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The "Perfect" SOAP Note: A Chiropractic Holy Grail

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Following my last column ("Insider's Secrets About Recovery or Postpayment Audits," Dec. 16, 2009), I received a boatload of e-mail inquiries in regards to audit protection or prevention strategies. The most common question in this regard was an interesting variation of the quest for the chiropractic Holy Grail: the "perfect SOAP note." Much like the Holy Grail of Arthurian legend, the assumption by many DCs is that such an instrument, example or software program (if it exists) would make the chiropractor invincible from all documentation denials or audits.

First, let me disappoint you. Then, if you don't tear this article to shreds, allow me to give you some suggestions for improving your documentation from an auditor's perspective. And just for clarification, I am not speaking from the vantage point of any one particular insurance or payer type. Rather, the recommendations I will dispense are straight from my training as a certified professional medical auditor, which enlightened me on the strategies and methods auditors use to review your documentation.

Depending on which literary conceptions of the Holy Grail you read, there is a common theme of elusive mystery that surrounds all counts of the tale. Later legends throughout history have found the grail popping up in churches throughout Spain, Italy and modern-day Turkey. Similarly, there are software vendors, EMR companies and even certain expert authors who lay claim to possess knowledge of the chiropractic Holy Grail: the perfect SOAP note.

The Challenge of the Grail

As promised, here is the bad news: I will not reveal for you the "perfect" SOAP note that you can copy and use for every one of your patients. Here's why: The purpose of a SOAP note (or any documentation) is to communicate what is going on with your patient to someone (like an insurance company) who is not there. While there are certain elements that should be part of every good SOAP note, it also should be a document flexible enough to change with the patient. For example, if you have three patients, all have neck pain, one is 5, one is 35 and one is 85, shouldn't something about their documentation look different, even if they have the same presenting problem?

Similarly, what if you practice a technique vastly different than mine or your neighboring DC? Once again, there are some parts of your documentation that should be standard enough to transcend technique barriers. On the other hand, I have observed some chiropractors using an array of objective tests that I would never use, mainly because they are designed to give them information specific to their technique.

Is it wrong, invalid or lacking sufficient evidence to support such methods of assessing the patient's problem? From a clinical or research standpoint, you can probably find practitioners on both sides of

the fence. Certainly, it is not my position to judge the clinical merits of one technique versus another. However, there is one thing I can tell you: From a documentation perspective, these chiropractors will have notes that look vastly different than mine, and they should. They need to accurately report what they are doing, the same as you or me, regardless of whether they are using different methods to arrive at their clinical data or their adjusting approach.

The Trouble With Oversimplification

So, in respect to the "perfect SOAP note," the problem boils down to oversimplification. To proclaim that one possesses this chiropractic Holy Grail in the form of a template or a piece of software that can produce the perfect SOAP with the push of a button is nothing more than dangerous advertising.

To be most precise, however, the real problem may not even be the template or the software itself. Likely it is "operator error." For example, let's say you were able to get your hands on the such a product or method that could effortlessly produce a perfect SOAP note in seconds. What happens, then, when you encounter some trouble with an audit or denial due to inadequate documentation? Your first step would be to come back and claim that the perfect SOAP template wasn't so perfect after all.

In reality, the template might have been just fine, had you not used the same exact SOAP for the last 93 times your patient came in to your office. Similarly, to rely upon software to automate your documentation to the point that you just press the "enter" button every time and go to the next patient is *your* fault, not that of your EMR system.

The Hardest Things and The Right Things

Admittedly, all this makes good documentation all the more challenging. But these aren't my rules, nor yours. We are just required to play by them. So, how can we hone in on some concrete ideas to improve our documentation? There may not be a perfect template we can use, but realize that there are many simple strategies that can be employed to improve and achieve defensible documentation. Here are three of the most common mistakes I routinely see chiropractors make in the notes that I review:

Nonspecific Reporting of Treatment Response: One of the items on the CERT (Comprehensive Error Rate Testing) checklist used by Medicare carriers to review chiropractic documentation is the reporting of the patient's response to treatment. Stated another way, we need to document the change in the patient's condition as a result of our care. While Medicare will specifically point this out as a requirement, most other third-party payers have similar language in their policies recommending that we give them a status update on the patient. While this makes for good common sense, few chiropractors document this regularly. So, it is no surprise that third-party payers will also use the lack of reporting this against us. After all, they are footing the bill and want to know if our care is helping.

The documentation of the response to treatment need not be lengthy or difficult, but it does need to be there in your notes. At its most basic level, this may include reporting that the patient is "same, better or worse" compared to their last adjustment. Obviously, the more specific you can get, the better. Reporting that "the patient states that his low back pain is better after the last adjustment and that his home exercises are helping relieve hamstring tightness"conveys more information about your care than simply stating, "Better."

Mismatching Objective Findings With Treatment: From a payer perspective, reimbursement can only be made when medical necessity is proven for the care rendered. What this means on a practical level is that if you adjust the cervical, thoracic and lumbar spine, you'd better have objective findings to prove the medical necessity of your treatment in these areas if you want to be paid (or keep your money). A common mistake I see chiropractors make is having an objective findings "mismatch" with respect to their treatment rendered. In other words, the DC may adjust three areas of the spine, but have objective findings that only document medical necessity in two areas. When there is no objective findings to match up with your treatment, your claim will either be denied or downcoded (if you are lucky). Even worse, your claim will be paid and you will cash the check and spend the money, only to fail an audit and be asked to repay the money later.

Poor Legibility: The final mistake I would like to discuss is perhaps both the most inexcusable and the most common. It is legibility. Simply, stated, if your documentation cannot be read, it is considered improperly done. If it's not done right, you can't possibly prove medical necessity and you don't deserve to be paid. Let me define *legibility* a little more specifically: Legible documentation is readable by a third party. Legible documentation is not notes that you (and you alone) are able to translate. Your documentation is not legible if your staff member of 20 years is the only one able to decipher your hieroglyphics. Legible means any reasonable person can read it without aid of a magnifying glass, superhuman powers or a special decoder ring.

In the most basic sense, this is the biggest commercial for EMR that can ever be waged. A cranky auditor may abandon the gargantuan task of trying to read your chicken scratch, but I have yet to see any EMR system that could not produce a nice, legible note. Be ruthlessly honest with yourself here. If your notes would produce embarrassment, confusion or a migraine, do yourself a favor and protect your income. Switch to dictation and transcription, or get an EMR system that can produce a note you can be proud of. Your documentation may not be perfect, but it will be substantially better than a sizable portion of our profession because it will be legible.

I hope these suggestions help you in dispelling the myth of the shortcut to perfect documentation, because there really isn't any. But at the same time, I hope you are now in a better position to take some concrete steps to improve your documentation. These strategies are just the tip of the iceberg, but as the saying goes, "A journey of a thousand miles begins with a single step." Enjoy the journey and know that every step you take on this path will improve your practice and our profession.

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