Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Are You Ignoring the 10,000-Hour Rule?

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Having trained interns and mentored new practitioners, it has been my observation that their No. 1 clinical concern is adjusting skills. Their second clinical concern is their ability to read X-rays. Physical diagnostic skills are a distant third. It is wise to be concerned about adjusting skills and reading film. Both are fundamental. My concern is that physical diagnostic skills are of such little concern.

The clinical requirements for graduation usually require adjustment to physical examination ratios of 10:1. This is a shame, as adjusting skills are not 10 times more important than diagnostic skills. I would say they are equal, but before anyone thinks I am recommending the same requirements for both, I am not. My point is to raise awareness in students and new practitioners of the importance of physical diagnostic skills. Of course, the point is also applicable for experienced practitioners.

The 10,000-Hour Rule

In the book *Outliers,* Malcolm Gladwell details "The 10,000 Hour Rule".[1] The rule evolved from a study performed in the early 1990s at Germany's Academy of Music in Berlin. The primary researcher, K. Anders Ericsson, and colleagues divided the school's violinists into three groups. The first group included students with the skill to become world-class performers. The second group included "good" violinists. This group could be professional performers, but not at a world-class level. The third group included violinists with talent levels best suited for teaching music, not performing at a high level.

After dividing the students into groups, the focus was on discovering if pure talent or practice time had made the bigger difference in the students' skills. All of the students had started playing at age 5. The study showed there was a large difference in the number of practice hours logged by the students. The number of hours correlated with the students' skill levels. Students with world-class potential had logged the highest number of practice hours – approximately 10,000.

Gladwell used this study to analyze the careers of people who were successful in a variety of fields: sports, computers, business and other areas. He found remarkable consistency among leaders and successful people in each field. Almost without fail, they had all logged approximately 10,000 hours of training, practice or experience in their field prior to their biggest breakthroughs.

Interns are not going to leave school with 10,000 hours of practice experience. Divide 10,000 hours by 40 hours per work week; the result is 250 weeks. Divide 250 weeks by 52 weeks in a year – that's 4.8 years; 18 months longer than most chiropractic programs.

Obviously, the 10,000 hours will come during the first five years of full-time practice. That will take care of the adjusting skills; but it will not allow skills in physical diagnosis to catch up. There may never be parity between adjusting and physical diagnosis skills, but practitioners can and should narrow the gap to become great diagnosticians.

3 Ways to Narrow the Skill Gap

The first opportunity to narrow the gap, one usually forced upon the new practitioner, is working as an exam doctor while waiting for licensure. There are situations in which licensure will not be immediate for new graduates. In these instances, the new doctor can find employment as the examination doctor in a busy practice. This entails performing all new- and established-patient examinations; no adjusting. From the new graduate's vantage point, this is a setback. They want to adjust. They don't see themselves as a true chiropractor unless they are adjusting patients.

It is easy to see their point, but they have an opportunity to refine their skills in physical diagnosis and earn some income while they wait for their license. The situation also works well for the busy doctor needing help. The only drawback here is for the patients. The doctor with the least diagnostic experience is providing the examination and gathering the information that will lead to the diagnosis.

The Value of Progress Exams

The second opportunity is to develop the habit of performing progress examinations routinely. Performing progress evaluations during the course of a treatment plan is good patient care. The doctor needs to stay abreast of a patient's progress. The examinations also help the doctor develop and refine their skills.

Progress examinations are also important in case management. Third parties are requesting information from progress examinations more frequently than ever before. The Medicare PQRS program is an example. The pain and outcome questionnaires are required by Medicare every 30 days during an active plan of care. This coincides with progress examinations every 30 days.

This pattern is vital in case management. Progress examinations are the linchpins that tie together short chains of care. They reflect how the patient has progressed, and the future of the patient's condition and necessary care.

There seems to be a misconception that care which goes on and on, uninterrupted by interim examinations, can be justified simply because the patient continues to experience signs and symptoms. The truth is, without findings from progress examinations to justify the care, ongoing care will not be seen as reasonable to other parties. The doctor has to document accomplishments in the patient's care and plan for additional accomplishments. Short- and long-term goals must be established, and their status routinely verified, through progress examinations.

A side note must be provided for this discussion. Progress examinations should occur based on time, not numbers of visits. For example, if a doctor is using the number of visits as the indication for progress examinations, the patient on an initial visit frequency of three times a week for four weeks would be re-evaluated after the first 12 visits (one month).

Another doctor using time as the indicator for progress examination would re-evaluate in 30 days (one month). The two methods coincide. If a patient on a visit basis keeps his/her appointments, there will not be a problem. If the patient does not keep his/her appointments, there will be a problem.

A patient with erratic compliance might take six weeks to accumulate 12 visits. In this case, 12 visits and 30 days no longer coincide. The scheduled progress examination would not meet the 30-day Medicare PQRS deadline. It could also be a problem for other carriers.

If the patient continues to follow through in an erratic manner, all scheduled progress exams based on numbers of visits would be erratic.

However, the records of the progress examinations would still appear in the order initially planned. Unless someone reviewing the records paid attention to the dates, it would appear that the patient was compliant, when he/she was not.

If progress examinations are scheduled in 30-day increments for the noncompliant patient, the patient's lack of compliance can be seen in the pattern of the records. Documenting poor compliance with a treatment plan is important. Patients often complain about a lack of progress and blame the doctor, when in fact, *they* have not followed the recommended treatment plan. Patients have some right to complain if they followed all of the doctor's advice and no results are obtained; patients have a minimal right to complain if they don't follow the doctor's advice and no results are obtained.

Technique-Related Assessments

A third opportunity exists in the assessment related to giving an adjustment. Technique-related assessments help determine progress from one visit to the next, indicating where to adjust and post-adjustment success. The importance of these brief examinations is acknowledged in the CPT codes for chiropractic manipulation.[2] A brief examination is an aspect built into the manipulation codes. For Medicare, this would be the component of the adjustment code gathered through PART analysis during the visit.

This is why billing a progress examination performed in conjunction with a manipulation requires a modifier on the examination code. The modifier indicates the doctor performed an examination above and beyond, separate from the examination required for the manipulation. Without the modifier, the examination is not likely to be recognized or covered.

Every time the patient comes in for an adjustment, the doctor has the opportunity to examine the patient and refine his/her physical diagnosis skills. The checks may be brief, but they are important. The challenge is detecting subtle changes which occur between visits that are only days apart. These changes are harder to detect than changes seen during visits months apart.

While the gap between adjusting skills and skills in physical diagnosis is significant initially, a doctor can certainly narrow the gap by performing the progress examinations and daily evaluations necessary for good patient care. Remember: You cannot provide the correct treatment unless you have the correct diagnosis.

References

1. Gladwell M. *Outliers.* Boston: Little, Brown and Company, 2008.
2. *Current Procedural Terminology*. Chicago: American Medical Association, 2012.