Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Development of Documentation Parameters

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1. At the onset of a case the doctor should prepare a short narrative which relates:

(a) Identifying information.

(b) Minimum details of accident or disorder. For example: auto accident, falling down stairs, lifting while twisting, etc.

(c) The fact that the patient is under treatment for:---

(d) Tentative or initial diagnosis. For example: strain, sprain or whatever.

(e) The tentative prognosis. For example: expect to have under treatment a minimum of 30 days, or 60 days, or whatever.

No examination findings are to be reported at this time even though the examination is made and billed. This is a short, quick report designed to give essential information only. The initial claim form and any following soon after, when properly filled out to include the above information, will suffice as an initial report.

2. Subsequent claim forms, properly filled out, actually add to the information given above. Under normal circumstances that is all any reasonable insurance company will need to do its job.

All information should be aimed at allowing the insurance carrier to understand the nature of the condition. The treating doctor is not asking for advice in treating the patient when he files a claim.

3. When requested, and for an appropriate fee, a detailed narrative needs to be submitted. Again, the doctor's aim is to give adequate information to allow the carrier to understand the patient's condition and the treatment program being utilized.

4. Depending upon circumstances, an updated examination may be called for before this narrative can be considered reasonably complete.

5. If the carrier asked for other, additional information before the reasonably estimated time under treatment expires, as noted in the initial report or subsequent claim forms, it is difficult to think of this as other than an unnecessary harassment.

6. When requested, the examination findings should be reported, and when warranted, updated every 90-120 days or upon request of an insurance carrier. There will be a fee for all examinations and all reports except the initial short report. In acute conditions which resolve within 30 days there is usually no need to repeat the examination merely to make a report, unless the report asks for information not in the doctor's possession.

7. Re-examinations, with or without diagnostics, including x-rays, should be made at the doctor's discretion as the condition changes enough to:

(a) Require a change in the treatment program. (b) Require a change in the treatment status (whether acute goes to chronic or therapeutic treatment moves to rehabilitation). (c) Especially if a lack of improvement indicates further study for any reason.

8. Prognosis should be commensurate with "best educated guess" related to diagnosis.

(The 54-34-12 percentages related to strain/sprain cannot be predicted by any method known to modern man at time of onset. However, any sprain still exhibiting symptoms after 60 to 90 days is safely assumed to not be in the 54 percent group; and any sprain in which there is a retrolisthesis after 90 days, or evidence of DJD being exhibited at the point of injury is safely assumed to not be in the 34 percent grouping. Ligament laxity, especially in a weight bearing joint, and adverse modeling of bone as well as postural alterations will be counted in the 12 percent grouping.)

9. Any change of diagnosis and prognosis which varies from the original in a significant way will need to be recorded. Changes on claim forms will be sufficient for this purpose unless the carrier requests a narrative for a more detailed explanation.

10. Change of status of disorder: acute to chronic; acute to rehabilitation; pain relief to therapeutic or chronic to "as symptoms require," should be noted. Note that each calls for changes in the treatment plan and these changes should be recorded in your notes.

Assumptions

11. Any time an ICE or IME is ordered everyone should be aware that the condition is being examined further for complications of some type or another, usually to record a lack of progress or progress which seems unduly slow, and why, often to seek a second opinion, and sometimes to evaluate as a surgical candidate.

12. Once the treatment program is established there is no need (except harassment) to document the findings in every duplicate visit. Consider that the friendly MD examines, makes a diagnosis, and treats with aspirin, for example, for 90 days. There is absolutely nothing on his chart each time the patient takes his treatment -- nor should there be anything necessary on ours.

If there is significant comment or change in condition noted, record it. Otherwise, work and go on. To write a detailed word for word account on every patient visit with a chronic or ongoing condition, is serving no good purpose.

13. A carrier's request for office notes untruthfully implies that they can read and interpret them as well as the treating doctor. Portions of such notes should be encoded to further invalidate their use by third parties. Even the request for them should be viewed as harassment. Let the carrier ask for narratives; office notes should be reserved for attorneys at litigation.

14. Note: A diagnosis or prognosis made by an MD, especially orthopedic surgeons and neurosurgeons, which varies from the chiropractor's findings, should be challenged and we should refuse to accept it as valid except as it relates to surgery. They are surgeons. They are not treating doctors. They are not chiropractors. They have no chiropractic training. They usually cannot read stress x-rays to discover ligament tearing or deforming stretch.

Give them their due as surgeons; give them no slack when they try to be chiropractors. Be very vocal about it. Every time.

15. The Aranda decision by the Texas Supreme Court has something to say about ten minute examinations which findings are then used to stop a patient's benefits: It calls them unfair

insurance claims practices. Question your patients about how long their IME exams took, have them relate exactly what they did, determine how many times the doctor actually touched them. Very often the "shallowness" of such exams becomes transparent to both you and your patient. Make that a part of your report.

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