Forté EMR

What's in a Soap Note- Part 4 – Procedures

- Written by Alex Niswander

The procedure section of your daily soap is very simple. Don't over think or over document. It only confuses the issue and makes a trained reviewer roll their eyes when they see a paragraph explaining how great Electrical Stimulation is for healing a sprained low back.

There is a lot of confusion on what must be documented per procedure performed. Your procedures should simply be a cut and dry list of what was performed with the patient during their office visit. There is no reason to write a book about the success or validity of a specific procedure. It simply boils down to what you already probably know.

Here are a few things to consider about documenting procedures (in no particular order):

1. Does insurance commonly pay for this type of procedure, and are you using the code that you should be?
2. Does your subjective and objective note prove that the location you are doing the procedure on is valid?
3. Are you doing more procedures than really needed for this visit?

Let me break down each point above.

First, does insurance commonly pay for an item? This one is pretty common sense, but if insurance doesn't pay for a laser treatment for fertility, then why try to get them to pay you?

Second, are you using the proper code? This is important because if you are trying to bill low level laser as a neuromuscular or manual therapy code, you are just asking for trouble. Make sure you are using the right code, and if there is no code, you should be billing as a cash procedure directly to the patient and not submitting this to insurance.

Third, the rest of your note should backup what you are doing. Your Objective section needs to mention pain or discomfort in every area if you are documenting that you did a procedure on it. A most basic medical documentation example is that if you do a strep test, you better have 'my throat hurts' as a subjective complaint. I like to use medical documentation examples as much as I can because in Chiropractic we seem to document completely different, and we shouldn't. Do you think you would see a detailed description of why a strep test was performed in a medical note? Nope, this would be assumed that anyone in medical field or insurance can look up the test if they are questioning it.

Last, are you doing more than you should be doing for the patient? Let's talk about someone going into an Emergency room. The most important thing is to find out what the problem is ASAP. That is why we spend a quick $1,000 and learn we were just dehydrated and we can return home. Stick with this idea for a moment because it applies to your patients as well. When the patient first comes in, that is when it is more 'acceptable' to run the most tests and have the highest patient dollar visit.

It makes "insurance sense" to focus on just one major complaint at a time. This will of course reduce your per visit number of procedures, however, it will be more likely to get paid and will extend your patient life span of visits to your practice.

Below is an example of a simple, yet well documented daily procedures section. Keep in mind the title of your section really doesn't matter. It could be daily treatments, treatments today, treatments, procedures, etc.

Treatments

CMT 1-2 Spinal Regions (98940) was performed on thoracic and lumbar regions.

Neuromuscular Reeducation (97110) for 8 to 15 minutes was performed on the thoracic and lumbar regions.

Remember, keep it simple for procedures!

Forté EMR

800-456-2622

www. emr4dc.com