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The Danger of Documentation

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A few months ago, I read an article penned by Dr. Necela about Medicare audits – how to protect yourself from them, and how to profit from them. The idea was looking at your records and stats, recognizing the issues, and correcting the problems. Essentially he advocated a self audit to make sure your protocols and notes were up to par. I would like to expand on that topic a little more. I was recently involved in a legal seminar and the topic of reviewing records came up. There were a number of observations which I think give good insight into how our records are viewed, assessed, and interpreted. Using the self-audit strategy can help protect your practice and serve to increase your profitability.

The first and probably most scathing comments were regarding the reasonableness of the care provided. If you are going to treat a patient for a particular condition – treat that condition. This is not the place for philosophy – care has to be specific and relevant. In acupuncture, this is usually when distal points are treated for a problem. From personal experience I can state that doctors and attorneys typically do not understand meridian dynamics. I recall one case where I was grilled mercilessly for treating the lower Bladder meridian on a patient with neck pain – the opposing attorney kept coming back to: "but those points are in the lower back, and the injury was in the neck, correct?" I have already covered discussed this issue in previous articles. Make sure you can defend your use of the points you select.

Do your notes make sense?? Is there logic to your care plan?? Can someone reading your file tell what your care plan is? Current medical treatment protocols usually progress from acute pain relief to functional restoration to active rehabilitation. Make sure your notes are clear that you are moving your patient progressively through a continuum of care. Ongoing, unchanging treatment is very quickly perceived as palliative care that is not providing tangible benefit. That is not to say that the patient does not have relief – that is a good thing – but our responsibility goes beyond the feel good, we are to improve their overall condition. Especially when dealing with an injury claim, make sure you can show that the patient is measurably improving with your care. This advice also applies to products you may provide a patient – lower back supports, seat cushion, etc. Providing a patient a soft collar for a lower back injury is hard to validate . . .

Beware your advertising. I have seen this come up several times. Some practitioners like to use marketing gimmicks to get new patients – online coupons for a free initial consultation and treatment is a common offer, but this is bad practice! I have known attorneys to confront a doctor in court and ask why they billed for an exam on the patient when their advertising clearly says that the initial visit was free. OUCH. No way to defend that. Be careful how you advertise and what you offer – clever marketing gimmicks are not always your friend.

Billing forms do not constitute good office notes. Make sure you have good, clear, concise, relevant daily notes. Sending a doctor, an insurance company, or an attorney a stack of billing statements so they can interpret your care plan is not good practice. Often, they will be viewed as a simple listing of dates or treatment. With no supportive documentation this will quickly be interpreted as rote billing for procedures. This is highly suspect, and will usually be disputed. Billing records are for

billing, they do not contain the information of a full SOAP note to list your findings, your assessment, and the rationale for the care you provided on that date.

The last red flag I will discuss here is computerized records. Certainly the world is moving in that direction, and practitioners should keep their records in electronic format. However, be careful and pay attention – it becomes too easy to hit that "carry-over" button and copy the same records forward. I have been involved in some case reviews where there were 60 or more daily notes that were all exactly the same – the doctor just copied the same note forward each visit. As discussed above, this quickly supports the notion that care is static, ongoing, and of no benefit. Make sure you take the time to input data so that each daily note is accurate and relevant to that patient encounter on that date.

I will close with the advice of Dr. Necela: At this time, audits are a major source of worry and potential threat to many practitioners. However, if we practice what we preach and take some "preventative maintenance" with respect to what we do, we can turn this around to be a force for our own good. Take auditing seriously and use it preventatively. Those who have been on the down side of an audit wish they had taken steps like these before they were under the microscope. Had they done so, I am sure the outcome of their audits would have been much more favorable. Use the self-audit strategy today to help protect and profit from the good work that you do.

References

1. www.dynamicchiropractic.com/mpacms/dc/article.php?id=55915
2. www.dynamicchiropractic.com/mpacms/dc/article.php?id=54673
3. www.dynamicchiropractic.com/mpacms/dc/article.php?id=54361
4. www.dynamicchiropractic.com/mpacms/dc/article.php?id=56051
5. www.dynamicchiropractic.com/mpacms/dc/article.php?id=55183
6. www.dynamicchiropractic.com/mpacms/dc/article.php?id=55915

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