Case Studies

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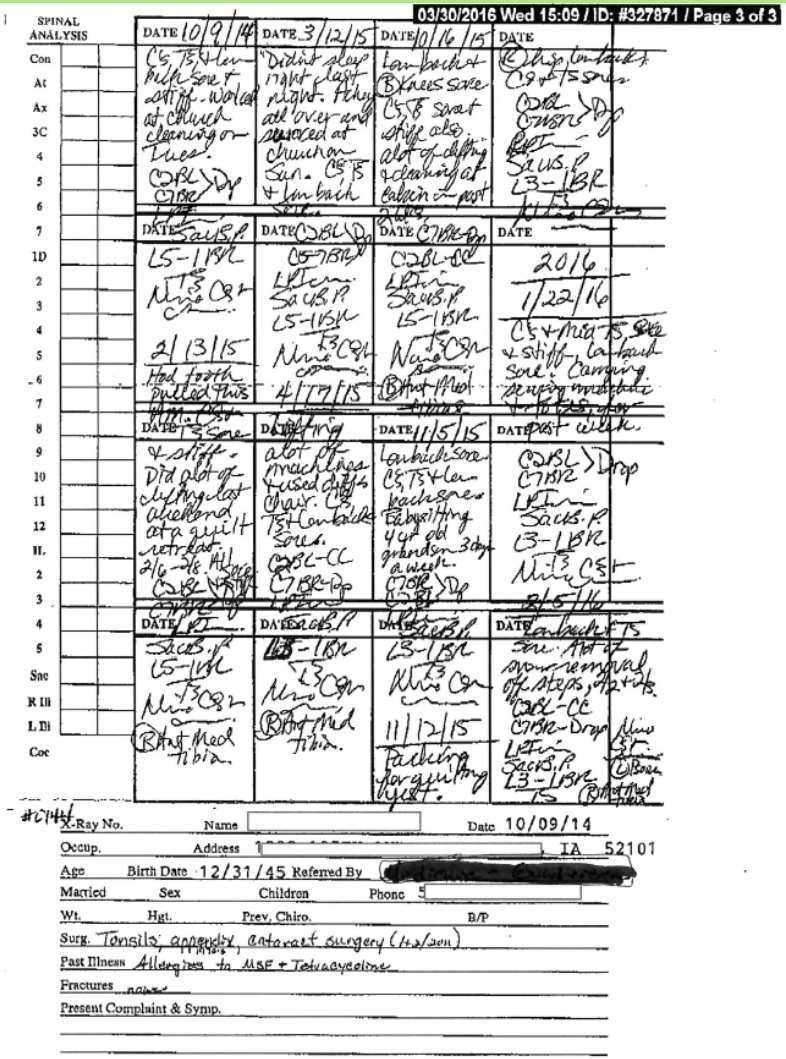
Quick Poll: 1986 or 2016?



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Instructions

* Review each Case Study with the people at your table.
* Complete the “General Patient Chart Audit Form” based on the information within your packets
* CCMI will share our responses to the “General Patient Chart Audit Form” for reference

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Case Study B

[redacted]

Telephone: [redacted] Fax: [redacted]

April 11, 2016

Re: SOAP notes for SAMPLE PATIENT **dob 12/31/45**

Subjective: Patient presented to the clinic on January 22, 2016 with pain in the cervical and thoracic and lowback sore after carrying her heavy sewing machine and totes this past weekend.

Objective: To lessen the pain in cervical, thoracic, lowback, and left hip pain so that this patient can continue her normal daily activities with much lessened discomfort or no pain.

Assessment: SLR, minors, segmental motion palpation for tight and taut muscles indicating moderate traumatic injury to cervical, thoracic, and low back with associated subluxation complexes of involved areas.

Plan: Specific chiropractic adjustment of involved areas with patient calling the clinic as needed.

Sample Sally PC

Subjective: Patient presented to the clinic on February 5, 2016 with pain in her low back and thoracic after shoveling snow from her steps on February 2 & 3rd, 2016.

Objective: To lessen the discomfort/pain in her low back and thoracic so that the patient can continue her daily activities with less pain.

Assessment: SLR, minors, segmental motion palpation for tight and taut muscles indicating moderate traumatic injury to low back and thoracic with associated subluxation complexes of involved areas.

Plan: Specific chiropractic adjustment of involved areas with patient calling the clinic as needed.

Sample Sally PC

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Case Study B

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?	✓		
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?		✓	
Is each entry signed or initialed by the treating doctor of chiropractic?	✓		
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?			✓
Is the patient's name and date of birth on every page for identification and authentication purposes?	✓		
If notes are handwritten, are they legible and indelible?	✓		
Are the notes in chronological order?	✓		
Are any corrections to notes made appropriately?			✓
Are there notes for every patient encounter?			✓
For services (including CMT, therapeutic procedures, and therapeutic modalities) rendered, does the note include the following:			

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Case Study B - Continued

Is there rationale for performing each service?		✓	
Is the type of service (and any settings, etc. associated with that service) documented?		✓	
Are the specific body regions or areas that treatment was rendered to shown in the medical record?		✓	
Is the length of time of the service (if required by CPT) recorded?			✓
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?		✓	
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?			
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?	✓		
Is a care plan recorded or referenced for each date of service?			

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Case Study B - Continued

Does the treatment plan include the expected duration and frequency of visits?		✓	
Does the treatment plan include specific, objective measurable treatment goals?		✓	
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?	✓		
Was informed consent obtained and documented in the chart?			✓
Is all of the necessary demographic information for the patient captured?			✓
Does the documentation support the level of evaluation and management service that was billed?		✓	
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			✓
If non-covered services were performed, is there a properly executed and signed waiver present?			✓

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Case Study C

Narrative Encounter - Treatment

Wednesday, March 30, 2016 5:33 AM

Problems List

- Unresolved - Pain with movement in: the knee on the right. (new)

Subjective

Chief Complaint

- Pain in: the sacroiliac joint on the right. (Pain Scale 3 of 10.)
- Pain in: the lumbar spine. (Pain Scale 2 of 10.)
- Pain in: the thoracic spine. (Pain Scale 1 of 10.)
- Much improved symptoms.She went walking on uneven terraine and felt right knee pain and soreness develop as well as right sided mid to low back pain. She is off of the prednizone now. Blood tests with no results yet.
- Pain with movement in: the knee on the right.

Objective

Examination

Musculoskeletal

- ***Orthopaedic Tests.*** Sacroiliac: Iliac compression test for sacroiliac joint pain localization - positive on the right. Lumbar intervertebral: Minor's sign for lumbar antalgia - neg. Nachlas test for sacroiliac or lumbosacral disorder - mildly positive on the right. SLR (straight leg raising) test - positive on the right. Kemp's test for L5 to S1 root compression - positive on the right. The Apley's scratch test for shoulder supraspinatus tendinitis - unremarkable. Abduction relief for localized tenderness for the shoulder bursae (Dawbarn's sign) - unremarkable bilat. (Improved.) Knee: The anterior cruciate ligament drawer test of the knee - performed well bilaterally. Drawer test for posterior cruciate ligament insufficiency of the knee - performed well bilaterally. McMurray sign for medial or lateral meniscal damage - unremarkable bilaterally. Apley's compression test for meniscus involvement of the knee - unremarkable bilaterally. Patella inhibition test for possible patellar chondromalacia - positive on the right.
- ***Muscle Strength Test.*** Shoulder strength test: abductors on the right - (+5/5 - 100% - normal) pain. Abductors on the left - (+5/5 - 100% - normal). Flexors on the right - (+5/5 - 100% - normal) pain. Flexors on the left - (+5/5 - 100% - normal). Scapular elevators bilaterally - (+5/5 - 100% - normal).
- ***Grip Strength.*** Grip strength: Right hand dominant: The estimated grip strength of both hands is normal.

Case Study C - Continued

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?	✓		
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?		✓	
Is each entry signed or initialed by the treating doctor of chiropractic?	✓		
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?	✓		✓
Is the patient's name and date of birth on every page for identification and authentication purposes?		✓	
If notes are handwritten, are they legible and indelible?			✓
Are the notes in chronological order?			✓
Are any corrections to notes made appropriately?			✓
Are there notes for every patient encounter?			✓

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Case Study C - Continued

Is there rationale for performing each service?		✓	
Is the type of service (and any settings, etc. associated with that service) documented?		✓	
Are the specific body regions or areas that treatment was rendered to shown in the medical record?		✓	
Is the length of time of the service (if required by CPT) recorded?			✓
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?		✓	
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?			✓
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?	✓	✓	
Is a care plan recorded or referenced for each date of service?	✓		

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Case Study C - Continued

Does the treatment plan include the expected duration and frequency of visits?		✓	
Does the treatment plan include specific, objective measurable treatment goals?		✓	
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?	✓		
Was informed consent obtained and documented in the chart?			✓
Is all of the necessary demographic information for the patient captured?			✓
Does the documentation support the level of evaluation and management service that was billed?			✓
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			✓
If non-covered services were performed, is there a properly executed and signed waiver present?			✓

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Case Study D

Narrative Encounter

Saturday, February 27, 2016 11:07 AM

Problems List

- Active - A history of migraine headaches. (created 07/09/2014)

Subjective

Chief Complaint

- Pt presents with CC of Migraine this AM. She woke up at 3am with severe migraine on the left side of her head. She has been dealing with a lot of stress at her home, and this is causing her to get more adn more HA's. She has 4-5HA's per month and Migraines every couple months. this is the worst one in 6mos. She also complains of neck pain on the left and low back pain. The Pain is there frequently, sharp and shooting. Seems to be getting a little better. The pain can be a 9/10VAS. Lying down makes it worse, sitting up relieves a bit. Has seen a MD and PT for this as well as other chiropractors in the past. She has fam hx of diabetes. See intake for more details. (She her son had an accident and she ran to him. That flared him.)
- A complaint of a headache.
- A history of migraine headaches.
- Headache.
- Pain in: the muscles of the posterior neck, the muscles of the thoracic spine, and the muscles of the lumbar spine. (Pain Scale 7 of 10.)

Past, Family, and Social History

Smoking Status

- Smoking status: never smoker.
- Smoking status: never smoker.

Objective

Examination

Constitutional

- ***Height.*** Height 62 inches. Height 62 inches.
- ***Weight.*** Weight 169 pounds. Weight 169 pounds.
- ***Body Mass Index.*** BMI 30.9. BMI 30.9.
- ***First Reading.*** BP 142/82 mmHg was taken sitting using the left arm. BP 142/82 mmHg was taken sitting using the left arm.

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Case D - Continued

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?	✓		
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?			✓
Is each entry signed or initialed by the treating doctor of chiropractic?	✓		
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?			✓
Is the patient's name and date of birth on every page for identification and authentication purposes?		✓	
If notes are handwritten, are they legible and indelible?			✓
Are the notes in chronological order?			✓
Are any corrections to notes made appropriately?			✓
Are there notes for every patient encounter?			✓
For services (including CMT, therapeutic procedures, and therapeutic modalities) rendered, does the note include the following:			

Case D - Continued

Is there rationale for performing each service?		✓	
Is the type of service (and any settings, etc. associated with that service) documented?		✓	
Are the specific body regions or areas that treatment was rendered to shown in the medical record?		✓	
Is the length of time of the service (if required by CPT) recorded?			✓
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?		✓	
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?			✓
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?			✓
Is a care plan recorded or referenced for each date of service?			✓

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Case Study D - Continued

Does the treatment plan include the expected duration and frequency of visits?	✓		
Does the treatment plan include specific, objective measurable treatment goals?		✓	
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?			✓
Was informed consent obtained and documented in the chart?			✓
Is all of the necessary demographic information for the patient captured?			✓
Does the documentation support the level of evaluation and management service that was billed?			✓
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			✓
If non-covered services were performed, is there a properly executed and signed waiver present?			✓

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Case Study E

Patient name and DOB as well as DC electronic signature is present but redacted.
DOS 2/4/2016
CPT Billed:
E/M 99202
Rad 72040, 72100
CMT 98941
EMS 97032
Mechanical Traction 97012

E

Subjective:
* Moderate frequent stiffness and radiating stiffness, rating a 6 on a 0-10 scale, where 0 is not severe at all and 10 is extremely severe, in the following regions: cervical and lumbar, radiating to: thoracic, sacral and pelvic. This condition was caused by insidious onset. Onset 1 month.

Objective:
* Patient's height: 6' 1.5".
* Patient's weight: 194 lbs.
* Patient's BMI: BMI
25.
* Patient's blood pressure recorded as: 138/80 mmHg.
* No triggers trigger points lbs pressure algometry.
* 7 Mm right short leg.
* High muscle tension T3,5,7,9,11,L1,3. Moderately high C2,4,6,T1,7,L5. Low T1,L1,3. surface EMG.
* Braggards, straight leg raise, Faber Patrick, shoulder depression, trunk flexion, Soto Hall, maximum foraminal compression, Kemps, anterior head shift, left shoulder drop, right pelvic translation and right head translation.
* Reduced cervical range of motion with pain and reduced lumbar range of motion with pain.
* Moderate-severe fixation Subluxations discovered during motion palpation in the following regions: C1, C5, C6, T2, T6, L1, L5, S1.
* Moderate-severe muscle spasm and trigger points weakness in the following regions: in L brachioradialis, in R brachioradialis, in L deltoideus, in R deltoideus, in L neck flexors, in R neck flexors, in L iliopsoas, in R iliopsoas, in L piriformis, in R piriformis, in L gluteus max and in R gluteus max.
* Subluxations discovered by X-Ray, abnormal curve, abnormal neck curve and disc degeneration.
* Fixation, taut/tender fibers, and myalgia at cervical and lumbar with severity moderate (6).

Activities of Daily Living:
(Based on most recent evaluation and/or outcomes of the assessment tools)
* Patient experiences moderate pain (6) while standing, sitting and sitting to standing for extended periods.
* standing, sitting and sitting to standing: 75% of normal.

Assessment:
* Cervicalgia (723.1).
* Cervical Disc Degen (722.4).
* Lumbosacral Neuritis Nos (724.4).
* Lumb/Lumbosac Disc Degen (722.52).

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Case Study E – Continued

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?	✓		
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?			✓
Is each entry signed or initialed by the treating doctor of chiropractic?	✓		
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?			✓
Is the patient's name and date of birth on every page for identification and authentication purposes?	✓		
If notes are handwritten, are they legible and indelible?			✓
Are the notes in chronological order?	✓		
Are any corrections to notes made appropriately?			✓
Are there notes for every patient encounter?	✓		
For services (including CMT, therapeutic procedures, and therapeutic modalities) rendered, does the note include the following:			

Case Study E - Continued

Is there rationale for performing each service?	✓		
Is the type of service (and any settings, etc. associated with that service) documented?		✓	
Are the specific body regions or areas that treatment was rendered to shown in the medical record?		✓	
Is the length of time of the service (if required by CPT) recorded?		✓	
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?		✓	
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?		✓	
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?		ICD9	
Is a care plan recorded or referenced for each date of service?	✓		

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Case Study E - Continued

Does the treatment plan include the expected duration and frequency of visits?		✓	
Does the treatment plan include specific, objective measurable treatment goals?	✓		
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?			✓
Was informed consent obtained and documented in the chart?			✓
Is all of the necessary demographic information for the patient captured?			✓
Does the documentation support the level of evaluation and management service that was billed?	✓		
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			✓
If non-covered services were performed, is there a properly executed and signed waiver present?			✓

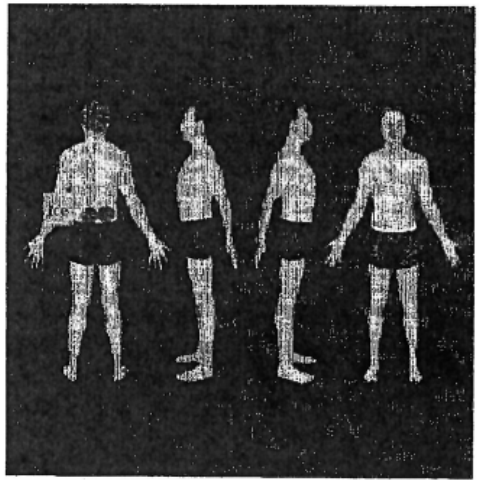
Case Study A

The patient is here today for a new episode of care.

Subjective

This patient presents with the following problem:
Low back pain
History of present illness/condition:
The patient rated the intensity of their pain/symptoms as an 8 on a scale of zero to 10 with zero being complete absence of symptoms and 10 being very severe or unbearable. The symptoms have been gradual insidious over the last 3 days. The symptoms have been present 100% of the day. The patient described the symptoms as worse in the morning. The patient describes their pain with the following qualifiers: sharp. Upon questioning, they related that the symptoms were aggravated by activities involving bending. The patient stated that some relief is obtained when standing. He gets relief with lumbar extension while standing (doing this exercise on his own as learned previously in PT).

He presents today with complaint of low back pain. It started two days ago for no apparent reason - he woke up with pain. He denies radiating leg symptoms. No abdominal pain. No recent illness. He didn't go to work today due to pain - it's getting worse each day. He works as a medical device technician and needs to bend and change clothes frequently and doesn't feel he can do that. He says he has a history of herniated discs in his low back and did physical therapy for this 20 years ago. He has been doing some back stretches. No ice. He twisted his left ankle 2 weeks ago when he fell on the stairs. He saw an MD and had x-rays which were negative for fracture. He is now wearing a soft ankle brace. He denies other changes in his health since his last visit here.



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Case Study A – Continued

Audit Category	YES	NO	N/A
Are standard abbreviations and symbols used?	✓		
If standard abbreviations are not used, is a legend of the non-standard abbreviations and symbols included with each patient's chart?			
Is each entry signed or initialed by the treating doctor of chiropractic?	✓		
If an assistant or other professional performs any of the services, is that indicated in the note and signed or initialed by that person?			✓
Is the patient's name and date of birth on every page for identification and authentication purposes?			✓
If notes are handwritten, are they legible and indelible?	✓		
Are the notes in chronological order?	✓		
Are any corrections to notes made appropriately?			✓
Are there notes for every patient encounter?	✓		
For services (including CMT, therapeutic procedures, and therapeutic modalities) rendered, does the note include the following:			

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Case Study A - Continued

Is there rationale for performing each service?	✓		
Is the type of service (and any settings, etc. associated with that service) documented?	✓		
Are the specific body regions or areas that treatment was rendered to shown in the medical record?	✓		
Is the length of time of the service (if required by CPT) recorded?			✓
Does the level of CMT billed match the number of spinal levels treated with a diagnosis indicated for each?	✓		
If manual therapy was performed on the same visit as CMT, and billed, was the manual therapy performed in a separate region from the CMT and documented as such? Was the -59 modifier used?			✓
Is the diagnosis(es) and/or assessment listed or referenced for each date of service?	✓		
Is a care plan recorded or referenced for each date of service?	✓		

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Case Study A - Continued

Does the treatment plan include the expected duration and frequency of visits?	✓		
Does the treatment plan include specific, objective measurable treatment goals?	✓		
Are objective findings including diagnostic testing results (including those received from outside sources) referenced appropriately?			✓
Was informed consent obtained and documented in the chart?			✓
Is all of the necessary demographic information for the patient captured?			
Does the documentation support the level of evaluation and management service that was billed?	✓		
If patient information was sent to another provider, is the accounting of the release of records properly documented in the chart?			✓
If non-covered services were performed, is there a properly executed and signed waiver present?			✓

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Thank you!

* Please remember to fill out your CE cards
  * In and out times with initials
* Remember to check out with CCMI staff
* Drive safely!

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