Dynamic Chiropractic

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Failing to Plan Is Planning to Fail: Make Your Treatment Plans Count

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The Centers for Medicare and Medicaid Services' (CMS) 2012 review of chiropractic's participation in Medicare revealed continued weaknesses in chiropractic documentation. One of these weaknesses was treatment planning. In the majority of cases, reviewed plans were either insufficient or non-existent.

This is not surprising, as many chiropractic treatment plans are simply a listing of the frequency and duration of treatments; for example, 3 x 4, 2 x 4 and 1 x 4. The specific techniques, adjustment site(s), modality use, nutritional recommendations, exercises and other procedures are not described. If they are, the listing is often just the name of the machine or procedure. Specific settings, dosage, sets, reps, etc., are also often missing. These situations are typical regardless of the type of payer – third-party or patient.

Many doctors fail to realize that if a treatment plan is mandatory for a carrier, as it is with Medicare, failure to provide the plan means denial of reimbursement. Even worse, many doctors fail to realize it is not really Medicare that makes a treatment plan mandatory; *standards for care* make treatment plans mandatory.

So, let's do something to help eradicate this problem. The following is an outline for a treatment plan for use with all patients, regardless of their condition or method of payment.

Plan Basics: Getting Started

The information recorded under the headings of the plan should be provided in short, straight-to-the-point statements. The document is not intended to be a full narrative report. The statements should also be truthful and expressed in a matter-of-fact manner. The practitioner should state the patient's history and diagnosis, what is going to be done for the patient, any special circumstances and the prognosis.

The beginning of the plan should identify all parties involved. The doctor and patient identification are primary. If the plan is to go to a specific entity, the information for that entity can be within the plan or the plan can be sent with a cover letter.

The doctor's name, practice name, address, phone, fax and e-mail address should appear in the plan. The patient should be identified by legal name (usually the name that appears on the patient's driver's license and/or insurance card.) In-house patient file numbers are also appropriate. The patient's insurance (Medicare) identification number may also be necessary.

If the report is going to an employer, worker's compensation or personal-injury carrier, the carrier's case number and the date of injury should be listed.

History and Examination

Chief Complaint should be the first category in the plan. This is a brief statement of the patient's current pain and/or dysfunction. It is important to describe the pain and dysfunction in the patient's own words.

History of the Presenting Illness (HPI) provides a short statement about the onset of the patient's chief complaint. The condition could be of gradual onset or the result of a specific event or trauma. If a specific onset is known, the date should be listed here. If the condition(s) is related to trauma, the mechanism should be listed. The details of severity, quality, relieving and exacerbating factors for the condition(s) are not necessary in the treatment plan.

Review of Systems for the patient can be summarized if the findings apply to the current complaint. For example, the patient might be diabetic and the doctor may feel the condition could delay healing. Otherwise, the comment "Unremarkable" can be used for the category.

Past, Family and Social History completes the history portion of the plan. As with the review of

systems, only findings that would affect the outcome of the current condition should be mentioned. Remember, this is a treatment plan, not a full narrative report. Also keep in mind that the social history includes occupational and recreational activities, as the stresses of these activities frequently influence clinical outcomes.

Physical Examination Findings include chiropractic technique findings, along with orthopedic and neurological test results. It is fine to list only pertinent findings. However, all results (positive *and* negative) must be recorded.

Imaging Results for internal and external studies should be listed. Again, findings pertinent to the current condition(s) are the focus. The full reports remain in the patient's record and should be available if requested. If no studies have been performed, use the following statement: "Imaging studies were not initially warranted. Studies may be utilized in the future if patient need dictates." This leaves the possibility of future studies open.

Lab and Chemistry study results should be listed if ordered for the current complaint(s). Studies unrelated to the current complaint(s) are not necessary. A statement similar to the one recommended above for imaging can be used if studies were not ordered initially, but may be necessary in the future.

Diagnosis, Goals and Treatment Plan Duration / Frequency

Diagnosis for the condition(s) the treatment plan covers follows all subjective and objective findings. The numeric codes and descriptions from the ICD-9-CM system are still in use through Oct. 1, 2015. Alphanumeric codes from the ICD-10-CM system take effect after that date.

Short- and Long-Term Goals must be measurable. *Measurable* means a scale of some type must be associated with each goal. Pain scales can be numerical. Disability indices are scored in total points or percentages. Activities of daily living, the ability to walk, lifting, and exercise can be measured in time, pounds and repetitions. Starting points, progressions and desired final results should be expressed.

The Medicare PQRS program is based on measurable goals, and compliance with the program cannot be achieved without pain and outcome assessments. An absence of short- and long-term goals is another weakness in chiropractic documentation repeatedly reported by Medicare.

Treatment Methods require more than just the vertebral segments to be adjusted. The chiropractic technique(s), modalities, nutrition, braces, exercises and other methods of care must be described. The number of regions to be adjusted should equate with the CPT code billed. The times and settings for modalities should be described. Nutritional doses should be defined. Exercises should be listed with sets and reps.

Which treatments are to be utilized together, and when changes in the mix of treatments are anticipated, should also be designated.

Frequency and Duration is discussed after treatment methods; refer to the frequency and duration tips above.

Home Care treatments such as the use of ice, heat, braces, exercises, supplements, etc., are important treatment factors. This is a neglected part of most treatment plans. Healing efforts must extend beyond the doctor's office.

The degree of home care needed can help convey the severity of the patient's condition(s) to third

parties. The more severe the condition(s), the greater the degree of home care necessary.

Other Considerations to Document in Care Plans

Special Circumstances and Risks should be discussed if any are present. This could be the need for modified work duty, the necessity to avoid strenuous or dangerous recreational activities (weightlifting, rock climbing), or anything else that would affect the outcome of the treatment plan.

Progress Examinations should occur periodically throughout the course of a treatment plan. The time frames for the exams and what they will consist of must be noted in the plan.

Prognosis must be stated for the outcome of the patient's condition(s) and the treatment plan. The patient may complete the treatment plan without residual problems, with residual problems or in some cases, with permanent impairment. The practitioner should be careful not to overpredict, as there are often surprises throughout the course of care.

The overriding idea when completing treatment plans is to provide information that justifies the patient's diagnosis and course of care. Covering the list of topics above in a treatment plan, even through short, simple descriptions, is extremely effective. The plan presented is as good as any – and better than most – of the plans the profession is now presenting.

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