Dynamic Chiropractic

BILLING / FEES / INSURANCE

The Trouble With Computerized Records

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

There can be no doubt that the current trend in health care is toward electronic record-keeping. At present you can find more than a dozen different software programs to help you generate or keep patient records. I have written many times in this publication about the importance of keeping clear and accurate records. I will be the first to admit that all that paperwork is a pain, but it is nonetheless vitally important to maintain clear, concise, contemporaneous records of your patient care. Many of the electronic health records (EHR) programs out there tout "quick and easy" recording of patient information - but is "quick and easy" the same as "accurate and appropriate?"

Certainly any amount of record-keeping is a pain, in the sense that it takes time away from what we love to do: take care of patients. But, like it or not, we have to have records of each patient's complaints, our objective findings, any and all treatments rendered, and the future care plan. Any tool that makes that job easier should be investigated; after all, who doesn't want easier?

That said, one of my primary concerns is that some of these programs have random vocabulary generators to "fill in" verbiage. This can become a big problem. It is great that you can plug in a few pain-score numbers or scan in a few bar codes for procedures and generate data, but the report process should not stop there. I have seen many cases in which the doctor uses a program to generate many pages of patient data - only to have that data become suspect because the narrative generated was either not sensible or suggested other findings.

It is probably best to illustrate this potential hazard by way of example. The following is an example of unedited, computer-generated verbiage I have encountered in an orthopedic examination report: "Positive Palpation Muscle Spasm Cervical Positive Palpation Muscle Spasm Thoracic Positive Palpation Muscle Spasm Lumbar Distraction Positive Lumbar Kemps Positive Thoracic Lesque Positive Lumbar." That's it - no explanation, no punctuation, not even proper spelling. Notations like this cannot be taken seriously and only serve to question the credibility of the doctor.

The next issue I've seen with electronic health record-keeping is treatment options listed in "check-off" format. It becomes impossible to interpret care when presented with a phrase such as, "Treatments rendered today may include: hot packs, cold packs, spinal manipulation, electric muscle stim, ultrasound, rehabilitation exercise, massage, fomentation, spinal decompression, and neuromuscular reeducation." Not only is it unrealistic and unreasonable to provide that many therapies on a given visit, but it also suggests that the doctor has no organized or coherent care plan. Make sure the records generated accurately show the specific treatments provided on that date of service.

Another problem I've noticed with some computer note programs is "rollover" data. If data such as pain scores is entered on a visit, future scores are compared and automatically notated. For example, if a patient's lower back pain was "acute" at an 8/10 on one visit, and the next visit the pain was down to 6/10, the change should be noted as "improved." But if the pain score does not change or goes up and down, the vocabulary generator may well state: "Patient reports no improvement in their pain complaint."
If the doctor does not go in and clarify such comments, the records end up stating that the care

provided did not help or made the patient worse. This is especially significant with programs that allow you to enter data for many dates of service over a period of time; if the patient hits a plateau or has a flare-up, the program may state that your patient was worse with treatment.

Just entering values and generating a report is not good practice - make sure you review the generated vocabulary to accurately describe the patient's condition on a given visit.

Electronic records are a great tool, but they are not an absolute. They may help you organize and collate your treatment data, but it is the responsibility of you, the doctor, to review these notes and make sure they accurately delineate the findings and care provided. There is a standard of care in this country that is clearly defined. It is dangerous to think that because we are chiropractors we do not need to keep records to the same degree as medical doctors. We must learn to think outside the chiropractic bubble in terms of health care in general. Ultimately, it is the patient we take care of, not the insurance companies, attorneys or other doctors. Whether or not you feel obligated to document your case, responsible patient care mandates it.

Chiropractic deserves every bit of respect that any other health profession does, but as I've said before, that respect comes with a level of responsibility. Yes, it is a pain; yes, it takes more time, but like it or not, documentation paperwork is part of professional health care.

FEBRUARY 2011

©2024 Dynanamic Chiropractic™ All Rights Reserved