ACUPUNCTURE Today

INSIDE YOUR CLINIC

Is Your Documentation Falling Short? Here's How (and Why) to Do It Right

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In addition to my personal practice, I also serve on the state workers' compensation panel. I am one of several practitioners on the panel – others include surgeons, pain management docs, neurologists and PTs. There are also attorneys and representatives from hospitals, labor unions, and insurance companies. We have been tasked with producing practitioner certification, guidelines for care, fee schedules, etc.

One of the issues that came up early on, and seems to keep coming up, is the standard of care and how to track what a practitioner does. Obviously, this involves *documentation*. I have discussed this in several different ways in the past, but I am still asked about what is expected for record-keeping.

SOAP Notes Done Right

Regardless of whether you are a physician, acupuncturist, therapist, rehab tech, or other patient care provider, the basic documentation requirements are the same. The modalities used and the plan of care may vary, but at the root we all have to keep the same information. A daily note or patient encounter (the "SOAP" note) is the default for most of us. I have seen forms with just S-O-A-P down the left side of the page and some stuff scribbled in – there should be a little more than that. For acupuncturists, these notes should include:

S – Subjective. This is a general discussion of the patient's status since the last visit. *It should be more than just a 1-10 pain score*. How is the patient doing? How did they respond / feel after the last treatment? Were they better or worse? What have they been doing? Has their level of activity changed? Did they stay in bed or were they out working in the yard? Did something change? Did they suffer an additional injury?

O – Objective. What are your findings *today*? What is tight? Are there muscle spasms or trigger points? What is the pulse? What is the character of the tongue? Cuts? Bruises? Blemishes? Changes in the patient's physical appearance or constitution?

You should also note if the patient is more active – able to stand or walk more, walk up stairs or farther, do some activity they could not do previously.

A – Assessment. Clinical decision-making and the care plan. Based on the S and the O, what is your summary of the patient's condition and what do you plan to do moving forward. *Note – writing "unchanged" doesn't count!* It may be the same for a period of time, but if the patient is responding to care, the S and O should change, and the A should also change over time.

P – Plan. What you did today and what you are going to do moving forward. For an acupuncturist – what points did you treat? How? Needle or needle with stim? Don't just list an area; clearly name the points. What else? *Gua Sha*? Cupping? Diathermy? What area(s)?

Forget the Philosophy

When documenting your care, remember, 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, treating distal points for a problem can be an issue.)

From personal experience, I can state that doctors and attorneys typically do not understand meridian dynamics. I recall one case in which 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?" Make sure you can defend your use of the points you select.

There should also be some discussion on how the patient responded with the treatment. Was there a circulation response? Change in pain? Improved range of motion? *How did they do with your care today*?

In many practices, the standard of care is now computerized record-keeping. This can help to make things a little easier, and often easier to store and retrieve. But in all honesty, good computerized records take at least as much time as handwritten ones, if not more. If you do computerized records, 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 in which 60 or more daily notes were all *exactly* the same – the practitioner just copied the same note forward each visit. This will quickly demonstrate that care is static, ongoing and of no benefit.

Billing vs. Documentation

If you do billing (and there is a much higher chance that you will in the coming years), your billing records do not count as documentation. Many carriers now expect you to submit a bill with the concurrent daily notes, but these are two different documents. 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.

Worth the Time Investment

Taking the time to do good notes is frustrating. Often it feels like a waste of time. But if you are ever asked about your care at a later date, you will be able to validate what you did.

The first time I had to appear before the Industrial Accident Board for a patient was for someone I had treated two years before – he had suffered a traumatic foot amputation and had phantom pain. There was no way that far out I was going to remember what I did, but I had the notes and we prevailed in the hearing. It was worth it to take those extra minutes.

It is dangerous to think that because we are acupuncturists, we do not need to keep records to the same degree as medical doctors. We must learn to think outside our practice bubble and think in terms of health care in general.

Acupuncture deserves every bit of respect any other health profession does, but that respect comes with a level of responsibility. Make sure you clearly and accurately document what you found, what you did, and why. Be known for offering the highest level of patient care – don't settle for anything less.

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