Excellus BlueCross BlueShield
Chiropractic Medical Record Documentation Standards

The following standards are based, in part, on National Committee for Quality Assurance requirements, established documentation standards and the use of medical necessity in establishing the need for continuing care. Each of the following components should be included in the patient’s chart. The text in italics provides further explanation of what is expected in each component, and what a reviewer might look for.

1. Patient name or patient ID recorded on every page.

   *Every page of the medical record has patient identification in the form of name or ID number. ID number may be a medical record number or insurance number.*

2. Demographics are documented.

   a) Patient’s date of birth *(may be kept in separate file or database).*
   
   b) Patient’s current address *(may be kept in separate file/database).*
   
   c) Patient’s home and work telephone numbers *(A home number should be listed for all patients. There should be a stated method of reaching the patient in case of an emergency.)*
   
   d) Employer and work phone number, if applicable.
   
   e) Marital status.

3. All entries in the medical record are signed or initialed for each visit or episode of care.

4. All entries in the medical record are dated.

5. Visits are documented in the SOAP format.

6. All records are LEGIBLE.

   *Several charts will be reviewed before the reviewer deems them illegible. The medical record review will be scored as “unsatisfactory” if the charts are deemed illegible.*

7. Related Problem List, separate from the progress notes, is present.

   *Problem list should contain all significant illnesses and active medical conditions pertinent to the patient’s health care. For those without active problems, the list should indicate “no problems.”*

8. Allergies/adverse reactions are documented.

   *Medication allergies and adverse reactions must be recorded in a prominent location in the chart. If the patient does not have allergies, NKDA or NKA must be recorded in the chart.*

9. Relevant past history:

   *Includes serious accidents, operations, physical and psychological illnesses pertinent to the patient’s health care.*

   If present, is the history satisfactory?

   *Chart needs to include evidence that there was an inquiry about important medical problems (such as heart disease, diabetes, cancer, etc.).*
10. Current complaint:
   a) History of presenting complaint is recorded.
      Chart needs to list presenting symptom, potential triggering event, and assessment of severity (amount of pain and/or interference with daily activities).
      History, if present, is satisfactory.
      Needs to indicate additional details such as what aggravates/relieves symptoms, relation to activity, treatments that have been attempted before chiropractic visit.
   b) Pain chart is included.
      Pain drawing is part of the record. Must demonstrate that the patient completed it.
   c) Examination is documented.
      1) Vital Signs
         At least one visit for the patient needs to include blood pressure and pulse.
      2) Neurological exam is documented.
         Neurological exam should be documented for at least the initial visit. The record should indicate that at least 80 percent of the pertinent examination has been recorded, and the follow-up neurological examinations are performed as clinically indicated.
      3) Orthopedic examination is documented.
         Orthopedic exam should be documented for at least the initial visit. The record should indicate that at least 80 percent of the pertinent examination has been recorded, and the follow-up orthopedic examinations are performed as clinically indicated.

11. Were imaging studies ordered?
   If studies were/were not ordered, were they appropriate? Were they indicated? Was this based on community standards?
   If studies were done, is there evidence (signed notation on the report or reference to the study in other notes) that indicates that the physician has reviewed the studies?

12. The differential diagnosis and/or clinical impression are consistent with the findings.
   The chart indicates, AT LEAST, the most likely diagnosis/condition reflective of patient’s symptoms and exam findings.

13. Treatment is appropriate.
   Does the treatment documented in the chart seem appropriate given the findings and clinical impression?
   If so, the documentation is adequate and reflective of the clinical impression.
   Is there sufficient detail in the chart to support and understand the treatments provided?
14. Timing (frequency and interval) of treatment is appropriate.

   Number of treatments and intervals between visits is reasonable based upon community norms/standards.

15. Date and time frame for follow-up visits are recorded in the chart.

16. Current medications are listed in a discernible manner.

   May be in the progress notes or on a separate medication record in the chart. Must, at least, indicate the names of the medications. Patient not taking medications should be indicated as “no medications.” If no medications are listed or there is no statement indicating “no medications,” then “no” is recorded. The record should also reflect any nutritional/herbal supplements that the patient is currently taking.

17. There is evidence of continuity of care between chiropractor and primary care provider or other referring specialist.

   Evidence includes written communication and/or documentation of telephone communications.

   Evidence of communication of care is satisfactory.

   Needs to include presenting symptom, likely diagnosis and a treatment plan.