Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Documenting Medical Necessity: A Case Example

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WHAT YOU NEED TO KNOW

- Whether you treat the patient five times or 25 times, your documentation must demonstrate medical necessity.
- It is my opinion that when the documentation is specifically demonstrating patient improvement with both subjective and objective data, you are providing proof of medical necessity.

More than 40 years ago, my friend and colleague, Richard C. Ackerman, DC, DABCO, taught me that diagnosis was the key to success. I have modified the statement to the following: “Diagnosis is the key to successful treatment.”

In this column thus far, I have attempted to stress the importance of making a correct diagnosis. The focus has been on the initial evaluation and the documentation of the initial examination in the SOAP format.

For the next 4-5 articles, I am going to stress the significance of documenting “medical necessity” with not only the initial evaluation, but also the subsequent patient visits. If you intend to receive compensation from a third-party insurance company, you must demonstrate medical necessity within your documentation. I offer the definition of medical necessity from National Association of Insurance Commissioners:

Medical necessity is a term used by health insurance companies to describe the coverage that is offered under a benefit plan. In the policy and benefit summary, the language that informs a person about what is covered under their insurance plan will generally describe benefits that are available “when medically necessary.” So, what does this mean? How does medical necessity affect coverage

for my health care services?

The way your health plan defines medical necessity impacts how it decides which health care services it will pay for. Generally, health plans pay a portion of the bill for covered services that fit the definition of medical necessity.

Establishing Medical Necessity

Your patient presents with a chief complaint of “My back and leg are really hurting.” He explains that he has experienced low back and right leg pain since falling off a ladder four months earlier. The pain is described as a sharp, stabbing pain on the right side of the lower back that shoots down the right leg to the mid-calf with certain movements, coughing or sneezing.

Using the 11-point numerical rating scale, the patient rates the pain at 10 of 10 at worst and three of 10 at best. Today, the lower back and right leg pain are at 8/10. Rest and NSAIDs reduce the pain. The patient mentions that he has experienced episodes of low back pain since a motor-vehicle incident during his high-school years. He has never received chiropractic care.

You determine that the low back and leg pain is due to a post-traumatic lumbar discopathy and nerve root compression with the following physical examination:

Posture: Left antalgia sign with listing forward and to the left.

Gait: Antalgic gait (right lower extremity) with foot drop.

Palpation: Performed at L4-5 right and over the supraspinous ligaments produces pain. Myospasia is present in the right quadratus lumborum.

Active lumbar ROM: limited and painful (lower lumbar spine right) with extension and right lateral flexion.

Kemp’s maneuver: Positive with pain radiating from lower lumbar down the right lower extremity to the mid-calf.

Straight-leg raise: Produces sharp shooting pain down the right lower extremity at 45 degrees of elevation. The left lower extremity is raised to 85 degrees without pain, but demonstrates tight hamstring muscles.

Three-part peripheral nerve examination: Sensory: hypesthesia right L4-5 dermatomes; motor: 4/5 right myotome; deep tendon reflexes: patellar reflex 2 + and brisk left lower extremity and 2+ sluggish right lower extremity

Pathological reflexes : Absent Babinski sign.

Treatment Plan: Spinal manipulation, cryotherapy and spinal flexion-distraction therapy to reduce pain and improve function daily for five treatments.

Supporting Continued Care

Now that you have completed your initial evaluation and completed documentation, which demonstrates “medical necessity” for both the patient and the third-party insurance company, how do you continue to demonstrate documentation that supports the follow-up chiropractic care? Whether you treat the patient five times or 25 times, your documentation must demonstrate medical necessity.

I offer the following examples of follow-up documentation of medical necessity for this patient.

Initial treatment included the above prescribed spinal manipulation of the lumbar spine, cryotherapy, and spinal flexion-distraction treatments, which were well-tolerated with reduced pain and improved function. I suggest that you support the positive outcomes with additional documentation.

For example:

Subjective: Patient reports that his pain level has reduced to 4/10 this morning and able to stand more erect. Post-treatment today, the pain level reduced to 2/10.

Objective: Kemp's maneuver produces lumbar pain without right lower extremity pain. Straight-leg raise 70 degrees before producing low back pain. Post-treatment today, SLR 70 degrees before producing lumbar pain.

Plan: Spinal manipulation of the lumbar spine, cryotherapy, and flexion/distraction was well-tolerated with reduced pain and improved function.

Assessment: Patient responding to conservative, non-pharmacological treatment of post-traumatic low back pain syndrome due to lumbar discopathy and radiculopathy.

Next Steps: Follow-up daily for the next three days with the prescribed care plan.

Discussion

It is my opinion that when the documentation is specifically demonstrating patient improvement with both subjective and objective data, you are providing proof of medical necessity. Hence, it is necessary for you to continue to provide conservative, non-pharmacological chiropractic care that will benefit your patient and hopefully avoid the need for medications and surgical intervention.

With this case example, it will be necessary to continue to evaluate not only the orthopedic findings, but also the neurological findings. Providing this patient responds well to care, you should notice improved spinal range of motion and negative orthopedic findings, plus neurological improvements.

Normally, the DTR finding should become 2 + and brisk bilaterally. Then the motor findings will return to 5/5 bilaterally. The last neurological finding to return to normal is usually the sensory deficits.

Quiz Time

Let me pose a few questions to enhance your engaged learning:

1. A positive Kemp's maneuver demonstrates which of the following?

a. Low back pain
b. Leg pain
c. Low back and leg pain
d. None of the above

2. A positive SLR test between 35-70 degrees indicate which of the tissues are potentially involved?

a. Lumbar facet joints

b. Thoracic facet joints
c. Lumbar discopathy
d. Cauda equina syndrome

Quiz Answers: 1. C; 2. C.

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