Chiropractic Documentation:
The S.O.A.P. Format and Additional Information

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The S.O.A.P. Documentation Format

- The acronym S,O.A.P. stands for Subjective, Objective, Assessment, and Plan.
- These elements outline the core of medical documentation regardless of the specialty of the doctor.
- Let's look at each of these elements individually.
- **Subjective**
  - The subjective element of the documentation contains information that the patient provides to you, whether on the history form or verbally during the consultation.
  - If it is information derived from the patient or from a parent, guardian, or other caregiver, it belongs in the subjective element of the documentation.
  - This information is important as it will inform and guide your choice of tests and examinations.
- **Objective**
  - The objective element of the documentation contains information that you observe from the patient.
  - These observations can take place during an examination when you see the patient's reaction to a particular test, while the patient walks into the room as you watch their gait, as you evaluate radiographs of the patient's involved area, and in many other ways.
- **Assessment**
  - Stated simply, the assessment is the doctor's opinion.
  - But it is so much more.
  - The assessment should contain the doctor's thought process, the doctor's conclusions, and the diagnoses.
  - By including all of this information anyone reviewing the documentation can determine why the doctor reached the conclusions that he/she did.
- **Plan**
  - The plan is better described as the plan of action.
  - It includes what will be done to and for the patient and by whom.
  - For the chiropractor this will include where the patient will be adjusted, at what frequency they will be adjusted, the duration of the care, what (if any) therapy will be performed on the patient at what settings and for what duration, any referrals or consultations, or any other actions that need to be taken to aid the patient.
  - You should also list the expected outcomes and how you will determine that these outcomes have been obtained.
  - This is also where you list the segments adjusted, the therapy performed, the scheduled date of return, and the appropriate procedure codes during the treatment visit.

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Additional Information

- There is additional information that you need to collect from the patient.
- For example, it would very quickly become chaotic if you referred to every patient as "Hey You".
- Therefore you need to collect demographic information on each patient.
- You also need to have specific consents signed by the patient depending on the type of patient and your state.
- There is also information that you should obtain from outside sources for specific types of cases.
- We will cover each of these in more detail next.

Patient Demographics

- The NCQA Guidelines state that:
    - "Personal biographical data include the address, employer, home and work telephone numbers and marital status."
- The Evaluation and Management Guidelines and the Medicare Benefits Policy Manual are silent on what information to collect.
- However the Medicare Claims Processing Manual, Chapter 26, Section 10.2 details how to complete the CMS-1500 claim form.
- The CMS -1500 form requires the patient's type of insurance, their health insurance claim number, the patient's first name, last name, and middle initial, the patient's date of birth, the patient's gender, any additional or supplemental insurance that the patient may have, the patient mailing address, the patient's telephone number, the patient's marital status, the patient's employment and/or student status, and the insured's information (if different from the patient).
- Now let's put this together and make a list of what information we need to gather:
    - The patient's name.
    - The patient's mailing address.
    - The patient's telephone numbers.
    - The patient's insurance information.
    - The patient's gender.
    - The patient's marital status.
    - The patient's employment information.
    - The insured's information (if different from the patient).
    - The patient's primary care physician.
    - The patient's emergency contact information.
    - The patient's Social Security Number.
- When a patient first presents at your office you should physically look at and copy the front and back of their driver's license.
- This shows that you made a good faith effort to confirm the patient's identification through the use of a government issued identification.

- If the patient doesn't have a driver's license then a government issued photo identification card will do.
- You should also look at and copy the front and back of any and all insurance cards that the patient has.
- This gives you a record on file of what insurance they have and any insurance contact information that may be on the card.
- I have prepared two Patient Information Forms for examples.
- One is for general use with most patients and one is specifically designed for use with Medicare patients.
- These forms are available in my book *Chiropractic Documentation.*
- The general form contains space for all of the information indicated in this section that you should collect from the patient when they first present at your office.
- There is space for information from two separate insurance carriers should it be needed.
- There are three major differences between the Medicare specific form and the general form.
- First there is only room for information for one additional insurance carrier.
- Since this form is Medicare specific it is assumed that Medicare is the primary third party payer.

Consent to Treat and Other Notices

- Most states require the doctor to review the risks of a procedure with the patient and obtain their written consent before performing the procedure.
- Each state has its' own particular nuance to their consent laws and, as such, a consent form that works in one state may not work in another.
- The best source for a consent to treat form that is appropriate for your state will be your malpractice insurance carrier.

HIPAA

- The Health Insurance Portability and Accountability Act of 1996 requires, among other things, that the doctor give each patient a copy of the office privacy policy on their first visit and that the patient sign an acknowledgment of the receipt of that policy.
- The policy itself will be developed as a part of your office Compliance Program.
- I have made up an acknowledgement form that includes patient contact information and a list of who can and cannot receive patient information.
- This form is available in my book *Chiropractic Documentation.*

Documentation from Outside Sources

- There are a few outside sources of information that you should consult regarding a new patient.
- These sources will vary depending on the type of patient.
- These sources include:
- Documentation from Other Doctors
- Police Reports
- Emergency Room Documentation

- Essential Job Function Requirements

Summary

- We all know the S.O.A.P. format for our documentation that we need to use.
- But there is so much more that needs to be included in our documentation.
- We need to collect patient demographics for business and billing purposes.
- We need consent to treat and HIPAA information for regulatory and malpractice purposes.
- We need information from outside sources in order to be thorough in our examination of our patients.
- Documentation needs to cover everything that you do to and for the patient, everything that you do to comply with state and federal regulations, and everyone that you consult regarding the patient.