Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Focus on Chiropractic Reporting

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The average chiropractic practice utilizes four basic types of documentation:

1. an initial history and examination report, which typically includes an initial radiographic or diagnostic report;
2. a treatment or management plan (which may be included in the body of the initial report);
3. a progress interim report; and
4. a patient consultation and chart, with subsequent or procedure notes, in SOAP (subjective data, objective data, assessment and plan) or older versions, in "travel-card" format.

For our purposes, we will exclude any final report requirements that may be indicated on a case-to-case or payor summary request, or on a "discharge summary" basis. Of these, the chiropractic treatment or management plan and the progress interim report have the shared characteristic of direct chiropractic clinical decision-making involvement for the provision of care. Thereby, it serves to substantiate "the medical necessity of care." This kind of care assumes responsibility for coordination, integration and efficiency of the chiropractor's professional role and clinician's duty to the patient.

Chiropractic care is based on continuous healing relationships. It is customized, according to the patient's needs and values, and makes the patient the source of control (utilizing the body's natural healing forces). Patients are provided with the necessary information and the opportunity to exercise the degree of control they choose over the decisions that affect them. With this in mind, I will share an example of a typical brief interim report format that includes the typical procedures when a patient's condition changes, a diagnosis is added (ruled in or out), and hence, the management care plan changes, all of which requires report documentation.

Chiropractic Physical Medicine Progress Report
January 3, 2003

RE: Jane Doe
DOE: 01-02-2003

To Whom It May Concern:

The above-named patient was seen in my office today for an interim chiropractic evaluation of a low back condition. She presented to this office when home instructions for pain control failed to subside the pain on 10-04-02. She reported an exacerbation of pain complaints secondary to an increase in driving and home activities described as "vacuuming." On a positive note, she is now returning to her usual activities of daily living, with an overall good recovery pattern. The initial diagnostic impression was sciatica.

Source of Facts:

1. history as provided by the patient, consisting of: outcome assessment forms; the Dallas Pain Questionnaire; the Roland Morris Low Back Disability Questionnaire; and
2. physical examination.

History, Forms and Questionnaires:

The patient complaint is low back pain. The pain level was rated as a 5 on a scale of 1-10, with 10 being severe pain with moderate interference in activities of daily living. Her resultant complaints are:

• the need to walk slower than usual and avoid jobs around the home;
• avoidance of bending or kneeling;
• sleep interference; and
• a 50% limitation in prolonged seated activity.

The patient was provided a detailed re-examination. On my medical record review today, the findings confirmed right-sided sacroiliac spine-sprain-resultant myofascial pain syndrome, with previous documented comorbidities, radiographic evidence of a lumbar spondylosis of levels L5/S1, and clinically documented intermittent sciatica involvement.

Physical Examination:

Patient gait is abnormal, and she presents with visible pain as indicated by a facial grimace when holding her back below the beltline. Osseous palpation of the sacroiliac yields limited posterior-to-anterior motion and painful muscle splinting. Lumbar active range of motion was restricted and slow; flexion was the worst and recorded at 30 degrees. The biaxial lumbosacral region displayed some tenderness to palpation with myospasm on flexion. Paraspinous spasm at right pirformis with referral pattern is indicative of myofascial syndrome demonstrated by active trigger point nodules, jump sign and purposeful withdraw sign.

Neurological Examination:

Seated deep tendon reflexes of the lower extremities demonstrated +1 asymmetrically using the Wexler Grading Scale. Ely's Heel-to-Buttock test was positive for sacroiliac dysfunction. Motion palpation yielded L-S vertebral apposition and glide restriction.

Diagnosis:

• myofascial pain syndrome
• sacroiliac sprain/strain
Treatment plan:
1. Monitor neurological status for potential herniation L-S vs. discogenic disease, and monitor for periods of sciatic involvement or impingement.
2. Apply myofascial release to associated muscles, followed by ultrasound with analgesic gel over source of sacroiliac dysfunction.
3. Perform chiropractic manipulation on region.
4. Repeat above procedures twice per week for 3-4 weeks for pain control.
5. Consider further diagnostic imaging; MRI lumbar and pain management referrals for therapeutic intervention to include trigger point injections and/or lumbar epidural under guided fluoroscopy.
Reasons for Opinions:
1. history as given by the patient;
2. the examination performed by the undersigned;
3. the pain as expressed by the patient and consistent with the written outcome assessment documentation; and
4. review of the diagnostic studies and medical chart note records.

Time: Face-to-face, 45 minutes
RVS: 99214

Treatment is suggested as brief and conservative for the residuals. Patient education is provided, and anatomical charts, models and scientific literature are utilized. Patient consent is obtained to provide the aforementioned treatment plan. Medical authorization is obtained to provide her general practitioner with a photocopy of today's interim findings and chiropractic care plan, should she decide that she requires a brief trial of pain prescription management at that provider's facility.

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