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It Doesn't Matter What You Say

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I have written in the past about the importance of clear and accurate documentation. I continue to receive comments about that topic. There is no argument. Paperwork is a pain, but it is necessary. Whether you like it or not, some day, someone will look at your treatment notes. Are they sufficient to explain your patient encounter on that date? It often seems like we are required constantly to do ever 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, and it doesn't matter what branch you are in. Whenever you encounter a patient, there should be some level of documentation. The classic way of keeping daily notes is in the "SOAP" format. For those of you who don't recall, SOAP is an acronym for Subjective, Objective, Assessment and Plan.This is the outline for the information you need to keep on every patient encounter on every visit.

Subjective: This is commonly where you note how the patient is feeling at this encounter. Information in this section of your notes should also include any changes in how the patient feels or functions since the last treatment. Did the patient see any other practitio-ners (medical, acupuncture)? What diagnoses or treatment plans were given? Was any other care given? How did these treatments affect the patient's level of complaint?

Objective: What were your findings today? This does not have to be a full, complete, formal exam report on every visit, but you should be able to note some degree of quantitative findings on every visit. The comment "unchanged" is not acceptable because this only serves to show your care is ineffective. Is there any change in muscle spasm? Is there any change in motion or function? These should be noted, even if they are only minor changes. Other nontangible changes should be noted such as a decrease in medication or increase in work function. These types of findings give a daily record of how your patient feels with progressive care. This section should also include any discussion of other diagnostic studies or evaluation reports you have received since the last patient encounter such as radiographic reports, functional-capacity exams and EMG summaries. These should all be referenced in your daily notes.

Assessment: Your interpretation of the patient's subjective complaints, the objective findings, the current diagnoses and your per-ception of their overall condition today.

Plan: This is not only the treatment you provide today, but also your plan for future visits. The standard of care dictates that you clearly define what you did. There are a number of clinical forms that provide you the ability to "check off" what you did, but this gives no detail. Swedish massage? To what areas? Deep Tissue? Efflurage? Tapotement? To what areas? Did you offer any advice on diet, exercise or activity? How did the patient feel after your treatment? These questions are all tedious, but this is clinically relevant data for which you are responsible in the care of your patient. You must provide clear, accurate, information contemporaneous to the visit.

I have known practitioners who prefer to save up data, and offer a summary after eight, 12 or 20

visits of care. This approach is reck-less and unprofessional. 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 medical doctors. We must learn to think outside our own practice bubble and instead think in terms of health care in general. Ultimately, it is the patient whom we take care of, not insurance companies, attorneys or other doctors. Whether or not you feel obligated to document your case, responsible patient care mandates it. We can say we deserve the same level 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 like it or not, documentation paperwork is part of professional health care.

NOVEMBER 2009