Treatment Visit Documentation

By
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ABN

- You are required to start using the new ABN on June 21, 2017.
- You also need to download the new ABN instructions as there are some subtle changes to how the ABN is administered.
- Specifically there are changes in how a non-participating provider would use the ABN.
- You can find both the new ABN and the ABN instructions in the "Forms" section of my website at www.chiromedicare.net.

Required Documentation

- Required documentation for Subsequent Visits (otherwise known as Treatment Visits)
  - History
  - Physical Exam
  - Documentation of treatment given on day of visit
- **Subsequent Visit History**
  - Review of chief complaint:
  - Changes since last visit;
  - System review if relevant
- **Subsequent Visit Physical Exam**
  - Exam of area of spine involved in diagnosis;
  - Assessment of change in patient condition since last visit;
  - Evaluation of treatment effectiveness.
- **Subsequent Visit Documentation of Treatment Given on Day of Visit**
  - Where did you adjust?
  - How did you adjust?
  - How did the patient respond to adjustment?
- **Subsequent Visit Notes**
  - The patient is improved HOW?
  - The patient needs care WHY?
  - The patient was adjusted WHERE?

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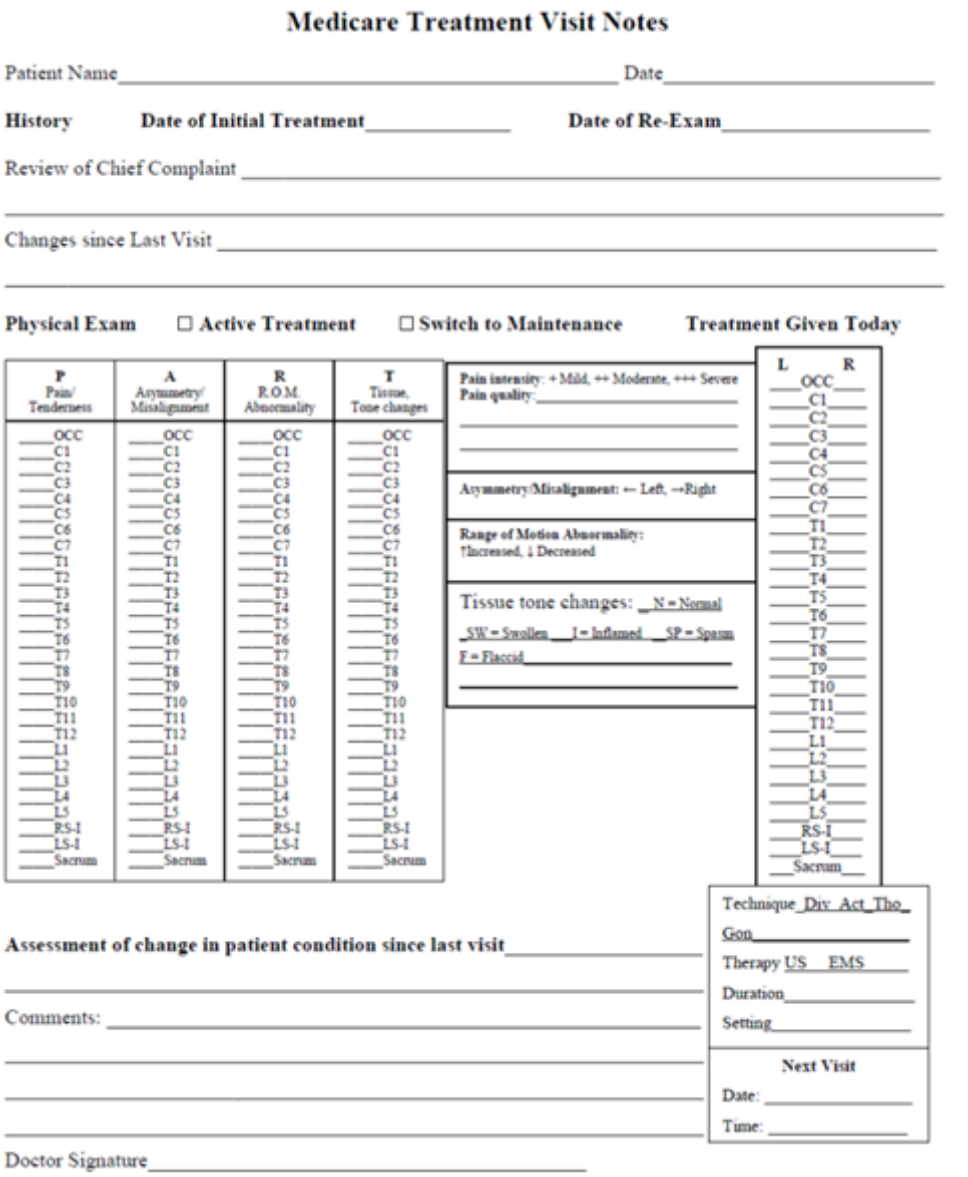
Treatment Visit Notes



Medicare Treatment Visit Notes

Patient Name_____ Date_____

History **Date of Initial Treatment**_____ **Date of Re-Exam**_____

Review of Chief Complaint _____

_____

Changes since Last Visit _____

_____

Physical Exam ☐ **Active Treatment** ☐ **Switch to Maintenance** **Treatment Given Today**

P Pain/ Tenderness	A Asymmetry/ Misalignment	R R.O.M. Abnormality	T Tissue, Tone changes
____OCC	____OCC	____OCC	____OCC
____C1	____C1	____C1	____C1
____C2	____C2	____C2	____C2
____C3	____C3	____C3	____C3
____C4	____C4	____C4	____C4
____C5	____C5	____C5	____C5
____C6	____C6	____C6	____C6
____C7	____C7	____C7	____C7
____T1	____T1	____T1	____T1
____T2	____T2	____T2	____T2
____T3	____T3	____T3	____T3
____T4	____T4	____T4	____T4
____T5	____T5	____T5	____T5
____T6	____T6	____T6	____T6
____T7	____T7	____T7	____T7
____T8	____T8	____T8	____T8
____T9	____T9	____T9	____T9
____T10	____T10	____T10	____T10
____T11	____T11	____T11	____T11
____T12	____T12	____T12	____T12
____L1	____L1	____L1	____L1
____L2	____L2	____L2	____L2
____L3	____L3	____L3	____L3
____L4	____L4	____L4	____L4
____L5	____L5	____L5	____L5
____RS-I	____RS-I	____RS-I	____RS-I
____LS-I	____LS-I	____LS-I	____LS-I
____Sacrum	____Sacrum	____Sacrum	____Sacrum

Pain intensity: + Mild, ++ Moderate, +++ Severe
Pain quality:_____

_____

_____

Asymmetry/Misalignment: ← Left, →Right

Range of Motion Abnormality:
↑Increased, ↓ Decreased

Tissue tone changes: __N = Normal
__SW = Swollen __I = Inflamed __SP = Spasm
F = Flaccid_____

_____

L	R
____OCC____	
____C1____	
____C2____	
____C3____	
____C4____	
____C5____	
____C6____	
____C7____	
____T1____	
____T2____	
____T3____	
____T4____	
____T5____	
____T6____	
____T7____	
____T8____	
____T9____	
____T10____	
____T11____	
____T12____	
____L1____	
____L2____	
____L3____	
____L4____	
____L5____	
____RS-I____	
____LS-I____	
____Sacrum____	

Technique_Div_Act_Tho_
Gon_____
Therapy US EMS
Duration_____
Setting_____

Next Visit
Date: _____
Time: _____

Assessment of change in patient condition since last visit_____

_____

Comments: _____

_____

_____

_____

Doctor Signature_____

- The treatment visit note form is designed to capture this information
- The top of the form captures that patient's name, the date of the treatment, the date of initial treatment, and the scheduled date of the re-exam.
- The History section captures the review of chief complaint and the changes since last visit.
- I would recommend that you include a Verbal Numeric Pain Scale rating with the review of chief complaint.

- If a system review is relevant you will essentially be doing a new exam and will use those forms.
- Indicate if this visit is Active Treatment or if you are switching the patient to maintenance care.
- The Physical Exam section uses P.A.R.T.
- Medicare developed P.A.R.T. to prove the presence of subluxation via physical exam.
- By using P.A.R.T. for the physical exam you prove that a subluxation was present at the level of diagnosis on the date of treatment.
- Each element of P.A.R.T. has a specific shorthand symbol to use.
- You can mark the findings of each segmental level as appropriate.
- The Pain/ Tenderness element is marked using a + symbol.
    - + = mild pain.
    - ++ = moderate pain.
    - +++ = severe pain.
- There is additional space to indicate pain quality.
- The Asymmetry/ Misalignment element is marked using ← and →.
- Each segmental level is marked appropriately.
- The Range-of-Motion Abnormality section is marked using ↑ and ↓.
- Each segmental level is marked appropriately.
- The Pain/ Tenderness element is marked with the appropriate abbreviation.
    - N = Normal
    - SW = Swollen
    - I = Inflamed
    - SP = Spasm
    - F = Flaccid
    - There is space for additional abbreviations.
- Each segmental level is marked appropriately.
- There is a section for the Changes in Patient Condition Since Last Visit.
- This is where you note changes in the findings in P.A.R.T.
- Examples would include:
    - Decreased spasm at L5.
    - Decreased tenderness at L4.
    - Increased mobility at right S-I.
- There is a column to note the treatment given on the day of the visit.
- You simply check either the right or left of the appropriate segmental level.
- Medicare is primarily concerned with which segmental level is adjusted as it relates to the diagnoses.
- You can note the technique used in this section.
- The abbreviations are for Diversified, Gonstead, Activator, and Thompson, the four most popular techniques in the profession.
- There is room to add an abbreviation for a different technique if necessary.

- You can note the appropriate therapy information.
- You can circle EMS for Muscle stimulation or US for ultrasound.
- There is space to note settings and time.
- The Next Visit section is for the date and time of the patient's next appointment.
- The bottom section is for any additional comments and for the doctor's signature.
- Remember that all patient notes must be signed by the person writing them.
- When properly completed by the doctor, this form conveys all pertinent information regarding this visit to the staff.
- The staff can use this to enter the information into the EHR.

Summary

- Just like the Initial visit there are specific documentation requirements for the subsequent (treatment) visits.
- Meeting those requirements is part of the process of proving the medical necessity of the care you render to Medicare beneficiaries.