



Chiropractic Associates of Minnesota, LLC

Documentation Guidelines Overview

INITIAL CASE PRESENTATION

3 KEY COMPONENTS

1. **History**
 - a. Present (chief complaint, history of present illness, concurrent care and review of systems) must include documentation of subjective complaints of all regions or systems being treated.
 - b. Past history
 - c. Family history
 - d. Outcomes assessments / visual analogue scale (VAS)
 - e. History containing functional limitations of daily activities and demands of employment
2. **Examination** (ranging from problem focused to comprehensive) Note: The examination must document an appropriate evaluation of all regions or systems that the provider is treating.
 - a. Vitals (age, height, weight, BP, pulse, and respiration).
 - b. Palpatory Findings
 - c. ROM specific to each region
 - d. Orthopedic testing specific to each region
 - e. Neurologic evaluation specific to each region
 - f. Imaging studies or other diagnostic studies including orders and report
 - g. Examination includes functional assessment
3. **Medical Decision Making** (Must be justified by the clinical findings, working and differential diagnosis must be supported by subjective complaints and objective findings.)
 - a. Red and Yellow Flags are identified
 - b. Diagnosis
 - c. Treatment plan and goals (are all procedures supported by the documentation, diagnosis and medical necessity?)
 - d. Treatment plan includes self care instructions and active care recommendations.
 - e. Discussion of alternative treatment options or referral are documented

DAILY DOCUMENTATION

1. **Subjective** (should encompass a brief description regarding the status of the patient from their perspective)
2. **Objective** (short narrative description which summarizes the doctor's objective findings on that date of service, objective information should support the current diagnosis and status of the patients as stated in the assessment)
3. **Assessment** (short description which summarizes the current diagnosis and status of the patient)
4. **Plan/Procedure**
 - a. Treatment plan, goals and expectations both short and long range.
 - b. Documentation of all care provided on that date of service as well as home care instructions. Active care must be documented including specific exercises and duration of time.

OVERALL REVIEW

(Chronological organization of submitted documentation)

1. Legibility of documentation
2. Encounter specific
3. Organization of documented material
4. Documentation reflects progression of care
5. The daily records are reflective of the specific changes in the patient's presentation and care for that specific date of service.