



# Clinical Best Practices: Clinical Quality & Documentation Standards

## Introduction

We all have a responsibility to help make our healthcare system more effective and efficient. As a clinically integrated physician network, HNS' strives to help our Network Physicians improve quality of care, treatment outcomes, and ensure care is delivered in the most cost-efficient manner.

To achieve these goals, in part, HNS has developed best practices to 1) improve quality of care and treatment outcomes, and 2) ensure accurate and appropriate documentation regarding each patient's care.

The term "Best Practice" is somewhat ambiguous, but is often used to indicate what institutions, and well-regarded practitioners are doing. In short, *a best practice is a method or practice that conventional wisdom suggests is effective and will reliably lead to desired and/or improved outcomes.*

HNS Network Physicians seek to provide excellent clinical care, and such care is evidenced through excellent clinical documentation in the healthcare record.

Proper documentation in the clinical record is essential for sound clinical decision-making. Excellent clinical documentation improves safety and quality of care, treatment outcomes, reduces errors and unnecessary testing, and is paramount to appropriate continuity of care. Conversely, the lack of appropriate and accurate documentation can lead to negative treatment outcomes, potential safety and quality of care issues, and higher healthcare costs.

These best practices were developed, in part, with guidance from HNS' Professional Affairs Advisory Boards (PAAB). The PAABs are comprised of more than seventy chiropractic physicians practicing in North and South Carolina. The standards contained herein are consistent with industry standards, federal and state laws, and the policies of HNS and its contracted payors.

These best practices may be periodically updated to address relevant changes in the industry, law, and payor and HNS policies.

## Statement of Intent:

Any treatment recommendations that follow are intended for the “typical” chiropractic patient. Such recommendations are not intended to be used as a substitute for the independent judgement of the chiropractor. Adherence to these best practices will not ensure a successful outcome for every patient. There are other acceptable methods of evaluation and treatment aimed for the same result. The decision to utilize a particular assessment, clinical procedure or treatment plan must be made by the chiropractor in light of the clinical data presented by the patient, the diagnostic and treatment options available, and the patient’s preferences and values.

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# Clinical Best Practices: Clinical Quality & Documentation Standards

## I. Clinical Care (Definitions)

Commercial and government payors contract with HNS in large part, because of our commitment to the delivery of safe, effective, and cost-efficient chiropractic care.

While physicians are always expected to provide clinically appropriate care to their patients, it is important to remember that clinically appropriate care does not always meet the definition of medically necessary care, as that term is defined by payor corporate medical policies. While more and more payors are recognizing the efficacy and cost-effectiveness of maintenance/supportive care, many payors still only cover medically necessary chiropractic care. As such, when making clinical decisions, it is helpful to be aware of, and consult as appropriate, the following terms and definitions:

### A. Medically Necessary Care

Medical necessity is a legal concept which refers to the healthcare services or products provided by a physician to a patient for the purpose of preventing, diagnosing, or treating an injury or disease in accordance with generally accepted standards of medical practice.

The American Medical Association (AMA) defines medical necessity as: Healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.

Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Health insurance contracts contain agreements to provide medically necessary diagnostic and treatment services. Generally, insurers will not pay for treatment unless they consider it to be medically necessary.

## B. Maintenance/Supportive Care

### 1. Maintenance Care

Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.

“Maintenance care” is “[e]lective healthcare that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient’s health status and give care/advice for these. Preventive/maintenance care is provided to optimize a patient’s health.” (*American Chiropractic Association*)

### 2. Supportive Care

“Supportive care” is “[l]ong-term treatment/care for patients who have reached MMI, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted.” (*American Chiropractic Association*)

## C. Maximum Medical Improvement (MMI)

MMI occurs when a patient with an illness or injury reaches a state where additional, objective, measurable improvement cannot reasonably be expected from additional treatment and/or when a treatment plateau in a person’s healing process is reached.

## II. Physician Responsibilities

These standards represent HNS’ performance expectations for Network Physicians; accordingly, Network Physicians are expected to consistently utilize these standards, relative to care provided to members whose healthcare plans contract with HNS.

### A. Ethical Standards

HNS is committed to conducting our business in accordance with the highest ethical standards and in accordance with federal and state laws

and regulations that govern our industry. HNS expects that same commitment from our contracted health care professionals.

Contracted health care professionals shall adhere to generally recognized standards of medical and professional ethics, the ethical and professional standards set forth by their respective licensing board, and the HNS Code and Standards of Conduct.

The HNS Code of Conduct is a guide that helps us carry out our day -to-day professional responsibilities in accordance with the highest possible standards of ethical behavior and in compliance with laws that regulate our business.

### **HNS Code of Conduct:**

Everyone in the HNS Network shall:

- At all times, conduct themselves in a manner consistent with generally accepted medical and professional ethics, this Code, and the HNS Standards of Conduct;
- Treat each other and all those we serve with kindness, respect, and the highest degree of integrity and professionalism;
- Conduct themselves in a manner consistent with all state and federal laws and regulations, HNS policies, and the policies of contracted health care plans; and
- Perform all responsibilities professionally, diligently, in good faith, in the absence of deception, misrepresentation, any conflicts of interest, and to the best of their ability.

### **Standards of Conduct**

Each of us is expected to act with the highest degree of integrity and professionalism.

At all times, conduct business with fairness, honesty, integrity, professionalism, and consistent with HNS Compliance Policies, and with respect for the laws applicable to the health care industry.

Even in cases where interpretation of policies, law or this Standard could be ambiguous, permissive, or lenient, HNS expects its contracted health care professionals to **always do the right thing, in the right way, and choose the course of honesty and integrity**

## B. Core Standards

The following are considered essential “core” standards intended to improve quality, treatment outcomes, and cost-efficiency.

1. Establish and document the patient’s chief complaint.
2. Unless the care is maintenance or supportive care, develop an individual treatment plan for each patient.
3. Based on the chief complaint and objective clinical exam findings, establish specific treatment goals for each patient which are *objective, measurable, reasonable, and intended to improve a functional deficit*.
4. Ensure the initial examination includes the use of standardized outcome assessment tools to establish a functional baseline *against which progress towards goals may be objectively measured*.
5. Re-evaluate the patient every 4 weeks or 12 visits (whichever comes first). At each re-exam, use outcome assessment tools and other objective measures to measure progress toward treatment goals, the effectiveness of treatment, and the appropriateness of additional care.
6. Use the comparison of the results of the outcome assessments and other measurable objective findings to determine when MMI has been reached, *then release the patient to maintenance/supportive care*.
7. Ensure all diagnoses, all services provided, the rationale for those services, and all treatment recommendations are properly documented in the healthcare record.
8. With the exception of maintenance/supportive care, ensure that all treatment billed to payors is consistent with the chief complaint, objective clinical findings, diagnoses, payor corporate medical policies, and HNS Policies.

## C. HNS Philosophy of Care

Adopt and comply with HNS’ philosophy of care:

### ***Treat and Release:***

Provide care to correct the presenting condition, bring the patient to MMI, and discharge the patient from active care with appropriate instructions regarding maintenance/supportive care, self-care, and prevention of future occurrences.



## D. HNS/Payor Policies

HNS has developed policies relating to clinical care, and HNS Network Physicians must be familiar with and comply with these policies.

Most contracted health plans have specific corporate medical policies for chiropractic care, and Network Physicians must be familiar with and comply with these policies.

HNS and most contracted payor corporate medical policies are posted on the HNS Website under “HNS/Payor Policies”. (While the *HNS Practice Protection Plan* is posted on the website, it may not include the most current policies.)

## E. Clinical Care Standards

### 1. Assessment

A thorough assessment is essential in order to determine the appropriate pathway of care for each patient.

The assessment should focus, in part, on the presence or absence of red flags.

The history and examination provide the clinical rationale for appropriate diagnosis and subsequent treatment planning. The history and physical examination should determine the appropriate treatment strategy.

The assessment should include, but is not limited to, the following:

- Review of the patient’s chief complaint.
- History (presence of red and/or yellow flags).
- Functional Deficit Measurement.
- Examination.
- Imaging and other diagnostic testing (as applicable).
- Diagnoses and prognosis.
- Obstacles to recovery and strategies to overcome, if applicable.
- Consideration of coordination of care/referrals.

#### **(i) Documentation Requirements:**

The healthcare record must include the physician’s assessment of the patient and the patient’s condition. The record must support that initial and ongoing assessments are consistent with the history, chief complaint, and objective examination findings.

## 2. History

A carefully obtained history inevitably yields critical information in the assessment, and should include:

- Onset and duration of pain.
- Site and radiation.
- Precipitating and relieving factors.
- Severity and functional impact.
- Neurological deficits.
- Symptoms of systemic illness.
- Current and past health conditions, including previous injuries.
- Past medical history, family medical history, and social history.
- Current and relevant past medications (both prescriptive, over-the-counter and natural products).
- Past and present treatment for the presenting condition and results of that treatment.
- Previous relevant imaging studies (or other diagnostic testing).
- All health risk factors.

During the history, obtain the name of the patient's primary care provider and/or medical specialist, and permission to contact in order to facilitate coordination of care.

### (i) **Red Flags**

A focused history taking is the most critical tool for identifying risk factors for serious disease (red flags). "Red flags" are the current clinical features and prior illnesses that warn of a possible specific cause which may lead to serious problems unless it is treated immediately.

At each visit, Network Physicians should evaluate for the presence or absence of red flags. Identification of a red flag warrants close attention, and suggests the need for further investigation and possible specialist referral as part of overall treatment strategy.

While positive red flags are typically indications for imaging, red flags should be evaluated in the context of the clinical presentation as a whole.

### (ii) **Yellow Flags**

While the presence of red flags indicates the potential for serious life or limb threatening pathology, psychosocial risk factors (yellow flags) include the patient's attitudes and beliefs, emotions, behaviors, and family and workplace factors.

As with red flags, Network Physicians should evaluate yellow flags in the context of the clinical presentation as a whole.

**(iii) Documentation Requirements:**

The healthcare record will include past history, family history, and social history (occupation, recreational interests, hobbies, use of drugs, etc.) and the date histories are taken.

The healthcare record will include past and present medical or chiropractic treatment for this condition and results of that treatment.

Current and significant past medication (including Rx, OTC, and natural products) use will be documented.

Allergies, medication allergies, intolerances, adverse reactions, and contraindications to potential treatments must be clearly noted.

The healthcare record must reflect any health risk factors that have been identified.

The healthcare record will contain documentation of routine preventive health measures such as exercise habits, screening for obesity, cholesterol and hypertension, routine mammography, etc.

**3. Functional Deficit Measurement (Baseline Outcome Assessment)**

HNS requires the use of Outcome Assessment tools at the initial visit to establish a functional baseline, and requires these at each re-evaluation to measure treatment effectiveness, progress toward treatment goals, and to assist in determining if and when MMI has been reached, and the appropriateness of additional care.

The importance of a patient's perspective regarding his/her condition relative to function, pain, health status, work disability, and effectiveness of treatment is well-known and should be established prior to the onset of treatment.

As Globe states in *Chiropractic Care of Low Back Pain*<sup>1</sup>:

For a trial of care to be considered beneficial, it must be substantive, meaning that a definite improvement in the

patient's functional capacity has occurred. Examples of acceptable outcome assessment tools include the following:

- a. Pain scales such as the Visual Analog Scale and the numeric rating scale.
- b. Pain diagrams that allow the patient to demonstrate location and character of their symptoms.
- c. Validated ADL measures, such as the Revised Oswestry Back Disability Index, Roland Morris Back Disability Index, and Bournemouth Disability Questionnaire.
- d. Increases in home and leisure activities, in addition to increases in exercise capacity.
- e. Increases in work capacity or decreases in prior work restrictions.
- f. Improvement in validated functional capacity testing, such as lifting capacity, strength, flexibility, and endurance.<sup>1</sup>

**(i) Documentation Requirements:**

The healthcare record must reflect that outcome assessment tools were utilized as part of the initial examination, and all subsequent re-evaluations, as well as evidence the results of outcome assessments at each re-evaluation are compared to previously completed assessments in order to measure treatment effectiveness, progress toward treatment goals, and to assist in determining if and when MMI has been reached.

#### 4. Examination

The examination is intended to identify the etiology of the patient's presenting complaints, and at a minimum, must include an examination of the area(s) noted in the chief complaint. The history should focus on the extent and region of the examination.

Key aspects of the physical examination include:

- Vitals (at a minimum, weight, pulse and blood pressure).
- Observations (e.g., patient's posture, gait, demeanor, pain behavior).
- Palpation, including structural abnormalities, tenderness, muscle spasticity, etc.).
- Appropriate chiropractic tests including range of motion testing (reported in degrees), and spinal palpation findings.
- Relevant orthopedic and neurological tests as necessary to establish the extent and severity of the injury.
- Outcome assessments to establish a functional baseline

- Consideration of imaging studies and other diagnostic tests.

Careful history-taking and physical examination are crucial in attempting to diagnose the underlying cause of the patient's problem, and in determining the most appropriate pathway to treatment.

**(i) Documentation Requirements:**

The healthcare record shall:

1. Include written evidence of the results of the examination (including examination of area involved in the chief complaint).
2. Include evidence vitals were obtained (at a minimum weight, pulse, and blood pressure).
3. Include all clinical examination findings (objective and subjective).
4. Include evidence that outcome assessments were used during the initial exam to determine a functional baseline.
5. Include the specific tests/studies performed, as well as the results of each.
6. As applicable, include specific segments and location of subluxations.
7. Include sufficient documentation to 1) make clear the basis of code selection (time or medical decision-making, and 2) substantiate the specific level of E/M code reported.

**5. Diagnostic Testing**

Imaging and other diagnostic tests are indicated in the presence of severe and/or progressive neurologic deficiencies or if the history and physical examination cause suspicion of serious underlying pathology.

Clinical decision-making regarding the appropriateness of all diagnostic testing (particularly x-rays) should be determined by the physician in light of the clinical data presented by the patient, the diagnostic and treatment options available, and the patient's preferences and values.

For a very thorough review of clinical indications for the appropriate utilization of spinal imaging, refer to Bussieres, et al. *Diagnostic Imaging Practice Guidelines for Musculoskeletal Complaints in Adults*. J Manipulative Physiol Ther. 2008;31(1).

**(i) Imaging**

The following types of imaging modalities are most frequently used in the diagnostic process:

- Plain film or digital radiographs
- CT
- MRI
- Spine Bone Scan
- Ultrasound

CT and MRI testing should be considered only after a careful review of the history and results of the physical examination, and/or in response to treatment.

**(ii) Plain Film/Digital radiographs (Low Back Pain)**

The National Commission for Quality Assurance (NCQA) maintains quality and performance standards for certain conditions, including, but not limited to, the use of imaging studies for patients with a primary diagnosis of uncomplicated low back pain.

The NCQA Standard relating to imaging for LBP states that for patients between the ages of **18-50** with a primary diagnosis of low back pain, ***in the absence of certain red flags***, imaging studies within 28 days of the initial diagnosis of low back pain are not considered clinically appropriate

Many health plans, including BCBS, are expected to ensure compliance to these standards, and expect participating providers to comply with these standards

It is the position of the HNS Professional Affairs Advisory Boards, however, that clinical decision-making regarding the appropriateness of all diagnostic testing (particularly x-rays) should be determined by the chiropractor in light of the clinical data presented by the patient, the diagnostic and treatment options available, and the patient's preferences and values.

### **(iii) Other Diagnostic Tests**

As with imaging studies, other diagnostic tests, including but not limited to electrodiagnostic and laboratory tests, should be considered only after careful review of the history and results of the physical examination, and in response to treatment.

#### *Electrodiagnostics*

Electrodiagnostics are primarily used to confirm whether a person presenting with acute low back pain has lumbar radiculopathy. The procedures include electromyography (EMG), nerve conduction studies (NCS), and evoked potential (EP) studies.

#### *Laboratory tests*

There is evidence that indicates laboratory tests are generally not necessary in the initial chiropractic evaluation.

### **(iv) Diagnostic Studies Taken Elsewhere**

If the patient brings (or provides) past healthcare records, including but not limited to, results of imaging studies, copies of these should be added to the patient's healthcare record.

Further, the healthcare record must include a summary of all relevant information obtained from the review of the records/studies, and this summary must be signed by the DC.

### **(v) Documentation Requirements:**

1. The healthcare record will indicate appropriate imaging and diagnostic studies were performed to determine the extent and severity of the injury or condition and the results of those studies.
2. The healthcare record will clearly indicate the name of the provider that reviewed the studies, the date reviewed, and the interpretation of the study.
3. The healthcare record will indicate that all imaging or other diagnostic studies ordered are consistent with the patient's chief complaint and clinical examination findings.
4. Should the physician obtain the results of imaging studies or other diagnostic tests performed elsewhere, the healthcare record shall include evidence of the

review of those studies/tests and a summary of findings.

## 6. Coordination of Care/Referral

### (i) **Primary Care**

Coordination of care with primary care providers and/or medical specialists should be considered.

### (ii) **Specialty Care**

Specialty referral should be considered for potential surgical candidates, those for whom the diagnosis is uncertain, or those unresponsive to treatment.

### (iii) **Documentation Requirements:**

The healthcare record shall include all information relating to referrals to any other healthcare provider, including but not limited to whom the patient was referred, when referred, and all communications between the Network Physician and the healthcare provider to whom the patient was referred.

The healthcare record must include any recommendations to the patient to see his/her Primary Care Provider, and the basis for the recommendation.

Should the Network Physician receive a referral from another physician, the healthcare record must clearly reflect coordination of care. The healthcare record will reflect the referral, including the name of the referring provider and the date of the referral.

All communications (written, telephone, etc.) to and from other healthcare professionals shall be included in the healthcare record.

### **Consultations:**

#### (iv) **Documentation Requirements:**

The healthcare record will reflect all consultations. (Consultation codes will only be reported on insurance claims when another physician, insurer, employer, or other appropriate source has requested the opinion or advice of the physician.)

If consultation has been requested:



- The healthcare record will include evidence of the request (whether verbal or written), including the name of the provider or organization requesting the advice or opinion and the date it was received.
- The healthcare record will include a copy of the provider's written report to the requesting physician or appropriate organization, including his opinion, advice, and/or any services ordered or performed.

## 7. Education

Patient education and managing the patient's expectations are an important part of the treatment of most chiropractic patients. Successful treatment depends on the patient's understanding of the condition and his/her role in recovery and in avoiding re-injury.

Prior to initiating treatment, it is essential to provide the patient with clear, concise information regarding their condition, the treatment recommended, the anticipated length of treatment, the anticipated outcome, and his/her role in helping to achieve the desired outcome. Additionally, information should be provided on the causes of pain, pain resolution, usual activity/work, prevention strategies, when to contact the chiropractor, and as applicable, when referral may be appropriate.

At a minimum, education should include these points:

- Patients should take responsibility for, and actively participate in, the rehabilitation process.
- As applicable, stress the importance of staying active and continuing daily activities as normally as possible.
- Emphasize the importance of compliance to the treatment plan.
- Review what symptoms to watch for and when to contact the chiropractic physician.

### (i) **Documentation Requirements:**

At a minimum, the healthcare record should clearly reflect all information provided to the patient regarding all of the above.

## 8. Diagnoses

Establish a diagnosis (or diagnoses) based on the history and clinical exam findings.

The diagnosis or diagnostic impression must be reasonable based on the patient's chief complaint(s), results of clinical exam findings, diagnostic tests, and other available information.

With the exception of maintenance/supportive care, all services/DME recommended or provided shall be supported by an appropriate diagnosis in the healthcare record.

**(i) Documentation Requirements:**

The patient's healthcare record must reflect all diagnoses/clinical impressions, which must be supported by documented clinical findings, diagnostic tests, etc.

Any changes in diagnoses must be documented in the healthcare record.

All services/DME documented in the healthcare record shall be supported by an appropriate diagnosis.

**9. Consent**

Prior to initiating treatment for any condition, informed consent must be obtained from the patient.

Physicians must keep in mind that informed consent is a process, and involves making sure the patient understands the proposed treatment, the risks of the treatment, and agrees to accept both. To assure an appropriate level of patient understanding, the process should involve discussion and should always include an opportunity for the patient to ask questions. *A signed written consent is not a valid substitute for, nor does it replace, a discussion between doctor and patient.*

Physicians shall obtain new informed consent when presented with a new condition that was not addressed when the previous informed consent was obtained.

While HNS recommends the use of the *HNS Informed Consent Form*, any similar form is acceptable, *provided the form clearly states the treatment to be provided and addresses the specific risks discussed with the patient.*

All informed consent forms shall be dated and signed by the patient.

**(i) Documentation Requirements:**

The healthcare record shall include written evidence that informed consent was obtained prior to initiating care and shall reflect that new consent was obtained when the patient presents with a new condition not addressed when the previous consent was obtained.

## 10. Treatment

At the onset of treatment, the physician should provide the patient with estimates of the time within which to expect initial improvement and the time within which to expect maximum therapeutic benefit. The physician should adequately explain to the patient the nature of the patient's condition, the goals of treatment, and the treatment strategy.

### ***Treatment Plan***

Generally speaking, the goals of treatment are to relieve pain, improve function, reduce time away from work, and develop strategies to prevent recurrence.

Once a diagnosis has been established based on the history and clinical exam findings, an individualized treatment plan should be established.

*The treatment plan should include specific treatment goals, which are objective, measurable and reasonable, and intended to improve a functional deficit.*

As Globe states in *Chiropractic Care of Low Back Pain*, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion and rehabilitative exercises."<sup>1</sup>

- i. Unless the care is maintenance/supportive care, a treatment plan shall be developed for each episode of care.
  - ii. Each treatment plan should be *individualized* and specific to each patient's presenting complaints.
  - iii. Treatment plans shall be consistent with the chief complaint, objective clinical findings, and diagnoses documented in the healthcare record.
- Treatment plans shall be consistent with HNS' Philosophy of Care:

#### *Treat and Release:*

Provide care to correct the presenting condition, bring the patient to maximum medical improvement, and discharge the patient from active care with appropriate instructions

regarding maintenance/supportive care, self-care, and prevention of future occurrences.

- Each treatment plan shall include all recommended treatment, including but not limited to, manipulations, modalities/therapies, DME, and the rationale for each.
- Each treatment plan shall include recommended activity modifications and home care instructions.
- Each treatment plan shall include anticipated duration of treatment, including frequency of visits.

The *initial* treatment plan should not exceed approximately 4 weeks or 12 office visits, (whichever occurs first), but may be modified should the objective data from the first re-evaluation indicate the appropriateness of additional care.)

- Each treatment plan shall include objective measures to evaluate treatment effectiveness.
- Treatment plans shall include expected outcomes.
- Treatment plans shall reference obstacles to recovery and strategies to overcome them.
- Treatment plans shall be modified in response to changes to the patient's condition.

**(i) Documentation Requirements:**

The healthcare record must include documentation of all of the above.

The record will include any changes to a treatment plan and rationale for those changes.

The healthcare record will include patient's progress as it relates to treatment goals.

**Treatment Frequency and Duration**

During the initial phase of treatment, the decision regarding treatment must be made in light of the clinical data presented by the patient, the diagnostic and treatment options available, and the patient's values and expectations.

During the initial course of treatment, Network Physicians should continue to evaluate for the presence or absence of red flags.

As previously noted, the *initial* treatment plan should not exceed approximately 4 weeks or 12 office visits, (whichever occurs first), but may be modified should the objective data from the first re-evaluation indicate the appropriateness of additional care.)

The frequency and duration of treatment will vary for each patient. Although most patients respond within expected time frames, frequency and duration of treatment may be influenced by factors, including but not limited to, co-morbidities, yellow flags, and patient compliance to the treatment plan (including recommendations regarding activity modification and home care instructions). Depending on these factors, additional time and treatment may be needed.

The patient should be reevaluated every 4 weeks or every 12 visits, (whichever comes first), in order to evaluate the effectiveness of treatment, progress towards treatment goals, determine whether maximum therapeutic benefit has been reached and to determine the appropriateness of additional chiropractic treatment.

*As the patient's condition improves, the frequency of treatment should gradually decline until the patient reaches the point of discharge.* An acute exacerbation may require more frequent care. The treatment time may be extended due to complicating factors.

The following are treatment considerations for the *typical* chiropractic patient.

**(i) Manipulation/Mobilization**

Most literature regarding spinal manipulation is based on high velocity, low-amplitude (HVLA) techniques, and mobilization, such as flexion-distraction. Therefore, in the absence of contraindications, these methods are generally recommended. However, best practices for individualized patient care, based on clinical judgment and patient preference, may require alternative clinical strategies for which the evidence of effectiveness may be less robust.

The decision regarding the use of HVLA or instrument-adjusting should be based on clinical judgment, experience, and patient preference.

## **(ii) Cautions/Contraindications**

In certain cases, the appropriateness of manipulative procedures must be considered.

In some complex cases where biomechanical, neurological, or vascular structure or integrity is compromised, the clinician may need to modify or omit the delivery of manipulative procedures. Chiropractic co-management may still be appropriate using a variety of treatments and therapies commonly used by chiropractors. It is prudent to document the steps taken to minimize the additional risk that these conditions may present.

## **(iii) Activity Modification**

Patients should be evaluated and advised regarding physical activity, and in many cases, should progressively increase their physical activity levels according to a plan agreed upon between the physician and the patient.

## **(iv) Therapeutic Modalities and Therapeutic Procedures**

In conjunction with spinal manipulation, therapeutic modalities/procedures may provide therapeutic benefit and or reduction in pain. These include but are not limited to, ice/heat, electrical stimulation, laser treatment, ultrasound treatment, decompression, acupuncture, and transcutaneous electrical nerve stimulation.

During the initial phase of care, no more than two therapies or modalities per visits are considered usual or customary.

As soon as clinically appropriate, consideration should be given to moving from passive therapies to active therapies to increase function and return the patient to regular activities.

## **(v) Manual Therapy**

Manual Therapy (97140) should be reported on the same day as chiropractic manipulation ONLY if the therapy is provided to an anatomical region different than the regions manipulated. Additionally, when reporting manual therapy on the same day as a manipulation, the diagnoses listed on the claim form must substantiate this, and the diagnosis

pointer on the service line on the claim must first point to the diagnosis specific to the manual therapy.

*If the manual therapy was performed on the same anatomical region as the manipulation, it should not be reported.*

**(vi) Documentation Requirements:**

The healthcare record must clearly and accurately reflect all information regarding all care recommended and/or provided.

For therapies and modalities, documentation must include:

- Type of modality
- Rationale
- Area of application (specific areas/regions involved in the therapy)
- Setting and frequency (as applicable)
- If the service is a time-based code, the actual time the service was performed.

## 11. Reevaluation

If the patient is still under care after 4 weeks (or 12 visits), a focused reevaluation must be performed.

As part of the reevaluation, and throughout the treatment, DCs must remain watchful for the appearance of red flags.

At each re-exam, an evaluation of treatment effectiveness and patient progress towards treatment goals must be completed.

Outcome assessment tools must be utilized (as well as other objective measures) to evaluate the effectiveness of treatment, progress towards treatment goals, determine whether maximum therapeutic benefit has been reached and to determine the appropriateness of additional chiropractic treatment.

Use the comparison of the results of the outcome assessments and other measurable objective findings to determine when MMI has been reached, *then release the patient to maintenance/supportive care.*

Reevaluation should include the following:

- Vitals (at a minimum, weight, pulse, and blood pressure).

- Pain reassessed with a repeat VAS and appropriate disability outcome assessment measures.
- Function and ADLs reassessed with outcome assessments
- Evaluation of patient's progress as it relates to treatment goals.
- As applicable, recommendations regarding modifications to activities/work.

The results of the reevaluation should guide clinical decision-making regarding the next steps in care and should be clearly explained to the patient.

**(i) Documentation Requirements:**

The healthcare record must clearly and accurately reflect all information regarding the reevaluation.

The healthcare record shall:

1. Include all clinical examination findings (objective and subjective).
2. Include evidence vitals were obtained (at a minimum weight, pulse, and blood pressure).
3. Include the specific tests/studies performed as well as the results of each.
4. Include evidence outcome assessments and other objective measures were utilized during the reexam.
5. Include evidence of a comparison of results of outcome assessments (and other measurable objective findings) to previously obtained data and *an evaluation of progress towards treatment goals*, the effectiveness of treatment, and, as applicable, the appropriateness of additional care.
6. Include sufficient documentation to 1) make clear the basis of code selection (time or medical decision-making) and 2) substantiate the specific level of E/M code reported.

## 12. Continuing Course of Treatment

During each office visit, the physician should inquire as to the patient's presenting complaints, perform the treatment called for in the treatment plan, and monitor the patient's clinical picture through the use of objective tests such as range of motion, segmental range



of motion, presence or absence of spasm or swelling, presence or absence of positive orthopedic findings, and pain assessment.

As the patient's condition improves, the frequency of treatment should gradually decline until the patient reaches the point of discharge. An acute exacerbation may require more frequent care. The treatment time may be extended due to complicating factors.

If maximum therapeutic benefit is not reached during the initial course of care, and provided there is clear evidence that substantive, measurable function gain has occurred, a follow up course of treatment may be warranted. During this phase of care, generally speaking, patients should be encouraged to return to usual activity levels.

The decision regarding continued treatment, and the frequency of it, largely depends on the severity and duration of the condition and whether the patient has reached maximum therapeutic benefit.

HNS refers to (and agrees with) the following clinical guideline included in *Chiropractic Care of Low Back Pain*:

When the patient's condition reaches a plateau or no longer shows ongoing improvement, a decision must be made on whether the patient will need to continue treatment. Generally, progressively longer trials of therapeutic withdrawal may be useful in ascertaining whether therapeutic gains can be maintained without treatment.<sup>1</sup>

**(i) Documentation Requirements:**

The healthcare record must clearly and accurately reflect all information regarding the entire course of care. (Please refer to *Standards for Documentation* under Section III.)

### 13. Exacerbation/Flare-ups

Additional chiropractic care may be indicated in cases of exacerbation or flare-up in patients who have previously reached MMI if criteria to support such care (substantive, measurable prior functional gains with recurrence of functional deficits) have been established.

**(i) Documentation Requirements:**

The healthcare record must clearly and accurately reflect all information regarding the exacerbation or flare-up. (Please refer to *Standards for Documentation* under Section III.)

### III. Standards for Documentation

As previously noted, excellent clinical care should be evidenced through excellent clinical documentation in the healthcare record.

As the legal document substantiating healthcare services provided to the patient, the healthcare record serves as a method of communication among healthcare providers caring for a patient and provides supporting documentation for reimbursement sought for services provided to a patient. As such, a healthcare record must be created (and maintained per legal requirements) for each patient who receives care at the provider's practice, whether care was provided by the physician or his/her support staff.

Thorough, precise, and timely documentation of services provided is in the best interests of each healthcare provider, his/her patients, and of the payors responsible for the payment of those services.

The following are basic standards for documentation regarding healthcare records and are consistent with industry standards. *These standards are in addition to documentation standards noted elsewhere in this document.*

1. The healthcare record shall be clearly legible to someone other than the writer.
2. Healthcare records will be maintained in English.
3. Records that are not electronically generated will be typewritten or written in ink.
4. Each patient will have a centralized record containing all healthcare records for that patient.
5. The healthcare record will be clearly labeled with the patient's name or other unique patient identifier.
6. A healthcare record will be created at the time of the patient's first visit.
7. Contents of records will be organized in date-order; entries will be added chronologically.
8. Each page of the healthcare record will include the signature (or electronic equivalent) of the rendering provider, including the professional designation "DC". If entries are made on the same page by more than one provider, the author of each entry must be identified.

9. Entries into the record will be contemporaneous with the encounter.
10. Each entry in the record will be dated with day, month, and year.
11. No entries should be erased, deleted, or “whited-out”. Corrections or changes shall be made by marking a single line through the original entry. Both the entry that is marked through and the corrected entry will be dated and initialed.
12. Primary language and/or linguistic service needs from patients with limited English proficiency, or patients with disabilities requiring special assistance, should be prominently noted in the healthcare record.
13. If abbreviations are utilized, only standard abbreviations common to all healthcare providers should be used.
14. Abbreviations in the healthcare record should be legible. An abbreviation key (or legend) should be maintained in the physician’s office and produced in response to requests for healthcare records from HNS, contracted payors, and/or regulatory bodies.
15. The healthcare record shall include documented evidence that informed consent was obtained prior to treatment.
16. The healthcare record shall include evidence of the anticipated frequency and duration of treatment and shall include complete documentation regarding each visit, including but not limited to the day, month and year the treatment was provided.
17. The healthcare record will include evidence of an appropriate assessment, including but not limited to history, examination, and as applicable, appropriate diagnostic studies.
18. Outcome assessments must be utilized on the initial visit to establish a functional baseline and completed outcome assessments must be included in the healthcare record.
19. Unless the care is maintenance/supportive care, the healthcare record shall include an individualized treatment plan with objective, measurable, and reasonable treatment goals.
20. The healthcare record shall include all diagnoses/diagnostic impressions.
21. The healthcare record shall include evidence of the review of all diagnostic tests.

22. The healthcare record will include **S.O.A.P** notes.
23. The healthcare record must include completed outcome assessments from each re-evaluation, and evidence those were compared to previous outcome assessments in order to determine effectiveness of care and to measure patient progress towards treatment goals.
24. All services provided and all treatment recommendations will be documented in the healthcare record, including but not limited to, examinations, diagnostic studies, manipulations, therapies/modalities, DME, patient education, and home care instructions.
25. Other than maintenance/supportive care, the healthcare record will reflect that all services provided, and all treatment recommendations, are consistent with the patient's chief complaint, clinical examination findings, diagnoses, and treatment plan.
26. Other than maintenance/supportive care, for all care billed to a payor, the healthcare record will clearly support the medical necessity of the care.
27. If manipulations are performed, the record will include documentation to demonstrate subluxations existed, relative to the manipulations, and are evidenced by either radiographs or physical examination. If subluxation is demonstrated by physical examination, the healthcare record will establish that two of the four P.A.R.T. criteria are met (pain, asymmetry, range of motion, tissue changes); one of which must be range of motion or asymmetry.
28. The healthcare record shall include all manipulations performed and shall include the location and specific segments or regions manipulated.
29. The clinical record will include all DME/modalities/therapies performed, and documentation for each shall include:
  - Type of modality
  - Rationale
  - Area of application (specific areas/regions involved in the therapy)
  - Setting and frequency (as applicable)
  - If time-based code, the actual time the service was performed.

30. The clinical record will substantiate that therapies/modalities/DME are consistent with the patient's chief complaint, clinical findings, diagnoses, and treatment plan.
31. The clinical record should indicate a reduction in the number of therapies as the patient's condition improves.
32. If time-based therapies are performed (constant attendance or therapeutic procedures), the record will reflect the actual time the therapy was performed. (Ex: 15 minutes or 1 unit)
33. The healthcare record shall indicate that re-evaluations were performed every 4 weeks or 12 visits (whichever comes first).
34. The healthcare record will include complete Outcome Assessment tools from the initial examination as well as all re-evaluations.
35. The healthcare record will clearly indicate when MMI has been reached (or if not reached, next steps).
36. The healthcare record will indicate when the patient has been moved from active to maintenance or supportive care.
37. The patient's healthcare record should include patient status on discharge, recommendation upon discharge, and prognosis.
38. The healthcare record should include all relevant information regarding patient non-compliance.
39. The healthcare record should reflect any missed or canceled appointments.
40. The healthcare record will include all correspondence and evidence of all communication from other sources regarding the patient, the rationale for any referrals to other providers, and all communications to/from the provider to whom the patient was referred.
41. The healthcare record will clearly indicate any requests for consultations and copies of all written reports back to the healthcare provider who requested the consultation.
42. With the exception of maintenance/supportive care, the healthcare record will objectively substantiate the medical necessity of care provided and billed to HNS' contracted payors.

43. The healthcare record will support the appropriateness of each CPT/HCPCS code reported on insurance claims.

## IV. Confidentiality of Healthcare Records

All providers have legal, professional, and ethical obligations to protect patient confidentiality, and Protected Health Information (PHI), which includes information in the healthcare record. (HNS Compliance Policies for Contracted Health Care Professionals include policies relating to HIPAA/HITECH. Those policies are posted under the “Compliance” section of the HNS Website.)

It is essential that the confidentiality of the information in the healthcare record be safeguarded and shared only as necessary to protect the interests of the patient.

Network Physicians shall:

- Ensure the privacy and security of the patient’s healthcare information in a manner consistent with state and federal laws.
- Develop and implement practices that protect confidentiality of information and data.
- Ensure that healthcare records are stored and archived in a secure environment.
- Ensure that those accessing (or seeking to access) healthcare records have the authority to access it.
- Unless otherwise required by law, ensure that patient-specific health information is only released to:
  - The individual to whom the information relates.
  - HNS or a healthcare plan contracted with HNS to perform healthcare delivery, payment, administration, and/or management functions on their behalf.
  - A third-party only if specific authorization is obtained from the individual to whom the information relates.
- Except as otherwise provided by law, Network Physicians will make member’s patient-specific health information available to the member for inspection or copying. (See “Requests for Records” below.)

## V. Requests for Records

Copies of healthcare records and associated financial records for patients whose insurance plan contracts with HNS may be requested at any time by a patient, HNS, a HNS contracted payor, and/or by regulatory bodies.

(HNS is a Covered Entity as defined by HIPAA, but acts as a *Business Associate* of each Network Physician, and a release from a patient is not required when HNS requests healthcare records.)

*When healthcare records are requested from those with a right to the healthcare record, physicians shall promptly respond to such requests.*

Requests for copies of records will be clearly documented in the healthcare record and will include the date of the request and the name of the person or entity requesting the records, as well as the date the copies were released.

Original records should never be released; only copies of the records should be released.

If the patient's authorization is required to release records, the healthcare record will include a copy of the patient's signed and dated authorization to release, and the name of the person/entity to which the records were released.

If abbreviations are used in the records, copies of records will be accompanied by an abbreviation key (or legend).

### A. Requests from Payors or Authoritative Bodies

Network Physicians must promptly comply with requests from contracted payors and regulatory bodies (such as state licensing boards and Departments of Insurance).

If a due date is provided in the request, records must be received by the stated due date. *If a due date is not provided, records should be submitted within 10 days of receipt of the request.*

### B. Requests from HNS

As a business associate of all Network Physicians, HNS is authorized to have access to, and review, healthcare records of patients whose healthcare plan is contracted with HNS. (A release from a patient is NOT required when HNS requests healthcare records.)

Network Physicians are requested to submit copies of healthcare records if requested by HNS, and physicians must promptly comply with such requests. All requests from HNS for patient healthcare records will

include a due date, and records must be submitted to HNS by the stated date.

### C. Requests from Patients

Network Physicians are required to provide copies of healthcare records if requested by the patient and must promptly comply with such requests. Network Physicians will provide patient with copies of his or her healthcare record *within 10 days of receipt of the request from the patient.*

## VI. Record Retention

Healthcare records must be organized and stored in a manner that allows for immediate access and easy retrieval.

Healthcare records shall be stored in a secure manner that allows access only by authorized personnel.

Complete patient healthcare records (including billing and payment information, such as EOBs) must be maintained for a minimum of 10 years from the last date of service OR, if the patient is a minor, for 10 years after the minor patient reaches age 19. Once the patient reaches 19 and is still under care, the physician should retain the patient healthcare record for 10 years from the last date of service.

## VII. Accuracy of Data on Healthcare Claims

It is worth reminding all Network Physicians that healthcare claims must only be submitted to HNS when the information reported on the claims is supported by documentation in the healthcare record, and that documentation is consistent with these *Best Practices*, HNS' Fraud, Waste and Abuse (FWA) policies, and when such documentation is available for audit and review.

From *HNS Compliance Policies for Contracted Health Care Professionals* (FWA):

“The validity, reliability, accuracy and quality of healthcare data submitted to HNS by contracted healthcare professionals shall be the *sole responsibility* of the healthcare professional who provided the services (and/or under whose supervision the services were provided), and whose name is on the claim as the rendering provider.”



## VIII. Accuracy of Codes

It is also worth reminding all HNS Network Physicians that services reported on healthcare claims must be reported using the CPT or HCPCS which most accurately describes the services provided.

## IX. HNS Performance Expectations

As previously noted, these *Best Practices* represent HNS' performance expectations for Network Physicians; accordingly, Network Physicians are expected to consistently utilize these best practices, relative to care provided to members whose healthcare plans contract with HNS.

HNS monitors for compliance to the standards set forth herein and reserves the right to conduct investigations relating to non-compliance to these standards. Such investigations may include requesting copies of healthcare records, and/or conducting site visits to review records.

Failure to comply with these best practices, correct identified deficiencies in a timely manner, and/or cooperate during any investigation related to the standards herein may result in termination of participation in the network. If standards are not met, HNS may take one or more of the following actions:

1. Require the physician to review all HNS standards, policies, and the policies of HNS contracted payors and submit an attestation indicating his/her agreement to comply.
2. Require the submission of a written corrective action plan.
3. Require the submission of copies of patient healthcare and financial records for review.
4. Require the physician to obtain additional continuing education.
5. Place the physician on probationary status.
6. Terminate the physician's Practitioner's Participation Agreement.
7. Report the issue to the appropriate state and/or federal authorities, including but not limited to, state licensing boards and NPDB.
8. Other such actions as deemed appropriate by the HNS Quality Management & Improvement (QMI) Committee.

## X. Summary

These best practices were created for the HNS physician network (and other key stakeholders) and are intended to improve quality and treatment outcomes, ensure appropriate continuity of care, and promote a more efficient healthcare system.

In a value-based healthcare environment, there is a vast difference between merely treating someone versus delivering best practices. The essential step for improving clinical outcomes is to provide the most effective care for every

patient on every visit. Timely and positive clinical outcomes cost effective management, high patient satisfaction, and thorough and precise documentation are the key metrics to which all physicians should aspire.

## XI. References

1. Globe G, Farabaugh RJ, Hawk C et al. Clinical Practice Guideline: Chiropractic Care for Low Back Pain. *J Manipulative Physiol Ther.* 2016;39(1):6-9.