is no question that documenting patient files has become more demanding over the past few years. This demand has been necessary to correct a history of poor documentation which did not substantiate treatment regimens. Again, the key to winning peer reviews is to provide outstanding documentation which reflects treatment falling within accepted guidelines. You can do it. No one ever said it would be easy.