Top 10 Most Common Documentation Errors

With Mario Fucinari DC, APMP, MCS-P, CPCO
Presented by NCMIC

1. Altered Records
    - It is better to defend you, knowing you have *NO* records, than to know you altered records
    - Cloned records are considered fraud

2. Not Documenting Phone Calls
    - If it is not documented, it NEVER happened
    - Document any patient contact
    - Document patient non-compliance

3. Box 14 in Medicare
    - This indicates the start of the "Episode of Care"
    - When did you first begin treating the patient?
    - Has there been a NEW injury or an exacerbation?

4. Illegible Notes

5. No Rationale for Tests or Obtaining Records
    - The examination consists of
        - History
            - Chief Complaint
            - HPI
            - ROS
            - Past
            - Family
            - Social
        - Examination
            - Visual inspection (biomechanical and skin)
            - Orthopedic and neurologic tests
            - Palpation findings
            - Pinprick sensitivity tests
            - Reflexes
            - Range of Motion - Give plane and degrees so it can be referenced later to show progress. The more specific the degrees, the better. Note pain.
            - Muscle strength
            - Outcome Questionnaires
        - Medical Decision Making (MDM)
            - The complexity of establishing a diagnosis and/or selecting a management option.

- It is the E/M component in which providers assess, advise and assist their patients in managing their health.
- The end result is an individual plan of care.
- If you do not have an x-ray machine, get the past imaging records

6. No Documentation of Functional Loss
    - Outcome Assessment Tests (OATS) required in Medicare and Blue Cross
        - Have patient complete on initial exam, on re-exam as clinically indicated and at any exacerbations.
        - These tests *quantify* the amount of patient deconditioning present.
        - A measure of the patient's **functional** impairment of activities of daily living.
    - LBP is the #3 cause for Disability
    - Must show Functional Loss and then Functional Improvement
      97110 is used when the treatment goals are to increase strength, endurance, functional capacity, range of motion, and flexibility.
7. Poor Assessment
    - Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
    - How is the patient improved?
    - Wy do they still need care?
8. Improper Treatment Plan
    Specific Treatment Goals
        - What are you trying to accomplish?
    Objective measures to evaluate treatment effectiveness
        - How do you know when the treatment has been accomplished?
    Recommended Level of Care
        - Duration and frequency of visits to accomplish the above goals
9. Unspecified Diagnosis
    - Do not give put a diagnosis on the claim form that you would not give them face-to face.
    - Code what you know: Codes that describe symptoms and signs are only acceptable if that is the highest level of diagnostic certainty documented by the doctor. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established.
    - Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
10. No Signature on Notes
    - Always read dictated notes for accuracy
    - Use written signature with credentials,
    - Electronic signature
    - Signature Attestation

You cannot add a signature to a record later (this does not include the brief time to transcribe the record), instead use an attestation statement.

No signature on progress/treatment note submitted – attestation sample

"I, (name of doctor)_____, hereby attest that the medical records entry for the date of service _____ , accurately reflects signature/notations that I made in my capacity as a D.C. when I treated/diagnosed _____."

I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Signature: X _____ Date Form Completed X _____

See our website for CHIROPRACTIC based manuals:
OIG Compliance Manual
HIPAA manual
ICD-10 Training
www.Askmario.com

ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office by Dr. Mario Fucinari www.Askmario.com

New information posted regularly at www.facebook.com/askmario "Like" us Put us in your notifications

If you have questions…
www.AskMario.com
E-mail: Doc@AskMario.com

Consultations available to answer all your questions www.askmario.com