Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Examination Essentials

All examinations, be they full body or regional, should consist of the following relative tests:

> height; weight; head tilt; shoulder level; anterior/posterior and lumbar curves; lateral cervical/thoracic and lumbar curves; level of hips; leg lengths; feet-normal/pronated or supinated; heel/sole wear; level of arches; Deerfield; teres spasm sign; mandible drop; palpation of subluxations; fixations; rigidity; edema; tenderness; spasm; inductions; masses or nodules and superior/inferior and middle ganglions; cranial 1-12; and color of eyes.

Ranges of motion of the cervical, thoracic and lumbar spine should be measured and recorded using the two inclinometer method, as well as:

> muscle group integrity; palpation of the cervical lymph nodes; hyoid and thyroid; finger to nose; finger to finger; heel to shin; pupillary accommodation to bright light; vertebral basilar artery; carotid bruits; cervical compression/distraction; foramina compression; Soto hall; O'Donahue's; Dejerine's; Lhermittes'; Naffziger's; upper extremity reflexes; grip strength; dermatome distribution; cervical stethoscope crepitus; Valsalva's; Adson's; Allen's; Wright's; Codman's; supraspinatus; Apley's scratch; Bryant's; Cozen's; Hoffman's; Phalen's; Wartenberg's; Froment's; carpal tunnel tests, and bilateral circumference measurements.

Ranges of motion and palpation of the shoulders, elbows and wrists, major trigger points, blood pressure (bilaterally sitting and standing), and radial and fingertip pulses are essential, usual and customary. In addition to offering the doctor the option of performing the tests, the standardized forms and computer documents we use also give an explanation of each test, the rationale for performing it and its diagnostic significance. Doing so has proven to be of interest to the patient and assists in justification for insurance reimbursement. It also saves a great deal of time by eliminating typical questions that insurance companies ask when said information is not automatically made available to them.

Lower Extremities

The same holds true for the thoracolumbar spine and lower extremity problems. Consider including the thoracic and lumbar ranges of motion; Kemp's; O'Donahue's; the deep reflexes; Trendelenburg's; sciatic nerve palpation; toe/heel walk; Lasegue's; Braggard's; Fajerztajn's; Homan's; Fabre-Patrick; Laquerre's; Gaenslen's; double leg raise; muscle testing; dermatome distribution; circumference measurements; Naffziger's; Babinski's; Oppenheim's; Chaddock's; Sicard's; Linder's; Lewin's; Thomas's; Bechterew's; Ober's; Ely's; Yeoman's; Dejerine's; somatoform differentiation; and ranges of motion of the knees, ankles and feet. If there is complaint of knee problems, include McMurray's; Drawer's; collateral ligament; Osgood-Schlatter's; Apley's; the popliteal, tibial pulse and toe pulses; and the major trigger points. All spinal ranges of motion should be evaluated by sight as well as by the two inclinometer method.

Polaroid Pictures

It is a good idea to request that your patients authorize you to make Polaroid pictures of their

posture. They should consist of standing front and back and of the feet while sitting. Doing so allows the patient to see how you see their posture. If you like, said pictures can be made with the patient standing in front of a plumb line.

Be Organized and You'll Do Things Simply and Effectively

If you're organized and use standardized forms or computer documents that make examinations easy, you should (and can) examine the whole person. It takes very little time to examine the whole person. Some of the tests can be conducted by assistants, i.e., height, weight, blood pressure, radial tibial/pulses, etc., all of which lead to suggestions for further diagnostic tests, a diagnosis and treatment plan.

The Importance of Somatoform Differentiation Tests

As suggested in previous articles, all practitioners should include tests that assist in determining possible levels of hypersensitivity to pain and possible psychogenic entities. There are many tests that can be utilized by having the patient answer questions on paper, i.e., Oswestry Pain Disability Questionnaire, Hender back screening, etc. The following tests can be utilized in the office during the examination:

Libman's, marked pain suggestibility and related joint motion tests indicate the possibility of low-pain threshold. When appropriate, the utilization of Burn's bench; axial trunk loading; Flip's; flexed knee; Magnuson's; Mannkopf's; plantar flexion; tripod; trunk rotation; Hoover's; COP; and bilateral limb drop tests serve valid purposes in differentiating between organic and possible psychogenic entities. Performing one or more of these tests not only assists in determining the relative nature of the patient's symptoms, but offers data to determine the correct diagnosis and treatment plan indicators for further diagnostic tests. Far too often, chiropractors are accused of treating back problems that are of an emotional entity. Those accusations are easily prevented when somatoform differentiation tests are included in their examinations.

Further Diagnostic Testing

Based on the history, present complaints, the patient's responses to examinations performed, education, research and your experience, you now have a solid foundation upon which to base further diagnostic recommendations. In our clinic, we use standardized computer documents that offer our doctors further diagnostic options for musculoskeletal as well as metabolic and nutritionally related conditions. The only thing we have to do is select diagnostic options that the document automatically brings up.

For example, the computer document we use brings up the typical x-ray view options that most conditions would necessitate. If we are using the document for metabolic conditions, it offers options regarding urinalysis; chem screen, complete blood count; ESR (erythrocyte rate); CRP (C reactive protein); candida antigen titer; health appraisal questionnaire; food allergy testing; urine bone density analysis; urine hormone analysis; amino acid analysis; lactose breath analysis; salivary IgA; hair mineral biopsy; adrenal stress index; and stool analysis; and leaves room for the doctor to add any other diagnostic recommendations. The doctor then can move very quickly through the program, choosing any further appropriate diagnostic tests, or deleting any not of his choosing.

Treatment Planning

Boards of examiners, all insurance companies and review organizations not only expect the doctor to conduct an initial consultation, examination and reexaminations, but to justify them as well as

other diagnostic tests and provide a treatment plan. The documents we use in our computers bring up treatment plan options that most chiropractic offices encounter. The only thing the doctor has to do is select from the following treatment options to include in the treatment program:

1. any second opinion referrals;
2. number of treatments per week for a specific number of weeks;
3. types of therapy that may be utilized;
4. type of rehabilitative exercise program that's going to be prescribed for the patient;
5. instructions on accommodating lifestyle both occupationally and nonvocationally;
6. prescription of cervical collar; back support; TENS; cervical support pillow; BackSys; NeckSys; and corrective shoe orthotics;
7. spinal massage;
8. time off of work;
9. date of the patient's next reevaluation or any other things we feel are called for in the patient's care.

The computer documents we use give diagnostic options and the ICDA codes, and state what reference texts we use to base our opinions. Doing so saves all of our staff time and reduces unnecessary paper work.

Daily Chart Notes

Daily chart notes are not only vital to minimizing your risk of having problems with insurance companies, attorneys, peer review committees and your respective board of chiropractic examiners, but facilitate good communication with the patient's insurance company as well as payment of your billings by the insurance company. Let us also see to it that confidentiality is maintained by all staff members. No staff person should allow any patient records to be seen, or transmitted without the patient's written authorization. This holds true even in the area of publicizing or publicly acknowledging patient's birthdays or saying thank you for referrals on display boards in the clinic or clinic newsletter. As good as the idea may be, it does violate patient confidentiality. If you're going to use such ideas you must have written permission from the patient to do so. There are a lot of public relations ideas, that at first glance appear good, but they may not be legal and may violate doctor/patient confidentiality.

Number One Complaint? Poor or Inadequate Records

Insurance claims handlers and records reviewers are very busy people who must have proper documentation for all services before they can authorize payment for those service. In like manner, they have nothing but copies of your records upon which to base their opinion of you and the patient's health status. You can be the finest physician and be doing an excellent job for your patients, but if your records are not of the nature that is universally used and ever more required, you are judged accordingly. As unfortunate as it is, the number one compliant regarding chiropractors by insurance companies, attorneys, arbitrators and hearing officers always involves poor and insufficient records. Insurance claims handlers have jobs to do and they hate having files piling up on their desks. They are by and large good people who are attempting to do the job they were hired to do. When practitioners give them what the practitioners respective licensing board requires, the practitioner increases the likelihood of being paid promptly.

The Causes

The problem with the majority of chiropractor's records involves: 1) illegible penmanship; 2) using generic SOAP notes; 3) using forms where the doctor makes check marks, abbreviations and/or

symbols that a nuclear physicist let alone a claims handler would have difficulty interpreting.

In countless cases, even I as a chiropractor have had difficulty reading or interpreting the penmanship and oddball systems used by many chiropractors. In previous years, most insurance companies have not aggressively reported poor record keeping problems to the practitioner's board of examiners, but that is no longer the case. The same holds true for reviewing x-rays. If they demonstrate poor quality, complaints are being filed with the practitioner's board of examiners.

The best advice is to attempt to be better than expected in all aspects of practice and you'll minimize potential problems. There are some people involved in reviewing claims who are negative, take pleasure in finding fault or seeing things from a negative and critical perspective. They can make trouble, but the wheel is always turning. Reviewers come and go. Those who in some way have a vested interest in making life difficult for chiropractors pay terrible prices. We all have the need to justify ourselves, but the best way to live a healthy and happy life, is to see the best in one another and stay out of situations that promote or authorize us to judge others. Judging others is not positive work and like everything we do is seed sown. Sooner or later, we bring into our lives the harvests of the seeds we sow. Therefore, we do good unto ourselves when we involve ourselves in work that's good and positive.

Causes of Poor Records

The causes of poor or insufficient records in chiropractic offices is by and large related to the following:

1. Chiropractors who have been in practice more than 10 years often were not taught or forced to keep the traditional SOAP format while in college and thus were not habituated to that regime as are medical doctors, nurses and other health care personnel.

2. Many chiropractors have aligned themselves with certain treatment techniques or office procedure groups that advocate their system of chart notes which may not be traditional in nature.

3. Some are just lazy, stubborn or rebellious and think they can fight the system and make life difficult for claims handlers.

Regardless of the reason for not following the traditionally accepted SOAP note format, you can't lose if you choose the traditionally accepted method of chart notes. Regardless if you like or dislike insurance companies and the personnel assigned to process your patient claims, they are doing the jobs they're paid to do. If you're nice to them, treat them as human beings and supply readable and understandable copies of your records in the traditional SOAP format on a regular monthly basis, you'll do a lot to garner their favor.

It never pays positive dividends to be abrupt or abrasive with a claims handler. Never ever be caustic or abusive to anyone. If you're hot under the collar about something, resist the temptation to make a caustic telephone call or send a angry letter. Claims handlers are human beings created by the same higher power that you were. They never get thank you telephone calls, but they do get hundreds of calls from clients and doctor's offices every day about problems, many of which are not their fault.

The same holds true for boards of chiropractic examiners in that they are made up of human beings who have very difficult jobs. Regulatory boards were created to protect the public, not be shields for wayward chiropractors.

When you're under pressure to minimize claims payouts or constantly bombarded by negative people or situations, it's very difficult to maintain a positive perspective. Your problem is not the only problem claims handlers are attempting to deal with. Like all of us, they are human beings who are trying to do the jobs they've been hired and/or appointed to. You greatly minimize your risk of having problems with claims handlers, attorneys and boards of chiropractic examiners if you know your state statutes, rules and regulations regarding record keeping, as well as all aspects of the chiropractic laws, and see to it that you do the best possible job in living up to those requirements. As independent as some chiropractors want to be, chiropractic is not an island unto itself. We are part of the health care community and we have to be in sync with record keeping requirements. Doing so does not weaken us or give ourselves over to medicine, but rather helps us grow and promote better communication and understanding.

Those Who Refuse to Play by the Rules Don't Get Paid

If your records fail to contain the information in the traditional SOAP note format, the patient's insurance company does not have to pay your bills and they have the right to file a complaint against you with your board of examiners. Any of you who have had that happen, know that you may be in for some sleepless nights and legal expenses. Even if your board of examiners finds satisfactory evidence to support your bills, the time that it takes to receive payment is going to be far longer than if you had followed the rules from the beginning. Those who don't follow the traditional SOAP note format are going to have increasing difficulty getting their bills paid, will cause their records to be more closely scrutinized by insurance companies, cause attorneys and insurance companies to file complaints with the practitioner's respective board of examiners, all of which is avoidable and unnecessary.

Let's face it, the longer an insurance company can legitimately delay paying bills, the more money they have. If you have excellent records you close the door to them hassling you.

What's Required Is Simple

In justifying the necessity of and for chiropractic care, the following must be in the patient's daily chart note records on every visit:

S (Symptoms) -- You must clearly and legibly state the patient's subjective complaints. This does not involve writing long daily paragraphs. Just repeat what the patient tells you regarding their present symptoms. For example: "My neck, mid and lower back hurt, my headaches aren't as bad, I'm better".

O and A (Objective and Assessment) -- This is a discussion of the methods and/or procedures utilized by the doctor to evaluate the patient's health status on each visit. Ask the patient relative questions that keep you up to date on their status. For example: "Are you better, the same, worse? Are you sleeping better, is it easier to move about," etc. Recheck spinal ranges of motion, mention the comparative status of the ranges of motion, mention what your palpation revealed, etc. Mention what treatments you utilized: "Manipulation of subluxations in the cervical, thoracic and lumbar spine, cervical traction, acupressure, acupuncture, electrical muscle stimulation," etc. If you're manipulating subluxations of other articulations such as the shoulder, knee, foot, etc., document it. You're already doing these things, so write them down or (better yet) type them into a computer document that has a SOAP format.

P (Plan) -- If you aren't changing the treatment plan (see "Solutions to Preventing Practice Pollution" in the February 9 issue) that you gave in your initial report or most recent reevaluation, then say something like, "Treatment plan remains the same, next visit: as previously scheduled."

If the doctor persists in using abbreviations and/or symbols to denote information in the SOAP, a key must be included which explains what the abbreviation or symbol means. Avoid using generic SOAP notes or SOAP notes that say the same thing on every visit. People who review copies of your records aren't stupid. Nothing stays static and neither do your patient's or their condition, and it should be reflected in your reexamination and daily SOAP notes.

In our clinic, we utilize computerized documents that follow the SOAP format. All treating doctors and therapists in our clinic are required to use those computer documents. They are responsible to enter the SOAP notes for all patients, any telephone calls and all information including any correspondence, missed appointments or no-shows that transpire regarding their patients before they leave the office for the day. Said information is printed out and a staff person checks all SOAP notes to ensure that the doctor has discussed all services rendered before the SOAP is filed in the patient's file. The SOAP is compared to the services rendered as indicated on the patient's travel card which the doctor is given before each visit. On that card, the doctor uses symbols to note the areas and/or articulations manipulated, any therapies utilized, etc. The charges for said services are taken from the patient's travel card and entered on the patient's financial statement. This prevents any services from being missed and makes sure that a SOAP note for every visit and all services are in the patient's file.

(Incidentally, that is what claims handlers do when they review your bills. If you have charges for services that are not documented in your SOAP notes, they will deny payment.) We require that the patient initial each visit on the travel card so there is a record that they were there on that date and that they acknowledge that the services indicated were rendered. Having them initial on each visit prevents a lot of potential problems if the patient, attorney or insurance company turns adversarial and attempts to say that the patient never received said services.

For years we used hand entries, then we moved up to dictating our SOAP notes but we have found it more efficient and less costly to follow this current SOAP note procedure for all members of the staff. Every bill that goes to an insurance company has attached to it photo copies of the patient's current SOAP notes and copies of any other information that has transpired since the date of last billing. This eliminates the need for the insurance claim's handler to write letters requesting SOAP notes which in turn facilitates quicker payment and saves our staff a great deal of time that many clinics are wasting by not following that procedure. The easier we make other people's jobs, the quicker we are going to be paid for the services we render.

In all insurance cases our computer prints out a sheet of labels that are addressed to the claims agent handling the file. Doing so saves a lot of time every month when insurance billings are mailed. Even though we are cash-based, we still divide our automobile accident monthly billings in half by alphabet. This allows the staff responsible for billings to spread out their work and have a better and more balanced flow of payments throughout the month.

In our next article, we will begin looking at independent medical/chiropractic examinations from the perspective of preparing your patients for them and how you can protect your patient and yourself from abusive independent medical/chiropractic examinations.

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