Dynamic Chiropractic

Essential Ingredients of Proper Record Keeping

Physicians who implement and maintain proper record-keeping procedures will find themselves freed from unnecessary administrative problems. The key is that record-keeping be placed as a high priority and kept there. If a patient is involved in an automobile accident, the practitioner should be familiar with state laws regarding chiropractic care for automobile accident victims.

Notice Of Doctor's Lien

Depending on the practitioner's state laws pertaining to automobile accidents, most practitioners should consider having the patient and the patient's attorney (if they have an attorney) sign a "Notice Of Doctor's Lien". This form basically states that if there are any unpaid bills for chiropractic care, the patient and attorney agree that the doctor will be fully paid from any court or insurance settlement. This is a legally enforceable document. Without it in your files, the patient and/or the attorney can avoid paying you any money owed with insurance company settlements.

All New Patient Records should clearly state:

1. Personal information (name, address, telephone number, date of birth, age, marital status, occupation);

2. Past conditions and trauma (past injuries and all medications past and present);

3. Family history (heart disease, cancer, diabetes, back problems, emotional problems, smoking, alcohol use/abuse);

4. Past treatment received (hospitalization, surgery, medical, chiropractic, dental, massage, etc.).

Current Treatment from Other Health Care Providers

If the patient has been receiving care at another facility, appropriate authorization forms should be signed by the patient and those records should be obtained. If there are current x-rays, laboratory reports, etc., then new films should not be made until the other films have been reviewed. Unnecessary exposure to radiation or duplication of services is unacceptable.

X-Ray Exposure Record Form

Any and all x-rays made of the patient must be detailed on a form that lists the x-rays views made; the size of each film; the views made; the distance the tube was from the patient; the time, MA, MAS and KVP used. The x-ray exposure record form must also state the reasons that the x-rays were made, including:

1. to rule out joint instability;

2. to rule out fracture;

3. to rule out anomalies;
4. to evaluate foraminal encroachment;
5. to evaluate the ability to withstand osseous adjustment;
6. to evaluate biomechanical alignment;
7. to evaluate degenerative disc disease

The form must also ask the date of the patient's last menstrual period, if she has had a hysterectomy, entered menopause and/or wears an IUD. If the patient is a minor, you must have an authorization signed by the parent or legal guardian. The form must also be signed by the doctor and permanently recorded in the patient's file.

Gonad Protection

Every patient must be offered gonad protection, and you must have their signatures on file authorizing you to take x-rays of them.

X-Ray Darkroom Forms

In every office where x-rays are made there should exist forms that record the following procedures: testing of darkroom fog; cassette maintenance record, x-ray processor or manual processing record; and education/training record of persons involved in taking and/or processing x-rays.

Description of Current Condition(s)

If the patient has been involved in an accident or work related injury you should utilize a specific automobile accident or injured workers form to assist in obtaining;

1. time of onset
2. description of trauma
    1. date of accident(s)
    2. location
    3. time
    4. weather/working conditions
    5. seatbelt
    6. body position
    7. driver/passenger
    8. estimated cost of damage

In other words, document the who, where ,what and how of the patient's current condition.

Accident Report - a copy of the accident report (if one was made) should be obtained from the patient and kept in the patient's file.

Present Symptoms and Complaints

In addition to a written description (in the patient's hand writing), human body illustrations should

be provided from the front, back and side views for the patient to mark areas of pain.

Effects on occupation and or non occupational activities and effects on physiological function should also be recorded--women in particular should note any changes in menstrual cycle and/or to breast tissue (for example, if the breasts were injured by wearing a shoulder belt.

All of the aforementioned information can easily be obtained on a two-sided "new patient entrance form".

Examination

All doctors of chiropractic should make sure that their examinations are not only relative to the injuries, but include the customary postural, orthopedic, neurologic and laboratory tests. It does not matter what other practitioners may or mat not be doing in their offices. What matters is that you do what is required and that you go the extra mile to obtain the aforementioned information, perform comprehensive examinations and record the results (to be discussed in next month's "Principles Of Risk Management") in a manner that makes it understandable and readily available to those who are authorized to obtain it.

The results of the tests must be recorded in a clear and concise manner. Abbreviations should be avoided. If any abbreviations are used, an accompanying explanation must be included.

Laboratory Tests

If the patient's history and responses to the examination indicate that x-rays, MRI, CT Scan, urine or blood chemistry should be performed, or referrals made, there must be a record of those suggestions in addition to the authorization signed by the patient.

The results of the examinations should offer a preliminary diagnosis as well as trial treatment plan which will be discussed in next month's "Principles Of Risk Management" article.

Diagnosis--Your records should also contain a preliminary working diagnosis (causal/noncausal) and a current/present diagnosis.

Treatment Plan

Make sure you record the following:

1. which procedures you intend to utilize;
2. frequency of care;
3. duration of care;
4. referrals, if any;
5. re-evaluation date.

It is a good idea to use a travel card to record the date and services per visit. All services being billed should be reconciled with the services recorded in each SOAP and on each travel card.

Experience has proven that copies of current examinations, diagnostic tests, and daily SOAP notes should be mailed with all billings to insurance companies. The same holds true for keeping good lines of communication open with patient's attorneys. Any information sent to an insurance company should be sent to the patient's attorney. Any changes in chart notes should have a line drawn through the word(s) or sentence and should be initialed by the person who made the change.

Re-examinations

These should be in accord with the treatment plan. They should be within three to five weeks of the previous examination, or appropriate to the patient's health status. A specific appointment should be made for re-examination and should consist of the following:

1. interim case history
2. any aggravations or new injuries
3. present symptoms
4. work status
5. non vocational status

Re-examination should include the tests that are relative to current condition as well as the tests that were positive on initial examination. (The standardized forms and computer documents we use in our clinic are formatted to record several re-examinations). This information is easily obtained by using standardized "progress survey", "patient subjective disability evaluation" and "interim report of progress" forms.

New Diagnosis

If the status of the patient has changed, then the diagnosis should be modified to reflect those changes (i.e., is the condition acute, chronic, or plateaued?) One of the major problems insurance file handlers have with chiropractors is that re-evaluations are often made on an irregular basis, or the diagnosis never changes. Unless the patient's health status remains unchanged, the diagnosis should change according to the patient's responses to re-evaluations.

New Treatment Plan

If the present status indicates that a change in the treatment plan is needed, it should be changed. Again, the new treatment procedures should be documented, along with the goals and the date of the next re-examination.

This outline of the essentials of appropriate record-keeping are very typical of what most chiropractic boards of examiners and insurance companies require today.

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