Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Going Beyond the Feel Good

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

We all know most patients come to us for some pain complaint: neck pain, back pain, sciatica, carpal tunnel, etc. We also all know chiropractic is a great first-line option for these neuromusculoskeletal issues, as well as for supporting overall health and wellness. That said, for many doctors, the problem is not in getting the patient to feel better; it's knowing what to do *next*.

The unfortunate reality today is that many patients define their need for care by what their insurance covers. I would never suggest that you limit your care to the narrow scope of some insurance limitation – arguably, that path only allows insurers to "control and eliminate" chiropractic just by decreasing the parameters of coverage. But sometimes, John Q. Public only wants a service if their insurance approves it.

It is our responsibility as physicians to review an appropriate care plan with a patient, regardless of their coverage. At that point, they may elect for some or all of your recommendations. What you recommend to a patient for care may reasonably be very different from what their policy coverage allows or what the patient even expects. Your care plan should never be defined by a third-party policy, but the treatment you ultimately provide might be.

When the Pain's Gone

As a care plan progresses, one would expect that a patient will feel better. But of course, just because someone *feels* better does not automatically mean that they *are* better. There are plenty of medications that can make someone feel good, but that doesn't mean they are the right choice – good care goes beyond just the "feel good."

When reviewing the stages of healing, remember that as the acute phase resolves, often the pain will, too. Stopping care at this point is rarely advised. Often the patient needs further care to stabilize function and rehabilitate the compromised mechanics. I usually explain to a patient that if I make them feel better today, but the pain comes right back tomorrow, then I have not really helped them at all – I need to make them feel better today and then make sure the problem does not recur. This needs to be discussed with the patient up front, at the beginning of care, while they still have pain. If the whole focus from the outset is the resolution of their pain, then they have not understood the bigger picture. That means when they feel better, they will assume their care is done.

Documenting Your Care

It is the physician's responsibility to fully document all aspects of the case – the initial consultation, case history, examination findings, care plan, treatment rendered, and the response to the care rendered. Follow-up evaluations should review these findings, note the changes in the patient's condition, and discuss appropriate modifications to the care plan. The normal standard of care for follow-up evaluations is every 12 visits. If a patient has not returned for care in more than 90 days and

then comes back in for treatment, it is also reasonable to perform at least a cursory file update – even if their complaints are exactly the same.

Often, insurers will base a decision to deny care solely on improved pain scores. In my experience, this is often because the provider has not accurately documented any other objective data to support the care rendered. The patient's record, examinations and SOAP notes should include more than just a subjective notation of pain level (the 1-10 scale). Improved pain scores are a good sign, but are not a valid indicator of the patient's condition; activity, medications, therapies, and even the weather are all variables that can impact a pain level.

The notes must include good, objective documentation of the patient's changing status as well. Orthopedic testing, palpatory assessment, motion palpation, ADL questionnaires, and functional capacity tests are important measures that can show improvement with treatment, but can also show there is still irritation or limitation that needs treatment. Other good objective measures could be improved motion, less medication, increased activity, or even a decrease in your recommended treatment frequency.

It is also important to notate other information regarding the patient's case in general. Other physician evaluations or recommendations, diagnostic testing, and parallel care should be noted. If the patient has a significant life change – a move, a divorce, a new job – these are also factors that may affect their response to care. Certainly if there is a new exacerbating injury – an MVA, a slip and fall, an injury at home or while playing weekend sports, these are also worthy of note and will show a need for further care or validate the need for a new course of care.

Any of this information must be noted in the patient's record *at that time* – not retrospectively at some later date. The notes should always be contemporaneous with the patient's status – notes after the fact give the impression that the provider is not well-organized and does not have a good handle on the patient's care.

As I have emphasized in previous articles, there is a standard of care in this country that is clearly defined. It is dangerous to think that because we are chiropractors, we do not need to keep records to the same degree as medical doctors do. We must think outside the chiropractic bubble in terms of health care in general. Always remember that it is the patient that we take care of; not the insurance companies, attorneys or other doctors.

Resources

- Iyer, P, Levin B. *Medical Legal Aspect of Medical Records, 2nd Edition, Volume 2*: *Clinical Specialty Records.* Chapter 1. Lawyers & Judges Publishing Company: Tucson, AZ; 2010.
- *Clinical Documentation Manual – Clinical Documentation Essentials for Doctors of Chiropractic, 2nd Edition*. American Chiropractic Association: Arlington, VA.

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