Dynamic Chiropractic

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SOAP: A Chiropractic Perspective

DOCUMENTING ASSESSMENT AND TREATMENT VISITS.

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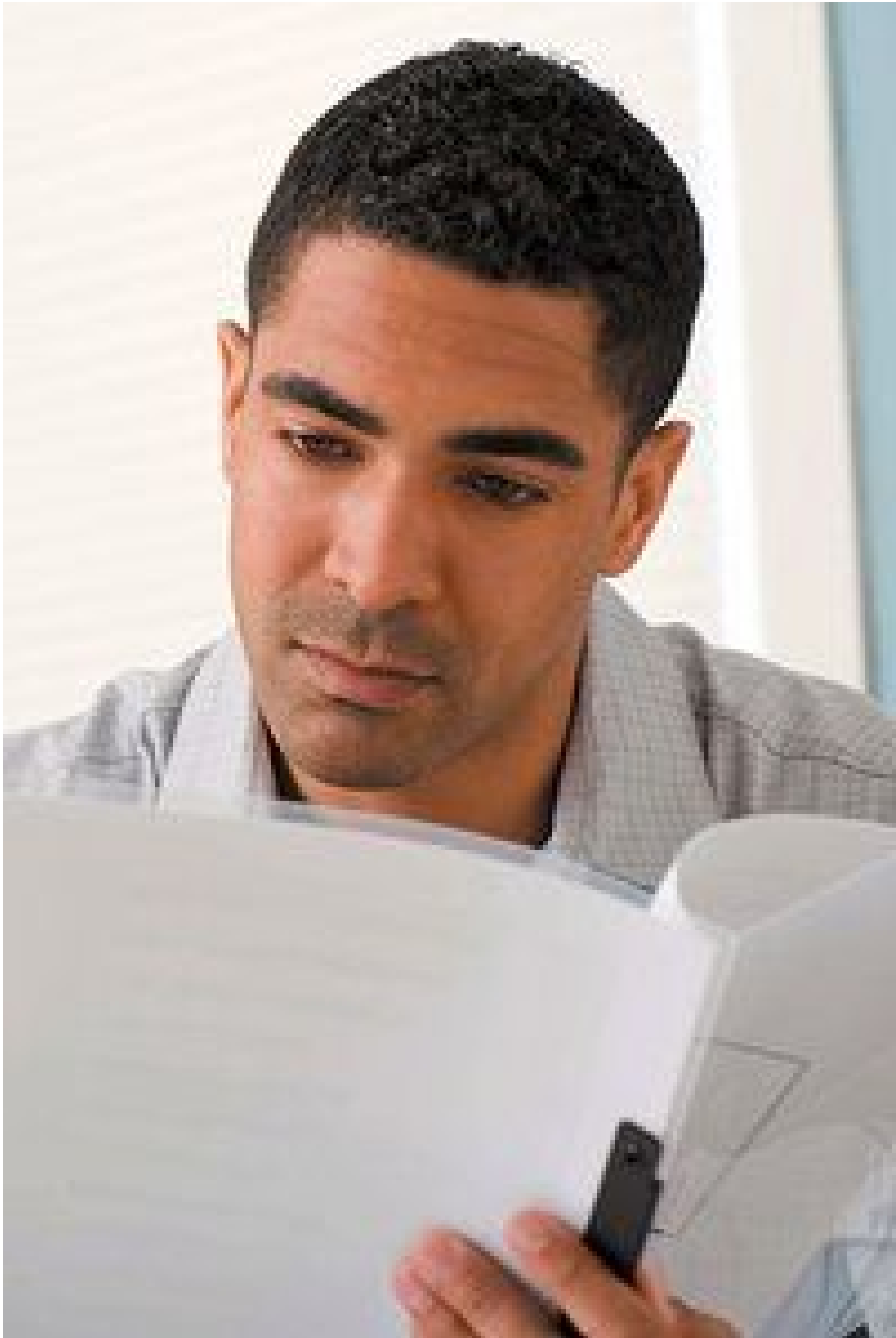
S.O.A.P: We all learned it in school and we all do our best to follow it in our daily charting of patient encounters. My good friend Dr. Mario Fucinari expresses it as a formula: S+O=A yields P. Your subjective findings plus your objective observations equal your assessment, which leads to your plan. Simple. Easy to understand.

The important thing to remember regarding the SOAP is that it was designed for the practice style of a medical doctor. To illustrate this, let's assume a scenario. You are working in your garden, clearing under a rose bush, when you are startled by a small snake. You reflexively jerk your arm back and cut your forearm on one of those monstrous thorns that reside at the base of the rose bush. You now are the proud owner of a 4-inch gash on your forearm. You know you should go inside, and clean and bandage it, but you are nearly done and it is getting dark, so you blot it with a towel (that isn't too dirty) and keep working.

Two days later, your forearm is swollen, red, painful, and hot to the touch. You go to your MD and tell them of your gardening misadventure. This is the subjective portion of the encounter. The doctor then examines your arm, noting the redness and swelling, and how you flinch when they instinctively touch the sorest point on your arm. They order a CBC and note an elevated white count. This is the objective portion of the encounter.

The doctor determines that you have an infection. This is their assessment. They write you a prescription for a course of amoxicillin and tell you to take four pills each day for the next 10 days, and to come back if the arm gets worse or if the pain, swelling, and redness are not gone by the time the pills are gone. This is their plan.



You take the prescription to your pharmacy and purchase 40 units of therapy, which you take home and self-administer. By the time the pills are gone the pain and swelling are nothing more than a bad memory. You are done and the whole episode lasted less than two weeks. This is how a medical doctor practices.

Chiropractors practice similarly, but with a few significant differences. When you jerked away from the snake, you felt a "pop" in your low back and the pain has been getting progressively worse and has started to radiate down your right leg. You go to your chiropractor and tell them of your gardening misadventure, and that the pain is getting worse and radiating down your right leg. This is the subjective portion of the encounter and is essentially the same as it was with the medical doctor.

Next, your chiropractor has you complete an outcome assessment questionnaire and conducts some orthopedic and neurological examinations. They suspect an underlying problem and order low back X-rays. This is the objective portion of the encounter. Your chiropractor reviews the findings and determines that you have lumbosacral sprain-strain with sciatica, complicated by degenerative disc disease of L3, L4 and L5. This is the assessment portion of the encounter. The chiropractor prescribes an adjustment and electro-stim therapy three times per week for four weeks.

Here is the point where we deviate from the medical doctor. We cannot write a prescription for the adjustments, have you pick them up at the pharmacy and take them home to self-administer. You have to come back to the chiropractor for each adjustment. This means we have two distinctive types of patient encounters: the assessment visit and the treatment visit.

The assessment visit is essentially the same for both chiropractors and medical doctors. We note the subjective information that the patient supplies to us and the objective observations we make while performing examinations and tests. We take this information and formulate an assessment of the patient's condition, and then develop a plan of action to address that condition. The assessment visit should occur every 30 days to effectively evaluate the patient's progress.

The treatment visit is where we implement the plan of action, or treatment plan. The documentation requirements for the treatment visit would be different from the requirements for the assessment visit. You would want to note the subjective statement from the patient as to the current state of their condition. You would also want to note the findings from palpation or other preparatory exams. Then you would note the treatment administered and the patient's response to that treatment.

To accurately determine the effectiveness of treatment, a reviewer would need to consider the records from the assessment visits before and after the date in question, as well as records from all of the treatment visits in between. Trying to evaluate the treatment effectiveness of a chiropractor from the records of a single date of service would be like trying to evaluate the effectiveness of a course of antibiotics from the notes generated after the patient has taken a single pill. At best, the reviewer would get an incomplete picture of the effectiveness of a course of care.

To state it simply, it is absolutely impossible to determine the effectiveness of a course of chiropractic care by reviewing the records from a single date of service. This is an important concept to understand as we come under tighter scrutiny by insurance and Medicare reviewers. When you receive a records request for a single date of service, you know that you need to send sufficient records to prove the medical necessity of the care. If the reviewer does not take all records sent into consideration, then

you have a valid argument for appeal of the denial.

Medicare reviewers are required to use a principle called clinical review judgment when conducting reviews. Clinical review judgment involves two steps: (1) the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient; and (2) the application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. Simply stated, the Medicare reviewer must take into consideration all records sent, not just the records requested.

Understanding the concept of the assessment visit versus the treatment visit is very important. A client of mine was under review and the reviewer did not understand chiropractic. The reviewer insisted that the doctor conduct orthopedic and neurological exams at each treatment visit. This would be the equivalent of requiring a medical doctor to perform a CBC after each pill of a course of antibiotics.

The failure of those outside of chiropractic to understand our treatment protocols has led to unnecessary claim denials. Communicating the difference between assessment visits and treatment visits will help to overcome that problem.

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