Dynamic Chiropractic

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Record Keeping, or Wheel of Fortune, or Pick a Letter

Dennis Semlow, DC

Today, every practitioner in every health care discipline is confused about what they need to keep in the patient's file in regard to information and documentation of patient care -- from writing three pages, to dictating volumes, to the use of three by five cards, to nothing. As with everything in health care, it goes in cycles; the pendulum swings to the far right, then to the far left, and then comes back to settle in the middle where it belongs, and in many instances, where it started.

Keeping patient records isn't, or shouldn't, or doesn't have to be a costly and tedious process. Most practitioners are keeping good records without knowing it. As with most any problem in the world, communication and understanding are important. Once we can agree on terminology, things usually become easier and smoother. Today's practitioner has been bombarded by third-party payers wanting more and more information, narrative reports, and SOAP notes, or they say that payment will decrease to nothing. So the practitioner scrambles to buy or develop an elaborate system to beat or fulfill this request, feeling that a new standard has been made that they must follow in all patient care. Many times a phone call to the third-party payer will reveal that the narrative report they wanted is really nothing more than a simple diagnosis/prognosis and that the SOAP notes request was of recent examination findings. It is my opinion that most of this could be avoided if updates are done and sent on a 30 to 60 day basis, thus keeping payers informed of care and prognosis of the patient.

In regard to patient documentation, there is a difference in most states in SOAP notes and chart notes. There are also a few state statutes (usually workers' compensation) that require a specific type of record keeping, but in most states, doctors' records must be reproducible by the doctor.

The main question today on the minds of most is the use of the format "SOAP." If there is to be a standard, we would need a national referendum by the chiropractic profession to deem it so. But before that could happen, we would have to establish what the letters SOAP stand for. I have seen the letters stand for the following: S: subjective spinal systems review, supportive, sometimes, severity. O: objective, observable, other. A: assessment, another, associated with. P: procedures, plans, problems, progress. If we can't agree on what it is, how could we use it as a standard? That analysis would be very much like the following line of questioning that is used very often in malpractice and personal injury cases: Doctor, you are answering under oath and would you please give us the name of the "authoritative" books on the practice of chiropractic? This question cannot be answered. First of all, authoritative is a legal term; secondly, there is no one "cookbook" on chiropractic. There may be many books that give opinions about chiropractic, but there is no authoritative book or single source, as there is no absolute when it comes to patient records.

The use of "SOAP notes" in most instances would be kept when periodic re-evaluations or examinations are done on patients. Many times, patient findings will not change on a day-to-day basis, symptoms will not be present on a day-to-day basis, diagnosis does not change on a day-to-day basis, and once you have developed a plan and it has been adopted, it won't change until a re-evaluation or a status change is made.

"Chart notes," on the other hand, would be a running, daily record of what services and care were performed on that day, or changes in condition. But to demand that the patient have a symptomatic complaint every day, or to have different objective findings day to day, is an attempt to force you into improper care and reporting. I have observed before that many practitioners will be looking for something just to write down or make up information just to complete the form. Never make up records or alter patient documents.

There are electronic chart notes today and some doctors wish to use this type, but this is a personal preference choice and many of these systems today do not have to be used in a strict SOAP format, but are able to be used as chart notes. Again, my involvement with doctors using electronic notes has been that many of them make up information to fill in the form to complete the SOAP format.

Conclusion:

Record keeping is as important, if not more important, than the patient care itself. If a malpractice action arises, the records that are kept will be, in most instances, the difference between a favorable or unfavorable outcome. These records will be scrutinized, in many instances, four to five years down the road. What is written down must be defensible and show a rationale for care. Reporting in a SOAP format is not a standard of care. Chart notes must be maintained on every patient on a visit-by-visit basis. There is no special formula or information that is to be kept. But the doctor needs to show a rationale of care, what services were performed, how they were performed, if and when the patient was rescheduled, and any other information that the doctor feels pertinent to that patient or that diagnosis. In-office coded records are acceptable as long as the information can be transferred into the written word.

Please send personal comments about record keeping, good and bad, to me at the following address:

119 N. Stone Rd.
Fremont, MI 49412

This case study is provided from the claim files of the OUM Group Chiropractor Program. The study is based on actual incidents, however, circumstances have been changed.

Dennis Semlow, D.C.
Fremont, Michigan

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