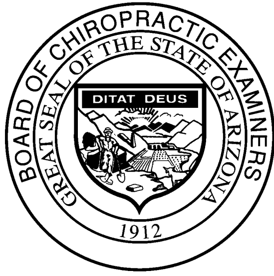

State of Arizona
Board of Chiropractic Examiners

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3/26/2008

State Of Arizona
Chiropractic Profession Stakeholders

Re: Board Staff's Records Review Forms

Dear Stakeholders,

In an effort to continue the Board's communication with the stakeholders of the chiropractic profession in Arizona, Board staff is supplying the attached forms used by Board staff in review of patient records received during the course of normal Board business. The forms do not show all aspects of a record review, but are used to assist staff in conducting thorough and consistent reviews of physician's records.

The production of these forms for the public and the profession is not meant to provide any person with a fail proof mechanism for creating or reviewing any patient records. In addition, failure of a patient record to contain information noted on the attached forms does not necessarily constitute a violation of law. Board staff does not determine violations of law. The express purpose of producing these forms is to increase public knowledge of what the Board's staff basic review of records may involve.

Board staff hopes that these forms may help create a better understanding of the Board's record review process, and help in the creation of legally compliant and efficient patient records within the Arizona chiropractic profession.

If any member of the profession or public has any questions, please contact me at (602) 864-5088 extension 13.

Sincerely,

Charles Brown
Deputy Director

Review Form
Diagnostic Tests

The Board of Chiropractic Examiners has determined that the following criteria must be met regarding any in-office diagnostic testing, including testing performed by "mobile labs":

The physician must clearly document the medical necessity for each and every test. The physician shall determine that the service is medically appropriate, necessary to meet the patient's health needs, consistent with the diagnosis, and consistent with widely accepted clinical standards of care concerning reliability, validity, and timing of the test.

The physician must clearly document that the chosen diagnostic test is the best or most appropriate test available and that it will provide results that will support a diagnosis and/or assist in clinical decision-making regarding treatment and/or referral.

The physician must be sufficiently trained in the utilization of the diagnostic equipment to be able to perform the chosen test and to supervise (as defined in R4-7-101(10)) the performance of the test. The physician shall determine that that the equipment is in good operational order, is reliable, and presents no harm to the patient.

If a technician is utilized, then the physician must supervise the technician as described in R4-7-101(10), verify the technician's training, and retain documentation verifying the training.

The physician shall disclose any pecuniary interest in the testing. In determining whether to order any diagnostic test, the physician's primary consideration shall be whether the test is in the best interest of the patient.

Keep in mind possible violations of **R4-7-902. Unprofessional or Dishonorable Conduct.**
23. Promoting or using diagnostic testing or treatment for research or experimental purposes:
a. Without obtaining informed consent from the patient, in writing, before the diagnostic test or treatment. Informed consent includes disclosure to the patient of the research protocols, contracts the licensee has with researchers, if applicable, and information on the institutional review committee used to establish patient protection.
b. Without conforming to generally accepted research or experimental criteria, including following protocols, maintaining detailed records, periodic analysis of results, and periodic review by a peer review committee; or
c. For the financial benefit of the licensee.

The below check list is to help evaluate a diagnostic test for adherence to the Board's expectations in the above substantive policy statement.

1. Is the physician properly trained to perform and supervise the test? YES NO
2. Does the record show a documented history of complaints related to the objective of the diagnostic test? YES NO
3. Does the timing of the diagnostic test reasonably match the recognized standard for the diagnostic test? YES NO IF no is there a documented reason? YES NO
4. Does the patient record document the physician's medical reasoning for the test there by documenting the tests medical necessity? YES NO
5. Are the testing parameters documented in the patient record? YES NO
6. Are the persons administering the tests and the person reporting on the test results clearly documented in the patient record?
7. Does the patient record document the physician's reasoning for the testing was explained to the patient? YES NO
8. Does the patient record document that the test results were discussed with the patient? YES NO
9. Does the patient record document the reasoning for altering or continuing treatment based on the test results? YES NO

<u>Patient Records Audit Sheet</u>

Adequate patient records- means legible chiropractic records containing, at the minimum, sufficient information to identify the patient and physician, support the diagnosis, identify the specific elements of the chiropractic service performed, indicate special circumstances or instruction provided to the patient, if any, identify a treatment plan, and provide sufficient information for another practitioner to assume continuity of patient care. *They will include, at a **minimum**, the following:*

Item		Yes	No		Notes
1. Health History (From Patient and/or Taken by the Doctor)		☐	☐	(Required)	Notes:__________________
2. Diagnostic Results		☐	☐	(Required)	Notes:__________________
3. Examination Findings		☐	☐	(Required)	Notes:__________________
4. X-rays Taken		☐	☐		Notes:__________________
5. X-ray Report	(If X-Rays Taken)	☐	☐	(Required)	Notes:__________________
6. Treatment Plan (Includes Goals, and Reexamination)		☐	☐	(Required)	Notes:__________________
7. Billing Record (Includes Billed Amounts and Amounts Received)		☐	☐	(Required)	Notes:__________________
8. Daily Notes Taken	(Every Visit)	☐	☐	(Required)	Notes:__________________
A. Patient Name	(Every Visit)	☐	☐	(Required)	Notes:__________________
B. Date of Service	(Every Visit)	☐	☐	(Required)	Notes:__________________
C. Physicians Findings	(Every Visit)	☐	☐	(Required)	Notes:__________________
D. Services Rendered	(Every Visit)	☐	☐	(Required)	Notes:__________________
1. Type of Service		☐	☐	(Required)	__________________
2. Area of Service (Includes associated findings and/or diagnosis)		☐	☐	(Required)	__________________
3. Length of Service		☐	☐	(If Required in CPT Code)	__________________
E. Name or Initials of Treating Doctor	(Every Visit)	☐	☐	(Required)	Notes:__________________

Subjective **O**bjective **A**ssessment **P**lan (Format Not Required)

Subjective- designating a symptom or condition perceived by the patient and **not the examiner**.

Objective- indicating a symptom or condition perceived as a sign of disease by someone **other than the afflicted person.**

Assessment- to evaluate.

Plan-any detailed method worked out beforehand for the accomplishment of an object. A proposed or tentative goal.

Evaluations (E/M Code)/Consultations Comparison Sheet

		Yes	No	
Doctor Billed For:	New Patient Evaluation	☐	☐	
	Dates			
	1.			Code:_______
	2.			Code:_______
	3.			Code:_______
	4.			Code:_______
	5.			Code:_______
	Established Patent Evaluation	☐	☐	
	Dates			
	1.			Code:_______
	2.			Code:_______
	3.			Code:_______
	4.			Code:_______
	5.			Code:_______

Investigator: Records Support

Date of Service	History	Examination	Decision	Code (Suggested)
1.	______	__________	_______	____________
2.	______	__________	_______	____________
3.	______	__________	_______	____________
4.	______	__________	_______	____________
5.	______	__________	_______	____________
6.	______	__________	_______	____________
7.	______	__________	_______	____________

99201- Problem Focused History-chief complaint; brief history of present illness or problem, Problem Focused Examination-limited examination of the affected body area or organ system, Strait Forward Medical Decision Making-minimal number of diagnoses or management options with minimal amount of data to review and minimal risk of complications. 15 Minutes of Face to Face Time.
99202-Expanded Problem Focused History-chief complaint; brief history of present illness and problem pertinent system review, Expanded Problem Focused Examination-a limited examination of the affected body area or organ system and other related systems or areas, Straight Forward Medical Decision making- minimal number of diagnoses or management options with minimal amount of data to review and minimal risk of complications. 20 minutes of Face to Face Time.
99203-Detailed History-Chief complaint; extended history of present illness; review of systems an areas directly related to problem identified in the history, Detailed Examination-extended examination of the affected body area and other systems or areas related, Low Complexity Decision Making-limited diagnosis or management options with a limited amount of data to review and low risk of complications. 30 minutes Face to Face Time.
99204-Comprehensive History-chief complaint and a review of the entire affected system and review of all additional body systems; complete past , family and social history, Comprehensive Examination-general multi-system examination or complete examination of a organ system, Medical Decision making of Moderate Complexity-Multiple diagnosis or management options with moderate amount of data and moderate risk of complications. 45 minutes of Face to Face Time.
99205-Comprehensive History-chief complaint and a review of the entire affected system and review of all additional body systems; complete past , family and social history, Comprehensive Examination-general multi-system examination or complete examination of a organ system, Medical Decision making of High Complexity-extensive diagnoses or management options with extensive amount of data to review and high risk of complications. 60 minutes of Face to Face Time.

Established patient exams only require two of the three components. 99211 is 5 minutes and does not require the doctor. 99212 is 10 minutes and compares to 99201, 99213 is 15 minutes and is compared to 99202 with a decision of low complexity , 99214 is 25 minutes and is compared to 99203 with decision making of moderate complexity, 99215 is 40 minutes and is compared to 99205.

Recognized Areas:
Head, including the face
Neck
Chest, including breasts and axilla
Abdomen
Genitalia ,Groin , buttocks
Back
Each Extremity

Recognized Organ Systems:
Eyes
Ears, Nose, Mouth, and Throat
Cardiovascular
Respiratory
Neurologic
Hematologic/Lymphatic/Immunologic
Gastrointestinal
Genitourinary
Musculoskeletal
Skin
Psychiatric