Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Collecting Information during the Examination

In our preceding article we looked at the importance of finding your niche in practice: proper documentation; the need for establishing an office procedure system that simply and inexpensively collects, stores and, when called for, easily provides the results of the initial consultation, examination, diagnostic findings and daily chart notes. In this article we review the information that should be collected during the examination.

Record Keepers Are Record Breakers

Regardless if you conduct telephone intake consultation, or choose to take the added time to conduct a consultation in the office, you should now collect the following information, which can be entered into a computer or on specialized forms.

As you review the following information, keep in mind that most boards of chiropractic examiners, insurance companies, attorneys and courts of law are ever more demanding that this information be collected and available. Fulfilling the requirements is not difficult or time consuming if you have taken the time to acquire the computer documents and/or forms to assist in collecting this information. In our clinic each office contains a laptop computer with documents that our doctors are required to use for consultations, examinations and daily chart notes.

This Is Serious Business

Interestingly the number one problem and complaint that insurance companies, plaintiff's attorneys, courts and peer review organizations have regarding chiropractors is poor record keeping and inadequate documentation. When your records are reviewed, and believe us your records are more and more closely reviewed. If the information these organizations require isn't there, they do not have to pay your bills, authorize diagnostic services or treatment or, in the case of boards of examiners, support the services you have dispensed. This is a major area over which most boards of examiners have great control. There is a significant movement among boards of examiners and courts to increase their regulatory powers by enforcing rules regarding good record keeping and proper documentation. The insurance companies know this and are utilizing the rules and regulations of boards of examiners, the courts, and commercial review services to deny bills for services based on poor record keeping and inadequate documentation. The same holds true for plaintiff's attorneys who are litigating malpractice suits. You Are Your Records

In the courts, at insurance companies and with boards of examiners, you are your records. As important as it is that all practitioners upgrade and continue to provide the best possible diagnostic and treatment services. And in spite of the miracle life-saving things accomplished through chiropractic care, if one fails to excel in collecting adequate records and proper documentation, you are a high risk for (1) not being paid, and (2) being turned over by attorneys, insurance companies and courts to your board of chiropractic examiners. There is absolutely no reason whatsoever to have problems with attorneys, insurance companies, courts or boards of examiners regarding your records. You are the person who has total control of patients' records, but third parties are often in control of what is to be reimbursable (based on your records), and as your future license to practice chiropractic.

Date; name; address; claim number; date of injury; history; present symptoms/complaints; preexisting conditions; past medical history; chiropractic history; family history; medications. It doesn't take much time to ask these questions, and it's far more efficient and cost effective because we have this information in standardized computer documents that we simply follow and fill in the patient's responses to the tests when they come in for examination.

Because we have taken the time to take a case history over the telephone and enter it into the computer before their appointment, it saved us a great deal of time during the first visit. Essentially, when that patient comes in all we have to do is review what they previously told us, make sure that we have their history and get on with the examination. If you follow well established examination procedures on all new patients and scheduled reexaminations that are in standardized forms and/or computer documents, you merely have to do the examination, have the results of the examination entered into the computer or on standardized forms by yourself or an assistant.

You are doing a good job throughout the visit, the patient's health interests are being well served, and in the process you're collecting proper documentation and readily available for parties that have rights to them.

Inform As You Perform

We always attach copies of the computer-generated case history and examination findings to the patient's report of findings. Copies of those records are also sent to their attorney(s) and, if insurance is involved, attached to the HCFA or billing statement. Doing so keeps everyone involved up-to-date, eliminates the time usually needed to fulfill future requests for records, and facilitates the speed with which insurance companies pay us or reimburse the patient when they have already paid us. Before sending any information to an insurance company, attorney, or any third party, be sure you have the patient's signed authorization to do so. Seek Excellence and Success Will Follow

Postural pictures are made with a Polaroid camera and given to the patient, while a photo copy of the pictures are kept in the patient file. The old adage, "A picture is worth a thousand words," is true; so is the new adage: "Four pictures are worth more than four thousand words." When a doctor of chiropractic takes a thorough case history, begins the examination aspect of the visit with a chiropractic postural examination and follows through with a comprehensive orthopedic and neurological examination, one sets oneself above the majority of health care practitioners. In our years of review of medical and chiropractic generated records, very few of the records of medical doctors and a large percentage of doctors of chiropractic's records indicated less than adequate case histories and examinations. This was not only evident in the records of the diagnosing and treating physicians, but it was worse in the majority of the independent medical/chiropractic examiners. Nothing gives you more credibility with the patient or with an insurance company, attorney or board of examiners than documented quality in the case history and examinations results.

Nothing will prevent or tear down your potential credibility than lack of an adequate case history, reasonable examinations and poor daily chart notes. As true as that is, we believe that there is now far too much emphasis placed on record keeping, which is the result of over-reaction by regulatory agencies, who in spite of their good intent, play right into the greedy hands of insurance companies who now over scrutinize records, with the intent of avoiding payment of claims.

Next month we will look at more essential ingredients of proper record keeping.

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