DEFINE YOUR KNOWLEDGE

So How Do We Take Notes?

Each patient encounter should be regarded as unique, and proper documentation is required of any and all interactions with the patient on any given day. Whether it be a phone call, care rendered on a particular day, or a referral made, it must be included in the patient's file. Therefore, documentation such as "same as last visit" is not acceptable. Patient notes are not for the sole purpose of your office knowing information but for other health care practitioners as well.

***SOAP** notes are the most common method of documentation within the Chiropractic profession

S=Subjective – Anything the patient reports about their symptoms and progress. It is information based solely on the patient's opinion, perception, and self-expression, and not based in objectivity.

O=Objective – The opposite of subjective in that they are not based on the patient's opinion at all. Rather these findings are measureable, repeatable, reproducible and have a basis in common evaluative procedures.

A=Assessment – This portion of the notes takes into account the provider's opinion of the subjective and objective portions, as well as the amount (if any) of patient progress. Therefore S+O=A.

P=Plan – This puts the S, O, and A into action. Now that we have an idea what is going on with the patient, what are we going to do about it? What action steps are going to be taken, and over what time frame, to assist the patient in their recovery?

Medicare has its own rules….

Medicare requires special documentation. Due to the fact that the Centers for Medicare and Medicaid Services (CMS) currently only pay for manual manipulation of the spine to correct a subluxation, there must be proper documentation in order to establish the medical necessity for treatment at the time of each visit.

STUDY TIPS

The three components Medicare requires to establish medical necessity are:

1. *A subluxation that causes a significant neuromusculoskeletal condition*
2. *Documentation of the presence of a subluxation*
3. *Documentation of the initial and subsequent visit*

Proper documentation of Medicare patients requires that the **"PART"** system be used.

P = Pain / Tenderness –

Examples of how to determine this include the following:

- **Observation:** How does the patient present to you? Are they hunched over or do they limp? Do they exhibit signs that they are in pain? Be sure to note the location, quality, and severity of the pain.

- **Percussion, Palpation, or Provocation:** Ask the patient when touching them or asking them to perform a movement "Does this cause you any pain or discomfort?"

- **Visual Analog Type Scale:** Ask the patient what their pain level is today, using a visual aid depicting the progression of pain levels. Using the 0 – 10 scale, 0 is the least amount of pain and 10 is the most.

- **Audio Confirmation:** The patient is asked to verbally grade their pain from 0-10.
- **Pain Questionnaires:** The patient answers questions that will determine how much pain an activity causes.

A = Asymmetry / Misalignment –

Identify differences by one or more of the following:

- **Observation:** How is the patient's posture and their gait?
- **Static and Dynamic Palpation:** Describe the misaligned vertebrae and symmetry.
- **Diagnostic Imaging:** X-ray, CT, or MRI

R = Range of Motion Abnormality –

Use one or more of the following to identify an increase or decrease in joint motion, whether it's gross motion such as the lumbar spine or fine motion such as the first digit.

- **Observation:** Is there a visual increase or decrease in the patient's range of motion?
- **Motion Palpation:** Record the areas that are involved including the vertebral listings.
- **Stress Diagnostic Imaging:** X-ray the patient using bending views, not just with them standing straight.
- **Range of Motion Measuring Devices:** Goniometers and inclinometers can record these specific measurements.

T = Tissue / Tone Changes –

Using one or more of the methods below identify any changes in soft tissue.

- **Observation:** This includes any visible changes such as signs of spasm, inflammation, swelling, etc.
- **Palpation:** What does the area of complaint feel like? Is it hypertonic, in spasm, or inflamed? Is there edema, tautness, rigidity, flaccidity, etc.?
- **Instrumentation:** Document the instrument used and your findings.
- **Tests for Length and Strength:** Document if there is a leg length difference, if a scoliosis has created muscular contracture on one side, and the strength of the muscles that relate.

Medicare requires that two of the four components listed previously be documented each visit, and that one of those must always be either the "A" or the "R" component.