ACUPUNCTURE today

BILLING / FEES / INSURANCE

# Welcome to the Big Show

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

It had been just over a year since my first submission to *Dynamic Chiropractic* (which I also write for) when I noticed a letter to the editor in *DC* from a chiropractor in the Netherlands.[1,2] He seriously disputed the need for orthopedic testing in the assessment of the patient, suggesting that these tests are only performed to satisfy the insurance companies. My original article was on the topic of short leg and some of the tests used to clinically evaluate that finding.

My original idea for the article grew out of several comments made by some of the residents here in the hospital; they just automatically assumed it meant one leg was indeed shorter. I knew the short leg could signal different functional conditions, and I had to go back through several of my books to look up and re-learn what they were.

At first, I was surprised at the response to my article, maybe even a little angry. Why would someone apparently get so mad at me for sharing what I had spent time researching? But the more I thought about it, the more I had to agree with Dr. Morris' comments. As he stated, it truly is a pity that we have to go to such great lengths for documentation. Dr. Morris raised some valid points, most notably: "Why waste time with all these orthopedic tests, and then do all that paperwork?"

Before I go any further, I will state that my writing was not a mandate, I looked up those tests so that I personally could remember them; then I compiled them in a format so I could share them with my colleagues.

Depending on your specialty or style of practice, you may focus more on tongue, pulse or hara evaluation, observation or palpation to reach your diagnosis. As I find little clinical pearls or specialized testing tricks, I like to share them. I have learned more from my colleagues in this way than I ever have in a seminar or classroom.

I can also say that it is a pain in the butt to do all that paperwork. It does often seem like we are required to constantly do more paperwork for less money. However, the standard of care for our profession is that all patient contact and care needs to be documented. One of the reasons medical doctors can only see a limited number of patients in a day is because they have built time into their schedules to do the required paperwork. Paperwork is a part of health care today - it doesn't matter what branch you are in. Whenever you encounter a patient, there should be some level of documentation. Were their complaints better or worse? What treatments did you provide? What techniques did you use? What therapy procedures did you provide? Good record-keeping is an integral part of good patient care.

So, Why Bother with All Those Notes?

1. It allows you to track your patients care and progress. Most patients come in with pain. Hopefully, they will get better under your care. What did you do? Good notes let you look back and review what you did along the way to care for your patient. If an attorney or an insurance company ever asks for a narrative summary of your patient's care, the data is

ready for you to put a report together.
2. It allows you to communicate your findings, your treatments and the patient's response to other professionals in a way that they recognize and understand. It also allows them to have a copy of your treatment notes in their file so that their records on the patient are up-to-date. One of the most common tactics insurance companies will use to deny care is the phrase: "Treatment plan not supported by documentation." The only way you can fight such a comment is to have the notes already completed and in the file so you can address those denials immediately.
3. Thorough examinations and good records raise your level of professional credibility. In a recent article, in *DC*, Dr. Steven Kraus discussed the "credibility gap" facing practitioners in the mainstream health care system.[3] Although we know how effective conservative care is, there is a bias. One of the points he raised is that we cannot change the system when "our own insufficient documentation practices fail to show the effectiveness of our approach."
4. It's good marketing. What better way to get your name in front of doctors with whom you work than to send them a report on their patient with your name attached? They have to see it. The more patient notes you send them, the more they see your name.
5. If you ever have a case go to court or trial, your notes are your strongest defense for your treatment plan and care.[4] The first time I went to court for a patient was for a young man I had treated for phantom pain. He suffered a traumatic amputation of his foot in an industrial accident. I had treated him twice with acupuncture and his symptoms resolved. My care was not questioned until two years later; I had totally forgotten what I did to treat him by then. My notes were the only evidence I had to justify my care. By the way, we did win that case. The chiropractic insurance company NCMIC points out that the treating provider is automatically suspect when in court.[5] Your records can be your biggest asset in defending your treatment.
6. It reflects on your image as a professional. In my work with legal nurses, I have heard the comment that many alternative practitioners believe that because they practice outside the realm of "traditional" health care, they are not subject to its rules. That is not a professional image with which any of us want to be associated. Failure to meet the documentation standards of the profession reflects badly on the profession as a whole, and helps reinforce a negative image that is already out there.[6]
7. Because it's the standard of care.[7] Documentation is part of practice. It doesn't matter what style you practice: TCM, Cambodian, Japanese, needle, non-needle, laser, moxa or any other technique; it is your professional responsibility to document what you find, what you plan to do and how you treated the patient. Whether you like it or not, your treatment notes will be looked at by a medical physician, insurance company or attorney at some point. The rule of thumb is: "If it isn't written down, it didn't happen." That is not the medical rule; that is the general rule for all of health care. It doesn't matter if you are an MD, a DC, an acupuncturist, a massage therapist or a physical therapist. The medico-legal obligations apply.

I can appreciate that Dr. Morris does not see the need to spend a lot of time with specialized testing. He lives in a place with a controlled health care system that allows him to practice in that way. That is fantastic; I can only imagine not having that level of stress in my daily practice.

But I don't live in Holland. I live in the United States, and the fact is that there is a standard of care in this country that is clearly defined. It is dangerous to think that we do not need to keep records to the same degree as do medical doctors. As they say on ESPN before a big game: "Welcome to the Big Show." We must learn to think outside the bubble of our own practice and in terms of health care in general. Ultimately, it is the patient of whom we take care, not the insurance companies, attorneys or other doctors.

Whether or not you feel obligated to document your case, responsible patient care mandates it. Acupuncture deserves every bit of respect that any other health profession does, but that respect

comes with a level of responsibility. Yes, it is a pain; yes, it takes more time, but documentation paperwork is part of professional health care.

*References*


1. www.chiroweb.com/archives/23/05/16.html
2. www.chiroweb.com/archives/23/09/21.html
3. www.chiroweb.com/archives/24/17/07.html
4. Case Study #1590ZRB. *NCMIC Examiner,* Summer 2006.
5. Case Study #1590ZRB. *NCMIC Examiner,* Summer 2006.
6. Meadowlands Hospital Medical Center & Emergency Department Protocols. The America Association of Hospital Chiropractors. Meadowlands Hospital, N.J., June 2005.
7. Briggs DR, Curley DM, Cohen SS, Mahoney JJ. Understanding chiropractic case management. *Journal of Legal Nurse Consulting*, April 2003;14(2):9-13.


JANUARY 2009