Dynamic Chiropractic

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The Death of the Travel Card

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As long as I have been in practice, the travel card has stood as the primary style of documentation for chiropractic. It is quick, simple and direct. Unfortunately, the rules have changed. Travel cards may still have a place in the contemporary practice, but if that is your only form of documentation, you will soon find yourself with a wave of treatment denials due to insufficient documentation.

Travel Cards: The Pros

We still use travel cards in my practice. We use the same style we used almost 20 years ago. With my travel card I can get a quick overview of the care that has been provided to the patient and a good picture of how they are progressing with my care. There is a section to score the patient's complaints on the 1-10 scale, a place for objective palpatory findings, and places to note what therapies and spinal regions were adjusted. I can also note on what dates exams or diagnostic studies were performed.

The Cons: No Longer Enough

This format gives me a great reference for a quick overview of several weeks of care at a glance. However, by the current standard of care it is wholly inadequate – a general overview is nice, but it lacks the clinical specificity required for medical documentation.

The ACA states that the primary purpose of quality medical-record documentation is to provide a tool of clinical communication among care providers and others, for the benefit of the patient. Good records memorialize relevant facts of the patient's care, such as subjective and objective findings; the doctor's assessment; the plan of care and subsequent progress; and reasons for continued care, discharge or referral.

In 2009, the FCLB presented its Model Practice Act, which states that clinical documentation should include, *at a minimum*, the following:

- Identity of the patient and provider(s)
- Reason for the patient visit
- Current (that visit) objective findings and discussion of any recent diagnostic studies
- Diagnosis or updated assessment
- Treatment plan and goals
- Documentation that the patient was informed of potential risk and that they consented to receive care
- For Medicare, PART, G-codes, and AT must also be documented on each visit (Stage II meaningful use will require an additional G-code regarding blood pressure.)

Again, that is the *minimum* information required by the current standard of care. It is impossible to fit all that on a travel card. The current solution to this problem is usually the use of one of a number of documentation programs. It is reasonable to state that electronic health records (EHRs) are becoming

the baseline standard for clinical documentation. It should also be noted that doctors who participate in Medicare are required to adopt an EHR system by 2015.

That said, the hazard of EHR is the same as it has been for travel cards – the tendency to just copy the same information forward. If anything, many of the EHR programs have a "clone last note" function, which makes this very easy. But it is incumbent upon the doctor to be careful to customize every note to make it encounter-specific. It is the responsibility of the provider to make sure each note is specific, accurate and complete.

Passive repetition of the same verbiage on every visit quickly makes the notes suspect – it suggests the doctor is not paying attention to the case documentation.

It is also arguable that the travel-card style of documentation is not HIPAA compliant. If records for a specific date are requested and you provide a travel card covering a range of dates, you have released additional information not requested. Sharing information on other dates of service can be considered a violation of the patient's privacy.

Documentation: Time Well Spent

As I shared above, I do still use a travel card in my office – but this is for *my* reference. Every patient encounter has its own, individual note in the system. If requested, I can provide a complete SOAP note covering each of the details of a patient's encounter on any date of service.

Yes, it takes time – I can spend up to 40 percent of my day just on documentation. I don't have to like it, but complete documentation is the standard of care – anything less is not acceptable.

I believe that chiropractors are (and should be) primary care providers – we represent what true *health* care is all about. Keeping good records does not mean we are reshaping the profession into an allopathic model; it is just part of what we have to do as health care practitioners. We are part of the larger health care system and we need to play by the same rules as everyone else.

Remember, ICD-10 is coming – documentation is only going to get more involved. Maintaining the medical record properly allows anyone reviewing the patient's records to be able to clearly understand the details of the professional care: what was done, why it was done and the outcome of the plan of care. Travel cards are nice as a reference, but they can no longer serve as a primary method of documentation.

Resources

- *Clinical Documentation Manual – Clinical Documentation Essentials for Doctors of Chiropractic, 3rd Edition*. American Chiropractic Association. Arlington, VA, 2013.
- Fucinari M. "Documentation, Compliance, and ICD-10 Coding" (CE seminar), 2014.
- Iyer P, Levin B. *Medical Legal Aspect of Medical Records, 2nd Edition, Volume II: Clinical Specialty Records*. Lawyers & Judges Publishing Company: Tucson, AZ, 2010.

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