

Documenting Disability: How Can a Clinical Record Best Fulfill Its Purpose?

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Chiropractic practices often encounter patients who are significantly limited in one or more major life activities. It is the treating chiropractor's responsibility to document any impairment or limitations as it relates to one or more body systems. Doing so is a duty to the patient that impacts not only their health, but also future claims and accommodations being sought. A chiropractor's documentation also may represent the patient's "protection" under the ADA ([American Disability Act](#)) of a physical impairment that limits certain activities.

The case below demonstrates a record review and independent examination of a physical impairment that affected two of the patient's body systems: neurological and musculoskeletal. The claimant was reliant on chiropractic care over a 36-month period to assist in the treatment of her mobility disorders. She reported that chiropractic care enabled her to "achieve a level of improved pain tolerance and movement." Unfortunately, her chiropractor's record was substantially limited in its documentation of these systems in terms of demonstrating any disability for the claimant.

For this particular review, greater reliance on the medical diagnostics, as well as an impairment evaluation, was necessary. What follows is an actual condensed version of this claimant's case and recommendations for reporting clinical encounters.

Independent Case Record Review

Reason for examination: request for record review for disability evaluation. Current symptoms include a diagnosed disorder that creates significant limitation and impairment of spinal and extremity function and mobility.

Chief complaint: numbness and clumsiness of the hands, arm weakness, leg stiffness and loss of balance.

History of the present illness / injury: 46-year-old woman with chronic pain syndrome involving the neck and low back. Chronicity documented by multilevel failed cervical and lumbar disc surgeries requiring lumbar revision; plating, allografts and pain management trials; and chiropractic supportive care after maximum therapeutic benefit reached with reported progressive deterioration when this treatment was periodically withdrawn.

Physical examination: sensory and motor loss below level of right forearm to index, ring and little finger; sensory loss bilateral medial and distal thigh (L1-3 dermatomes) to right lesser toe (L5-S1). Hip flexion weak during gait (L1-2 motor) and limited to level surfaces. Spinal restricted active and passive range of motion.

Diagnoses: Post-operative failed spinal surgery; patient remains symptomatic even with current medical treatment to date.

Record review: Medical evidence reports documented abnormal imaging and neurodiagnostics,

special studies, neurosurgical examinations, pain management evaluations and pharmacologic interventions (Fentanyl patches and Norco).

Suggested Reporting Methodology

If a patient's record demonstrates an abnormality in electrodiagnostic testing, the examiner should document the residual area of loss within the affected extremity. For example, a critical analysis of any peripheral nerve involvement for the upper extremity should be recorded. Assess the extent of sensory loss and degree of pain above or below mid-level forearm, above or below wrist, and which fingers are involved. Assess the extent of motor loss in a similar manner. Is there a loss in function?

Don't simply state it. Which functions are affected - grasp, handwriting, turning a door knob, etc.? This provides [medicolegal](#) evidence that the applicant's loss of function is affecting activities. For example, let us assume that a sensory loss affects only the thumb and index finger. The maximum value for this distribution is about 27 percent loss, because we are only assessing the affected portion of the entire nerve affected.

In documenting a patient's complaints, I cannot overstate the importance of using the patient's "own words." Even MDs and DOs will document in *their* words, which often becomes a "medical synopsis" of the patient's actual complaint. Instead, indicate symptoms such as pain, weakness, numbness, etc., according to the patient's own description. Indicate frequency of symptoms: occasional, intermittent, frequent or constant upon the performance of "specified activities."

Indicate the activities of daily living (ADL) that are affected. Activities of daily living as described by the *AMA Guides* (page 599, Tables 1-2) refer to common ADLs that any record reviewer needs to consider when establishing a permanent impairment rating. Documenting the patient's complaints includes recording their impact on the following ADLs at every clinical encounter: self-care (urinating, brushing hair, dressing, eating); communication (writing, typing, seeing, hearing, and speaking); [physical activity](#) (standing, sitting, reclining, walking or climbing stairs); sensory function (hearing, seeing, tasting, tactile feeling, smelling). Include non-specialized hand activities (grasping, lifting, tactile discrimination); travel (riding, driving, and flying); sexual function; and sleep (restful, nocturnal sleep patterns).

In recording the patient's symptoms per these guidelines, a chiropractor may verify that services submitted for any continuing care of chronic pain syndrome meet the definition of medical necessity, fulfill the duty to the patient, and provide medical evidence for the patient's protection under the ADA.

Resources

1. Metz RD. The chiropractic clinical record and quality management. *Topics Clin Chiro*, 2000;7(1):61-66.
2. Souza T. *Differential Diagnosis and Management for the Chiropractor*. Jones and Bartlett Publishing LLC, 2009.
3. Lawrence DJ. *Fundamentals of Chiropractic Diagnosis and Management*. Baltimore: Williams and Wilkins, 1991.
4. Kettenback G. *Writing SOAP Notes, 2nd Edition*. Philadelphia: F. A. Davis, 1995.
5. Herbert J, et al. Clinical decision rules, spinal pain classification and prediction of treatment outcome: a discussion of recent reports in the rehabilitation literature. *Chiropr Man Ther*, 2012;20:19.

