Dynamic Chiropractic

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Documenting Intuition

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Intuition can be defined as *the ability to understand something immediately without the need for conscious reasoning*.[1] This is a great definition because of the words "understand ... without ... *conscious* reasoning." Intuition is a subconscious process.

As our clinical experience accumulates and we evolve into skilled practitioners, intuition becomes an invaluable tool. We begin to recognize many of the clinical findings in our patients' presentations in a subconscious manner. We then act, at least in part, based on what is recognized subconsciously. This is part of the "art" of practice. Unfortunately, this vital aspect of our art has a routine deficiency, one that in today's day and age cannot be overlooked: Many of the subconscious clinical findings we act upon do not make their way into clinical records.

The Importance of Documenting Intuition

For example, a doctor may realize a patient is unable to view his surroundings without having to turn his entire body. Intuition tells the doctor the patient likely has spasm of the cervical musculature causing decreased cervical range of motion.

This is a key observation. If documented, the observation provides a lifelike picture of the effects spasm and decreased range of motion have on the patient's activities of daily living. Customarily, cervical spasm and decreased range of motion are the clinical findings that would be documented, while the description of the patient having to rotate his body to see his surroundings would not.

Documentation of intuitional observations is essential. Initially, it helps establish the full extent of the patient's illness and disability. Later, documenting the resolution of intuitional observations helps establish clinical progress.

Returning to the patient who cannot rotate his head: If the patient were driven to the clinic initially because he could not turn his head to drive, and a week later drives himself to the clinic, positive clinical progress has been obtained and should be documented. These events are real time for the doctor and patient.

Conversely, these events are *not* in real time for other parties interested in the case. Without documentation, the lifelike picture of the patient's progress is not available. This can be a detriment if a third party has a duty to make decisions in the patient's case: payment, assignment of disability, etc.

Paint a Picture

With the initiation of required electronic records in this decade, doctors were forced to select software for clinical documentation. Regrettably, some software is limited when it comes to dictating or typing in any information that is not already programed. Only short statements and phrases can be added to

the system. This limitation can reduce the doctor's ability to document a wide variety of intuitional observations.

In this situation, instead of painting a lifelike picture by dictating or typing in a full paragraph regarding the patient's inability to turn his head, two short statements could be embedded: "The patient's current condition is making it difficult or impossible to drive" and "The patient's condition is no longer interfering with his ability to drive." This also paints the picture of the patient going from stranded to self-reliant.

Another method for painting a picture of the effects of clinical findings on activities of daily living is the use of functional assessment / disability indices. For the example here, the Neck Disability Index might apply.[2] Indices are well-accepted methods of documenting a patient's capabilities for activities of daily living.

Indices provide other advantages. The patient is involved in recording his own disabilities, painting his own self-portrait. This reduces time spent by doctor and staff on documentation. Early in practice, when a doctor's intuition is still evolving, indices can help capture and track vital clinical information that may not be "understood ... immediately without the need for *conscious* reasoning."

In some ways, the Medicare-based PQRS system that was in place in recent years aided all doctors in getting a lifelike picture of a patient's disabilities. The requirement of functional assessment / disability and pain indices initially and at specific intervals during care compelled the painting of a patient's picture in the record.

Why Medicare's Documentation Requirements Are So Important

There is a saying about Medicare: "As goes Medicare, so goes all other carriers." This is true, as there has always been a trickle-down effect of Medicare policies and regulations to other carriers. However, Medicare documentation is not the gold standard for clinical practice. The initial documentation can be overkill for initial complaints that are straightforward. Medicare documentation can also be redundant, requiring as much documentation for a routine follow-up visit as it does for a new-patient visit.[3]

However, recording intuitional observations and the required indices helps meet Medicare documentation requirements and enhances documentation for all third parties.

Doctors often search for clinical documentation to meet Medicare policies and regulations. Fortunately, there really is no need to search. Much of the necessary information is available and its use requires a conscious effort to convert subconscious observations and realizations, and the actions based on them, into clinical documentation.

References

1. Apple Inc., dictionary embedded in Siri/iOS software, 2017.
2. Vernon H, Mior S. The Neck Disability Index; a study of reliability and validity. *J Manip and Physio Ther,* 1991;14:409-415.
3. *Medicare Benefit Policy Manual*, Chapter 15: Covered Medical and Other Health Services. Revised July 11, 2017.

Editor's Note: This is the second article in a series by Dr. Miller based on his e-book, *Chiropractic Medicare Documentation Self-Inventory*. Dr. Miller has graciously made this book available for free download for a limited time (Oct. 1 – Dec. 1, 2017). The code to download the book for free is LD96X.

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