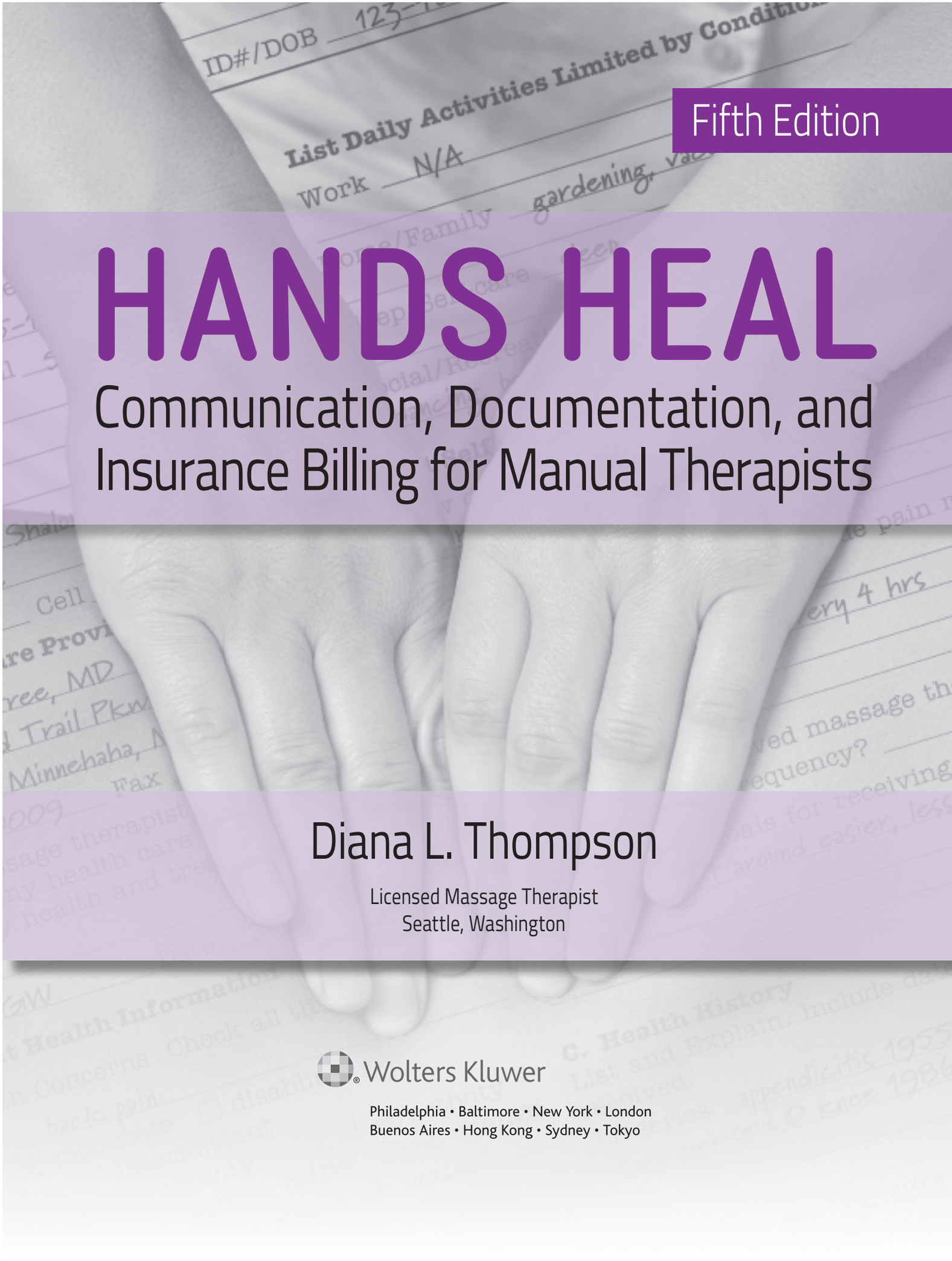
Fifth Edition

HANDS HEAL

Communication, Documentation, and Insurance Billing for Manual Therapists



Fifth Edition

HANDS HEAL

Communication, Documentation, and Insurance Billing for Manual Therapists

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Seattle, Washington

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I dedicate this edition to my mentor and guardian angel,
Lisanne Yuricich, DC. This book would not exist if not for you.
Thank you for helping me realize my worth so that I may be
empowered to help others. I miss you so.

Foreword

The licensed massage therapist has so much to offer the individual consumer and the health care community. More and more massage therapists are realizing the importance of their work and creating greater awareness and momentum about the benefits of massage therapy. Despite the gains that are being made with individual consumers, nonmassage health care practitioners and insurers remain reluctant to embrace massage therapy as an integral part of modern health care. This reluctance stems from a list of issues, including lack of practice guidelines and standards of care, perceptions of professionalism, effective chart note documentation, and responsiveness to the communication needs of other health care professionals.

Seen in this light, Diana Thompson's book is a very timely and much-needed bridge to overcome these real and perceived obstacles surrounding practice guidelines, professionalism, treatment protocol, and documentation. Diana Thompson brings forth unending experiences in understanding patient needs, figuring out what is important to the referring doctor, and satisfying insurance companies in the paperwork process. She brings practical information to life by blending years of experience, stories, and humor that undoubtedly will make this book required reading for all massage students, as well as for those practitioners wanting to work more closely with medical doctors, osteopaths, chiropractors, and physical therapists. It will also help practitioners have an easier time when dealing with insurance companies.

The value of this book is multidimensional for massage therapists and the massage profession. Practitioners will find practical, simple, and easy-to-use information and forms that comprehensively capture relevant information. Paperwork will become more efficient and effective. The profession benefits immensely because the book raises the bar on expectations within and outside the massage profession concerning communication, documentation, and professionalism.

Hands Heal facilitates the mission of each licensed massage therapist and massage therapy association that seeks greater access for the consumer to obtain massage treatment and care and relief for illness, injury, and disease, as well as for those wishing to obtain maximum health. Diana Thompson has made a very valuable contribution. It is now up to each licensed massage therapist, massage therapy organization, and massage school to join her in advancing a most worthy cause.

Richard H. Adler
Attorney-at-Law, Editor

Preface

Background of Hands Heal *and Massage Therapy*

Hands Heal was conceived in the early 1990s. At that time, complementary and alternative medicine was just beginning to catch the attention of mainstream health care systems. Massage therapists, bodyworkers, movement therapists, and energy workers were receiving patient referrals from physicians, many for the first time. Increasingly, massage therapy services were being covered by insurance plans.

Not everyone in allopathic medicine greeted the complementary providers with open arms. Skepticism was widespread. Many questioned the validity of manual therapies. Insurance carriers demanded statistics and scientific studies proving that treatment was curative and not palliative. Few were found. Independent medical examinations were implemented early in personal injury cases, and health insurance utilization review boards audited practitioners, in attempts to deny or to limit the use of manual therapies.

In this atmosphere of litigation and peer reviews, charting focused on proving the legitimacy of the practitioners and their modalities. I wrote the first edition of *Hands Heal* to prepare massage therapists for the charting requirements of those skeptical times. My information was based on years of experience in the early stages of the integration of massage therapy into health care. My teachers were chiropractors, attorneys, and insurance adjusters. I have been videotaped for depositions, given testimony in court, have submitted narratives to lawyers, and have seen my charts reviewed by utilization management panels. On the upside, when my claims were denied, the decisions were reversed after I submitted convincing progress reports. I filed liens in county courthouses and requested letters of guarantee from attorneys, and, as a result, I received payment in full when others were being asked to cut their bills in half. I wanted to share what I had learned.

Much has changed in a short time. Massage and other bodywork therapies are now considered a viable treatment option, are included in many integrative health care practices, and are a covered benefit in an increasing number of insurance plans across the United States. As a result of this widespread integration of massage therapy into private health care benefit packages, charting requirements have also changed. The focus of documentation is shifting from legitimizing the practitioners and validating massage modalities to proving that the treatments improve patient outcomes and cost less than biomedical treatments. The shift demands progress-oriented functional outcomes reporting, a style of charting recently adopted by physical therapists and other health care providers. Progress is apparent when the patient's quality of life improves. Quality of life is measured through functional outcomes—the patient's increased ability to participate in activities of daily life.

Research supports the emphasis on functional outcomes for all health care providers. No longer limited to pain scales, researchers employ quality-of-life measurement tools, disability indices, and bothersomeness scales to demonstrate effectiveness. When we, as manual therapists, persist in trying to demonstrate patient progress solely through a reduction in pain, we are less able to provide our patients with encouraging results or to demonstrate the curative nature of our modalities. We, too, have found that when we show patient progress through improved function we validate the success of massage therapies.

More recently, research is applying mental health indices, such as anxiety, depression, and stress, to measure the effectiveness of massage therapy. It is important to use measures that stay within our scope of practice. Therefore, in this edition, we introduce mood scales. You will find the mood scale in the examples of electronic health records. There, the use of multiple measures, graphed before and after sessions and over time, adds concrete data to help demonstrate the impact of massage therapies on patient health.

This shift in charting is exciting. By adding another way to measure the patient's condition, we ensure a more well-rounded assessment of health and wellness. Stress contributes to illness, complicates healing, and negatively affects patient–caregiver and family relationships. We can present a more complete picture of our patients' struggle and progress by adding this simple scale.

Regarding terminology, it is not my intent to offend anyone with my choice of words. Therefore, I wish to explain my terminology. My goal is to be inclusive and representative of the diversity within complementary health care professions. However, the words I choose may not be the terms you use in your practice. Please insert words appropriate to your discipline and beliefs where you find it necessary to do so. For example, I refer to *massage* instead of listing *massage, bodywork, movement, and energy*, and *therapists* as *practitioners* or *health care providers*; you may call yourselves *educators* or *therapists*. I use the term *patients*; you may prefer *clients* or *students*. I say *referring health care provider* instead of *primary care provider*, so as not to imply that physicians are the only acceptable primary care. I attempt to be inclusive of all genders, cultures, races, and body types. Know that I strive to be increasingly sensitive to those I share the world with.

Changes in the Fifth Edition

In previous editions, the wording of the original subtitle changed from "Massage Therapists" to "Manual Therapists." In this edition the title remains the same, but the text reverts back to massage therapists. My intention to be inclusive of all massage, bodywork, energy work, and movement disciplines remains. However, as our inclusion in integrative health care advances and our access to the public via insurance coverage expands, the terminology consistently and universally uses the phrase *massage therapy*. For example, government-funded studies on massage therapy use licensed massage therapists to perform the protocols, and the National Center for Complementary and Integrative Health names massage therapy as the number two most used one-on-one practitioner-based health approach. Therefore, it seems important to use the term most commonly recognized in health care, regulatory agencies, and insurance and with the public. Internally, we know that massage therapists are trained in and combine techniques from many disciplines. As licensed health care professionals, massage therapists have access that unlicensed therapists do not. There is no hierarchy in my mind, only opportunity to reach people in need who might not otherwise have access to massage and bodywork.

The fifth edition includes the shift to ICD-10 codes, the adoption of evaluation CPT codes newly accessible to massage therapists, and an introduction to electronic health records. Look for two new case studies showing examples of how advancements in electronic charting can simplify charting, enhance the ability to document assessments, and demonstrate progress with acutal data comparisons.

Pedagogical Features and Resources

An array of stories, exercises, and quotations are included to enhance learning:

From the literature—Research and quotes provide information from scientific studies and thought-provoking mentors.

Refine your skills—Individual and group exercises provide experiential learning.

Tales from experience—Anecdotes provide learning through the experience of others.

Throughout the book, important words appear in bold type and important phrases are italicized. The boldface terms make up the glossary. The italicized phrases represent what can be written on the SOAP charts.

Hands Heal includes additional resources for both instructors and students that are available on the book's companion website at http://thePoint.lww.com/Thompson4e.

INSTRUCTOR RESOURCES

Approved adopting instructors will be given access to the following additional resources:

- Instructor Manual—The Instructor Manual is organized into lessons that correspond with the chapters in the textbook. The lessons explore four categories of information: communication, documentation, insurance billing, and ethics.
- PowerPoint slides—The PowerPoint slides are designed to assist instructors in presenting lecture material.
- Brownstone Test Generator—The Brownstone Test Generator contains a full bank of questions that instructors can use to create examinations. The program allows instructors to add, delete, and otherwise customize the test questions to construct unique examinations. The test bank includes questions that require the student to demonstrate knowledge and comprehension as well as apply, analyze, synthesize, and evaluate information.
- Hands Heal Forms—An array of blank forms that can be photocopied and distributed to students for use in class exercises.

STUDENT RESOURCES

- Quiz Bank—The Quiz Bank provides questions that readers can use to review material from each chapter and self-check their progress and comprehension.
- Quick Reference Abbreviation List—This convenient reference will assist readers with learning and using abbreviations common in documentation.
- Forms—All of the blank forms that appear in the book are included on the website. These can be printed and used for class activities or in professional practice.

I hope that you will find *Hands Heal: Communication, Documentation, and Insurance Billing for Manual Therapists* to be current, comprehensive, and critical to the integration of manual therapy into mainstream health care systems. It is my belief and intention that integration will positively influence the current health care environment.

Acknowledgments

To all of you who generously shared your stories, appreciation, and feedback at conventions and workshops, thank you for providing additional material for each new edition. Thank you Kerry Ann Plunkett; Eileen Stretch, ND; and Alternáre Health Services for the opportunity to embrace the needs of managed care documentation. You planted the seed for the second edition. Diane Hettrick and Bob May, ND, from Alternáre and Christine Carpenter from Regence helped shape the third edition. My time with Dan Cherkin and Karen Sherman at the Group Health Research Center and the staff and board members of the Massage Therapy Foundation influenced the fourth edition. The push from paper charts to electronic health records gave rise to the fifth edition. I thank Karen Ramsey for making my dream to bring massage into the technological world come true. All of this comes from a deep-seated desire to ensure massage therapy is included in integrative health care.

A special thanks to Lori Bielinski and Deborah Senn, the Washington State Insurance Commissioner, for your dedication to complementary medicine and for setting national precedence in complementary and alternative health care integration; and to attorneys Richard Adler and John Conniff for their commitment and service to massage therapists. Without their work, there would be little need for this book.

I offer my warmest respect and heartfelt thanks to the people who made this book possible: my guardian angels, Richard Adler and Lisanne Yuricich, who taught me what I know and gave me the opportunity to share it; the staff at Wolters Kluwer who raised the ante on professionalism and quality; and my reviewers whose brilliant insights shaped the final product. Huge thanks to Janice and Ananda at Ask Us! for reviewing the billing chapter and to all the people who helped out in various ways over the life of this book and its many editions.

In addition, I wish to acknowledge the Body of Knowledge Task Force for creating an exceptional document that will help inform the massage therapy profession (mtbok.org); I am grateful to have it influence my book. Finally, I am especially beholden to Jackie Phillips for removing fear from my vocabulary. Without your support emotionally and financially, this would not have been possible. You espejo my soul.

Reviewers

The publisher and author gratefully acknowledge the many professionals who shared their expertise and assisted in developing this textbook, appropriately targeting our marketing efforts, creating useful ancillary products, and setting the stage for subsequent editions. These individuals include:

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Contents

SECTION I

Communication

CHAPTER 1

Communication and the Therapeutic Relationship

After mastering the concepts in this chapter, students will be able to:

- Apply interpersonal skills in a patient interview sufficient to establish a therapeutic relationship
- Recognize the difference between creating professional boundaries and personal oversharing
- Extrapolate patient information into measurable subjective data
- Integrate patient feedback into treatment planning
- Develop patient-centered self-care strategies

Case Studies

Hands Heal presents five case studies throughout the fifth edition to support and illustrate the content of the book. Three of these have been used in previous editions: Darnel Washington—motor vehicle collision (MVC), Zamora Hostetter—workers' compensation (L&I), and Lin Pak—wellness. This edition of *Hands Heal* introduces electronic charting and uses new case studies to illustrate electronic health record keeping: Heather Pratt—private health (PH) and Sinan Nagi—wellness.

Each case study unfolds throughout the following chapters, and the stories give life to the information presented.

The stories begin with Sinan Nagi, a healthy, athletic, 27-year-old male computer technology specialist. He is self-referred for structural integration, motivated to get a series of sessions after talking with one of his functional movement classmates. He sits at the computer 8–12 hours a day, 5–6 days a week, bikes to work, practices advanced yoga several days a week, and is even trying out functional movement classes in the park. Working at a desk gives him a stiff and sore neck and shoulders, and his mid-back gets painful spasms. When working on deadlines, he often gets headaches and eyestrain. He is equally as intense in his workouts. They are strenuous: he often does yoga on a paddleboard, has had some hard falls on the ground trying to jump between tree limbs, do back flips, and navigate obstacles. His bodyworker, Louise, has helped him identify the following goals for care: to stay limber, improve his balance, and prevent headaches.

Louise has an interesting challenge in working with Sinan. His religious beliefs do not permit him to be unclothed and touched by a woman outside of his family, except by a medical provider. He is tentative about working with a woman, but his friend highly recommends her. He acknowledges her health care status as a licensed massage therapist and certified rolfer and lets her know of his concerns due to his religious practices.

Louise asks questions to ensure Sinan is as comfortable as possible in her care. She learns to be sensitive to his preferences—no touching outside the hands-on part of the therapy session, such as casual gestures common during greetings or when saying goodbye—and takes care to respect them. There is nothing that could interfere with her ability to practice her healing art, so Louise is confident that she can, with practice, be sensitive to his requests. Her focus is to create a safe and trusting environment for Sinan and not be distracted by beliefs that are previously unknown to her.

Through her practice of kindness and her dedication to be present to his cultural and religious needs and attend to his goals for health, they created a strong therapeutic relationship that is productive and lasting.

Introduction

A sound therapeutic relationship is fundamental to a successful health outcome. The therapist is responsible for building and maintaining the therapeutic relationship, a relationship based on safety and trust.[1] In addition to using nurturing touch, the following skills are critical: clear communication, active listening, empathy, and a therapeutic environment.[2]

The Triple Aim approach, established in 2011 by the Institute for Healthcare Improvement and implemented by the Affordable Care Act, requires that health care institutions improve health care delivery by pursuing the following three goals: improve the patient experience of care, improve the health of the population, and reduce the per capita cost of health care.[3] As a result, biomedical and complementary health care providers are working together, learning from each other, and advancing health and wellness with the patient as an integral part of the team. Manual therapists have long relied on the therapeutic relationship to enhance health outcomes and have much to contribute to the integrative health care team. Patient evaluations combined with research data clearly demonstrate the importance of feeling heard, being touched, and given hope in establishing a safe, trusting, and therapeutic bond with their care providers.[4,5] In fact, current research confirms that each person in the therapeutic relationship affects the other's nervous and cardiovascular systems equally, requiring the therapist to be present with each patient.[1,6-8]

Develop this essential building block of the therapeutic relationship—presence—by understanding and practicing altruistic kindness:

- Nurturing touch stimulates the release of hormones and deepens the empathetic response in both the therapist and the patient.
- People who are suffering need compassion.
- A warm and generous affect seems to bring reassurance and joy to others.
- All human beings are of equal worth.[9-11]

The therapeutic relationship not only builds trust, enabling a patient to open up and share important information, but can also motivate the patient to partner with the practitioner, embrace the treatment, and use the chosen therapy with greater success. A successful therapeutic relationship enhances treatment outcomes and sustains our practices, resulting in quality referrals and repeat clientele.

This chapter breaks down the important components of a therapeutic relationship. Practice the guidelines presented to build and maintain therapeutic relationships, develop clear boundaries, and promote success outcomes.

REFINE YOUR SKILLS

Morning Pages

The best way I have found to get to know myself is to write three pages of whatever comes to mind, every morning, no excuses. This writing is called morning pages, a term I much prefer to "journaling," which feels so formidable and permanent. I learned of morning pages in Julia Cameron's *The Artist's Way*. I scribble thoughts, feelings, opinions, anger, grief, desire, gossip, reactions to television shows, and movie critiques onto those pages, thus sparing my friends, loved ones, and patients. Writing morning pages has helped me sort out emotions and situations and has allowed me to express myself in ways I can be proud of. I have fewer regrets since practicing my daily writing routine. That alone is worth every minute of "I don't know what to write this morning." Try it. You will be amazed at what you discover about yourself.

Reprinted by permission from Cameron J. *The Artist's Way: A Spiritual Path to Higher Creativity*. New York: Tarcher/Putnam; 1992.

Interviewing Skills

Interviewing is an information-gathering process. Patients possess all the information you need, and you must simply create a trusting relationship in which information flows freely. Ask questions that lead to pertinent information and listen carefully to the replies. Every bit of information expressed by patients—verbal and nonverbal, symptoms and perceptions—leads to a deeper understanding of them and their health condition, as well as to potential solutions.

The primary goals of interviewing are as follows:

1. Develop a relationship.
2. Gather information.
3. Identify goals for health.
4. Choose and implement a treatment plan.
5. Evaluate progress, integrate feedback, and modify the plan.

CREATE A RELATIONSHIP

Developing a deep and meaningful relationship that is productive for both the patient and practitioner is the primary goal of the interview process. This goal requires the practitioner to be mindful of the relationship from beginning to end. Creating and preserving a meaningful relationship calls for our constant attention, understanding, compassion, and faith in the patient's personal strength and abilities. To foster such a relationship, practice interpersonal skills, such as the following:

- Presence
  - self-awareness
  - self-acceptance
  - self-regulation
- Communication
  - active listening: silence, reflecting, open-ended questions
  - confidentiality: patient disclosure
  - body language
  - empathy: compassion, nonjudgment, acceptance
- Hope
  - positive expectations
  - visualizations
  - humor

REFINE YOUR SKILLS

Practice Acceptance

Exercise your ability to recognize a variety of human behaviors or characteristics in yourself.

Pick a day, preferably one with a full patient load. You may have one or two patients who push your buttons. If so, pick a day when they have appointments scheduled. If you are in school, use conversations with your classmates for this exercise. The task is to observe the conversations with your patients and notice when your "judgment flag" waves, such as when the patient does or says something about which you form a negative opinion. Throughout the day, take time to consider these observations. It is possible to do this exercise and still be present for your patients. Make a mental note of the experience, or jot down a reminder word on a sticky note.

Later that day, take a moment to review the situations that raised the judgment flag. Pull out all the sticky notes and lay them out before you. Give yourself permission to be honest and compassionate with yourself. Hold up the proverbial mirror and consider whether you have any of the traits you found fault with in your patients. Remember, a mirror should reflect a clear image, not a sermon.

Repeat this exercise on another day, replacing the judgment flag with the times when you felt admiration for the person before you. Again, make mental or physical notes reminding yourself of the situations, and review them later in the day. Consider how you might find yourself in their stories.

Practice several times to strengthen your ability to accept all aspects of yourself. You will then experience deeper compassion for others as well.

A commitment to be present and available for your patients is the first step in manifesting trust and respect, which are the cornerstones of any productive relationship. Presence is about being awake and aware and receptive.[12] Try the following:

- Limit the distractions in your treatment room; bring your mind back to the present when you find your thoughts drifting.
- Practice self-awareness by learning to discern yourself from your patients. Often, the lines blur between our patients' thoughts and feelings and our own. Take 5 minutes between patient sessions to breathe, be silent, separate from your last patient, and collect your energy.
- Recognize all aspects of your character and trust that you are enough. Accepting the good and the bad in ourselves makes us better able to accept the positive and negative aspects of our patients.
- Avoid talking about yourself. Recognize the impact self-disclosure has on the therapeutic relationship. It takes a practitioner with a developed sense of self-awareness and self-acceptance to know how to express the true self without revealing personal information.

REFINE YOUR SKILLS

Gain Perspective

Refer to Refine Your Skills: Practice Acceptance. After raising the proverbial mirror and considering the possibility that you may possess some of the same qualities as your patient, add the following piece to the exercise:

Evaluate each situation separately. Put yourself in the shoes of each patient. View the situation from the patient's perspective, with his or her history and values, and see whether you can understand some of the motivations behind his or her actions.

Reflect the words, paraphrasing or summarizing to show you understand, and nonverbally demonstrate a sense of caring and respect. Develop good listening skills by paying attention to not only what the patient says but also how he or she says it. Body language is the primary means of emotional expression.

Use silence to invite patients to continue expressing their feelings; resist the urge to complete sentences or fill pauses with more questions. When asking questions, phrase them as open-ended inquiries to deepen the search. Practice tolerance and compassion when delving into their physical and emotional well-being.

Demonstrate confidentiality by storing the previous patients' files before the next patient enters the room. Do not share patient information with other patients; they will no longer trust that you are keeping their information confidential.

Hope is a product of knowing what is possible and visualizing a positive outcome. Whenever you can, maintain perspective, provide encouragement, boost patients' self-esteem, educate and provide options, and demonstrate that behavior (self-care) can lead to positive outcomes. Be flexible, consistent, positive, and responsive to your patient's needs.

Countless opportunities exist for us to build productive relationships with our patients. The interview process is ongoing. It often begins before we meet the patient (through our Web sites and phone conversations), and it extends beyond the time spent together. For example, the greeting on your phone can encourage or discourage the

next step in initiating a relationship. Asking patients for permission to touch them and informing them of our intentions before massaging the chest may eliminate fear and open potential for change, rather than resistance. Patients have described how, during times of pain or trauma, they heard their therapist's voice in their heads, instructing them to breathe, look, and listen for clues telling them how to take care of themselves. Relationships are developed before, during, and after every session, whether we are communicating actively or processing information indirectly. Make the most of these opportunities.

GATHER INFORMATION

Two primary obstacles to gathering information exist: thinking you already know the answer and being afraid to ask the question.[13] Proctoring countless practical examinations has shown me that it is human nature (or the product of watching television game shows) to leap to conclusions. We are so eager to solve the problem and to be the first to get the right answer that we don't take the time to thoroughly explore the possibilities or look beyond the obvious. We fall into what is most familiar to us. An examiner for a doctoral program in neurology explained that more than half the candidates failed the oral examinations, largely, he believed, because they didn't listen to everything the patient said and therefore didn't obtain adequate information. They were too apt to focus on a key phrase or word that pointed to a familiar dysfunction. Instead, they should pursue lines of questioning suggested by the patient's comments and gather additional information on which to base their conclusions.

TALES FROM EXPERIENCE

Explore Possibilities

I received a phone call from a chiropractor who was hosting a student apprenticeship program at her office. I was the faculty liaison. She wanted to report on a situation she had with a student. They had already discussed it and worked out a solution, but she thought I should hear the story: The student practitioner was treating all the patients as though they had rotator cuff injuries. Some patients did indeed have rotator cuff injuries, but others had thoracic outlet syndrome, carpal tunnel syndrome, or whiplash injuries. The student had recently studied rotator cuff injuries in a pathology and clinical treatment class. As a result, she was listening for familiar information and didn't bother to register other important information. Instead of exploring all possibilities, she jumped to the explanation that she had the most immediate information about: If the patient had shoulder pain, it must be caused by a rotator cuff injury.

Sometimes the process of asking questions and gathering information can be far more important than identifying a cause or pinpointing a dysfunction because it can lead patients to a better understanding of themselves, their relationship with their bodies, and their role in their own health.[14] Be more curious than being afraid. If the question arises in your mind, and a part of you believes the answer could contribute to the patient's health, trust your instinct and ask. A pointed question, such as, "Is there anything I should know about you that would help us reach your goals for health today?" could heighten the

experience of your massage by inviting a deeper level of participation, which may ultimately lead to a session that satisfies specific health needs. At the end of the interview, even if you think the questioning is over, ask one more time, "Is there anything else?"

TALES FROM EXPERIENCE

Be Curious

Do not let fear limit your ability to serve. I remember the first time a patient cried during a session. I handed her a tissue and considered stopping the work I was doing on her legs because it seemed too emotionally difficult for her. I was afraid to break the silence and ask her about it. Eventually, I summoned the courage to say, "I see that you are crying. Shall I stop what I am doing, or would you like me to continue?" She said, "Oh no, please continue. I am crying because I have never been touched in such a respectful and caring manner before." I almost missed out on the most moving comment anyone has ever made about my work.

Some patients have difficulty talking about their concerns or asking for what they want. Take your cues from the intake forms. Patients may find discussing their problems uncomfortable, but have no trouble putting the information on paper. The difficulty may lie in your choice of language or your focus on a particular condition. To let the patient lead you, ask, "What should I know today so we can meet your goals for health?" Complement patients on what they have done for their own health—even making the commitment to self-care. Complements may help them open up.

Acquiring information from patients is an art. You will need to cultivate a flexible style to accommodate patients' differences in background, in knowledge about manual therapy, and in other health matters. It is important to use language that your patient understands and to use consistent terminology. As you ask your questions, define the specialized terms you use. Avoid either speaking down to patients or speaking over their heads.

The Preinterview

Patients initiate the relationship by gathering information about you and determining whether you are the right manual therapist for them. Make sure your external image—ads, Web site, office space, and the like—attracts the type of patient you are seeking. Identify your target clientele and speak directly to them in your marketing efforts and in the way you present yourself.

Once the patient takes the next step and contacts you directly, gather enough information before scheduling the appointment to determine whether you want to pursue the relationship. Find out why the patient is seeking care and get a few details about his or her health history so that you can decide whether you can and want to be of service or whether a referral is in order. Ascertain in advance whether you will need a doctor's prescription or consultation before treating the patient so that the first session will not be a waste of time for either one of you.

In advance of the first appointment, share any information you feel is important for preparing patients emotionally and physically for the session. Explain what they can expect during the session, what the fees are, and what to wear, for example. Invite prospective patients to ask questions about your experience, modalities, education, affiliations,

and references to assure them that they have made the right decision and to put them at ease. Be prepared to mail information to them before the first session, such as your credentials, office policies, intake forms, directions, and so on. Avoid confusion and limit the potential for unmet expectations.

The Interview

Gather information that helps the patient relax, enhances the relationship, and opens the dialogue. Begin by asking how the patient prefers to be addressed—Ms. Freeman? Karen?—and tell her how you prefer to be called. Chat a little bit to make her comfortable and to get to know her a little bit. For example, you might begin with "Did you have any trouble finding parking?" Place the focus on getting to know the patient.

Review how you work and what the patient can expect during the session. For example, "To begin with, I need to understand as much about your goals for health and your expectations of me as possible. In addition, it is helpful to explore how your past may be influencing today's concerns, so I may be asking you a lot of questions. All this can take a while, but I promise there is a purpose to my questions. In the future, a couple of minutes may be all that's needed to get me up to speed before we begin the therapy." Even if you explained things over the phone, information can be received differently when people are face-to-face. Watch patients' reactions to your information and be responsive to their needs.

Initial interviews can be extensive and time-consuming. It is advisable to schedule time for the interview in addition to the treatment session. **Insurance companies** may or may not pay for extended initial visits, depending on the **insurance plan** and the type of provider. You should know this in advance of scheduling the appointment. You may have to shorten the hands-on part of the initial session to allow for the extensive interview and to stay within the reimbursable time frame. The information obtained in the interview is critical to conducting safe and effective treatment, and it increases efficiency in the long run. It is best to do a complete interview in the first session or two, rather than having information trickle in over time.

Patients may have health conditions that make it difficult to sit for extended periods. Others may get antsy. Be attentive and responsive to their spoken and unspoken needs. Be flexible and gather information with your patient in sitting, standing, or lying positions. Intersperse movement assessment tests with the question-and-answer format. Patients may want to begin the hands-on part of the session immediately. Make sure you have obtained adequate information before you begin treatment. Try juggling verbal questions with hands-on information gathering or relaxation techniques to keep the patient comfortable. Avoid beginning therapy before you have enough information to provide safe treatment.

Review the intake form, find out what the patient's goals and expectations are for the visit, and reflect the patient's general goals for health and priorities for treatment. Ask, "How can I be of service?" or "What do you hope to get out of the massage today?" Hearing the patient speak adds to the written information on the form. It also apprises you of any inaccurate presumptions or unreasonable expectations and gives you an opportunity to change these instead of disappointing the patient. Setting reasonable goals is essential to a productive relationship, a subject that will be discussed at length in this book. Begin the discussion by listening and comprehending the patient's goals for health and for sessions with you. Later, move to shaping and developing the patient's goals with the purpose of tracking outcomes and promoting patient participation.

REFINE YOUR SKILLS

Share Information During a Relaxing Foot Bath!

Initial interviews may extend beyond a half-hour for adequate information gathering. A foot bath is a creative way to keep your patients relaxed and the information flowing. If they think they are missing out on precious treatment time answering questions, they might tighten up the lips. A foot bath is a way to ensure that the patient is comfortable and feels that therapy has already begun.

To provide a foot bath in the initial interview, prepare two plastic dish tubs—one with hot water and one with cold. Before inviting the patient to select a tub, find out whether any health conditions would preclude benefit from either water temperature. If no contraindications are present, invite the patient to choose one, alternate between them, or scoop water from one to the other to obtain the preferred temperature. Tailor the foot bath by providing marbles to roll around underfoot or by adding essential oils. Have towels available within reach so that the patient can remove his or her feet from the bath at any time.

Explore the treatments the patient has tried and the techniques and modalities he or she is considering. Ask, "What worked or didn't work?" or "Do you have a sense of why the previous treatments did not work?" These questions will make your sessions more efficient because you can use treatments the patient likes and believes are effective and try new modalities rather than spinning your wheels with treatments that have already been proven ineffective.

Use the intake forms to begin a direct line of questioning regarding history and current conditions. Take note of your patient's priorities and focus on them. You may be interested in his or her respiratory history when he or she is intent on getting attention for a recent knee injury. Make the patient feel that his or her needs are being met before focusing on less urgent details.

TALES FROM EXPERIENCE

Memories Affect Healing

Explore relationships between current symptoms and previous history. Stimulate the patient's memory to connect previous events such as traumas, illnesses, repetitive movements, and the like that may have initiated the current condition. Little things may trigger important memories. For example, as a patient was watching a large family board an airplane, she noticed and identified with the eldest child's difficulty carrying a younger sibling. There were too many kids for the parents to take care of, so the older kids were helping with some of the younger ones. My patient, too, was the eldest in a large family. Her mother had died when she was young, and she shouldered a great deal of responsibility in caring for her younger siblings. That recent memory, combined with the interview question, "What kinds of things did you do as a child that might have been stressful to your neck?" pulled it all together for her. She not only had a great deal of physical stress with her younger brothers and sisters clasping their hands around her neck to help her lift them, but also carried the weight of the responsibility of trying to replace her mother. By recognizing the origin of the physical stress and acknowledging an emotional component, she reduced the occurrence of her neck spasms dramatically.

Explore the details of patients' health concerns. Prompt patients with consistent adjectives such as *mild, moderate*, and *severe* as you gather information. Using consistent terminology to describe, for example, the intensity of pain, will show progress more clearly over time. Comparing *moderate pain* with *mild pain* is easier than distinguishing between "hurts pretty bad" and "is kinda sore." The ability to prove progress is an important component of documenting information—measurable data lead to measurable results. Let them know the importance of using consistent terminology and paraphrase the details they provide until they are accustomed to the terminology. Soon, they will be reporting, "I had a constant, moderate headache in my temples that lasted for 2 days and interfered with my ability to concentrate at work."

Information regarding the patient's medications can be enlightening and helpful in creating a safe treatment plan. The list of medications on the intake form can be daunting at times. You can access information on any drug online by typing the name into a search engine, or keep the ***Drug Handbook for Massage Therapists***[15] or ***Physician's Desk Reference*** **(PDR)** handy to look up medications and their side effects. Better yet, ask the patient for information. Find out why he or she is taking the medication. You may uncover a condition not listed on the intake form. Ask about side effects. Manual therapy has the physiological effect of increasing circulation and may increase the metabolic breakdown of the medication.[16] Be alert to an onset or increase in those side effects. (For general principles regarding safe massage choices for patients on medications, refer to Persad RS. *Massage Therapy and Medications: General Treatment Principles*. Toronto, Ontario: CuriesOverzet, 2001.)

Hands-On Interview

The interview—asking questions, listening, and observing—segues into the hands-on interview—questioning the whole body, listening, observing, palpating, and testing. Make it a point to acknowledge that you are moving from hands-off information gathering to hands-on information gathering. The initial touch affects how the patient will respond to subsequent physical contact. He or she may relax into your touch or pull away or be open to treatment or resistant to it. Ask patients for permission to touch them before your first hands-on contact. This demonstrates respect and instills trust. It can make the difference between feeling poked and prodded, and being handled with compassion and caring. Tell patients where you are about to touch them and why you will be touching them there and ask for their consent before you follow through with the contact. You may need to do this for only a session or two. Once trust is solidified, you can obtain their permission to discontinue the consent questions.

Educate your patients throughout the hands-on interview. Prepare them to stand up, sit down, and walk before you put them through the paces. Let them know why you are palpating their neck, especially if it is their back that hurts. Tell them your goals for each modality and invite them to visualize the results you intend. Inform them of your options and allow them to have some choice in the techniques you will use, for example, deep or light touch, active or passive techniques.

The interview and the hands-on interview involve verbal and nonverbal communication, and they may present you with conflicting information. You may hear the patient say one thing, yet you may witness the opposite response in facial expressions or tension patterns. Reflect both findings when this happens, and invite the patient to make sense of the possible conflict. The patient may be unaware of the contradiction. Presenting your findings in a neutral or curious way invites the patient to work with you to resolve it. This

promotes partnership and gives the patient a deeper understanding of himself or herself rather than putting him or her on the defensive.

Hands-on information gathering can take many forms, depending on the modalities used. You will use various techniques—palpation, assessing system integrity, postural analysis, motion testing, and the like—according to your individual specialty or training as a manual therapist. As you ask questions, the body responds as well as the voice. Develop your individual skills and gather adequate information for determining safe and effective treatment.

The hands-on interview is a mixture of information gathering, treatment, and evaluation. As new information presents itself, treatment shifts to comply. The effectiveness of the treatment application is immediately assessed, providing new data. The interview cycles continuously throughout the hands-on session. Be aware of this and don't reserve the information gathering for before and after only. If necessary, stop periodically throughout the hands-on session to record the information obtained. An invitation to rest for a few minutes or to check in with how they are feeling gives you a chance to take notes without the patient feeling that he or she is being ignored.

TALES FROM EXPERIENCE

Listen with Your Hands

Aisha came in for her monthly session after the holidays and was bubbling with stories of her festivities. After chatting for a moment, I asked her, "What do I need to know to be of service to you today?" She replied that she was fine and couldn't think of anything to tell me. I struggled for a moment to release her respiratory diaphragm and asked her again. Again, she replied that she couldn't think of anything. As she said that, her abdominal muscles tightened even more. I informed her that her belly was tighter than usual, but with her holiday glow, it sounded as though there was no stress in her family or social life. I asked her if anything unusual was going on at work. "The mayor is coming!" It was as though she was just remembering. She oversaw a community service program and had spent the entire week preparing for the mayor's visit on Monday. Her stress level was over the top, and she put the site visit out of her mind to cope. Her body hadn't forgotten. She acknowledged that it was Friday, that there was nothing else to do, and that she felt prepared for the event. As she spoke about her week at work, her abdominal muscles softened and her diaphragm released. She admitted she could now relax, and she did.

As you share the information you are gathering with your patient, reflect positive findings as well as the negative findings. Say, "You are responding really well to the treatment," as well as "Your shoulder is really tight" or "Your ankle feels congested." Instead of judging the patient's joint mobility, ask him or her to describe what he or she feels. For example, "How does your shoulder feel when I move it like this?" Asking the same question after you have applied the treatment can help integrate the solution, making a mental connection to the physical change. "Now how does your shoulder feel when I move it? Notice what it feels like when you move it." He or she may not be able to discern a difference immediately, but the question might invite him or her to check the shoulder mobility again later and reflect on how it feels. Reinforce the work he or she contributes between sessions. "Your tissue feels great here. You must be very successful with your stretching routine."

Postinterview

In the final stage of the interview process, summarize the information gathered throughout the session and confirm your findings with the patient. Ask the patient which treatment techniques and modalities and application locations felt productive and which ones were not so effective. Present your assessment of the patient's progress and response to the treatment. Complement the patient on his or her participation during the session and verbalize your thanks for contributing to the outcome. By summarizing the information and drawing conclusions about the effectiveness of the treatment, you increase your patient's awareness of the value of the session, make him or her conscious of the benefits, and acknowledge his or her ability to contribute to the outcome.

REFINE YOUR SKILLS

Separate Self from Patients

Take 5 minutes between patient sessions to breathe, stay silent, and be with yourself. It may be helpful to sit in a quiet, dark room with no distractions. During this time, mentally separate from your last patient. You may need to run through the events of the last session and experience the feelings you may have chosen not to express in front of the patient. A medical intuitive told me that to separate from the previous patient, say silently or aloud, "I separate myself entirely—mentally, physically, spiritually, and emotionally—from Darnel. I call back all my energy, and I send him back all his energy."

Prepare for the next patient by inviting your internal wisdom to surface during the session. Maybe you want the strength to refrain from judging Sara when she doesn't do her homework exercises, or the confidence to listen to your intuition when you see Clint tense up when he reports he is fine. Affirm your self-awareness skills and open the door to your intuition by saying, "It is my heartfelt intent to be present with Sara, to offer her my understanding and compassion, and to facilitate her healing by tapping into her strength and internal wisdom."

IDENTIFY GOALS FOR HEALTH

So far, the focus has been on building productive relationships with patients and uncovering information that aids in providing safe and effective treatments. To be truly effective in producing ongoing results, however, we must understand our patients' needs and identify goals that direct the treatment plan and illustrate progress over time. The goals should be specific, measurable outcomes that the patient and the practitioner strive to attain.

Health goals are hinted at early in the therapeutic relationship. During the initial consultation, patients describe the physical complaints and the desired results. Intake forms record their health concerns and goals for health. Throughout the interviews, the practitioner listens to the patients' needs, explores their symptoms, researches their history, and tries to understand the impact of the condition on their lives. This information empowers the practitioner to formulate goals to ensure that the patients' needs are met.

When developing goals with patients, explore the following questions: How do your patients define wellness? What are their expectations of you and of themselves? How can you contribute to their vision of their own health?

Define Patient Needs

First, focus on the needs of the patient. Often, we have agendas based on what we think is best. We may see things that need fixing and be eager to impress our patients with our ability to treat their conditions. We may pressurize people into fixing problems they are not emotionally or physically prepared to address. Therefore, we should fully understand our patients' needs and support them to accomplish *their* goals for health—when and how they choose. We do not have the final say on what is best for our patients.

We must help patients articulate their needs. They may have well-formulated complaints but limited experience in transforming symptoms into goals. When needs become palpable, patients can identify significant, tangible goals. For example, Darnel complains of low back pain. He hopes the manual therapist will get rid of his pain. The goal—to eliminate the pain—can be intimidating and its pursuit frustrating for both the practitioner and the patient. It is difficult to measure changes in pain, and it is nearly impossible for the patient to experience progress—a decrease in pain—when the pain continues to be endured daily. Do not focus on pain when exploring the needs of the patient. Instead, focus on function—how pain limits the patient's ability to participate in specific daily activities. We are better able to comprehend the needs of our patients when we understand how their symptoms affect their quality of life.

Construct Measurable Goals Based on Activities of Daily Living

Once we discover how our patients' symptoms are affecting their daily routines, we can formulate **functional goals** (or measurable goals) for health. For example, Darnel cannot pick up his granddaughter Madi and give her hugs because of the pain in his low back. Both Darnel and Madi are negatively affected by the loss of intimacy. Rather than selecting a goal based on a symptom—to eliminate low back pain, which is difficult to measure and problematic to experience accurately—develop a goal based on a function, such as lifting Madi and hugging her, which is of great importance to Darnel and his granddaughter. Take a significant activity the patient is yearning to get back to and develop it into a well-defined goal that both you and he can strive to accomplish.

Functional goals are set by the patient, with assistance from the massage therapist, to address the specific needs of his or her everyday life with the purpose of leading to an effective treatment plan. Goals must be specific to an activity of daily living and be measurable and achievable in a reasonable amount of time. The patient and therapist can further define the goal by specifying the parameters for success. How often does the patient want to perform the activity? What is a reasonable time frame for success? Will Darnel be satisfied when he can lift Madi five times a day but must increase his pain medication as a result? A well-defined goal should reflect the following:

- Quantity, duration, or both—How much or for how long (duration)? What number of pounds to lift or stairs to climb three times a day or 4 hours a night (quantity)?
- Frequency—How often? Eight hours a day or 5 days a week?
- Quality—How are symptoms affected? Does the patient awake feeling moderately fatigued or does he experience mild pain?
- Time frame—When will goal be accomplished? Is it within 2 weeks or by the end of the month? Is it a short-term goal or a long-term goal?

A functional, measurable goal for Darnel might be to lift and hug Madi three times a day, 5 days a week, and to feel no more than moderate pain in his low back, in a time frame of within 30 days.

Part of defining and developing goals with patients is to help them participate in life, look for alternative ways of living a quality life, and ultimately regain their ability to do the things they want to do. This is easily accomplished by setting short-term goals that they can achieve and by motivating them to stretch a little farther each week, to get closer and closer to their goals for health.

CHOOSE AND IMPLEMENT A TREATMENT PLAN

Treatment plans encompass both the patient's self-care routine and homework exercises and the treatment provided by the manual therapist and other health care providers on the team.

TALES FROM EXPERIENCE

Functional Outcomes Demonstrate Massage Efficacy

I gave a presentation at a symposium to 100 doctors on the integration of biomedical and complementary health care and how to refer to massage therapy. A well-known researcher, Dr. Dan Cherkin, was scheduled to present his findings on the effectiveness of IHC care on chronic low back pain immediately after my talk. By way of introducing me, the moderator waived Dr. Cherkin's newly published research paper in the air, contending, "Can you believe these results? I'm sure you are as shocked as I am. Really, have you ever seen a SOAP chart from a massage therapist show that massage relieves pain anywhere?" Looking out over a crowd of physicians shaking their heads "no" was a humbling experience to say the least, but a telling one.

Unfortunately, the moderator was accurate in proclaiming that massage therapists' charts often do not adequately reflect the positive outcomes that result from our patient/practitioner relationships. I have reviewed thousands of SOAP charts from manual therapists as part of my work with insurance credentialing. It is rare that the charts reflect a cessation of pain. As a result, one could surmise that the treatment was ineffective. If, instead of focusing on the patient's pain, our charts recorded the patient's increased ability to perform daily activities, the 100 physicians at the symposium would have embraced the research results as affirming common knowledge.

The key to our credibility lies in charting functional outcomes. Dr. Cherkin and Dr. Eisenberg demonstrated this very issue in research results: Massage therapy resulted in a statistically and clinically significant improvement in the ability of patients to perform their daily activities when compared with self-care exercises ($P < .001$). Massage was also more effective than self-care exercises in decreasing pain ($P = .01$), but the benefits were less pronounced.[17] These results are easily understood when you consider one's threshold of pain. People feel compelled to follow their routines—bathe, dress, work, exercise, garden, and play—and tend to stop only when they reach a certain level of pain. If we rely solely on charting pain, we are likely to see a steady level of pain over time, even when the patient reports improvement, whereas charts that record a patient's ability to perform daily activities may reflect considerable progress toward his or her goals for health. Translate patient complaints into functional limitations and set measurable goals based on activities of daily living, and you will be able to clearly demonstrate progress because of your manual therapy sessions.

Self-care Strategies

Discover the patient's strengths. Find out what he or she is already doing to take care of himself or herself. Use questions about comfort, not pain, to discover the patient's abilities to heal. Focus on the positive whenever possible. We ask patients to chart their pain on intake forms; we question patients about their pain during the interview; we ask, "Does this hurt?" when we touch them. Instead, ask how frequently they experienced pain today and ask about when they felt good. Use this discussion to explore their strengths. Find out what was going on around them when they felt good. Did they do something that triggered that good feeling? Help them see how they contributed to the good feeling. Complement them on knowing what to do to feel better, reinforce that activity as a solution to their condition, and encourage its use. If we are to involve our patients in their healing process, we must tap into the resources already available to them.

Explore additional ways in which patients contribute to their own healing. The goal is to create homework and self-care activities that the patient can successfully apply to improve his or her health. These discussions may take time in the beginning, but they will save time in the long run. The discussions promote self-awareness and reinforce the concept that the patient can affect his or her own well-being. The patient will learn from this experience and explore other solutions between sessions. Failed attempts at homework assignments will be reduced because the homework will be the patient's idea. Treatment applications will be welcomed because they were discussed and agreed upon in advance. Show respect for your patients and consider their input in all decision-making.

Educate your patients on the effectiveness of various self-care strategies. They may have several ideas that they are willing to implement but lack knowledge about when to use one option over another and how each option works. If patients understand when to try an exercise and how that exercise helps them attain their goals, they may be motivated to try it more often. Self-care falls by the wayside when their value is not realized.

Narrow the list of possible self-care strategies, and discuss the pros and cons of those remaining. A long list of possibilities can overwhelm the patient. Select one or two to implement between now and the next session. Plan what, how, when, and where to do it. Remind the patient how it works. Demonstrate proper technique and correlate them with other activities. For example, teach Darnel proper lifting techniques to prevent reinjury and promote recovery. Invite him to practice his newfound lifting techniques with his granddaughter and apply the same techniques to lifting groceries and laundry.

Be vigilant in pursuing patient-centered exercises. Practitioner-imposed exercises are often unsuccessful. Too often, we classify patients as resistant or uncooperative when they do not follow through on assigned homework or self-care activities. Take responsibility. It is possible that you selected homework that doesn't fit their lifestyle instead of focusing on their own healing abilities.

Encourage self-awareness exercises. Teach patients to pay attention to internal warning signs, such as tension in the shoulders, and to respond before their symptoms get out of hand. Simple exercises such as asking patients to notice what is going on around them when they feel pain can help identify triggers. Invite them to notice what makes the pain feel better and use those experiences to develop self-care exercises.

Treatment Options

Treatment is about collaboration. Often, patients defer to the expert practitioner regarding treatment choices. They do not know the language of manual modalities or the full scope of what is available, they do not have experience in the variety of techniques, and they do

not understand the pros and cons of the options before them. None of these facts justifies leaving patients out of the decision-making process. Whatever your treatment techniques, educate your patients on the advantages and disadvantages. Discuss the various places on their bodies where the techniques can be applied. Ask about their preferences to any style of treatment, the places you touch, or the order of application. Find out whether any technique does not sound appealing and should be avoided. Demonstrate the techniques if necessary. Be flexible. If the patient feels something isn't working at any time in the session, do something else.

Some patients want to respect your expertise and not get between you and your knowledge. When a patient says, "Just work your magic!" you may take this as a compliment, but don't stop there. Let them know you value their input. Give the patient a choice, no matter how simple. For example, "Shall we begin the session with you lying face up on the table or face down?" or "Do you prefer that work be done on your low back while you are prone or supine?" Most patients are not accustomed to being asked for their input. It may take a little encouragement for them to discover that they really do have opinions and preferences. Always give patients the option to choose how, when, and where their treatment should be applied. Make sure you give them plenty of information on which to base their decisions.

Involve your patients during the treatment itself as well as during treatment selection. As you are working, invite them to notice how they feel before and after a treatment technique. For example, as you move a patient's shoulder, you might notice limitations in the available movement and that the quality of the movement is compromised. Rather than point out the limitations, ask what the patient notices. "How does this shoulder feel to you as I move it? Now move it yourself. How does that feel?" Apply the treatment and move the shoulder again. "Now how does your shoulder feel?" Show the patient how to perform the same or similar treatment techniques at home to get the same result. Don't make the treatments mysterious or magical. Share your expertise and knowledge, and empower your patients to heal themselves.

EVALUATE PROGRESS, INTEGRATE FEEDBACK, AND MODIFY THE TREATMENT PLAN

Communicate through all stages of the interview by evaluating the patient's progress and sharing feedback that can strengthen, modify, or correct the results. Progress hinges on all aspects of the therapeutic relationship: communication; trust; faith in the patient's strength and healing abilities; quality of touch; understanding the patient's needs; developing meaningful goals; providing education; and listening to the body, mind, and soul of the patient. If you intend to give quality service, you must evaluate each step of the healing process and elicit feedback from the patient continually.

Evaluate progress by summarizing your observations: what you hear, what you feel, what you see, what you interpret. You can present your summary to the patient immediately after your observation, during the postinterview, or at scheduled reevaluation sessions, depending on how pertinent the information. For example, the patient's response to a treatment technique may be critical if it is the first time the technique has been used or the response was significant. Otherwise, wait until the end of the session to summarize the results. At the end of a series of sessions, evaluate the treatment plan together. Were the goals accomplished? Was the treatment style effective? Which techniques will you continue to use? Receive the feedback with an open mind and heart. Modify your treatment plan to accommodate the patient's preferences.

Use assessment techniques to reinforce the results of the session. Help the patient experience the changes in his or her body on many levels: physically, mentally, and emotionally. Often patients leave the session with little awareness of their progress. They may feel better but have no context to understand their experience or words to explain the sensations. Verbalize your findings and demonstrate the increased movement. Have them observe postural changes in the mirror and celebrate the progress. Complement them on their ability to respond to the treatment and to integrate changes. Help them recognize their contribution to the results and reinforce the effects their homework will have on maintaining and furthering their progress.

Regularly schedule reevaluation sessions. Some patients are shy about giving feedback during the session. They may feel vulnerable on the table or they may enter a deep state of relaxation that makes it inappropriate to push for feedback. Setting aside time periodically for evaluation can provide a safety net for patients and will let them know you are committed to hearing their concerns and responding to their needs.

Summary

Developing the therapeutic relationship is central to the interview process and is even more important than gathering information or accurately assessing the patient's condition. Trust, compassion, and understanding are the cornerstones of a productive relationship. Your ability to be fully present for your patients and to exhibit faith in their strength and healing abilities help lay these cornerstones in place. Without a strong bond, patients are reluctant to share their concerns and treatment planning becomes a guessing game.

Concentrate on building the therapeutic relationship while striving to achieve the goals of the interview. Your tasks include the following:

1. Develop a relationship.
2. Gather information.
3. Identify goals for health.
4. Select and implement a treatment plan.
5. Evaluate progress, integrate feedback, and modify the treatment plan.

To foster a therapeutic relationship, practice interpersonal skills, such as the following:

- Presence
  - self-awareness
  - self-acceptance
  - self-regulation
- Communication
  - active listening: silence, reflecting, open-ended questions
  - confidentiality: patient disclosure
  - body language
  - empathy: compassion, nonjudgment, acceptance
- Hope
  - positive expectations
  - visualizations
  - humor

Use this checklist as a guideline for conducting an interview:

Preinterview

- Develop an external image that will attract your target market.
- Gather basic information from the prospective patient to determine fit.
- Provide intake forms and information to prepare the patient for the first visit.

Interview

- Review intake form.
- Use answers to explore health more deeply.
- Prioritize current health concerns.
- Discuss goals for session.

Hands-on interview

- Verbal questions continue.
- Listen and observe responses to verbal and hands-on inquiries.
- Palpate and assess.
- Reflect positive and negative findings.

Postinterview

- Summarize findings from session.
- Construct functional goals with the patient.
- Develop a treatment plan together.
- Explore self-care strategies.
- Explain the fluidity of plan, based on patient input and responses to treatment.

Develop and use effective communication skills. Lead patients to discover and accomplish goals for health. Maintain an open line of communication throughout the preinterview, interview, hands-on interview, and postinterview. Ensure optimal results for the patient by eliciting feedback with the intent to strengthen, modify, and correct the treatment plan.

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CHAPTER 2

Communication with the Health Care Team

After mastering the concepts in this chapter, the student will be able to:

- Prepare a letter of introduction to a potential referring health care provider
- Apply the guidelines of communication to write an initial report
- Translate treatment notes into a progress report
- Design a prescription pad complete with information that can support medical necessity

This chapter provides examples of reports using scenarios where communication with health care providers (HCPs) is common: motor vehicle collisions (MVC), workers' compensation (L&I), and private health (PH). Every patient referred by an HCP warrants regular communication, initially to acknowledge the referral and report on your treatment plan, progress reports to update and request additional prescriptions, and discharge reports to acknowledge the end of care for that condition. But these are not the only situations where communication with the health care team is important. It is also beneficial to write reports with the intent to share goals and communicate progress with the patient's primary care provider (PCP), and to encourage additional referrals.

Many wellness patients come self-referred. Lin Pack, a 36-year-old healthy woman, has been getting bi-monthly massages for many years to keep herself healthy. She self-referred to massage therapy for wellness care and asked her massage therapist to keep her physician informed of her findings. She has type 1 diabetes and a family history of heart disease. So far, she has no complications typical with type 1 diabetes, nor does she have any heart disease, and she wants to keep it that way. Her blood pressure is slightly elevated at times, because of a high-stress job, and her blood glucose levels are occasionally outside of normal range, although her A1C is always within goal range.

Lin's PCP, Dr. Chandler, has developed a self-care plan that Lin adheres to. She tests her blood glucose level four times a day, and she takes her blood pressure in the morning and before bed three to four times a week. Naomi, her massage therapist, read a research study that found massage can affect blood pressure and has learned through experience with Lin that massage can also affect blood glucose levels. She has Lin test her blood glucose level before and after each massage, and she records the results in Lin's medical record. She has juice boxes available if Lin's blood glucose level drops below normal. Naomi also keeps an eye out when massaging Lin's feet, looking for sores or neuropathies that may have developed. Quarterly, or more frequently if problems arise, Naomi writes a report to Dr. Chandler and shares her findings. Dr. Chandler respects Naomi and appreciates her unsolicited communication and has sent her several of her patients as a result.

Manual therapists typically spend much more time with patients than PCPs (an average of 60-minute sessions vs. 15-minute sessions) and can encourage patients with diabetes to test their blood glucose level often and do more foot care, as in Lin Pack's case. In Sinan Ngai's case, it may be helpful to introduce yourself to his PCP for marketing purposes. Your success with Sinan's headaches may be a good opportunity to demonstrate your skill at helping to resolve headaches. Write up a report, share your approach to working with headaches, and include the progress graphs. Request referrals as a specialist in working with diabetes or treating headaches, and share your ability to provide other therapeutic services as well.

Introduction

Interdisciplinary health care team consists of a group of practitioners with a common goal: to provide patient-centered comprehensive care for the shared patient. Groups are often defined by the patient, usually with the guidance of a PCP. Members of the group are selected according to the patient's needs and each practitioner's ability to meet these needs. The group members form a team by consulting with one another, sharing information, and providing individualized care. Together, the patient and the practitioners complement and strengthen each one's efforts. The team approach is beneficial to the patient, the practitioners, and the patient's insurance company in many ways because it provides the following:

- Increased safety
- Increased productivity
- Increased efficiency
- Reduced duplication in treatment

Manual therapists are among the **complementary health care (CHC)** practitioners commonly added to integrative health care teams today. In the past, massage therapists, in particular, had little motivation to seek medical referrals or to participate in team health care and were comfortable working separately in nonmedical environments. Consumer demand, however, is changing this. Manual therapists of all types are actively being solicited by consumers, **referring HCPs,** and medical specialists for their participation in health care teams. Consumer use of massage therapy for health care purposes has increased dramatically since 2002—ranking second in practitioner-based CHC use (or complementary and alternative medicine [CAM] in this study), close behind chiropractic/osteopathic manipulations—and consumers are willing to pay out of pocket

to do so.[1] A study in 2009 showed that 34% of Americans had received care in the last 5 years from massage therapists, up from 28% in 2002 and 17% in 1997.[2] Of these consumers, 31% report they did so for health conditions such as pain management, injury rehabilitation, and migraine control or overall wellness and 32% to reduce stress or for relaxation.[2] When 96% of consumers agree that massage therapy should be considered part of the health care field and 76% of massage therapists currently receive health care referrals,[2] it becomes essential that manual therapists learn to be productive members of the health care team.

TALES FROM EXPERIENCE

Communication Is Key

Frequently, I am invited to speak with doctors and their staff on the benefits of manual therapy. During these discussions, doctors often complain: "I tried referring patients to massage therapists. I never heard back from them. Why should I refer to a therapist who does not apprise me of the patient's status?"

Manual therapists are increasingly being included in integrative or interdisciplinary health care teams. It is important to recognize that communication helps to establish rapport, build trust, and create productive relationships (and more referrals!). Be an active team member and reinforce the inclusion of manual therapy in integrative health care.

Guidelines for Communication

Communication through documentation is expected in all health care practices, biomedical, complementary, and integrative. Insurance companies demand a paper trail that demonstrates **medical necessity, functional outcomes**, and **cost efficiency**. Referring HCPs feel the third-party pressure of justifying referrals and the responsibility for results, especially in this era of insurance tactics to reduce utilization, such as prior-authorization. Reassure referring caregivers by providing them with the necessary paperwork—without being prompted—and demonstrate competency in documentation and report writing.

Keep correspondence with the referring HCP and the integrative team simple and direct. Many doctors do not have time to decipher handwritten chart notes, to analyze test results, or to discuss issues over the phone. Correspond directly with the referring HCP through **initial reports** (brief letters that summarize important findings) and **progress reports** (brief letters that summarize details on patient progress). Send copies of relevant treatment notes/**SOAP charting** (acronym for Subjective, Objective, Assessment, Plan) with the reports only when the referring HCP requests them. With the adoption of electronic charting, treatment notes look more professional and may begin to replace some of the need for summary reports (see Figure 2-1).

Send copies of the reports to all members of the patient's integrative health care team. Do not write additional reports to other members of the team, but rather send them copies of the original report that you have sent to the referring HCP. Do not be discouraged if you do not receive the same courtesy. Team health care is not universal. Specialists are expected to report back to the referring HCP, but the reverse is not always standard. Set a good example of team communication and send reports to the entire team.

Follow these guidelines when communicating with the health care team:

- Type all correspondence on a word processor and paste or print it on professional letterhead.
- Write in a narrative format in letter style.
- Use the patient's last name with Mr. or Ms.
- Avoid handwritten, fill-in-the-blank forms (update to electronic health records).
- Avoid abbreviations and symbols (save these for daily note-taking).

FIGURE 2-1. Treatment Note from Electronic Health Record

Session Info
Heather Pratt
Massage Therapist: Diana Thompson

Hands Heal
6720 14th Ave SW
Seattle, WA 98106
Phone: (206) 755-5564

Date: 1/15/2017

Pre-Session Information

Stress Scale: 2
I am adapting to my double mastectomy and choosing not to have reconstructive surgery

Pain Scale: 4
I am trying to wean off the pain meds so feel it more when I move and fatigue easily still

Activity Scale: 7
I can do most things in moderation except lift heavy things over head or out in front of me.

Health Status:
First appointment…

Wellness

Duration: 0 minutes

Treatment Position/Location

Treatment Techniques

Treatment

Duration: 60 minutes

Client Complaints
Puffy around scars. Pulls with getting dressed. Has to wear clothes that button or zip in front. Can't lift anything over head or hold anything heavy out in front.

Treatment Position/Location
Supine, focus on neck, shoulders, chest and back

Assessments/Findings
Shoulder range of motion limited in extension and abduction at end ranges L>R. Scar tissue BL. Swelling L>R.

Treatment Techniques
MLD neck and arms
NMT with movement chest
MET arms

Additional Notes
Goal to be able to lift arms up over head to get dressed in pullover shirts and sweaters with no more than mild pain in chest.
Homework: arm circles in elephant position. When able to do that, bring arm circles out in front - horizontal, then regular arm circles with movement as close to full extention as possible.

Post-Session Information

Stress Scale: 1

Pain Scale: 2

Activity Scale: 8

- Provide information promptly.
- Be brief; summarize details and state progress.
- Enclose copies of treatment notes in addition to reports, only if requested.
- Send duplicates or photocopies; file the originals (if using paper files).
- Fax, mail, or use secure e-mail to send.

Document conversations, phone and text messages with HCPs. Voice mail and secure e-mail allow information to be shared without calling back or interrupting the patient sessions. Take notes. Record date, time, names of participants, and content in the patient's medical record. Follow the rule: "If it isn't written down, it didn't happen."

The patient's medical record is also the place to file all patient-related correspondence with the health care team, including letters, reports, e-mails, faxes, phone calls, and meeting minutes. To document nonpaper correspondence, such as phone calls, or to track record requests, create a correspondence form (see Figure 2-2). If patient files are electronic, upload related correspondence files to the patient's electronic folder.

Standard Methods of Communication

Use familiar pathways and common language to establish communication and enhance relationships with referring HCPs. Many electronic charting systems provide report writing functions. Some even populate the reports with key information, making report writing quick and easy. Standard methods of communication include the following:

- Introductory letters
- Prescriptions
- Initial reports
- Treatment notes (SOAP charts) when requested
- Progress reports

Communication with the health care team should establish rapport and accessibility, convey professionalism, and create a conduit for requesting information and exchanging data. Initial correspondence educates others on the benefits of your treatments and explains how to use your services effectively. Once contact is established, a prescription will identify treatment preferences and provide some billing information such as diagnostic codes (ICD-10). If necessary, call or e-mail the referring HCP to clarify contraindications and cautions for treatment. After the patient's first visit, an initial report will acknowledge the referral and state your plans for treatment. Write progress reports every 30 days to update the team on the patient's progress and to suggest changes in the **treatment plan**. Make sure reports are based on and substantiated by information recorded in the treatment notes.

FIGURE 2-2. Correspondence Form for Verbal Conversations (Phone or Face-to-Face)

From: Dr. Chandler <chandlerOMD@chandlerOMD.com>
Subject: RE: patient conversation
Date: August 8, 2010 12:30:30 PM EST
To: Naomi Wachtel

Patient: Lin Pak

Patient reported a decrease in blood sugars immediately following massage sessions. Please make sure she tests her blood sugar before and after every massage for the next two months and record the results.

INTRODUCTORY LETTERS

Introduce yourself to other HCPs in your area. Many referrals are casual and often do not name a specific practitioner or style of manual therapy. Physicians, naturopaths, chiropractors, and others who are well educated on the various types of massage, bodywork, and movement therapies are better able to serve their patients by providing individualized referrals. Encourage direct referrals by establishing a relationship with HCPs in advance. Send a letter introducing yourself (see Figure 2-3). A mailed letter often stays on their desk longer and is touched more than once, making a more lasting impression. E-mails from unknown senders may be quickly discarded. Enclose information on your references, credentials, and professional affiliations. Include articles and research that demonstrate the benefits of your techniques (see "Refine Your Skills: Select Research Articles That Demonstrate the Effectiveness of Manual Therapy on Conditions Associated with Targeted Clientele").

REFINE YOUR SKILLS

Create a Business Identity Package

Invite a graphic designer to your Journal Club or study group to present information on creating business cards, letterhead, logos, etc. If you do not know a designer or cannot afford one, invite a salesperson from a local photocopy center who has a portfolio on business card standards. They may be willing to speak to the group in exchange for printing business. Invite participants to come prepared: bringing images, business names, even sketches of business cards and letterhead. After the graphic designer presents the portfolio, have the group share their ideas with each other, getting feedback from the designer as well. If possible, and you are willing to pay for the service, ask the designer to create identity packages on the spot for as many willing participants as time allows. Observing the process may help streamline it for those who are not quite ready to create a professional identity.

Begin by writing to your patient's HCPs. Mention that you share a patient—with your patient's permission, of course. A built-in recommendation from him or her often puts a doctor at ease. Contact providers in your community or neighborhood. Target caregivers whose clientele is similar to yours. For example, if you specialize in chronic pain, contact the chronic pain clinic in your area. If you are fluent in sign language, write to providers who have patients in need of that service.

An introductory letter includes the following:

- Credentials and certifications
- Experience with similar referrals
- Assurances that you support the HCP's treatment plan and will communicate regularly
- A list of your specialties (include research articles that demonstrate manual therapy as a viable treatment option for those conditions, or case reports that demonstrate your effectiveness with those conditions)
- Request for referrals based on your specialties
- Education and advanced training
- Professional affiliations and references

In the first paragraph of the letter, introduce yourself and state your credentials and intent.

"Hello. I am a certified polarity therapist. You and I share a patient—Kate Nelson. I wish to take this opportunity to introduce myself and tell you about my work. I enjoy working with other HCPs, and I am committed to providing quality care. I hope we will work together."

In the second paragraph, state your experience working with similar HCPs. The intent is to demonstrate interest in them, create trust, and convey confidence.

FIGURE 2-3. Letter of Introduction

Naomi Wachtel
567 Sunnydale Dr.
Flat Irons, CO 80302
PHONE 303 555 8866 • EMAIL wachtel@email.com

Dr. Shawn Hall
1234 Main Street
Flat Irons, CO 80302

Dear Dr. Hall:

Hello! I am established in your area and would like to introduce myself. I am a licensed massage therapist certified in lymphatic drainage. I have an office down the street from you and am looking for a doctor specializing in chronic pain whom I can refer to and possibly receive referrals from.

I am experienced in working with chronic syndromes and other chronic systemic conditions such as diabetes and Lyme disease and am accustomed to the needs of chronic pain patients and the level of documentation and communication required to participate on the health care team. Enclosed are copies of treatment notes and progress reports of a recent chronic pain case and a letter of reference from the referring physician.

I understand the complications of chronic pain syndrome and am trained to work with the passive congestion of phase two inflammation—a typical component of the condition that hinders healing. I have received advanced training in lymphatic drainage (MLD), which can help resolve the inflammatory issues of chronic pain syndrome in some patients. MLD has been shown to be safe and effective in cases where long-term use of NSAIDS has failed or is contraindicated. Enclosed are a few articles that detail specific findings.

Enclosed are brochures designed to inform patients about the benefits of manual lymphatic drainage. These brochures explain what to expect from a lymph drainage session. Detailed in the brochures are my services, hours, and fees, and directions to my clinic. If my services are of interest to you, please hand these brochures to your patients.

If possible, I would like to schedule 5 minutes of your time to meet you and find out more about your services. I would like to pick up some of your brochures to pass out to my patients, and answer any questions you may have. I will call within the next week to schedule an appointment with you.

Thank you for your time and consideration. I look forward to meeting you.

Yours in health,

Naomi Wachtel, LMT

"I understand that you are fluent in sign language and have many patients with hearing disabilities. I, too, am fluent in sign language and have deaf and hard-of-hearing patients. I am experienced in participating in team health care, communicating regularly, and supporting referring caregivers' treatment plans. I am skilled at medical documentation and am accustomed to writing regular progress reports. I am looking for doctors to refer to and receive referrals from."

Next, describe your specialties, modalities, and treatment philosophy. Ask for referrals specific to your area of expertise.

"As a polarity therapist, I palpate points and patterns in the patient's energy anatomy to assist in the flow of healing energy in the patient's body. I teach a series of self-help exercise techniques to promote self-awareness and create relaxation and balance.[3] I specialize in facilitating healing in patients preparing for and recovering from surgery. Enclosed is a research article describing the benefits of presurgery and postsurgery energy treatment. I also enjoy working with individuals who seek a natural, effective way to reduce stress and increase wellness. Please think of me when referring these types of patients for manual therapy."

Include your educational background, years of experience, and professional affiliations. Enclose copies of one or two of the following: therapy license, certifications, professional memberships, Code of Ethics or Standards of Practice, and research articles on related studies. Including research articles will demonstrate your use of evidence-informed practice, an important component when working to integrate manual therapy into traditional health care practices.

REFINE YOUR SKILLS

Select Research Articles That Demonstrate the Effectiveness of Manual Therapy on Conditions Associated with Targeted Clientele

Gather several classmates or colleagues together for a study session or Journal Club meeting. Identify several conditions to research, conditions common with patients or family members. Divide into small groups and assign each group a condition. Conduct Internet searches on the conditions, using "integrative medicine" (IM), "integrative health care" (IHC), or "complementary and alternative medicine" (CAM) on PubMed, Google Scholar, or other search engines or databases accessible and useful for finding research articles. Critique the articles as a group, using criteria outlined in Chapter 10, Researching and Writing Case Reports, and identify ones that would make excellent resources for patients and health care team members. Distribute them to patients and potential members of the health care team as demonstrations of your evidence-informed practice skills. If you are not adept at searching research databases for current literature or there is no Journal Club in your area, there are an increasing number of resource texts available that cite research for different conditions or on a variety of techniques or disciplines, such as Dryden and Moyer's *Massage Therapy: Integrating Research and Practice* and Thompson and Brooks' *Integrative Pain Management: Massage, Movement, and Mindfulness Based Approaches*.[4,5]

"I have been a certified polarity therapist and a member of the American Polarity Therapy Association for 5 years. My precertificate and postcertificate training includes more than 500 hours of class time and 250 hours of supervised clinical time. I studied anatomy, physiology, kinesiology, and polarity theory and practice, and I have clocked more than 1,000 hours of patient sessions. Enclosed is a copy of my polarity therapy certification and Code of Ethics."

End the letter with a request for referrals and provide the necessary information to facilitate referrals, including fees, hours, location, services, and contact information.

"If you feel that I may be of assistance to any of your patients, please pass along my name. I am interested in working with you to serve them. Enclosed are several brochures explaining my treatment style and details of service. Please make these available to patients who could benefit from my work."

REFINE YOUR SKILLS

Prepare a Patient File to Share with a Potential Member of the Health Care Team, or Write a Case Report That Highlights Your Evidence-Informed Practice Skills

To use an existing patient file, request permission from the patient before doing so. Remove all identifying information, or as HIPAA refers to it, private health information (PHI), such as name, referring HCP's name, and date of birth. Include forms that demonstrate your use of gathering intake information, measurement tools, and SOAP charts. Include examples of your reporting, showing the frequency and ability to share information. If you are ready to write a few case reports that represent your skills with a variety of conditions, follow the guidelines presented in Chapter 10, Researching and Writing Case Reports, and submit a copy of a pertinent case report to the potential referring HCP. This is sure to clinch their respect for you and desire to participate on a health care team together.

Once you have contacted the HCPs you are interested in working with, call to schedule a brief appointment. Five minutes is enough to make an impression and to establish a physical connection. Place a smiling face and a firm handshake behind your letter and brochures. Always remember to ask how you can best serve the caregiver—don't focus entirely on yourself. Start the conversation by inquiring about the caregiver's practice. Then, ask how you might best fit in and serve. Go to the meeting stocked with additional brochures and prescription pads. Explain how to use the prescriptions (detailed in the next section) and reiterate your request for patients who fit your specialty. This is an effective marketing technique to ensure that your name comes to mind first when your type of patient shows up. Of course, let the practitioner know that you are able to treat less specialized cases, but if you are perfect for one or two patients, the ball will be in motion and more referrals will follow.

TALES FROM EXPERIENCE

Marketing

Lucas, the owner of a large massage clinic, has a unique way of introducing himself and his therapists to chiropractic offices in his neighborhood. The entire massage team takes on-site chairs and healthy box lunches to the chiropractor's office during a prearranged lunch hour. Everyone on the chiropractic staff gets a chance to ask questions and experience 5–10 minutes of each therapist's work. Even the busiest doctors find a moment to peek in on the fun their staff is having. Once the doctors have been rubbed and grubbed, Lucas can engage them in a relaxed conversation and make a lasting impression.

PRESCRIPTIONS

Prescriptions are formal referrals for adjunctive services, and they communicate information from the patient's primary HCP to the manual therapist (see online, Appendix A, Blank Forms). Prescriptions mandate medical necessity and define treatment parameters. Sometimes, referrals come in the form of a suggestion. An HCP may say, "Try massage for your shoulder pain …" or "Have you thought about getting Trager® for your back pain?" General referrals such as these are often oral and may or may not include a recommendation for a specific treatment technique or a specific practitioner. Prescriptions, on the other hand, are very specific. The referral outlines instructions to be followed and is often directed to a particular specialist. Timelines and frequencies are mandated, and specific treatment goals and treatment areas are often defined. Prescriptions can be as detailed as the following:

> 10 sessions of neuromuscular therapy with Rafael Hernandez. Complete treatment by June 23. Treat the neck and shoulders to reduce pain and restore function. Address other direct and indirect symptoms resulting from carpel tunnel syndrome—including posture, inflammation, and muscle tension—and treat related structure. Treatment should include hot/cold packs and stretching exercises as needed.
>
> Or as simple as:
>
> 10–12 massage sessions for 6 weeks.

To expedite referrals, create your own prescription form[6] and send pads of them to HCPs (see Figure 2-4). Their use guarantees that you will have the information you need to provide safe treatment and facilitate insurance reimbursement. If a patient has serious health problems or a condition that manual therapy may exacerbate, a prescription provides critical information and peace of mind. A prescription gives permission to treat the condition and sets guidelines for safety.

A prescription is also necessary whenever you or your patient seek reimbursement from an insurance company for medical services. Insurance only covers treatment that is deemed **reasonable and necessary**. A prescription states that the treatment—in this case, manual therapy—is medically necessary for the patient's condition. The prescription includes the patient's diagnosis, which is also necessary for insurance reimbursement. Manual therapists without diagnostic capabilities are able to use the diagnostic codes necessary for bill processing when the diagnosis is recorded on the prescription by the referring HCP and is on file in the patient's medical record. Keep in mind, however, that a prescription does not authorize insurance coverage, but it is necessary for facilitating reimbursement of authorized services (see Chapter 8, Insurance Billing, for information on insurance billing).

If a patient schedules an appointment based on an oral referral, and later, you determine that a prescription is necessary, contact the referring HCP and request the information you need to ensure proper care and to facilitate reimbursement. An oral referral for general services or a prescription that simply states "massage" is insufficient documentation for insurance reimbursement. In the event of an oral referral or

FIGURE 2-4. Sample Prescription

HANDS HEAL

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
PHONE 612 555 9889

PRESCRIPTION

Patient Name Darnel G. Washington Date 1-30-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789

A. Diagnosis

(Include ICD-10 codes that specifically address Manual Therapy Treatment)

Scoliosis 754.2
Spasm 728.85
Neck Pain 723.1
Thoracic Pain 724.1

B. Frequency & Duration

☒ 1× wk for 6 wks
☐ 2× wk for _____ wks
☐ 3× wk for _____ wks
☐ 2× month for _____ months
☐ 1× month for _____ months

C. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary & Secondary)

☐ Head whiplash
☐ Neck whiplash
☐ Chest scoliosis
☐ Shoulders 2°—as needed
☐ Abdomen 2°—as needed
☐ Back scoliosis
☐ Lowback/Hips whiplash
☐ Upper extremities 2°—as needed
☐ Lower extremities 2°—as needed
☒ All of the above
☐ Other: _____

Treatment Goals

☐ Decrease Pain
☐ Decrease Inflammation
☐ Decrease Muscle Tension/Spasms
☐ Decrease Compensatory Patterns
☐ Increase Mobility
☐ Increase Strength
☐ Restore Function
☐ Restore Posture
☐ Patient Education
☒ All of the Above
☐ Other _____

Specific Instructions/Precautions:
as needed

D. Referring Health Care Provider (HCP)

Contact Information
HCP Name Sage Redtree MD
Address 87 Old Trail PKWY
City Minnehaha State MN Zip 55987
Phone 555-0009
Fax 555-9000
Email _____

Reporting—I will send an initial report after the first visit and a progress report after every 6–8 sessions. Please check how you would like to receive this information:
☒ Fax ☐ Mail ☐ Email
☒ Send Copies of Chart Notes with each report

HCP Signature: Sage Redtree MD Date 2-30-17

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an incomplete prescription, prompt the referring HCP to write a prescription, state the diagnosis and ICD-10 codes, and direct the frequency and duration of treatment. To expedite a response from a busy HCP, fill in the pertinent details on the prescription form and fax or e-mail it to his or her office with a request for approval and a signature.

Suggest a treatment plan to referring HCPs who are unfamiliar with manual therapy or your style of work. If the HCP writes a prescription for a treatment plan that is inconsistent with your treatment style, discuss the issue with the HCP. The doctor may suggest treatment twice a week for 4 weeks, and you may wish to change the frequency to three times a week for the first week, twice a week for 2 weeks, and once during the last week. Rather than contradicting the prescription, request a change. Most referring HCPs are amenable when the request is substantiated.

To amend a prescription, initial and date the changes and write "Authorized per phone: Dr. Lutack ND."

Prescriptions for manual therapy are an indication of medical necessity and at a minimum must contain the following:

- Patient's diagnosis, including ICD-10 codes
- Number of treatments (12 sessions, for example)
- Frequency and duration of treatment period (twice a week for 6 weeks, for example)

Manual therapists who cannot diagnose or prescribe treatment rely on referring HCPs to provide both the diagnoses and the corresponding ICD-10 codes. When a patient is self-referred and there is no prescription, a manual therapist without diagnostic scope (in some cases) may be able to use ICD-10 codes that are considered "symptom" codes (see online, Appendix E for a list of symptom codes). Verify specific regulations regarding self-referrals with each insurance company before submitting ICD-10 codes that have not been provided by a referring HCP. Some states have very strict limitations on this. In WA, for example, the consulting attorney for the AMTA-WA has advised massage therapists *not* to provide ICD-10 codes unless specified in writing by a referring HCP.

The prescription should state diagnoses that pertain to the manual therapists' treatment. For example, a cervical subluxation may not be treatable within the scope of practice of a massage therapist; however, it may be appropriate to treat a spasm in the neck. Confirm that the prescription contains ICD-10 codes applicable to your treatment. If not, make suggestions and call in or fax the changes to the HCP's office for authorization.

The frequency and duration of treatment must be specified, such as once a week for 6 weeks or twice a month for 3 months. Many HCPs will defer to the manual therapists' expertise. All nondiagnostic practitioners must state their preferences to the HCP and record (on the prescription form) the specific number and frequency of sessions authorized.

Make sure the prescription specifies all areas where treatment should be applied. If the diagnosis only indicates that the neck, for example, is involved in the whiplash injury, treatment to the back and arms may be considered unnecessary and may not be covered by insurance. As a holistic practitioner, you may find it impossible to treat whiplash without treating pain in the back and arms, for example, which often accompanies whiplash injuries. The referring HCP must authorize treatment to indirect areas of concern. A prescription that simply states, "neck and related areas" may also be acceptable.

In addition to the diagnosis and basic treatment plan, prescriptions may include further instructions, such as the following:

- Types of treatment (massage, hot/cold packs, self-care, for example)
- Treatment goals (decrease pain, decrease muscle spasms, and restore posture, for example)
- Cautions and contraindications (avoid lying on right side for 6 weeks postsurgery, for example)

Avoid requesting authorization for specific techniques. Manual therapists rely on a variety of techniques to elicit the desired response in a patient, and many referring HCPs do not know the difference between, for example, muscle energy technique and strain/counterstrain. Prescribing specific techniques limits the practitioner to the techniques identified and may not be reimbursable by the insurance company. If, for example, trigger point therapy is prescribed, the cost of providing lymphatic drainage techniques may not be reimbursed. Offer general treatment options on the prescription form or none at all.

Request permission to instruct the patient in self-care exercises. This is helpful in states where rules are vague concerning the manual therapist's **scope of practice**. Although insurance companies encourage teaching the patients stretching and strengthening exercises, some manual therapy professions compete for the right to this scope of practice. Stay within your governing law and ask referring HCPs to use this section of the prescription to authorize the instruction of patients in self-care exercises in which you are trained.

If you seek additional instruction for your treatment plan from the referring HCP, provide a checklist on the prescription form for treatment goals rather than specific techniques. Include goals such as decreasing pain or increasing range of motion. This approach authorizes the use of any techniques within the practitioner's training and scope to accomplish the specified goals.

It is always helpful to request information from the referring HCP about cautions and contraindications to treatment. The referring HCP may have information that will assist you in providing safe and effective care.

Use the prescription to determine the referring HCP's preferred style and frequency of communication. For example, find out whether he or she prefers to receive copies of the treatment notes with each report and whether he or she wants the reports faxed, e-mailed, or mailed to her office. If the referral is oral, send an introductory letter to find out how the doctor would like to receive your reports.

INITIAL REPORT

The initial report thanks the HCP for the referral, offers a brief summary of the patient's presenting complaints and your assessments, and informs the HCP of your goals and treatment plan. The HCP is usually familiar with the patient's condition, so limit the information to key data. The most important information is the treatment plan—what you want to accomplish in the next 30 days and how you and the patient will work together to achieve the goals (see Figure 2-5).

The initial report is a summary of the **initial SOAP notes** written in paragraph form. The initial report contains the following:

- Initial treatment date
- Functional goals
- Treatment plan
- Commitment to report back by a set date

To support your treatment plan and the functional goals, include a brief summary of the patient's presenting symptoms, functional limitations, and pertinent objective data. It is not necessary to list all of your findings. Include compelling data that is both quantitative and qualitative. For example, you might write that Ms. Hostetter is unable to cook because of severe pain and fatigue in her shoulders, back, and neck … or that Mr. Tu reports moderate headaches that affect his ability to concentrate at work, lasting 2–3 days, occurring weekly. Omit lists of tight muscles or findings that are vague or cannot be substantiated. The focus of the report should be on the treatment plan:

- Treatment goals (based on objective data, such as reduce muscle spasms and reduce trigger point pain)
- Treatment techniques and modalities (address how you plan to accomplish treatment goals and functional goals)
- Treatment application (where you will apply various techniques and modalities)
- Frequency and duration of treatment sessions (such as 60-minute sessions twice a week for 3 weeks)
- Homework and self-care education (such as ice packs twice daily for 15 minutes)

A functional goal states in measurable terms the activity to which the patient wishes to return (see Chapter 6, Documentation: Session Notes, for in-depth information on setting

FIGURE 2-5. Initial Report with Treatment

Hands Heal™ EHR

Progress Report
Heather Pratt
Massage Therapist: Diana Thompson

Hands Heal
6720 14th Ave SW
Seattle, WA 98106
Phone: (206) 755-5564

Client Info

Heather Pratt (DOB 9/8/1977)
987 65th Ave NE
San Diego, CA 98765
(555) 987-6543
heather@handsheal.com

Health Info

I have a lot of scar tissue from my recent surgery that is limiting my range of motion. There is some remaining swelling and pain. The only medication I take for the cancer is Anastrozole, other than over-the-counter pain meds and supplements. I am not doing chemo or radiation.

Health History

Double mastectomy in December 2016. Surgery was preventative; I have the *BRCA* gene and have had two breast cancer occurrences over the past 10 years. I am active (road biking, hiking) and have an active job (carpentry). I have had no other major illnesses or accidents.

Report Summary

Heather Pratt presented for her first massage with mild pain and swelling one month post double mastectomy. The scar tissue was moderate and restricted her shoulder range of motion. Our treatment plan is to reduce the pain and swelling, and increase the function of her scar tissue in order to increase her range of motion. Her first functional goal is to improve her shoulder range of motion so she can pull shirts and sweaters on over head with no more than mild pain, instead of having to wear button and zip-up clothes. Her self-care includes arm circles in varying positions, increasing in difficulty as her range of motion improves. I would like to work with her twice a week for the first two weeks, and once a week for the next four weeks, and will report back at that time. Thank you for the referral.

goals and charting outcomes). Include a time frame, such as 30 days, by the end of which the patient will have achieved the goal. For example, you might write that Ms. Hostetter will be able to stand for 30 minutes while cooking, repeatedly lifting and extending up to 25 pounds over a stove and tossing food, 3 days a week, with moderate pain and fatigue, within 30 days. Functional goals demonstrate progress in terms the patient can comprehend on an experiential level.

Treatment goals provide the parameters by which the practitioner will measure the patient's success, such as decrease muscle spasms, increase range of motion, or reduce inflammation. All parameters must be measurable in quantifiable or qualifiable terms, such as mild, moderate, or severe; or 0–10; or normal, good, fair, or poor.

Treatment techniques and modalities listed should address the needs of the goals. Include the areas of application. For example, lymphatic drainage will be applied to the neck to reduce pain and inflammation and strain/counterstrain to the shoulders and spine to decrease muscle spasms and increase range of motion. State how the patient will participate in accomplishing the goals. For example, you might write that Ms. Hostetter will continue to apply ice packs to the neck using a towel as a barrier for 10–12 minutes twice daily.

Recommend a set number of sessions you believe is necessary for accomplishing the goals. For example, Ms. Hostetter will receive six 1-hour sessions, two per week for the next 2 weeks, and then one a week for the remaining 2 weeks. I will report on her progress at the end of the series of sessions. If the referral did not result in an appointment with the patient, write a simple report explaining the reason. For example, the patient neglected to attend the scheduled appointment, or I am currently unavailable for new patients (see Figure 2-6).

A standard report form for referrals that do not result in appointments is provided (see online, Appendix B, Blank Forms). It is necessary to inform the referring HCP of the status of the referral. The intent is to be courteous without investing time in a relationship that is not producing income, yet at the same time, leaves the door open for future referrals. This is one instance in which a handwritten, fill-in-the-blank form is appropriate. This can be done quickly and easily by checking off the applicable reason from a list of possibilities explaining why the referral has not resulted in a therapeutic relationship.

If the initial report is your first correspondence with the referring HCP, include a modified introductory letter and several brochures. The referral may have come your way because the patient already has a relationship with you, your reputation precedes you, or the patient selected your name from a list of providers. Take the opportunity to educate the referring HCP on your services, the benefits of your techniques, and how to refer to you in the future.

PROGRESS REPORT

Progress reports summarize the patient's progress over a period. The period may be 30 days, 6–8 sessions, or the length of the prescription, whichever coincides best with the treatment plan. Progress reports are critical for keeping the HCP informed of the success of the referral (see Figure 2-7). Do not delay in sending progress reports and never wait until they are requested. An omission in reporting can result in a loss of referrals. Progress reports consist of the following:

- Most recent functional outcomes
- Status of the patient
- Plan for care
- If you are recommending ongoing patient care, include the following:
  - New functional goals
  - Updated treatment plan

Progress reports focus on functional outcomes—the patient's increased ability to participate in daily activities. It is not necessary to repeat information stated in the initial report or in previous progress reports. Focus only on the patient's progress and, if necessary, any requests for authorization of additional treatment. The improvement in the patient's health is noted by comparing the current report to the previous reports. Each consecutive progress report builds on the last, making it unnecessary to repeat the patient's initial condition.

FIGURE 2-6. Initial Report Without Treatment

Naomi Wachtel
567 Sunnydale Dr.
Flat Irons, CO 80302
PHONE 303 555 8866 • EMAIL wachtel@email.com

Dear Dr. Hall:_____:

Thank you for referring Jackie Shenge to my office. Your patient and I were unable to connect for the following reason(s):

_____ The patient did not schedule an appointment.

_____ The patient did not attend the scheduled appointment.

_____ I am not scheduling new patients at this time. I anticipate my schedule to open back up again _____.

__X__ I am unable to benefit the patient for the following reason(s):

Her condition necessitates intraoral techniques outside my scope of practice. I recommend referring to Sari Goldsmith, LMT, who also has a license in dental hygiene and specializes in craniofacial pain syndromes. Her number is (303)555-5434.

Thank you for the referral. I hope to work with you again in the future.

Yours in health,

Naomi Wachtel, LMT

Initial reports state a functional goal, and progress reports give an accounting of the status of that goal. If the goal has been accomplished in its entirety, it is stated as an outcome—Ms. Hostetter has accomplished the initial goal of being able to stand for 30 minutes while cooking, repeatedly lifting and extending up to 25 pounds over a stove and tossing food, 3 days a week, with moderate pain and fatigue. At times, the patient and practitioner are only partially successful in accomplishing the functional goal. In those circumstances, the outcome is stated as accomplished, and the new functional goal becomes a modification of the previous goal.

FIGURE 2-7. Progress Report

Helena LaLuna, CR
123 Sun Moon and Stars Drive
Capitol Hill, WA 98119
PHONE 206 555 4446 • EMAIL laluna@email.com

4041 Bell Town Way, Ste. 200 5-12-17
Capitol Hill, WA 98119

Patient: Zamora Hostetter
DOI: 3-31-17
Claim #: C98-7654321

Dear Dr. Yuricich:

Thank you for referring Ms. Hostetter to my office for manual therapy. After 10 sessions of myofascial release, Ms. Hostetter has achieved her initial goal. She is able to stand and cook for 30 minutes, while repeatedly lifting and extending up to 25 pounds over a stove and tossing food, 3 days a week, with moderate pain and fatigue.

To facilitate Ms. Hostetter's return to work, ongoing care is requested. We must extend her cooking time to 90 minutes, 3 days a week, and include 3 hours of additional time at work preparing food. However, Ms. Hostetter is able to sit down at work and take frequent breaks during her preparation time. With 3 additional sessions of myofascial release, we should be able to reach the new goal of cooking for 90 minutes, while repeatedly lifting and extending up to 25 pounds over a stove and tossing food, 3 days a week, with mild pain and moderate fatigue. Ms. Hostetter will attend sessions weekly for 3 weeks, receive additional self-care instructions including alternating hot and cold pack applications, and participate in home exercises to stretch and strengthen injured areas during this time.

Please inform me of your decision to continue Ms. Hostetter's manual therapy. I look forward to working with you in the future.

Yours in health,

Helena LaLuna, CR

In some cases, functional goals and outcomes are not applicable and treatment goals are the only measures of success. Report measurable changes in symptoms and objective findings whenever functional limitations were minimal or nonexistent and functional goals were not set. For example, Mr. Tu's headache has changed from moderate to mild and occurs weekly, lasting for 2–3 hours rather than 2–3 days as previously stated.

State the current status of the patient in each report. Here are some common statements explaining the patient's status:

- Patient has achieved identified goals
- Patient has not achieved identified goals
- Plateau in patient's progress

State the current plan of care. Care may be complete or additional care may be necessary. Suggest changes in the treatment plan, referrals to another type of practitioner, or assistance with self-care education. You may have reached the limits of your abilities and can suggest additional care that will take the patient beyond a plateau. The patient may not have reached his or her long-term goals or returned to preinjury status and may request ongoing care from you. Common care plans include one or more of the following:

- Care is complete: Patient has reached the limits of the referral; patient met the goals under the referral limits; anticipate that patient will reach long-term goals independently
- Additional care is necessary: Ongoing care is requested; a change in the treatment plan is suggested; a referral is recommended
- Patient to return to referring physician

If the patient could benefit from ongoing care, state the new goals for treatment. Propose an updated treatment plan by explaining how the goals will be accomplished. Identify the treatment techniques that will be used and explain why they are necessary, specify the treatment frequency and duration necessary for accomplishing the goals, and describe how the patient will contribute to the plan.

Send progress reports to adjunctive therapists and to referring HCPs. Keep all members of the health care team apprised of the patient's progress.

All the information in a progress report comes from the treatment notes, but occasionally, referring HCPs need more than a brief summary to create their reports and treatment plans. Send copies of the treatment notes when they are requested.

REFINE YOUR SKILLS

Learn to Write a Progress Report from a SOAP Chart

Pair up with another student or colleague. Exchange an evaluative (progress) treatment note, with patient identifiers blacked out. Write a progress report using only the information available on the treatment note. Do not ask each other for additional information on the patient. This will train you to write reports based on information that is written down, not on conversations with patients. Reports must reflect information contained in the records.

Summary

Conventional HCPs have a standard protocol for communicating with each other: specialists report to referring PCPs after the first visit. If the treatment plan includes regular visits, the specialist is to evaluate the patient's progress every 30 days and report the progress to the primary HCP. If a manual therapist can comply with the communication protocols and effectively convey patient progress, then the HCP is more apt to refer patients to the therapist.

Use familiar pathways and common language to establish relationships with the members of the health care team and to share information. Be brief and professional with your communications.

Establish communication with caregivers by sending letters or e-mails introducing yourself and outlining your services. Create prescription pads to streamline referrals. Once you have received a referral from a HCP, send an initial report describing the status of the patient. Every 30 days, or at the end of every prescription, send a progress report. Use the information recorded on the patient's daily treatment notes to write the reports.

Progress reports include the following:

- Current functional outcomes or summary of current subjective and objective progress:
  - Status of the patient
  - Plan for care
- If a request for ongoing care is needed, include the following:
  - New functional goals
  - Updated treatment plan

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CHAPTER 3

Communication with the Legal Team

After mastering the concepts in this chapter, the student will be able to:

- Apply basic knowledge of personal injury (PI) law to ensure financial security when treating PI patients
- Understand the massage therapist (MT) role with the legal team
- Identify the required content of a health record
- Write a narrative report
- Determine when to require a Guarantee of Payment from a patient's attorney
- Recognize the need for a medical release of information and apply the HIPAA requirements for tracking and distributing private health information
- Prepare for a deposition or in-court testimony

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Uncle Darnel was in a car crash on the way to a hockey game. He was riding in the passenger seat, chatting with his nephew, when a large pickup truck rear-ended them. Initially, there were no serious injuries, just some fender damage. The guys were eager to get to the game and were ready to leave after exchanging phone numbers

when a police officer pulled up to assist. She asked each of them a few questions. As it turned out, the driver of the pickup truck was uninsured and a report needed to be filed.

At first, Darnel was not in pain, just a little shaken up, and he and his nephew were able to attend the hockey game after all the paperwork was completed. Later that evening, however, he developed a headache, as well as stiffness and soreness in his back and neck. A few weeks later, his back pain was getting worse. Darnel finally went to his family physician, who prescribed anti-inflammatories and referred him to a manual therapist. After a month of manual therapy, the neck symptoms were clearing up but the back pain was not. John, the manual therapist, and Darnel were both concerned, so Darnel returned to the doctor. The doctor ordered x-rays, which confirmed what they all suspected—spinal degeneration. Darnel had a history of scoliosis, but with regular exercise, he had been successful in halting the degenerative process early on and had been pain free until the car crash. Now, he was in constant pain, and his spinal degeneration had accelerated.

Unfortunately, the scoliosis was not Darnel's only worry. There were financial complications as well. Darnel's private health insurance did not cover manual therapy. The at-fault party had no insurance. Neither the nephew's nor Darnel's car insurance carrier was coming forward to pay the bills. Which one was responsible? Did Darnel have a choice about whom to bill, based on quality of coverage? John wondered whether he could treat the scoliosis and bill the car insurance for the treatments. Darnel was beginning to worry that he was going to be stuck with the medical bills. He was ready to quit therapy, even though the treatments eased his pain and helped him stay active.

John knew just enough about personal injury law from experiences with other patients to know that Darnel needed some professional help. Before the next session, they sat down together and discussed the financial problems. John wanted to help Darnel relieve his financial worries so that Darnel could focus on getting well. First, they had to determine whose insurance would pay the medical bills and what type of coverage was available. Second, they needed assurance that the insurance carrier would pay for the scoliosis treatments because the collision caused the flare-up of Darnel's symptoms. John suggested that Darnel consult with an attorney specializing in personal injury law about access to health care and for advice about his financial concerns.

Darnel met with Charma Storro, JD and was immediately relieved. Under the laws of the state where the accident occurred, the nephew's car insurance was the primary insurance carrier responsible for Darnel's medical bills. The nephew's policy included **personal injury protection (PIP) coverage**, so Darnel's medical bills should be paid reasonably promptly. The insurance company's staff would be able to track down the at-fault driver of the pickup truck from the police report and would handle all communication with him. The attorney instructed the insurance company to put two different adjusters on the case to ensure fair representation for Darnel—one to handle PIP matters and the other to handle issues related to the uninsured motorist claim. Because Darnel's physician had treated him throughout his adult life, he had solid documentation that his scoliosis was asymptomatic before the crash and that the flare-up was related to the collision. As a result, the treatment for the scoliosis flare-up was covered under the PIP policy. John noticed a difference in Darnel's health when the stress of managing the claim was removed. Darnel was able to turn over the worry to the experts and focus on getting well.

Introduction

Every manual therapist must have basic knowledge of personal injury law, including an understanding of the rights and obligations of the practitioner and the patient, to avoid burdening himself or herself and his or her patients with unnecessary risk and stress. Patient records can be subpoenaed or testimony required years after treatment has ended, even if the patient never mentioned a motor vehicle collision (MVC). It is imperative, therefore, to keep good records on *all* patients and to understand your role with the legal team to act responsibly in the therapeutic relationship.

The legal team consists of an attorney hired by a person who has suffered injuries as a result of carelessness or recklessness by another person or business. The attorney's staff may include other attorneys, paralegals, investigators, and support personnel. The legal team and the health care team form the first line of protection between the victim and often debilitating physical and financial losses that can be the medical and legal consequences of physical injury, emotional injury, or both.

MVCs include collisions between cars, cars and motorcycles, and cars and pedestrians. Work injuries that result in short-term injury or long-term disability may also call for legal intervention, as may slipping, falling, or tripping at a private residence or a commercial location. For example, Alice suffered a ruptured disk while fighting a fire and was forced into early retirement, Lisa was helping her dad clean the gutters when she tumbled off the roof and broke both feet, and Steven was watching a baseball game at a sports bar when a ceiling tile fell on his head and gave him whiplash. All these injuries may have resulted from someone's negligence. The legal team will gather and preserve evidence to prove liability; will understand and defend the patient's rights; and will negotiate compensation for physical injury, loss of income, pain and suffering, health care expenses, and future health care needs.

The manual therapist is a natural and important part of the medical legal team. The manual therapist contributes to the team by keeping good patient records, communicating regularly, and understanding personal injury law (see Chapter 6, Documentation: Session Notes, for in-depth information on recordkeeping). An excellent resource to read and have available for your patients is *From Injury to Action: Navigating Your Personal Injury Claim* by Richard Adler.[1] Reading this helps you understand the nuts and bolts of personal injury cases, and sharing it with your patients takes the pressure off you to have to explain things.

The Role of the Legal Team in Personal Injury Cases

Some patients suffering from personal injury can receive health care benefits even when no fault can be established or when the car or home insurance policy includes PIP or **medical payments (MedPay) coverage**. For example, if Darnel had driven his car into a telephone pole after falling asleep at the wheel, he would still be eligible for medical benefits up to the limits of his PIP or MedPay insurance coverage, provided the services were deemed reasonable, necessary, and related to the collision. In other words, health care expenses are covered regardless of who caused the trauma. If Darnel had PIP coverage, he might also be eligible for lost wages and household services, in addition to medical coverage. Each state has laws, regulations, and rules establishing the mandatory minimum coverage that owners of vehicles must carry. It is critical for each health care professional to have a thorough working knowledge of his or her state's automobile insurance requirements.

Legal representation may be unnecessary if the injuries are minor, the car repairs are cosmetic, and the insurance company is paying the bills promptly (even when negligence can be established).

Some patients understand the benefits of legal counsel in personal injury cases and retain representation when a situation arises that requires it. Others will at least obtain a legal consultation to better understand the issues, rights, and duties of all the parties and insurers. Whether hiring an attorney or just consulting with one, follow the guidelines in this chapter to communicate with the legal team. Other patients are unaware of the benefits of legal representation, and they struggle unnecessarily with their insurance carriers or with the insurer of the at-fault party. Perhaps the insurance adjuster is not forthcoming about the coverage available or the injuries are complicated and the patient needs assistance in proving that the injuries resulted from the incident. Patients are often unaware of their rights regarding insurance coverage and personal injury law, and many health care providers shy away from answering legal questions or addressing legal concerns. If the interests of the patient would be served by professional legal consultation, then the manual therapist should say so. For example, an insurance carrier terminates care even though the patient continues to suffer from flare-ups and coverage is still available, significant physical injury exists and long-term disability is imminent, major health care expenses have been incurred, or applicable **statutory time limits** are fast approaching for filing a claim, to name just a few. Even though manual therapists cannot dispense legal advice, it is important to discuss the need for legal consultation rather than remain silent while the patient's rights slip away or the patient's financial and health care interests worsen. Fair resolution of a legal claim often provides resources for health care and bears significantly on the patient's physical and emotional well-being. Here are common scenarios in which patients could benefit from consulting an attorney experienced in personal injury and insurance law:

- The insurance carrier refuses to pay the medical bills or discontinues coverage.
- Liability is contested.
- **Proximate cause** is challenged because of the following:
  - The patient delays seeking initial treatment (implying that the injury is minor and does not need treatment); the patient's onset of symptoms are delayed (implying that the injury was not caused by the trauma); gaps of time exist between incident and treatment (implying that the patient failed to mitigate his or her injuries by not getting the treatment needed).
- Physical injuries are moderate or severe.
- Physical injuries are having an impact on the patient's ability to return to his or her usual work.
- Physical injuries are having an impact on the patient's earning potential.
- **Preexisting conditions** flare up after the accident.
- Additional accidents occur before previous injuries are resolved.
- The insurance company schedules an **insurance medical examination (IME),** also known as an independent medical exam (although "independent" is often a misnomer), selects the doctor, and pays for the examination of the insured.
- The at-fault party has no insurance, and the patient needs to present an uninsured motorist claim to his own insurer.
- The accident involved minor visible property damage, yet it resulted in injury. It is common for insurance carriers to argue that a person cannot be injured when the visible car damage is minimal.

The attorney and legal team can address issues and provide services to your patient regarding the following:

1. Evidence—Legal team reviews, retains, and preserves evidence regarding liability and biomechanics of the incident.
2. Statute of limitations—Legal team provides insight and advice in addressing state-mandated time limits pertaining to the filing of claims and lawsuits and can assist in settling the claim or in filing the lawsuit. In Oregon and Illinois, for example, the time limit for filing an injury claim is 2 years. In Washington and New York, the limit is 3 years.
3. Stress—Legal team can monitor the payment of bills, collect evidence, obtain records and reports, and deal with the insurance company, thereby helping to reduce the patient's stress and the daily burdens of keeping up with these tasks.
4. Negotiations—Legal team negotiates and represents the patient's interests (patients have little or no negotiating power with the insurer) with claims representatives who are also trained, experienced negotiators and understand that patients cannot file lawsuits without an attorney—not to mention their loyalty and duty to the insurance company—and who often try to settle the claim at the lowest amount possible.
5. Knowledge—Legal team brings in-depth awareness of personal injury and insurance laws and advocates for the patient's rights to make sure the insurer complies with good faith provisions of the law and, if not, can take legal action to remedy the situation.
6. Protection of patient when an IME is requested—Legal team may be able to negotiate with the insurer for the selection of a truly independent medical examiner. Moreover, if the insurance company insists on the IME with a doctor of the company's choosing, then the attorney can accompany the patient to the IME or retain another person to serve as the attorney's observer.
7. Compensation—Legal team works to ensure that the patient receives reasonable and fair compensation for injuries and losses (without an attorney, patients may be harassed, intimidated, or pressured into accepting unreasonable or unfair settlements and forfeiting their rights).
8. Contingency fee arrangement—Legal team receives no payment for time expended if there is no recovery from the settlement or lawsuit.

Be prepared to respond to patients whose circumstances require a legal consultation from an attorney who specializes in personal injury law *and* who understands the benefits of manual therapy. To help the patient and the practitioner, the attorney retained should be knowledgeable and supportive of the manual therapist's role in the patient's care, should encourage compliance with the practitioner's treatment plan, and should not try to compromise or reduce the therapist's bill once the case concludes. Become familiar with the attorneys in your area who specialize in personal injury law and are pro-manual therapy. Find out which attorneys work as a team with health care providers and support **complementary and integrative health care**. Also, find out which ones frequently ask manual therapists to discount their bills or who refuse to sign letters that guarantee payment from the settlement. Know your allies and work with them.

Look for the following qualities in a personal injury legal team:

1. Understands the manual therapist's role in rehabilitation of injuries and ensures the patient's right to complementary and alternative medicine (CAM) care.
2. Encourages compliance with the referring health care provider's (HCP) prescription for manual therapy.

3. Assists in communication about the patient's case with all members of the health care team.
4. Readily knows whether insurance coverage is available, how much PIP coverage is available, when PIP coverage will expire, and whom to bill.
5. Advises the practitioner if there is secondary insurance coverage through the patient's health care plan (when PIP is not available or has been exhausted) and provides accurate information about whom to bill (see Figure 3-2 for a sample of an insurance status request form).
6. Intervenes when the insurance company is not complying with laws, regulations, or the terms of the insurance policy, such as not making reasonable and prompt payment of bills.
7. Answers the practitioner's questions about deferring payment and waiting for settlement in the event that PIP, MedPay, or secondary insurance is not available or has been exhausted.
8. Honors the patient's written commitment to be responsible for the manual therapist's bill at the conclusion of the personal injury case (see Figure 3-5 for a sample of a Guarantee of Payment for Medical Services contract).
9. Challenges the legality of an insurer's request for a medical opinion about the necessity of manual therapy, and in the case of an IME, attempts to ensure that the examination is independent.
10. Assists in educating the patient about the effectiveness of manual therapy.

REFINE YOUR SKILLS

Invite a personal injury attorney to speak to your class or local massage network meeting. Better yet, ask several attorneys, and have a panel discussion. Attorneys knowledgeable in working with manual therapists and other complementary practitioners will want to come, provide education, and promote their firms. Quiz them on their support of manual therapies, guarantees of payment for practitioners, and the services they provide patients. Discover ways to be a better advocate for your personal injury patients, and gain a better understanding of personal injury law.

Communication with the Patient's (Plaintiff's) Attorney

ESTABLISH RELATIONSHIP

Send a letter to your patient's attorney introducing yourself and your practice (Figure 3-1). Include an insurance status request form (Figure 3-2). For a blank sample of this form, see online, Appendix B. Ask the attorney to complete the form and fill in information about the patient's insurance coverage. The attorney will have the most accurate and current information on whom to bill and on whether PIP coverage is in effect and how much PIP money is available. Having this information is critical if you are sending bills directly to the insurance company and the patient has agreed to defer insurance payments to you. If the PIP money has been exhausted on hospital stays, lost wages, household services, or other medical services, you will need to bill the patient directly or decide whether to defer payment until a settlement has been reached. The attorney can answer your questions, ensuring that the patient's access to health care remains open.

In your letter, inform the attorney that you will be in touch monthly to send copies of the bills and update statements. If you bill the insurance company directly, send statements to the patient's attorney as well. This way the attorney can monitor PIP availability and track expenses, and your bill and balance will be known throughout the case. Your statements will also keep the legal team and the patient apprised of the insurance company's payment record. The patient can see how the insurance company is handling the claim and can intervene when bills are not being paid. The attorney can step in for your patient when the insurance company does not make payments in a timely fashion.

End the letter by asking the attorney how you can support the patient's case. Find out how the attorney wishes to receive information—by fax, e-mail, or regular mail, for example. Does the attorney want information in addition to the medical bills and statements?

FIGURE 3-1. Introductory Letter

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
PHONE 612 555 9889 • EMAIL olson@email.com

B. Charma Storro, JD
5 Hive Lane
Minnehaha, MN 55987
(612)555-2337

Dear Ms. Storro:

I am treating your client, Darnel Washington, for injuries sustained in a motor vehicle collision on January 6, 2017. I look forward to working with you on this personal injury case. I have enclosed one of my brochures and I am available by phone and e-mail if you have any questions about my work or my practice.

I have been unable to confirm which car insurance carrier to bill for Mr. Washington's treatments. Please advise me of the applicable insurance company, the name of the adjuster assigned to the case, and the claim number. Please include information regarding insurance coverage: is there PIP coverage? Med Pay? Health insurance? Uninsured Motorist coverage? If so, how much is currently available?

Enclosed is a form for your use. If Mr. Washington does not have PIP or Med Pay coverage available, I will forward two copies of a Guarantee of Payment for Health Services for you to sign. Please keep one for your records and return the other to me in the envelope provided.

I will update you monthly with copies of the patient's billing statements. Is there any other information you would like me to send in addition to the monthly statements? Do you prefer that I send you the information by fax, mail, or e-mail?

Yours in health,

John Olson, LMP, GCFP

FIGURE 3-2. Insurance Status Request Form

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
PHONE 612 555 9889 • EMAIL olson@email.com

INSURANCE STATUS—PERSONAL INJURY

Patient Name Darnel G. Washington Date 2-15-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789

A. Reporting to Attorney

Which information would you like to receive monthly and how do you prefer to receive information:

- ☐ copies of billing
- ☐ monthly statements
- ☐ SOAP charts
- ☐ Progress reports
- ☐ fax
- ☐ mail
- ☐ email
- ☐ upon request

B. Primary Insurance Coverage

Effective dates: from _____ to _____

Please provide the following information regarding your client's/my patient's insurance status:

Insured _____
Insurance ID# _____
Insurance Carrier _____
Billing Address _____
City _____ State _____ Zip _____
Adjuster _____
Phone _____ Fax _____
PIP policy amount $ _____
Dates of coverage _____
PIP available $ _____
Med Pay policy amount $ _____
Dates of coverage _____
Med Pay available $ _____

C. Secondary Insurance Coverage

☐ N/A ☐ Effective date: _____

Insured _____
Insurance ID# _____
Insurance Carrier _____
Billing Address _____
City _____ State _____ Zip _____
Adjuster _____
Phone _____ Fax _____
PIP policy amount $ _____
Dates of coverage _____
PIP available $ _____
Med Pay policy amount $ _____
Dates of coverage _____
Med Pay available $ _____

If secondary coverage is through the patients' private health insurance, is manual therapy a covered benefit: ☐ Yes ☐ No ☐ Don't Know

D. Third Party Insurance Coverage

☐ N/A ☐ Effective date: _____

Insured _____
Insurance ID# _____
Insurance Carrier _____
Billing Address _____
City _____ State _____ Zip _____
Adjuster _____
Phone _____ Fax _____
Liability policy amount $ _____
Dates of coverage _____
Liability available $ _____
Uninsured/underinsured motorist (UIM)$ _____
Policy Amount $ _____
UIM available $ _____

Some attorneys want copies of the patient's session notes, outcome measures, and progress reports sent to them monthly. Others will wait until immediately before settlement to ask for the patient's file. (Remember: Patient records are confidential. All requests for patient information must be in writing and must include the patient's written authorization, even requests from the patient's own attorney. Record the date records were sent, as well as the date requests were received.) Most attorneys will tell you that keeping accurate, reliable, and relevant chart notes is the best thing you can do to support the patient and the legal team.

The next section provides information on handling requests for medical records.

MEDICAL RECORDS

Maintaining Client Health Records

Make sure your recordkeeping is complete, accurate, and well organized. A complete manual therapist's file will include the following:

- Session notes of every treatment date, including extensive charting of examinations and reexamination sessions
- Correct treatment date clearly stated on every session note, corresponding accurately with the treatment date billed
- Prescriptions covering every treatment date, verifying treatment as medically necessary
- Supportive documentation, including session notes, intake forms, and outcome measures, and all information written in progress and narrative reports
- Correspondence with the health care team, such as progress reports, requests for medical records, copies of other providers' progress reports, and notes from phone calls
- Legend of abbreviations and symbols

Strengthen your health records against common attacks by insurers. Currently, insurers are using the definition of proximate cause to deny payment. As stated in Washington Pattern Jury Instructions 15:01: "The term proximate cause means a cause which in a direct sequence (unbroken by any new independent cause) produces the injury complained of and without which such injury would not have happened." In other words, only the present trauma is directly and solely responsible for the patient's injury and nothing else happened to influence the result. Often, a delay in seeking treatment, a delay in the onset of symptoms, or gaps in treatment may be used as evidence that the injury is not as symptomatic as claimed or that a preexisting condition or a subsequent trauma is responsible for the patient's condition, thereby relieving the insurer of the responsibility of payment. The medical–legal–insurance context draws a distinction between asymptomatic or dormant conditions versus symptomatic or active preexisting conditions. An injury that "lights up" an asymptomatic or dormant condition requires the responsible party or insurer to cover all reasonable and necessary treatment expenses. However, an injury that "aggravates" a symptomatic or active condition requires the responsible party or insurer to cover only those expenses attributed to the aggravation of the condition.

Explain delays in the onset of symptoms and all gaps or delays in treatment. If treatment was not sought immediately after the injury, ask the patient to reflect on the reasons why and record his or her answers in your notes. An insurer could claim that another incident occurred during the time between the MVC and the initial treatment session. Often, it is possible that the patient waited to see whether the symptoms would dissipate, or the patient diligently tried self-remedies (such as rest, heat pads, or over-the-counter pain medications) and, weeks later, gave up and sought care. Also, patients who are unsure about their insurance coverage may try to tough it out because they cannot afford to pay for treatment out of pocket.

Similarly, a patient might take a break from treatment because he or she becomes concerned about mounting medical expenses. Others might discontinue care out of fear of losing their job because of time taken off for medical appointments, or they become overwhelmed by multiple treatments. An insurer might purport that the gaps in treatment are an indication of a new, independent event resulting in renewed care. Rule out intervening trauma and document the patient's worsening condition without treatment.

If the patient's onset of symptoms is delayed, chart possible functional or physiological explanations, such as the patient was on bed rest and it wasn't until he or she returned to work that the symptoms flared or inflammation prevented full range of motion, then with a reduction in inflammation and an increase in mobility, the patient began experiencing pain with activity. Be proactive by staying informed of insurance strategies for denying payment and recording information in the patient's chart that effectively responds to them.

Requests for Medical Records

The attorney will request the patient's entire medical file at some point in the personal injury case. Everything in the file should be sent, not just session notes, outcome measures, and progress reports. Include all intake forms and consent forms, requests from doctors and insurance companies—every piece of paper in the file.

Requests for medical records are made in writing and include the patient's signature authorizing the release of the patient's records to a specific party. *Never* share confidential patient information over the phone unless you have a current and valid legal authorization signed by your patient to release information to the caller. Always wait before sending documents until you have a written request with the patient's signature authorizing the release of medical records. After you receive the request and authorization, send copies of the patient's file. Sometimes, the request may specify whether the entire file is requested or simply the SOAP (acronym for Subjective, Objective, Assessment, Plan) charts and progress reports.

A release form is valid for a set period, depending on state law, after which a new release form must be signed to authorize the additional release of medical information. Check the release form for the expiration date and make sure you have a valid one on file before sending out copies of the patient's confidential file.

The attorney may ask the patient to sign a release form that contains a clause negating all previous release forms (see Figure 3-3). For example, Darnel signed a release form on January 12, authorizing his insurance company to receive copies of his medical records. On March 22, he retained an attorney to represent him and signed an exclusive medical release form voiding the insurance company's release form. Only the attorney's release forms are now valid. Be aware of any exclusive release clauses and honor them.

NARRATIVE REPORTS

The attorney may request **narrative reports** from the patient's health care providers that summarize the patient's injuries, treatment, and progress from beginning to end. These support the attorney in substantiating the patient's personal injury case. Ultimately, the attorney needs narrative reports from health care providers that contain a diagnosis, examination findings, test results, and a prognosis that establish significant injury, validate the medical treatments received, and, if necessary, demonstrate residual effects, disability, or the need for ongoing care. Manual therapists without **primary care status** have less to offer in a narrative report than do the referring HCPs because of their inability to diagnose or provide a prognosis. However, if the role of the manual therapist is primary in the patient's recovery, a narrative may be requested, but will be modified to only include information found in the treatment notes and progress reports (see Figure 3-4).

FIGURE 3-3. Exclusive Release of Medical Records

PATIENT'S RELEASE OF HEALTH CARE INFORMATION

Patient's Name Darnel G. Washington

Social Security Number 123-45-6789 Date of Birth 4-22-43

I hereby instruct my providers to provide full and complete information to B. Charma Storro, JD and to accept this authorization form and release the protected information requested without requiring any additional authorizations. I specifically waive any "minimally necessary" limitations of HIPAA.

Health Care Provider/Facility John Olson, LMP, GCFP
is hereby authorized to release health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, employees, and designated agents of my attorneys, to wit:

Attorney's Name B. Charma Storro, JD Phone (612) 555-2337
Address 5 Hive Lane
City Minnehaha State MN Zip 55987

This request and authorization applies to:
✓ Health care information relating to the following treatment, condition, or dates of treatment: MVC 1-6-17
____ All health care information:
____ Other: _____

How the Information will be used: Said information shall be used for any and all purposes for B. Charma Storro, JD to pursue payment of care expenses and in providing legal services to me in conjunction with my case. Following said disclosure the information may no longer be subject to HIPAA protection, as it may be subject to re-disclosure that is unprotected absent specific laws protecting specific sensitive information.

Revocation of Prior Authorization: All medical authorizations by the patient or patient's authorized representatives given before the date of this release for any reason whatsoever are hereby revoked.

Unlawful Disclosure Prohibited: State and Federal law prohibits any health care provider from releasing any health care information about a patient to another person without the consent of the patient. You are requested to disclose no such information to any insurance adjuster or any other person without written authority from me which is printed on the letterhead of my attorney.

Effect of Photocopy: A photocopy of this release shall have the same force and effect as a signed original.

Authorization expires 90 days from date of signature. Thereafter, no authorization exists unless an updated release is provided by: B. Charma Storro, JD

I understand that I have the right to revoke this release for any information not yet provided to B. Charma Storro, JD by providing notice of revocation in writing to the above named care provider. I also understand that I have the right to refuse to authorize disclosure at all.

Darnel G. Washington 2-15-18
Signature of Patient or Patient's Authorized Representative Date

FIGURE 3-4. Narrative Report

HANDS HEAL

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
PHONE 612 555 988 • EMAIL olson@email.com

January 20, 2018

Patient: Darnel G. Washington

DOI: 1-6-17

Claim Number: 123-45-6789

Date of Exam: 1-20-18

Mr. Washington was first seen in my office on 2-6-17 for manual therapy treatment to injuries sustained in a motor vehicle accident on 1-6-17. He was referred by Dr. Sage Redtree, MD, with an initial diagnosis of spinal sprain-strain in the neck, mid-back and low back areas, and headaches. Within 2 months of the accident, Dr. Redtree diagnosed Mr. Washington with a flare-up of scoliosis with accelerated spinal degeneration.

Mr. Washington stated: he was a passenger in a Honda Accord and was rear-ended by a Ford F250 pick-up truck. The Honda was stopping for a yellow light, and the Ford was speeding up to go through the intersection. It was a cold and snowy January afternoon and the roads were slick. The car was pushed across the intersection but did not come in contact with any other vehicles or objects. Mr. Washington was turned to his left in his seat to chat with the driver at the time of impact. His head was thrown from side to side.

Initial Subjective Data:

On 2-6-17, Mr. Washington complained of mild neck pain and stiffness, moderate mid-back pain and stiffness, mild low back stiffness, and a moderate headache. The symptoms were constant since the evening of the accident, and increased in severity with all attempts to to lift his granddaughter, garden with his wife, or sit for over 30 minutes playing bridge with the club he presides over.

Initial Objective Findings:

I palpated moderate muscle spasms in the right sternocleidomastoid and scalene muscles, left trapezius and rhomboids, and right quadratus lumborum. Trigger points were elicited with light digital pressure in the paraspinal muscles, intercostals, and diaphragm. Muscle tension was mild to moderate throughout the spinal postural muscles. Cervical range of motion was moderately limited with active flexion and extension, and passive lateral flexion bilateraly. Inflammation was palpable in the cervical and thoracic regions: redness, heat, swelling, and loss of function; pain and inflammation seemed to be preventing full range of motion. Mr. Washington's posture showed a moderate left shoulder elevation with internal rotation, mild right hip elevation, mild "hump" or kyphosis in the mid-back, mild curvature of the thoracic spine, and a mild forward head position. He was weight-bearing moderately more on the right, his leg swing mildly closed on the right and arm swing moderately closed on the left when I observed his gait.

Initial Functional Goals:

Mr. Washington is the primary caregiver for his granddaughter during the day. Because of her age, he needed to pick her up to put her into the high chair at meals, and into the car seat, and to put her to bed at nap time. At the beginning of treatment, he was unable to lift or carry her because of pain and stiffness. His initial goal was to be able to lift her 10 times a day with mild pain and fatigue.

(continued)

FIGURE 3-4. Narrative Report *(Continued)*

After the scoliosis flared up, his activity level dropped considerably. Simple activities such as getting dressed and driving a car became too painful without assistance or frequent rest periods. His goal was to wash himself, dress himself, and walk around the block every day.

A year later, he was able to accomplish his initial goal.

Current Subjective Data:

Mr. Washington has infrequent and mild episodes of pain and stiffness with mild activity, which increase to moderate episodes of pain and stiffness lasting for several hours if he exceeds the following: 5 minutes of carrying his granddaughter, 1 hour of gardening, and 2 hours of sitting.

Current Objective Data:

Mr. Washington's kyphosis and spinal curvature are more pronounced than they were initially. The muscles around the scoliosis are constantly and moderately tight. His muscles in the mid-back area spasm only with activities in excess of the limitations described above; the rest of the spasms have resolved. The trigger points have resolved except around the scoliosis, the headaches are gone, and his cervical range of motion is normal. His gait is excellent and his posture is compromised only by the scoliosis.

Treatment:

Initially, I used full body lymphatic drainage techniques to reduce the swelling and pain, increase mobility, and strengthen the immune system. Soon I began incorporating movement re-education techniques to find ways that allowed Mr. Washington to move and perform daily activities, such as sitting, standing, and lifting, with more comfort and ease. Initially, the treatment frequency was weekly, increasing to bi-weekly with the exacerbation of scoliosis. After one year of treatment, the frequency returned to weekly, then bimonthly as progress permitted. There was one gap in treatment, due to an extended vacation, during which time Mr. Washington increased his self-care activities.

Progress Summary:

Within six sessions, the neck pain and stiffness, headaches, and low back stiffness were infrequent and mild. Unfortunately, the mid-back pain and stiffness worsened for several months and were debilitating. After several months, the treatments slowly and steadily diminished the pain and increased Mr. Washington's ability to return to a modified level of activity, but it was more than a year before Mr. Washington's scoliosis stabilized and he could return to his normal activities.

Mr. Washington is able to lift his granddaughter as needed, but can carry her for only 5 minutes at a time. He is able to garden for up to 1 hour, and can sit at a bridge table for 2 hours, after which time the pain kicks in.

Patient Status:

Mr. Washington participates in a daily stretching and strengthening routine, and comes in monthly for group movement classes to maintain his daily activity level. We have attempted to discontinue his treatments and rely solely on his self-care routine; however, after 45–50 days without treatment, his ability to function is compromised and his pain increases to moderate and frequent.

In summary, Mr. Washington responded positively to treatments and adapted to a higher level of self-care responsibilities. Please call if you have questions.

Yours in health,

John Olson, LMP, GCFP

It has been my experience that attorneys rely more on manual therapists' session notes, outcome measures, and progress reports than on narrative reports to substantiate a personal injury case. Good documentation decreases the need for narrative reports from manual therapists, and, when necessary, a good narrative report decreases the need for testimony at depositions or trials.

Thorough documentation that is contemporaneous with treatment minimizes work in the future and is a tremendous asset and support to the legal team and your patient. In the event that a narrative report is requested, be prepared to write one that reflects accurately and completely the patient's course of treatment. Because a narrative is written for attorneys and insurers and not for health care providers, use common language and avoid using Latin or formal names for conditions. For example, use the term *headache* instead of *cephalgia*. Explain everything in ways that can be understood by any layperson. Make sure the report includes all pertinent information and is to the point and not excessive. Present the information impartially—do not exaggerate or advocate for the patient. Do not use the narrative as a platform to promote your style of therapy. A narrative report should state the facts of the case clearly from the point of view of an expert. A narrative report includes the following:

- Initial treatment date
- All *initial* subjective and objective findings that pertain to the condition
- All *current* subjective and objective findings that pertain to the condition
- A summary of the treatment plan for the course of treatments, including the following:
  - Treatment goals that substantiate the treatment as reasonable and necessary
  - Manual therapy techniques and modalities
  - Locations on the body to which treatment was applied
  - Treatment frequency and duration of sessions
  - Changes in the treatment plan and why, such as gaps in treatment
- A summary of progress that includes the following:
  - Changes in client complaints, such as symptoms (subjective)
  - Changes in assessments and findings (objective)
  - Functional outcomes
- The status of the patient that describes the following:
  - Whether the patient's care has ended (if it has ended, include the final date of treatment; if it has not, give a projected date of completion)
  - Whether the patient has reached preinjury status
  - Whether a course of self-care for the future is needed (if it is needed, provide one)
- Narrative reports differ from progress reports in several ways:
  - Narratives summarize the entire personal injury case from beginning to end. Progress reports summarize progress month by month.
  - Narrative reports include information from all four data sets in the session note: Subjective, Objective, Assessment, and Plan. Progress reports only report progress—information found in the Assessment section, if using the SOAP format. (Note: online charting [electronic health records, EHRs] tends not to adopt the SOAP structure, even though the information recorded easily fits into those data sets. Content is separated by more specific categories and screens rather than SOAP.)
  - Narrative reports are written for the attorney and reviewed by the insurers, are several pages in length, and are provided for a fee (a customary practice). Progress reports are written for the referring HCP, are a few paragraphs in length, and are complementary.

Guarantee of Payment for Health Care Services

If there is no PIP coverage or the PIP money has been exhausted and you agree to defer payment until a settlement has been reached, obtain a signed authorization from the patient granting permission for your services to be paid directly from the proceeds of the settlement or judgment (Figure 3-5). After the patient signs two copies of the contract, submit both copies to the attorney and request his or her signature on both. One copy will be kept on file; the other will be returned to you. This contract is sometimes called an **Attorney Lien** but is more appropriately referred to as an attorney contract or Letter of Guarantee (see online, Appendix B, Blank Forms). A contractual guarantee of payment is not necessary if the insurance company is making regular payments, but it is highly encouraged otherwise. The contract, when signed by the patient and attorney, guarantees that you will be paid. Also, it ensures that you will receive payment in full upon settlement, rather than having to collect the money yourself from the patient.

TALES FROM EXPERIENCE

Guarantee Payment upon Settlement

A patient of mine spent her settlement funds on a vacation. She spent the money that was supposed to pay her medical bills. She eventually paid $100 per month until the bill was retired, but it was 2 years from the last date of service before I was paid in full. A letter of guarantee, signed by the attorney, would have prevented this delay in payment.

Include a clause restricting the patient from revoking the contractual guarantee once it is signed and stating that the contract follows attorneys in the event the patient decides to change attorneys later in the case.

The same contract that guarantees payment directly from the settlement can prevent attorneys from reducing your bill. State in the contract that payment for health care services will cover the total balance due at the end of treatment. Include a statement that the payment of interest is owed to you (if you are charging interest) and that the patient has received written notification of the interest charges at the beginning of treatment. (Notification of interest fees can be printed on your fee schedule.) See Chapter 5, Documentation: Intake Forms, for additional information on fee schedules. If the attorney signs the contract, the only way the bill can be reduced without your express permission is if your bill is found to be unreasonable, unnecessary, or unrelated to the injuries in question, as determined by a judge, jury, or arbitrator. An experienced personal injury attorney who supports complementary and integrative health care will make sure that the settlement is adequate for all the patient's medical expenses.

Communication with the Liability Insurance Company Attorney for the At-Fault Party

MEDICAL RECORDS

The insurance company and the attorney for the at-fault party are not entitled to the patient's records unless (1) the patient signs a medical authorization giving them permission or (2) a lawsuit is filed and you receive a subpoena or stipulation (signed by all parties)

FIGURE 3-5. Guarantee of Payment for Health Care Services

CONTRACTUAL GUARANTEE OF PAYMENT FOR MEDICAL SERVICES

I hereby authorize and direct you, my attorney, to pay directly to my health care provider(s), John Olson, the total dollar amount owing for health care services, including applicable interest charges, provided for injuries arising from the motor vehicle accident on 1-6-17. I hereby authorize my attorney and the involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect my health care provider(s) and their office. I hereby further consent to a lien being filed on my case by said health care provider(s) and their office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree never to rescind this document and that any attempt at recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said health care provider(s) or their office for all health care bills submitted by them for services rendered to me. Further, this agreement is made solely for said health care providers' additional protection and in consideration of their forbearance on payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the office of said health care provider(s). I have been advised that if my attorney does not wish to cooperate in protecting the health care providers' interest, the health care provider(s) will not await payment, but will require me to make payments on a current basis.

Date 1-3-18 Patient's Signature Darnel G. Washington

Patient's Social Security Number or Driver's License Number 123-45-6789

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said health care provider(s) named above.

Date 1-6-18 Attorney's Signature B. Charma Storro, JD

Please date, sign, and return one original to

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
(612) 555-9889
Cell (612) 555-9886
olsen@email.com

THANK YOU.

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requiring you to provide the records. Many cases settle successfully before a lawsuit is filed, without the insurance attorney ever reviewing the patient's medical information. If settlement negotiations fail and a lawsuit is filed, the attorney for the at-fault party begins preparing for the case by gathering medical information from the patient's health care providers. No direct contact is permitted between the health care providers and the at-fault party's legal team, except to schedule a formal deposition. Requests for medical records by the insurer's attorney are often made through private record collection firms. There are two common types of requests for medical records. One, known as a **stipulation**, contains the consent of both the patient and the patient's attorney authorizing the release. The other is a **subpoena,** a compulsory demand for access to records.

Before sending medical records to the defense counsel, check the request for signatures and call the patient's attorney to verify that the records can be sent.

Track all requests for disclosure of confidential personal health information (PHI) according to HIPAA regulations. File the request form in the health record and log when the request was received, when the PHI was sent, and where you sent it.

DEPOSITION TESTIMONY

The opposing counsel begins formal preparations for a lawsuit by requesting the patient's medical records and scheduling depositions. All health care providers who treated the patient are potential witnesses and can be deposed. As a health care provider and member of the patient's health care team, you possess important information about the patient's injuries and treatment. To substantiate the patient's injuries and to explain his or her need for treatment, your expert testimony may be necessary.

A **deposition** involves the taking of your testimony under oath. It is conducted out of court, and the location can vary. For example, in Massachusetts, depositions take place in the opposing counsel's office; in Washington state, they generally take place in your office. You will be asked questions by the opposing attorney and, in some cases, by your patient's attorney. The meeting will be recorded by an official court reporter who will record every word of every question and answer. The primary difference between a deposition and a trial is that in a deposition, there is no judge or jury.

The opposing counsel will depose you to assess what you know and do not know regarding the case. He or she will ask specific questions to analyze your abilities as a health care witness and to test your credibility. In a deposition, the attorney will be looking for evidence of any or all of the following:

- Delay in initial treatment
- Delay in the onset of symptoms
- Gaps in treatment
- Patient noncompliance
- Patient history that differs from that given by other providers
- Preexisting conditions
- Subsequent injuries
- Inconsistencies in patient's reporting of symptoms
- Mistakes in billing
- Poor recordkeeping
- Unprofessional conduct

The patient's attorney will prepare you for the deposition. He or she will go over with you in advance about specific questions from the insurer's attorney that may be anticipated. Discuss the weak and strong points of the case before the deposition so that

you feel confident answering the attorney's questions. Use the preparation time as an opportunity to teach the patient's attorney about your work. Some of the information may be useful during the questioning. Review all your notes so that you can speak confidently about the patient's case. If relevant for the deposition, read the reports of the other practitioners on the patient's medical team so that you are familiar with all aspects of the patient's treatment.

Follow these guidelines when giving a deposition:

1. Tell the truth.
2. Never lose your temper.
3. Don't be afraid of the attorneys.
4. Speak slowly and clearly.
5. If you don't understand the question, ask that it be repeated or explained.
6. Answer all questions directly, giving concise answers. If you can answer simply "yes" or "no," do so and stop.
7. Do not provide information beyond that which is sought in a specific question. Never volunteer any information beyond that required to qualify the answer as needed.
8. Stick to the facts and testify only to that which you personally know.
9. Describe your patient's injuries clearly and simply, without magnifying them. You are a health care professional, not the patient's advocate.
10. Testify only to basic facts, not your opinions or estimates, unless you are asked and believe that you are informed and qualified to give such opinions.
11. If you do not know an answer, admit it. Do not think that you have to have an answer for every question asked.
12. Resist requests to interpret or draw conclusions from the records of another health care provider.
13. Do not be drawn into arguing with the insurer's lawyer.
14. If the patient's attorney objects to a question, stop talking. You will be instructed when or when not to continue with your answer.
15. Demonstrate competence, fairness, and honesty.

TRIAL TESTIMONY

If settlement attempts are unsuccessful after a deposition, the case will go to trial or arbitration. Trial or arbitration testimony is similar to that of a deposition except that it is done in a courtroom in front of a judge, jury, or arbitrator. Manual therapists are rarely called to testify because of their inability to offer a diagnosis or prognosis. Usually, the referring HCP or other specialist is called by the patient's attorney to testify and to explain treatment approaches, such as the referral for manual therapy. Make testifying on your behalf easy for the referring HCP. Provide documentation that he or she can use to explain, interpret, and defend with confidence the reasonableness and necessity of your treatment.

Follow these guidelines when you are subpoenaed to testify at trial:

1. Review your testimony from the deposition. Be consistent. Review the guidelines for giving deposition testimony (listed earlier in this chapter).
2. Educate! Everyone in the courtroom can learn a lot from you. Don't hesitate to explain, demonstrate, give examples, or cite authorities.
3. Define and explain every technical term you use. If jurors do not understand, they will tune you out.

4. Use visual aids when possible. Models, diagrams, slides, and transparencies make strong impressions.
5. Listen to the questions, wait, organize the answers in your head, and then speak. Do not try to outstrategize the attorney or anticipate the questions.
6. Face the examiner when answering questions. Do not play to the jury.
7. Balance support for the patient with the impartiality of an expert witness. Don't be an advocate. Leave that to the patient's attorney.
8. Be familiar with your records. Avoid thumbing through the file.
9. Stay within your area of expertise.
10. Don't respond to hypotheticals, such as "If the patient could perform a certain activity, would this change your opinion?"
11. Hold to your position and don't equivocate.
12. Be authentic, spontaneous, and professional.

Payment for Services

The patient's attorney is responsible for paying the practitioner for services related to the preparation and prosecution of the patient's personal injury case. For example, the attorney, on behalf of the patient, is responsible for covering the practitioner's expenses associated with prosecuting the case, including the following:

- Copying fees
- Narrative reports
- Consultations and preparation time for depositions and trials
- Testimony at depositions and trials, including travel time

Ultimately, the patient will reimburse the attorney for the expenses at the end of the case. Fees for services vary among individuals. Take special consideration to ensure that you are compensated for your time and that your charges are reasonable. Although the attorney pays you directly for litigation services, the patient eventually will pay for all expenses of the case. Here are some guidelines for determining fees for litigation services:

- Medical records—Some states regulate access to medical records and set maximum charges allowed for the copying of those records. This often includes a flat fee for clerical searching and handling and a per-page fee. Know the regulations for your state and follow them.
- Narrative reports—The value of the report is based on its clarity and content. A report is worth more if it provides a diagnosis, conclusive evidence (such as x-ray results), and a prognosis that substantiates the case. Research the charges of referring HCPs and other manual therapists in your area to estimate the value of your reports. Remember that referring HCPs can charge more because diagnosis and prognosis are within their scope of practice, so keep your fees lower than theirs. Check for state regulations that capitate fees for reports.
- Consultation and testimony—The hourly rate for consultation and testimony often reflects the practitioner's hourly rates for health care services because the time you spend being consulted, being deposed, or testifying in court is time spent away from your practice. If your maximum patient load equals 5 hours of billable time, you may consider estimating your fee for testimony based on your daily rate.

Prepayment for these services is the norm. Submit an invoice stating the fees for your services and request payment in advance of providing the service. Use the CPT code 99075 for billing medical testimony. Be prompt with mailing the information upon receipt of the payment.

Summary

Traumatic injury has medical and legal consequences. The legal team can be a valuable asset to the patient and manual therapist. Fair resolution of a legal claim often provides resources for care and improves the patient's well-being. Attorneys can:

- Gather evidence
- Reduce the patient's stress
- Negotiate on behalf of the patient
- Advocate for the patient's rights
- Protect the patient when an IME is requested
- Ensure that the patient receives reasonable compensation
- Provide immediate access to legal representation under a contingency fee arrangement, meaning that the legal team will not expect to be paid for its services if no compensation is recovered from the settlement or lawsuit
- File a lawsuit within a specified time frame governed by state law

Establish a relationship with the patient's attorney who has valuable information about the patient's insurance carrier, the type of coverage, and the risks involved in deferring payment. Be prepared to request a Guarantee of Payment from the patient and the attorney if the patient does not have insurance coverage that will pay for medical expenses before the claim is settled.

Keep the legal team apprised of the patient's treatment bills and the insurance company's payment record. Maintain complete, accurate, and well-organized treatment records to support the patient and the legal team in the personal injury case. Make sure the patient's file contains the following:

- Session notes for every treatment date
- Prescriptions covering every treatment date
- Documentation in session notes for all information included in progress and narrative reports
- Copies of all correspondence with the health care team
- Legend of abbreviations and symbols

The patient's attorney may request medical records or additional reports, such as a narrative report, on the patient's entire course of treatment. Check for valid authorization before releasing medical records to the insurance carriers or to attorneys. Look for proper dates and signatures and check other releases for exclusive clauses.

If a settlement cannot be reached, pretrial activities begin. The opposing counsel begins formal preparations by requesting medical records and scheduling depositions. The patient's attorney will prepare you for this type of testimony. Make sure that your

treatment notes are in order and that you present yourself professionally, confidently, and honestly.

Reference

1. Adler RH. *From Injury to Action: Navigating Your Personal Injury Claim*. Adler Giersch PS; 2011. info@adlergiersch.com.

SECTION II

Documentation

CHAPTER 4

Why Document?

After mastering the concepts in this chapter, the student will be able to:

- Recognize the important applications of documenting every manual therapy session
- Apply documentation skills to building therapeutic relationships with patients
- Observe potential effects documentation has on patient confidence and participation
- Apply documentation skills on building relationships and teamwork with other members of the health care team
- Explain the benefits of manual therapy through documenting measureable outcomes over time

Heather, a 47-year-old woman, retired military, grandmother of a 3-year-old, is a construction worker with a history of chronic back pain that has become a way of life for her. Her pain has further been complicated since her breast cancer surgeries. She tried drug therapies to rid herself of debilitating back pain while serving in the military, but the pain seemed to be getting worse rather than getting better after her cancer surgeries and treatment. Side effects of anastrozole include joint pain and muscle stiffness, and the adhesions from the mastectomy scars further limit her range of motion. On the advice of her physical therapist, Heather began to explore massage therapy. She tried out a few therapists and selected Wimsey Wolf, a licensed massage therapist who specializes in chronic pain conditions using structural balancing and scar massage techniques.

Wimsey thought things were going well, but one day Heather approached her for a referral—she wanted the name of another therapist who might better be able to rid her of pain. Wimsey was familiar with this kind of frustration and told Heather that, of course, she knew several good manual therapists in the area. She gently asked Heather to have a seat so that they could go over Heather's file and discuss her goals and results together. Wimsey wanted to clearly understand Heather's goals for health, so she could adequately select a therapist to match Heather's specific needs.

As Heather sat down, Wimsey opened the documents store in her electronic file and printed 10 pages with figures that had Heather's own handwriting on them. The computer showed the graphs with her premeasurement and postmeasurement scale results. As with all her patients before each session, Wimsey asked Heather to draw the location of the pain on a page showing human figures and complete the premeasurement and postmeasurement scales. Seeing all her pictures together, Heather now found it impossible to deny the changes that had taken place. She could hardly take her eyes off the drawings. Her hand shook in amazement as she retraced the circles of pain she had drawn on the figures. On her first visit, she had drawn a big circle around the entire low back and hips, a circle larger than the figure itself, and on a pain scale of 0–10 had numbered 9. Each picture that followed showed the circle of pain shrinking in size, and the intensity of the pain diminished in number on her presession and postsession measurement scales. Today's figure showed a circle tightly drawn around the sacrum, and the scale was marked with 4.

Softly, Wimsey asked what living with her condition had been like over the years. Heather explained that because she woke up every day in pain and went to bed every day in pain, she was frustrated. She felt that her condition was unchanged. She had gone from doctor to doctor, trying various treatments. Once again, she found herself on the verge of repeating the same pattern of going from practitioner to practitioner, seeking an end to the pain. She had never experienced an extended cessation of pain and therefore concluded that there was no change in her condition.

Heather had not recognized the subtle, progressive shifts in her pain. Looking at those pictures, however, she acknowledged her healing and became aware of the increase in time spent in her garden and the newfound energy to take her granddaughter to the park. She smiled at Wimsey and chose to continue care.

Introduction

Documentation is critical, necessary, and expected, but fun? Not exactly. None of us entered the hands-on healing arts because we loved paperwork. All manual therapists have stories of the patient whose life was changed because of their work together. Our work is about relationships and interactions with people—that's what fuels our fire. Neither **Wellness charting** nor **SOAP** (Subjective, Objective, Assessment, Plan) **charting** delivers the same emotional satisfaction.

Yet, there may be a way for the paperwork to contribute to the success of those healing relationships as well as preventing paperwork from getting in the way of healing relationships. If so, we might be motivated to put more energy into the task.

Who Should Document?

Every manual therapist should document *every* manual therapy session. All licensed health care providers (HCPs) are expected to document patient visits. Professional organizations publish practice standards that mandate documentation, insurance provider contracts require documentation, and malpractice insurers strongly urge therapists to document every patient visit.

Yet, health record keeping is a skill and a habit that not all manual therapists practice. Some manual therapists have not felt the need to document their sessions because laws in their state that govern their practice do not specifically require them to do so.

Rather, federal and state laws dictate how to retain health records and protect private health information. These laws rarely dictate the content, leaving that to individual profession's practice standards. Other manual therapists resist because they are not licensed HCPs, although the number of states licensing massage therapists has dramatically increased over the past 10 years. In addition, there are many manual therapists who *do* chart but feel it is only necessary to chart those patients who are referred by a physician or whose insurance company is reimbursing them for the sessions. However, wellness massage has been shown to have therapeutic benefits, and payment at-time-of-service does not mean they do not have a medical condition or won't claim injury as a result of your treatment.

Massage therapists were not considered HCPs until fairly recently. Leading the push are the consumers. Our patients perceive us as HCPs, regardless of whether state laws or insurance benefit packages do. As people are recognizing the value of massage, bodywork, and movement therapies, they are seeking manual therapy regularly for the treatment of physical, emotional, and spiritual ailments, as well as for wellness and preventative care. The implementation of the Triple Aim has played a role in increasing awareness of and access to massage therapy because of patient surveys in hospitals and medical clinics: Patient satisfaction is often linked to massage therapy in hospitals and clinics where it is provided. In the 2016 American Massage Therapy Association Consumer and Industry survey, 71% of American adults agree that massage therapy should be considered part of the health care field.[1] Of those surveyed, 89% feel massage therapy is effective for reducing pain, and 88% view massage as beneficial for overall health and wellness.[1]

The integration of complementary and biomedical providers is an international movement. Massage therapy, according to the National Institutes of Health in 2015, was no longer considered alternative, as evidenced by the inclusion of massage therapy services in hospitals and medical clinics. In 1999, a group of universities founded The Academic Consortium for Integrative Medicine and Health (Consortium) dedicated to advancing integrative medicine (IM) and health through academic institutions and health systems. They provided this definition: "Integrative medicine and health reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, health care professionals and disciplines to achieve optimal health and healing."[2]

We are responsible for the health of those who seek our care, and we must act accordingly. Documentation is a necessary skill to implement and master in our practices.

Why Document?

A common misconception among manual therapists, regardless of whether they are seasoned paper pushers, is that they chart for someone else. It is true that we *have* to document or we will not get paid in the insurance paradigm; therefore, we may only chart for the insurance adjuster. Maybe we chart for fear of being sued, or we drum up a report from memory to maintain the referral flow when a doctor requests a patient's file. On the other hand, we may be discouraged from charting because of pressure put on us by our employer. The spa manager, for example, may believe that there is no time for customers to fill out an intake form or no space to store patient files. We tend to chart for the many eyes that may see our records, including insurance adjusters, lawyers, and doctors. Perhaps we should chart for our patients.

Therapists have plenty of reasons not to document. Sometimes, we don't want to bother our patients with too many forms to fill out, especially when they arrive late for their appointments. Sometimes, we interpret a patient's squirms during the interview to mean, "Hurry up and get me on the table," so we cut short our questioning. At other times, we rush through the assessments because we think the only part of the session that the patient values is the hands-on part. Or we skip the closing interview to avoid disrupting the mood and spoiling the work we've just done.

The reasons to chart far outweigh the reasons not to chart. We chart because we care about the safety of our patients and we want to provide the best service possible. To avoid medical complications, we begin with a health history. To ensure that we are using the most effective treatment interventions, we track patients' responses to the various techniques and modalities we use to address various structures. It is difficult to encourage patients to keep up their homework exercises when we can't remember what we asked them to do. And without measureable outcomes, it can be difficult to convince them of their progress.

Ideally, serving our patients is the ultimate motivation for documentation. We document to gather and record information that ensures safe treatment and effective care, educates the patient, and clearly states the treatment results so that the patient acknowledges the benefits of the treatment. The financial and legal motivations are secondary reasons to document our patients' condition. We should maintain written records on all our patients.

To tame the paper tiger, let's look through the eyes of all the different parties invested in our documentation.

REFINE YOUR SKILLS

See the Benefits of Charting Through the Eyes of the Stakeholders: The Patient, the Practitioner, the Health Care Team, the Insurance and Legal Teams, and the Profession

With a group of students or professionals, divide into five or six groups, each representing the individual stakeholders. (The insurance and legal teams can be combined or each may have their own group.) Each group is to discuss the reasons why, while wearing the hat of the patient, for example, the patient is invested in having the manual therapist chart the treatment sessions. Give the groups 10 minutes and then have each group report out to the whole.

THE PATIENT

Professionalism

Some patients still consider manual therapies "alternative," meaning riskier or less evidence-based than other, more conventional biomedical practices. With the integration of complementary therapies into mainstream health care, some people are seeking the care of practitioners they have never before considered. The acts of completing health history forms, performing assessment tests, and answering questions while the practitioner takes notes can link wary patients to the familiar conventional therapies. This common thread can instill confidence and provide a professional atmosphere, reassuring the patient that you are a health care specialist providing safe and effective health care, sports injury treatment, or wellness care.

Trust

Manual therapy is intimate. Often, patients remove their clothes and lie on a table with only a sheet covering them. When they are lying face down, they are not able to see us enter the room or move around, and they may feel vulnerable. Even when they don't remove their clothes, we may be touching them in places few people outside of their immediate family touch. Interviews focused on gathering and giving information may ease their minds about how and why we will touch them and instill confidence that their concerns are our concerns. Receiving verbal and written consent to treat and discussing where you will work, why, and your draping protocol can help them relax on the table. The act of taking notes demonstrates that you acknowledge their pain and understand their situation. All of these things may contribute to building a solid relationship between the health care professional and the patient before we ever put our hands on the person. When we demonstrate concern for the patient's health and take a professional approach, in part through note-taking, we may build a strong bond of trust that can contribute to a successful treatment outcome. The hands-on part of the session may not be the only part that has value after all.

Historical Record

A patient's file is a historical record of wellness and health challenges over time, tracking health patterns and documenting treatment approaches. This is a valuable resource from the patient's perspective for many reasons. Patients may move or change providers and they may wish to share their health record with the new therapists, get them up to speed and avoid wasting time or money. Current HCPs may seek clues in our charts regarding progressive conditions—information that ultimately could help the patient toward recovery. Patient files may provide the evidence necessary to validate ongoing reimbursable treatment, allowing patients to get the care they need and deserve without bearing the financial burden. We may also need proof that we intentionally avoided treating an area with a potential local contraindication, or received permission to alter draping protocol to address radiating pain down the leg.

Safety

Patients need to feel safe in our hands. Repeatedly asking for the same information session after session does not instill a feeling of confidence. A written record serves as a database or repository of pertinent information. In completing a thorough health history, patients are assured that the practitioner has access to information that will assist in determining the treatments that are safe and appropriate for them. Nothing is left to memory, and patients do not have to repeat information each session to be assured that precautions will be taken.

Proof of Progress

As in Sandee's story, it is difficult to maintain an accurate perspective of one's condition when one lives with daily pain. An ongoing and measureable account of one's experience and expression of health is critical to supplement subjective memory. Daily charting can serve as a witness to the patient's pain and progress.

Quality Assurance and Value

When progress is evident and goals are being met, patients are better able to rest assured that their money is being spent well. Massage therapy is one form of health care that people

have traditionally paid for out of pocket.[3] (A testament to positive outcomes!) According to a 2007 survey conducted by the National Institutes of Health (NIH), massage therapy is the number one practitioner-based out-of-pocket complementary and alternative medicine (CAM) expense for US consumers.[4] This means we are competing with the groceries, mortgage payments, and childcare. Typically, for people to feel good about how they spend their money, the end result must outweigh the expense, or the need must be based on survival. Proper documentation can express our goal-oriented approach and be a record of the physical progress, thus proving the value. Even emotional and spiritual results have a measurable physical expression. If we are not able to demonstrate long-term, positive results, we may expect our patients to seek better value for their time and money somewhere else.

Education

Recordkeeping performed either in the presence of the patient or in part by the patient can be an educational experience. The intended result is to create a more patient-centered interaction and encourage patients to be more aware of their internal experience. By participating in the documentation process, they may feel the results on a deeper level, understand what contributes to positive results, and become motivated to make different choices as they move through their day. This may enhance their progress. They realize that you will hold them accountable for their homework because you wrote it down and will check in with them about it habitually. Often, they learn from the charting process and begin to discern what is working and why and can then assist in creating future treatment plans that they are more committed to. Involving patients in the treatment process, which includes charting, gets them participating actively, committing to the goals and striving for the outcomes. This educational experience can instill a sense of confidence in their own abilities to care for themselves and to control their experience of their situation, which ultimately is the best outcome we can provide for our patients.

THE PRACTITIONER

Financial Security

Patient charts that demonstrate positive outcomes can be financially advantageous. Whether you are self-employed or work in a clinic, hospital, or medical spa, patient flow depends primarily on your ability to form productive, healing relationships with your patients. Successful results lead to repeat patients and solid referrals. Documented evidence of effectiveness both before and after a session and over time helps them keep a positive perspective if they ever lose sight of their progress when, for example, they can't see beyond their immediate pain. It also demonstrates subjective and objective outcomes of your care to referring caregivers who have greater access to your charts than to your healing hands. The health record is often the referring HCP's only resource for identifying the positive benefits of patient relationships. Moreover, not providing updated reports to referring providers goes against documentation protocol.

The fundamental difference between charting for cash patients and charting for insurance patients is that insurance companies can refuse payment when no documentation exists or they can reverse or deny payment or even terminate treatment based on your documentation.[5] To any manual therapist who depends on insurance reimbursement for income, having documentation is essential for financial security. And not just any documentation—the contract between the insurance company

and the insured or the preferred providers requires that treatment be **reasonable and necessary**. This means that your documentation must demonstrate that your care addresses the patient's presenting condition and that the treatment provided produces documented, measurable results.[5] For example, State Farm's automobile personal injury protection (PIP) insurance policy specifically states that the treatment must be "essential in achieving maximum medical improvement."[7] We may be asked to present documentary evidence before payment, or the companies may elect to perform periodic audits of patient files. In any case, it is in the best interest of all practicing manual therapists to protect their financial investment by performing their charting appropriately.

Many patients who have been injured because of someone else's negligence may be involved in litigation. The outcome of the case may determine who pays the bills and how much money is available to cover those bills. Attorneys typically must prove that the patient was injured by the incident to legitimize the need for financial remuneration. They look to medical documentation for this proof. Your documentation can support the patient's case and contribute to the financial award—preventing the patient from having to pay your bill out of pocket and supporting you in receiving full payment before or at the time of settlement.

Legal Assurance

In litigation cases, documentation assists in securing payment for your professional services. In the case of a malpractice suit, documentation may save you more than money. Malpractice suits are rarely filed against CAM therapists because of the generally noninvasive approaches to care,[6] but in the unfortunate event you are named as a defendant in one, your job and reputation may also be on the line. Applicants for clinical positions or for preferred provider status on insurance lists can be rejected on the basis of complaints filed.

TALES FROM EXPERIENCE

Winning and Losing

In my personal experience with a malpractice suit, thorough documentation showed that the symptoms the patient accused my colleague's treatment of causing were already present before massage therapy was provided at my clinic. The massage therapist documented them during the initial intake, and the physician's records showed that those symptoms existed months before the patient came to my clinic. Good documentation on behalf of my colleague and the patient's physicians contributed to a positive result for us.

Here is a completely different situation, one in which the lack of documentation produced a detrimental result. I received a phone call asking for support in a malpractice suit. A person filed for damages resulting from a chair massage at a health fair. No one working in the booth that day remembered working on them. However, no documentation existed to prove it—no sign-in sheet, no signed consent to treat, and no treatment notes were available on any recipient at the booth. A favorable outcome for the manual therapist and the company that ran the booth seemed unlikely.

Without written records, few opportunities exist for manual therapists to fight such claims. Protect yourself with documentation.

Professional Image

Hands-on remedies have been in existence for thousands of years. Unfortunately, in our more current history, massage and reflexology is sometimes used as a front for prostitution and human trafficking. Perhaps no other health care profession has had to deal with this kind of stigma, at least to the same degree. Other manual therapy professions have had to deal with claims of quackery because of insufficient scientific evidence, or perceived competition. With all this working against us, it behooves all professionals in our field to apply certain professional practices stringently. The **scope of practice** or standard of practice for all health care professions requires providers to document. To gain or maintain credibility as a health care profession, all manual therapists must document all treatment sessions. Practitioners who do not consider their services "treatment" may consider the possibility that any session with a health benefit, such as improving posture, reducing muscular effort, or increasing circulation, is thereby treatment.

Communicating with the Health Care Team

The integrative team approach to health care relies on communication for its success. Information is rarely conveyed in person. Most communication, including referrals, progress reports, and the like, is in written (paper or electronic) form. Other members of the team evaluate your effectiveness by reading your health records, rarely through experiencing your touch. Luckily, patient testimonials have kept referrals flowing, however unconventional. The charts and reports must adequately reflect the treatment and patient outcomes, or ongoing referrals may not ensue. Regular, brief written communications demonstrate your professionalism and high standards and substantiate your effectiveness. Referring HCPs are more willing to work with manual therapists who follow familiar lines of communication. Consider this to be the least expensive form of marketing available to you.

Historical Record

Patient charts serve as a memory database, relieving you of the responsibility to remember all the details of each case. Thus, charts free you up to think ahead rather than backward. For example, instead of struggling to remember whether the right foot or the left foot had the broken metatarsal or whether the myofascial release or the muscle energy technique (MET) produced the quickest result, you can simply reapply the MET to the right foot, reassess, and move on to another stage of the treatment session.

Safety

A universal vow of HCPs is to do no harm. We are in this profession because we want to help others. Preparing ourselves sufficiently for our clients assists us in making safe decisions about massage. A health history can provide information about past or current illnesses. An online data search can provide additional information about complications of their condition or medication, prompting more interview questions. We can track the patient's response to treatments through the daily session notes and reduce the risk of overtreatment. Communication skills and recordkeeping give us access to patient information that helps us do our job with reasonable skill and safety.

REFINE YOUR SKILLS

What Do I Need to Know About My Patient to Provide a Safe and Skillful Treatment Session?

Pose this question during a discussion session in class or with your massage study group. List the items that arise. Is it possible to remember all the information from session to session without writing it down?

Efficiency

People on the paying end of health care generally insist on the most effective care available for the least amount of money.[6] The good news is, there is immerging, solid evidence of efficacy and cost-effectiveness for massage therapy as a treatment for pain and other symptoms associated with many conditions.[8-11] To maximize your effectiveness in the available time, you need to know what has worked in the past. Health history can provide information about treatments used for past conditions and give insight into their effectiveness. Keep a running log of the techniques and modalities you have used and the patients' responses to those. Wellness charts and SOAP charts record treatments and track the results. This information aids in creating individualized, effective treatment plans. Each session builds on the last, for increased effectiveness and efficiency.

SOAP charting provides a system for tracking the treatments that are effective and the condition and patient for whom they are provided. This allows you to make decisions that streamline the care you are giving on an individual basis and across the board. You may wish to study the results you have achieved with a given technique or for a particular condition. Reviewing many patient files allows you to use your own caseload as research and to evaluate your own effectiveness as a practitioner.

Clear Boundaries

Patient charts may also serve as a reminder to separate your experience from that of the patient. Transference and countertransference are as real in manual therapy as in psychotherapy. The lines between the patient's experience and the practitioner's experience can become blurred. It is not uncommon, for example, to take on the frustration of the patient and make it your own. Use your charts as a reminder of both your successes and your patient's progress. Evaluate plateaus in treatment and keep your self-esteem intact.

However, do not confuse ego with self-esteem. It is possible that the patient's frustration is warranted. Some HCPs, as an example, may take responsibility for the patient's successes yet blame the patient for the failures. A full assessment of the patient's experience is necessary. Start with good listening skills. Acknowledge the patient's experience as real for them, check in with yourself, and examine your role in their experience, and when appropriate, share your experience of the situation. Highlight the data collected or explore new options for treatment that could produce different results. It is helpful to review the patient's files before each treatment session, establish your own feelings based on the data collected, and prevent being drawn into the patient's feelings.

THE HEALTH CARE TEAM

The Team Approach

Every person is unique, even in his or her expression of trauma and disease, and has individual triggers for a condition, as well as unique manifestations and different combinations of common symptoms. Because of this, it is rare for any one treatment to cure a given condition for all patients. Applications of a standard of care can produce varying results. Not every person with stage II lung cancer who receives chemotherapy and radiation ends up with the same prognosis. Some people die, some fully recover, and some experience a recurrence of the disease. Life stresses, attitudes and beliefs, and general constitution, to name a few, contribute to the unique expression of a patient's situation. We must treat the whole person and consider all options.

A team approach to treatment can lead to the discovery of the most efficacious care for each person. It is in the patient's best interest for each member of the team to work together, and the team relies on communication for its success. In many situations, direct communication is rare. If we are to function as a team, documentation is essential.

REFINE YOUR SKILLS

What Is the Role of Manual Therapy in Health Care in General and in Biomedicine in Particular?

This is a great discussion topic for students and practitioners alike. If you work in an integrated health care clinic, have this discussion with other types of HCPs as well as manual therapists. Are there key areas of contribution based on the modality or theoretical approach of the various professions? What does true integrative health care look like? How might it improve? If in a group of massage therapy students, what professional options would you like to have available to you upon graduation? In an ideal world, where do manual therapies fit into integrative health care?

Communication

Communication among members of the interdisciplinary care team may promote complementary treatment plans, ensuring that treatments are not duplicated and that practitioners support one another's efforts and build upon one another's results. The patient may experience the power of the team and feel confident that the combined efforts will produce successful results.

When the patient moves and wishes to continue treatment in a new location, our charts may assist the next manual therapist in maintaining the progress. It is important for adjunctive therapists to be able to rely on us and continue the patient's progress without wasting effort. If you go on vacation and someone takes over your patients, a well-stated treatment plan can assist your replacement in a successful continuation of care. Solid documentation can ensure the success of the health care team, regardless of who is or will be added to it.

Education

Biomedical HCPs may not be well versed in the manual therapies. More and more, however, physicians are eager to educate themselves on **complementary therapies**. The birth of integrative health care as a movement is often attributed to the Eisenberg Study, which stated that "in 1990 Americans made an estimated 425 million visits to providers of unconventional therapy. This number exceeds the number of visits to all U.S. primary care physicians (388 million)."[2] In the follow-up National Survey, Trends in Alternative Medicine Use in the United States, 1990–1997, Eisenberg reports "a 47.3% increase in total visits to alternative medicine practitioners, from 427 million in 1990 to 629 million in 1997, thereby exceeding total visits to all U.S. primary care physicians."[12] Now the Consortium, which began in 1999 with six institutions including Duke, Harvard, and Stanford universities, boasts 64 U.S., five Canadian, and two institutions in Mexico.[13]

The manual therapists' documentation is a direct and immediate source for educating referring HCPs on how to employ our skills, when to refer to us, and why they benefit from working with us. The only thing better would be an additional cache of case reports describing common and uncommon patient interactions to complement our patient records. Read Chapter 10, Researching and Writing Case Reports, and begin writing your case reports to contribute to a growing body of evidence on massage therapy and bodywork.

Relationship and Referrals

There is a system in place designed to help build relationships in health care: written communication. As with all specialists, manual therapists are expected to send the referring HCP an initial report after the first session with the patient and a progress report every 30 days thereafter. It is common courtesy and a standard in medical documentation to report back to the referring caregiver about your findings and treatment plan periodically throughout the series of sessions. Without it, an HCP may be hesitant to maintain the relationship.

Responsibility and Liability

Everyone on the integrative team has the patient's best interests in mind, but few bear as much responsibility for the patient's health as the primary or referring HCP. Referring HCPs are accountable both to patients and insurance companies for the productivity of the specialists to whom they refer. A referring HCP may be held responsible for the actions of another practitioner in the event of a malpractice suit. The presence of familiar documentation can alleviate the weight of that responsibility. Chart every session, send progress reports, and thank HCPs for referrals. When you support referring HCPs' need for documentation, they will support you with referrals.

THE INSURANCE TEAM

Responsibility for Payment

Insurance personnel are accountable to three parties: the insurance company as an employee, the stockholders, as US insurance companies are rarely not-for-profit, and the insured for honoring the terms of the insurance policy. They must provide for the insured within the bounds of their policy and nothing more. Several issues are considered when they are determining whether a medical service is the financial responsibility of the insurance company. Your documentation is used by insurance personnel to help make this determination.

Insurance contracts with the insured and the providers require documentation to support and justify the services provided. Medical reviewers use manual therapists' charts to determine responsibility for payment. Document the necessary information and protect yourself and your patients financially.

Proof of Services

Insurance personnel look for evidence that the services being billed for were actually provided. It is not enough to have the patient's name in your appointment calendar. Treatment notes will suffice and must reflect the same date as the billing form. Services itemized on the billing statement must be recorded in the treatment notes. For example, if you billed for hot and cold packs, your treatment notes should reflect that an ice pack was applied to the neck for 10 minutes.

Medical Necessity

Services provided must be medically necessary to qualify for insurance reimbursement.[14] The health record can demonstrate medical necessity. Patient files must show that the services provided were consistent with the patient's symptoms and diagnosis. For example, reimbursement could be denied if a referral with a diagnosis of lumbosacral strain–sprain was received and the treatment notes reflect that the patient was treated for tennis elbow.

Insurance personnel rely on the manual therapist's documentation to verify that the techniques and modalities used improved the health of the patient. Functional outcomes demonstrate improvement in the patient's quality of life. Progress may be slight or significant, but it needs to be measurable over time and documented to validate the legal and insurance standard of reasonable and necessary care.

Safe and Economical

Finally, care must be safe and economical. Manual therapy has few reported complications, but proving that manual therapy is economical can be difficult. Insurance carriers have standards for determining whether fees are **usual, customary, and regular (UCR).** But more importantly, carriers want to know whether manual therapy services are more cost-effective than other equally effective services. The cost of treatment is calculated as total dollars spent, but rarely are the manual therapy dollars spent compared with the surgery dollars saved, for example. Insurance representatives at a CAM committee meeting in Washington state stated clearly that manual therapy dollars were considered to be in addition to other dollars spent not instead of. "Everyone can benefit from a good rub, but why should the insurance company pay for it? Prove that the surgery won't be necessary in the future, once the palliative care has worn off," they chided. There is increasing evidence on the efficacy and cost-effectiveness of massage therapy.[8-11] In addition to existing research, the onus is on the manual therapist to prove effectiveness in as few sessions as possible and to provide the case study statistics necessary for convincing the insurance companies that manual therapy produces long-term results with reasonable financial investment. Use documentation to improve efficiency, by tracking functional outcomes and challenging yourself to be more efficient with your treatments.

FROM THE LITERATURE

Therapeutic Massage Provides Long-Lasting Benefits

According to a research study: "Outcomes observed for massage and acupuncture at ten weeks remained relatively unchanged at one year. Massage was superior to acupuncture in its effect on symptoms ($P = .002$) and function ($P = .051$)… [and] use of medications (primarily nonsteroidal anti-inflammatory drugs) remained lower in the massage group than in both other groups (adjusted $P < .05$)." During the year after randomization, the number of provider visits, number of filled pain medication prescriptions, and costs of related outpatient services were about 40% lower in the massage group than in other groups.*

*From Cherkin DC, Eisenberg D, Sherman KJ, et al. Randomized trial comparing traditional Chinese medical acupuncture, therapeutic massage, and self-care education for chronic low back pain, published by the American Medical Association in the Archives of Internal Medicine in 2001. Reprinted with permission.

THE LEGAL TEAM

Winning a Personal Injury Case

Lawyers need evidence. Medical documentation is the primary source of evidence validating a personal injury case.[15] Clear and complete documents contribute to the solidness of the case. Typically, personal injury attorneys work on a contingency fee, meaning they are paid a set percentage upon conclusion of a case. Lawyers and their clients have a financial interest in the manual therapist's documentation.

Proof of Significant Injury

Lawyers look to our records for evidence that the patient suffered "bodily injury" that can be attributed to the collision. For the bodily injury to be relevant to the case, documentation must illustrate the patient's pain, location, severity, and frequency. Just as important is the ability of our paperwork to show how the injury has affected activities of daily living. Medical records are necessary to substantiate injuries resulting from the collision.

In addition to proving that the injury is significant and that it warrants treatment, the treatment provided must be proven reasonable and necessary before it will be included in the settlement. With your treatment records, the attorney can justify treatment that is effective in promoting a change in the condition.

Insufficient documentation can lead to requests for narrative reports or testimony at depositions or in court to clarify or defend the care provided. These are costly additions to the patient's out-of-pocket expenses. Recalling details of treatment can be difficult when you are in a stressful, unfamiliar environment, such as a courtroom, or in a deposition with a video camera positioned some mere feet away.

Winning a Malpractice Case

To defend a malpractice case against a manual therapist effectively, the attorney must prove that the treatment was within the therapist's scope of practice and was provided with reasonable skill and safety. Once again, medical documentation is the primary source of

evidence to substantiate the case. Solid documentation resolves claims and lawsuits. Lack of documentation weakens the evidence and can have a negative impact on the timely resolution and ultimate outcome of a case.

THE PROFESSION

Positive Image

Manual therapy organizations are invested in the public perception of their profession. A number of associations provide a professional affiliation; promote education, ethics, and standards; and work as a group to provide public education and increase public awareness. These benefits are highly regarded by members and consumers alike. Documentation is often among the standards discussed, defined, and required.

Manual therapy professions value relationships with the health care community. The public may view integration into biomedical health care as a stamp of approval that legitimizes the work. Increased public exposure increases the number of people receiving manual therapy. The number of new manual therapists entering the profession will grow as a result, and membership in professional associations will increase accordingly.

Research

Integrative health care is on the rise. Many university medical programs have received NIH grants to incorporate complementary health care education into conventional medical training. Only nonbiomedical therapies that are evidence-based are included in the programs. Research data supporting the efficacy and cost-effectiveness of manual therapy validate its use as a viable treatment option and promote public access. Insurance companies and physicians rely on research results to help them make informed decisions regarding health care services. With good data, manual therapy becomes increasingly available to all who can benefit from hands-on healing.

Conventional methods of research can be difficult to apply to manual therapy; placebos and sham treatments for massage therapy have not been successfully identified and as a result have not been incorporated into clinical trials. Rigorous randomized controlled trials exist but use comparison groups instead of placebos as controls. Comparison trials, whole systems research, combined methods, and case studies provide quantitative and qualitative information and are increasingly popular methods for drugless therapies. Case study research is something we can all participate in (see Chapter 10, Researching and Writing Case Reports). Keep in mind that case reports are only as good as the therapist's documentation.

Summary

Manual therapists who practice documentation display professionalism and high standards and communicate easily with other health care professionals. Documentation is vital to case study research, which provides statistics that can support health care integration and increased public access.

Manual therapists benefit in a variety of ways when documenting patient relationships. Recordkeeping makes good business sense because charting specifics of the patient's condition, treatment, and outcomes protects our investment of time and services and provides evidence of the necessity of care and the effectiveness of the treatment

provided, thus ensuring payment. Having adequate documentation means legal difficulties may be avoided and the patient's injury treated successfully. Patient charts can be used as a communication tool with referring providers, proving patient progress and the effectiveness of treatment and encouraging future referrals. Communication through documentation establishes rapport within the health care team, promotes a team approach to treatment, and ensures that your patient is well cared for when transition becomes necessary.

Manual therapy patients also benefit from our documentation efforts. We recognize that, in their eyes, thorough charting demonstrates our professionalism and high standards, provides written proof of their own progress and the value of their time and resources, documents the efficacy of treatment (which encourages confidence in their treatment choices), and provides an awareness that they can contribute to a higher quality of life for themselves.

Insurance companies look to our health records for proof that services were provided, were consistent with the patient's condition and the referring diagnosis, and were medically necessary. The patient files should show that the services improved the patient's quality of life and involved the most effective modalities for the least amount of money.

The legal team depends on medical documentation to win personal injury and malpractice cases. It's as simple as that.

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CHAPTER 5

Documentation: Intake Forms

After mastering the concepts in this chapter, the student will be able to:

- Apply key components of information gathering to build a safe and skillful treatment plan
- Develop intake forms appropriate to the venue
- Acquire informed and written consent to treat consistent with Health Insurance Portability and Accountability Act (HIPAA) regulations
- Explore possible motivations behind altering draping protocols with the patient, explaining therapeutic intent, to sufficiently determine comfort and obtain informed and written consent
- Build office policies and a fee schedule
- Integrate measurement tools into information gathering both at intakes and periodic evaluations
- Translate outcome measures to evaluate progress and modify treatment plan
- Carry out HIPAA requirements to ensure security and privacy of private health information of all patients

Darnel Washington, a 64-year-old retired certified arborist, has sustained injuries in a motor vehicle collision. He had a strenuous career as an arborist, climbing trees, and developed scoliosis that began to limit his ability to participate in the hands-on activities of his profession. After a year in physical therapy and restricting his work activities to managing and organizing job assignments, Darnel chose to retire at the age of 62. He now leads a pain-free active life, gardening, bowling, and playing with his grandchildren—that is, until the Ford truck rear-ended his Honda Civic.

John Olson, Darnel's massage therapist and movement educator, understands the importance of information gathering, especially when the patient has a preexisting condition. In Darnel's case—a personal injury case involving insurance reimbursement—John may be asked to justify treating the scoliosis in addition to the cervical sprain–strain trauma and help the referring physician determine something called apportionment: assigning a percentage of blame to the car collision. To build Darnel's profile, John asks a series of questions about how Darnel's back was feeling before the collision, how long his scoliosis had been in remission or asymptomatic, and whether he had received treatment for the condition recently, before the collision.

It is common for new symptoms to come to the surface in the first few weeks of a trauma, as the acute swelling dissipates and the patient attempts to return to activities of daily life. John tracked the onset of each symptom and the activities of daily living that precipitated, documenting the timing, severity, and functional limitations involved with each. He was careful to record information that accurately represented Darnel and supported the necessity of his care.

Introduction

Intake forms are the first step in gathering information from the patient. They ask general questions about personal identification, contact information, health history, and current conditions. This chapter introduces a variety of intake forms:

- Health information forms
- HIPAA privacy policies
- Fees and policies forms
- Health reports
- Pain questionnaires
- Injury information forms

All of these forms are completed before the initial session, and some are completed periodically to evaluate progress. Some forms are for all patients to fill out while others are only for patients whose medical conditions warrant additional information. This chapter explains the purpose of each form and provides assistance in determining the appropriate application of each form for your practice and your patients.

Intake forms are easy to use, and they don't require one-on-one attention from the manual therapist. They are self-explanatory and can be filled out by the patient before the initial session begins, without cutting into precious treatment time. It is a good idea to review the forms with the patient on completion. This ensures that they are filled out accurately and provides an opportunity to add pertinent details. For example, if an attorney or a physician has a question regarding the patient's responses on a form, it is critical that you know the responses are correct and complete.

Once you have reviewed the forms, you are well equipped to ask specific, personalized questions based on the information provided. These in-depth interviews are important in developing a better understanding of the individuals with whom you are working and in learning about each person's unique concerns and goals for health. Think of the forms and the ensuing interviews as stepping stones to building healing relationships.

TALES FROM EXPERIENCE

The Importance of a Health History

David was a good student. He performed his duties in the student clinic professionally and sincerely. One day, after a 30-minute massage on an elderly patient's neck and shoulders, the patient looked up suddenly and said, "I forgot to tell you, I have blood clots in my neck."

As David learned early in school, thrombosis is a contraindication for massage—blood clots could become dislodged and move toward the brain, resulting in a stroke. Luckily, the woman was not harmed by the session, and David learned a poignant lesson about the importance of taking a thorough health history.

Intake forms serve an additional purpose for patients who are relying on insurance for payment. Record-keeping needs to meet two goals for insurance reimbursement. First, there must be justification of care on the specific day the patient is receiving treatment. Second, there must be justification for the patient's overall treatment plan.[1] To justify care, documentation must demonstrate that the medical condition was significant and must record the patient's symptoms and functional limitations. To justify the treatment plan, the documentation must demonstrate that the treatment being provided is reasonable and necessary. In other words, the treatment is reimbursable if it has a positive effect on reducing the symptoms and returning the patient to his or her normal activities of daily living. Some intake forms (measurement tools) presented in this chapter will help you record this important information.

Personalize your paper intake forms with your logo, contact, and business location information. The forms shown in this book provide space at the top for inserting this information (see online, Appendix B for blank forms). Your name, address, and phone number should be added to every page of each patient's chart for identification in the event that your charts become part of an audit or subpoena, or the patient shares his or her files with another health care provider (HCP) or therapist. Electronic health records (EHRs) should automatically include your name, contact information, and National Provider Identifier Number (NPI#) at the top of each form (see Figure 5-1).

FIGURE 5-1. Electronic Health Record (EHR)—Personalized Header

Hands Heal™ EHR

Session Information
Jackie Phillips
ID #: (NPI) 1234567890 Date of Birth: 4/15/1958

Hands Heal
3302 Fuhrman Ave E Suite 110
Seattle, WA 98102
Phone: (206) 755-5564

Service Date: 10/16/2016

Massage Therapist: Diana Thompson

Pre-Session Information

Stress Scale: 6
Uncomfortable moving, isolating, feel worse when not active

Pain Scale: 7
Knees, feet, low back

Activity Scale: 5
Difficulty walking up and down stairs, kness hurt with rising from chairs, pain with walking, no longer able to run

Health Status:
N/A

Treatment

Duration: 60 minutes

Health Information Forms: For Wellness Care

There are a variety of brief health information forms specifically adapted for relaxation massage, spa therapies, on-site massage, and sports massage. Many clients use manual therapy to stay healthy and reduce stress or to recover from an athletic event. Intake questions that address these goals for health are designed to be quick and easy to use yet ensure the safety of the client. It is superfluous to gather a comprehensive list of symptoms and specific details regarding the client's medical condition when providing wellness care for healthy individuals.

The ealth information form on the wellness chart meets the three basic needs for alternative documentation:

- It is quick and easy to use.
- It gathers key health information that help to identify cautions and contraindications for care.
- It provides legal protection for the practitioner.

QUICK AND EASY CHARTING

The wellness intake questions indicate yes or no answers that can be checked off quickly by the client. In an on-site or sports venue, the questions can be asked orally. Only positive answers are recorded by the massage therapist. When reading the intake questions aloud, make eye contact to ensure that the client is paying attention and understands the questions being asked. The questions are brief but critical, especially at a sporting event when it is necessary to determine whether first aid is more appropriate than a massage (see Figure 5-2).

FIGURE 5-2. Wellness Chart—Quick and Easy Health Information Gathering

Naomi Wachtel
567 Sunnydale Dr.
Flat Irons, CO 80302
PHONE 303 555 8866 • EMAIL wachtel@email.com

WELLNESS CHART

Name Lin Pak ID#/DOB 5-31-69 Date 7-27-17

Phone (303) 555-0033 x 253 Email lin@pak.com

1. What are your goals for health, and how may I assist you in achieving your goals? Limit longterm complications of diabetes through relaxation and stress reduction.

2. List typical daily activities—work, exercise, home. I sit a lot at work and watch movies at home

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness ☒ No ☐ Yes: _____ stiffness ☒ No ☐ Yes: _____

PATIENT SAFETY

Intake questions are designed to ensure the safety of the patient. Wellness charts have very few intake questions, but the questions are designed to get right to health issues. Any "yes" answer to an intake question may require additional information to rule out potential harm. The manual therapist must be able to identify health situations that contraindicate treatment or require precautionary measures when providing treatment. For example, inflammation may indicate infection, which contraindicates massage in general. Numbness contraindicates deep pressure touch. Some symptoms are contraindications locally but not systemically; some techniques are contraindicated but not others.[2] Know how to respond to positive answers to intake questions.

Adapt the intake questions to discover possible contraindications specific to your work environment. For example, the intake questions for a sporting event cover signs and symptoms of shock—the primary contraindication for treatment after physical exertion. Intake questions for a spa environment emphasize allergies to scents, oils, and other products used during aromatherapy and herbal wraps. Include information-gathering questions specific to the treatment provided, such as a question about allergies to nut oils.

LEGAL PROTECTION

Protect yourself in the rare event of a malpractice case by demonstrating that health screening was conducted and treatment was appropriate. To do this, have the patient fill out, sign, and date a health questionnaire. If the practitioner completes the form for the patient, the patient is required to initial the entries. Show that you checked for possible health complications and provided safe treatment.

TALES FROM EXPERIENCE

Review Health History Before Treating

Always look over the health history before proceeding with the treatment. A malpractice case was filed in which a client accused an on-site massage therapist of harming him. Before the session, the therapist handed the intake form to the client. The client read the form and handed it back to the practitioner without completing it. The massage therapist proceeded with the treatment without realizing that the client had not signed off on the statement of health. As it turned out, the person had one of the conditions listed on the form as a contraindication and alleged that he was injured as a result of the treatment provided. Take steps to protect yourself and follow through with them.

Health Information Forms: For Curative Care

CONTENT

A health information form is designed for patients with medical conditions, such as whiplash, sports injuries, and carpal tunnel syndrome, and records five basic kinds of information:

- Personal identification and contact information
- Concurrent therapies and health care provider (HCP) contact information

- Current health information
- History of injuries, illnesses, and surgeries
- Contract and consent for care

Questions in the five categories may vary according to the specialty of the practitioner. For example, an acupuncturist may include detailed questions regarding the person's diet in the section for current health status. A massage therapist's form may request more specific information on musculoskeletal dysfunction in the health history section. All basic categories pertain to all patients, regardless of their reasons for the visit (see online, Appendix B for blank forms).

Personal Identification and Contact Information

The patient's name, date of birth, and that day's date should appear on every piece of paper in the patient's file. The name connects the data to the person and can be used to organize the files. Date of birth differentiates two individuals who have the same name. The date places the information in time, an important reference for tracking the progress of the condition. If multiple entries are made on a single page over a period of time, each entry should be dated.

Cases involving insurance reimbursement often require the patient's name, claim number assigned to the case, and date of injury (DOI), when applicable, on every form sent to the insurance company. Use the same header on all forms—name, date of birth, that day's date, insurance identification number, and DOI. If the insurance identification number and the DOI do not apply to the case, you may simply leave the spaces blank. If you omit these identifiers from the header, you risk omitting necessary information and causing a delay in insurance payment. (Note: Wellness charts are not appropriate for charting curative treatment and, therefore, will not include the DOI or insurance identification number in the header.) Record applicable contact numbers on the health information form (phone, email, address, etc.). Ask clients their preferred contact method: phone, text, or email; know how to reach your patient in a timely fashion in case appointments need to be changed or issues need to be discussed. Protect the patient's confidentiality—don't leave messages that disclose details of the treatment relationship in written correspondence without the patient's written permission to do so. Have the patient list a contact person who can be reached immediately in case of a sudden illness or accident; be prepared in the unlikely event of an emergency.

Concurrent Therapies and Provider Contact Information

Know what concurrent care the patient is receiving and how to contact the patient's primary HCP. Patients with complex health conditions, such as whiplash or cancer, may require additional information or treatment consent. In addition, you may want to apprise other members of the health care team of the patient's progress. Make sure you have phone number, fax, or email address information for team members and confirm how they wish to receive information. Before you refer outside your clinic to another provider, make sure you have the patient's permission to share their health information.

On the health information form, request permission from your patient to consult with the other HCPs on the patient's team. This simple permission request is sufficient for most purposes (see Figure 5-3). Asking permission is courteous, and it models open communication with the health care team. It may also be a legal requirement according to

FIGURE 5-3. Health Information—Permission to Consult with Health Care Provider

Primary Health Care Provider

Name Manda Rae Yuricich, DC

Phone: 555-3535 Email yuricichDC@handsheal.com

I give my manual therapist permission to consult with D.C. & P.T. regarding my health and treatment.

Comments re: work injury only

Initials ZH Date 4-4-17

some state and federal laws. Some state laws waive the requirement for written permission when sharing health care information between referring HCPs and specialists. Even if this is the case, patients will appreciate being asked. If you are required to comply with **HIPAA** regarding confidentiality because you store and transfer client data electronically, HIPAA permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities (45 CFR § 164.506). If you need patient authorization because a HIPAA exception does not apply to your circumstances, then the simple statement on the health information form is not, by itself, sufficient for HIPAA regulations. (For more information regarding HIPAA compliance, visit http://www.hhs.gov/ocr/privacy.)

Even when patients are not referred by an HCP, they may have a condition that warrants a consultation with their primary HCP. Although you may not be required by law to get a written authorization to consult, it is important to get written permission from these patients for a variety of other reasons (for example, their physician may not know they are receiving massage therapy, and they may want the chance to tell the doctor first). Some patients may have shared information with you that they do not want discussed. Let them know *what* information you will be sharing, with *whom*, and *why*.

Current Health Information

This section of the form asks the patient to list, prioritize, and classify current health concerns and to identify ways in which those conditions are affecting daily life (see Figure 5-4). The goal is to learn why individual patients are seeking treatment so that you can address their needs and contribute to their goals for health. Specific questions help patients clarify their reasons for seeking manual therapy. Unmet expectations are often the product of unspoken desires. Leave little room for interpretation and be clear about goals for the session.

Information in this section is also useful for insurance cases to prove significant injury and thereby justify treatment. Symptoms and their effect on normal activities as stated by the patient are considered by insurance adjusters and peer reviewers to validate care. Information the patient reports—subjective documentation—is critical. Intake forms record historical subjective information—everything before the initial treatment.

FIGURE 5-4. Health Information—Current Health Information

HANDS HEAL

John Olson, LMP, GCFP
345 Moon River Rd. Ste. 6
Minnehaha, MN 55987
PHONE 612 555 9889
EMAIL olsen@email.com

HEALTH INFORMATION

Patient Name Darnel G. Washington Date 2-6-17

Date of Injury 1-6-17 Email

A. Patient Information

Address 1209 Lake Winnetonka Dr.
City Minnehaha State MN Zip 55987
Phone: Primary (612) 555-1510
Email darnel@wanshington.com Cell
Employer IBM
Work Address N/A
Occupation retired
Emergency Contact Shalonda-wife
Phone: Primary 555-5511
Secondary N/A Email shalonda@washington.com

Primary Health Care Provider

Name Sage Redtree, MD
Address 87 Old Trail Pkwy
City/State/Zip Minnehaha, MN 55987
Phone: 555-0009 Fax 555-9000

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments
Initials DGW Date 2-6-17

B. Current Health Information

List Health Concerns Check all that apply

Primary back pain
☐ mild ☒ moderate ☐ disabling
☒ constant ☐ intermittent
☒ symptoms ↑ w/activity ☐ ↓ w/activity
☒ getting worse ☐ getting better ☐ no change
treatment received pain pills, back brace

Secondary headaches
☐ mild ☒ moderate ☐ disabling
☐ constant ☒ intermittent
☒ symptoms ↑ w/activity ☐ ↓ w/activity
☒ getting worse ☐ getting better ☐ no change
treatment received pain pills

Additional neck stiff
☒ mild ☐ moderate ☐ disabling
☒ constant ☐ intermittent
☒ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☒ getting better ☐ no change
treatment received stretching

List Daily Activities Limited by Condition

Work N/A
Home/Family gardening, vacuuming
Sleep/Self-care sleep, exercise
Social/Recreational play w/ grandchildren, dancing, bowling, bridge group

List Self-Care Routines

How do you reduce stress? watch sports, garden
Pain? heat, back brace, meds

List current medications (include pain relievers and herbal remedies)
hydrocodone 500 mg every 4 hrs

Have you ever received massage therapy before? no Frequency?

What are your goals for receiving massage therapy? get around easier, less pain

C. Health History

List and Explain. Include dates and treatment received.

Surgeries appendicitis 1955 removed, torn meniscus @ knee 1986 arthoscopy

Injuries bowling injury @ knee 1985 no treatment until surgery 1986

Major Illnesses scoliosis 1955 Milwaukee brace, exercise, pain meds

In addition to recording the patient's concerns, this form asks what treatment the patient has received for these conditions in the past and what self-care strategies they have used. Use this information to formulate a treatment plan. You can eliminate ineffective techniques, avoid duplicating those that other practitioners on the health care team are using, and use or encourage solutions the patient finds helpful. Consider the patient's goals for the session, and together with your ideas for a treatment approach, discuss the various options in the interview.

If the patient's condition is recent and the patient has not yet received treatment for this complaint, look to the general health history for information regarding a treatment approach. Something in the patient's history may have contributed to his or her current health, or the treatment sought for other conditions may provide information that shapes what could be a successful treatment plan for the unique individual before you. You can get a sense of the patient's preferences toward treatment based on the type of self-care he or she has incorporated into his or her daily care routine, such as conventional or alternative and participatory or passive.

Health History

This section consists of two parts: (A) a chart listing surgeries, accidents, and major illnesses and (B) a checklist of symptoms and conditions. The chart allows the patient to identify major health crises and provides quick referencing for the practitioner (see Figure 5-5A). The checklist provides important information regarding all systems of the body, enabling you to pinpoint conditions that may require special precautions (see Figure 5-5B). You can then apply your knowledge of indications and contraindications to the development of your treatment plan. Health history can provide insight into the origin of current conditions and identify factors that may influence those conditions.

TALES FROM EXPERIENCE

Health History Affects Current Condition

Physical trauma can result in weakness and compensational posture or movement patterns, especially when untreated. These complications may cause concomitant dysfunction or may contribute to chronic conditions. In one of our staff meetings, we discovered that most patients treated for chronic repetitive stress injuries at the clinic also had a history of previous soft tissue trauma—with whiplash topping the list. Sara, for example, was in a car collision as a teenager. She bounced right back and never thought about the experience again. Twenty years later, she suffers from recurring thoracic outlet syndrome. A pattern was emerging: Every spring after long gardening sprees, she came to the clinic complaining of numbness and tingling in her right arm and hand. It wasn't until we discussed her case as a group that we considered how her medical history was influencing her present condition. The accident was so long ago that no one gave it much thought, especially Sara. Once we determined that Sara had a poorly healed cervical sprain–strain injury, her treatment plan shifted and her condition subsided. Sara's case demonstrates that careful consideration of the chronological chart can help you identify preexisting conditions that are adversely affecting current conditions. This prompts you to adjust the treatment plan to address the old trauma.

FIGURE 5-5A. Health Information—Health History

C. Health History

List and Explain. Include dates and treatment received.

Surgeries none

Injuries Broken arm ® fell out of tree house in 1963 cast for 8 wks

Major Illnesses none

FIGURE 5-5B. Health Information—Checklist

General

current	past		comments
☒	☐	headaches	MVA
☒	☒	pain	scoliosis
☒	☐	sleep disturbances	can't get comfortable
☐	☒	fatigue	scoliosis
☐	☐	infections	
☐	☐	fever	
☐	☐	sinus	
☐	☐	other	

The health history section of the health information form is helpful for identifying preexisting conditions that are currently symptomatic. This information is critical in the event of a motor vehicle collision (MVC). In personal injury cases, patients can expect that every attempt will be made to return them to preinjury status and that their insurance will cover the health care necessary to the full extent of their benefits. This coverage should include treatment for preexisting conditions that were exacerbated by the collision.[1]

Contract and Consent for Care

The contract for care is an invitation for the patient to participate in treatment and share the responsibility for the result. It delineates the patient's commitment to the healing relationship. The goal is to empower the patient to become active in the healing process and to promise goodwill on behalf of the manual therapist.

The consent for care states that the patient is actively choosing manual therapy and giving permission to the practitioner to provide treatment. It may warn of possible risks and limitations of the therapy. Know the limits of your scope of practice and state them clearly here, or include a statement in your policy document if you choose to use a brief intake form. Include a statement about your practice philosophy and how you intend to assist the patient toward greater health.

TALES FROM EXPERIENCE

Sample Scope of Practice and Treatment Statement

George uses this scope of practice statement as a licensed massage therapist (LMT) in Illinois, a state with a legally defined scope:

I understand that massage therapists do not diagnose medical, physical, or mental disorders, nor do they perform spinal manipulations by the use of a thrusting force. I acknowledge that massage therapy is not a substitute for medical examinations or treatment; massage therapy is complementary to medical services.

George explains the intent of his treatment sessions on his health information form this way:

Manual therapy is intended to help you learn more about the dynamics of health that are within your control—increased awareness of your patterns of movement and holding, responses to stress, and accumulation of tension. Manual therapy is a holistic approach to bridging mind and body. Together we will recognize your physical signals of diminishing health and enable you to respond to them in ways that promote vitality, balance, and spirit.[3]

End the health information form with a dated signature confirming that the information provided is complete and accurate and that the patient is consenting to receive treatment. Require the signature of a parent or legal guardian when the patient is younger than 18 years. This signed statement is sometimes referred to as a treatment disclaimer or waiver. The patient's signature on the form may not protect you legally if something goes awry, but it demonstrates informed decisions regarding safe care. However, the most important element of the contract and consent for care is the verbal discussion that leads to an agreement to engage in a therapeutic relationship. As Jerry A. Green, a malpractice attorney in California and former president of the Medical Decision Making Institute, states, "Remember: Legal problems begin as disagreements. You prevent legal problems by making meaningful agreements."[3]

TIMING AND APPLICATION

A thorough history takes time to document. Instruct the patient to arrive 15–30 minutes before the initial appointment to ensure adequate time for filling out the forms. You may choose to save time by e-mailing the health information form and all other applicable intake forms to the patient the week before the first session or by sending the link to your electronic health record (EHR) system for them to complete online. If they complete the forms online or e-mail back a completed form, be aware that you fall under HIPAA laws regulating the protection of confidential patient information and must take steps to ensure your compliance.

People may breeze through the forms in your office because they are eager to get on with the session. When given their own time to think about the questions, to look up things when necessary, or to ask family members for help in reconstructing events, their information tends to be more complete. Occasionally, people forget to bring the forms to the initial session, but most remember and make it worth the trouble of sending the forms in advance. Even when they forget the forms, filling them out a second time goes much more quickly. Check in on the patient filling out the forms in the office. They may have challenges that require your assistance, such as a different learning or language ability. Reading the form out loud can assist them in filling out the form correctly and more quickly.

Regardless of individual goals for treatment, each patient should complete a basic ealth information form annually. If the patient has progressive or degenerative health problems or if the patient's health changes, the form should be updated semiannually or quarterly.

Use the form as an information database, and refer to it for interviewing the patient, designing the treatment plan, identifying possible cautions for care, and contacting the patient throughout the relationship. If an insurance case manager or an attorney requests the patient's file, this document may be used to substantiate the patient's injury and help determine the presence of preexisting conditions.

HIPAA Regulations for Electronic Transaction

The **HIPAA statute** was signed into law in 1996 and addressed health insurance rights, health care fraud, electronic health information sharing, and health information privacy. The health information standards constitute the "administrative simplification" part of HIPAA. Congress directed the Secretary of Health and Human Services (HHS) to adopt regulations to implement these information standards. When most people talk about HIPAA, they mean the information sharing and privacy rules even though Administrative Simplification is just one of many parts of HIPAA.

Over the past 15 years the administrative simplification rules have grown to incorporate similar laws enacted by Congress to enhance information sharing and privacy. The most significant of these more recent statutes is the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which established standards to promote the use of EHRs and improve information security requirements.

The "simplification" intended by HIPAA relates to the creation of common standards for the transfer and storage of information so that all HCPs who transmit health information electronically or use a billing service or clearinghouse to do this use the same set of codes, data content, and data formats and keep patient information safe and secure throughout the process.[15] Electronic transactions refer to exchanges of protected health information (PHI) between computers and other internet-connect devices.

Compliance with HIPAA regulations has been challenging. Certainly, confusion was common when treatment (CPT) codes and diagnostic (ICD-10) codes were first introduced. The intent was to create a universal language to standardize billing procedures and expedite reimbursement. Although not without limitations, the codes have served their purpose. In time, the benefits of these privacy and security regulations should become apparent.

Given that Congress limited the application of the complex HIPAA regulations to "covered entities" and "business associates," many people have struggled to determine how to apply the regulations to their circumstances:

To whom does HIPAA apply? What is required for compliance, and how should practitioners meet these requirements? The following section briefly addresses these questions and provides a few basic tools to point you in the right direction for obtaining the additional help you may need regarding HIPAA regulations and compliance.

- Access the official Web site of the Centers for Medicare and Medicaid Services (CMS). Determine if you are a covered entity: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AreYouaCoveredEntity.html
- For HIPAA basics: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf
- Visit the official Web site of the U.S. Department of Health and Human Services. For the most current versions of the Privacy and Security rules: https://www.hhs.gov/hipaa/for-professionals/index.html
- To ensure you are meeting the necessary regulations and using the most up-to-date forms available, consult a qualified attorney. For example, John S Conniff, Professional Limited Liability Company (PLLC) provides assistance in meeting compliance requirements, including the necessary forms and procedures, for a small monthly fee. The forms are updated anytime a change is made at the federal level. https://www.conniff.com/practice-forms/

There are HIPAA privacy forms available on a variety of Web sites that you can download for free and customize to meet your needs. Many sites provide basic forms for use by HCPs. These forms must be tailored to each particular practice and should be reviewed by a competent legal professional familiar with HIPAA requirements. Because HIPAA is a fluid document, these forms may become outdated and require revisions. Like many things on the web, there is no guarantee that they are current and will satisfy compliance requirements.

Three sets of standards from the HIPAA Administrative Simplification section are addressed in this chapter. They are

1. Privacy issues
2. Security issues
3. Transactions and code sets

DOES HIPAA APPLY TO ME?

HCPs who transmit confidential patient information electronically (receiving intake forms from patients via e-mail or sending progress reports to HCPs online) or use a third-party billing service or clearinghouse to transmit information electronically are required to comply with HIPAA regulations. Electronic transactions include the following:

- Claims or patient encounter information, such as patient files and billing information
- Patient eligibility requests
- Referrals, prescriptions, and authorizations
- Claims status inquiries

If you conduct all your business activities and health care transactions on paper, by phone, or by a dedicated fax (as opposed to faxing from a computer), HIPAA does not apply to you. However, you may be required to comply with state regulations that dictate health care privacy standards. Most state health information privacy laws incorporate HIPAA privacy and security standards to avoid conflicting standards. If the state law is stricter than HIPAA, the state law may override the weaker HIPAA standard. This is particularly true in states that grant juveniles special health privacy rights. Regardless of state and federal law, it is good business to protect your patients' confidential health information. Inform your patients of their rights regarding their health information, explain your privacy practices, and describe how you intend to use and disclose their health information. Secure patient information in your office so that only you and authorized staff members have access to it.

The U.S. Department of Health and Human Services has developed a "covered entity decision tool" for providers to help you determine whether you should be HIPAA compliant. Visit http://www.cms.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp#TopOfPage to access this tool (under General Information) and other educational materials.

NATIONAL PROVIDER IDENTIFIER NUMBER (NPI#)

Once you determine that you are a covered provider—an HCP required to comply with HIPAA standards—sign up for an NPI#. HIPAA has mandated the adoption of standard unique identifiers for health providers and health plans. The CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign unique identification numbers to covered providers. This number will become the only ID# necessary to communicate between and among other health providers, health plans, clearinghouses, and any entity that may need it for billing purposes. The numbers do not carry other information about the providers (intelligence-free), such as the state they live in or their medical specialty.

Some states are requiring this number for all health care and billing communications, regardless of the individual provider's observance of HIPAA. It may benefit each licensed manual therapist to obtain an NPI# now for the sake of ease and preparedness in case of future need. There is no charge for the application process nor for conducting searches for providers or businesses.

NPPES manages the application process. Go to http://nppes.cms.hhs.gov/NPPES/WELCOME.do to apply for your NPI#. The process is self-explanatory. The only difficulty you may encounter is in finding your taxonomy number. For massage therapists, the taxonomy number is 225700000X.

HIPAA PRIVACY ISSUES

Privacy is an important issue for people. All HCPs should take adequate measures to protect their patients' confidential information. The HIPAA privacy rules take a common sense approach useful for all practitioners. It has garnered a considerable amount of attention in health care practices because it is nontechnical and deals mainly with administrative policies and procedures. The privacy rules govern the collection, use, and disclosure of information and patient rights. The companion security rules govern the protection of health information and methods for practitioners to ensure compliance with policies and

procedures. Simply stated, patient information must be used only as authorized or permitted and must be protected at rest (i.e., storage) or in motion (i.e., spoken communication), as well as in electronic, oral, or written forms.

The HIPAA security rules establish safeguard measures to control the unauthorized disclosure of, access to, and use of PHI.[4] The HITECH Act expanded the security rules to apply directly to business associates of practitioners. These rules require the following:

45 CFR § 164.306 Security standards: General rules.

(a) General requirements. Covered entities and business associates must do the following:
- **(1)** Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity or business associate creates, receives, maintains, or transmits.
- **(2)** Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
- **(3)** Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this part.
- **(4)** Ensure compliance with this subpart by its workforce.[5]

At a minimum, HIPAA requires covered entities and business associates to "conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity or business associate." The risk assessment and the policies and procedures adopted to implement the findings of the risk assessment must be regularly updated to reflect changes in circumstances. Federal agencies have cooperated to provide risk assessment tools for practitioners (https://www.healthit.gov/providers-professionals/security-risk-assessment-tool).

To adequately protect your patient's PHI, identify all the places in your office, home, or other location in which patient information can be found, such as your appointment book, patient sign-in sheets, patient files, and address book. Then, identify privacy risks, such as anyone who may have access to this information or whether patient files, your address book, or appointment book are ever left unattended while you are, for example, in the treatment room. Next, come up with a system for protecting this information, such as locking these items in a file cabinet, putting away all files between patients, and using first names only in your appointment book if it is ever visible to patients. Create policies that are HIPAA compliant and require your staff (if any) to follow them.

Map out how PHI flows through your office. If you use an outside billing service, how is information transferred? If you take client files home because you don't have a computer in your office for writing reports, who has access to this computer? Where do you store patient files when you travel from office to office? When you have conversations about patients with officemates, such as chiropractors or fellow therapists, in hallways or other public areas, how do you keep the information confidential? The HIPAA privacy rule allows patients to access their health information, so where do you log the content of your discussions so your patients can gain access to it?

Next, write and implement a notice of privacy practices (NPP). This notice must describe **the use and disclosure** of patient health information and how patients can access this information. Review several NPPs from various practices and develop one that works for you. Search online or access the Web sites mentioned earlier for privacy statements that you may download and use to create your own practice policies. HHS provides sample NPP for practitioner use and contains instructions for their use (https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp_fullpage_hc_provider.pdf).

An effective NPP will

- Describe the health information you intend to protect, including medical records, conversations among HCPs, billing information, and patients' name and other identifying information such as contact information.
- State how you will protect your patients' health information. For example, explain when you will require patients' authorization to use and disclose their information and how you will limit access to that information and state that patient health information may be shared for the following reasons and in the following ways:
  - For treatment, health information may be shared within the office and outside the office with members of the health care team
  - For education and research to improve quality of care
  - For administrative functions, such as staff training
  - For setting appointments and contacting patient for health-related communications
  - For judging the practitioner's quality of care, information may be shared with the patient's health plan
  - For payment, eligibility, and claims purposes
- List the six patients' rights provided by HIPAA:
  - The right to request restrictions on certain uses and disclosures of protected health information
  - The right to receive confidential communications of protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to receive a copy of the NPP

The Office for Civil Rights (OCR) has been designated by HHS to enforce the HIPAA privacy rules. The patient may also contact a consumer advocate group, the state's attorney general, or the American Civil Liberties Union. If a complaint has been filed against you, your office will be asked to produce significant records documenting your privacy efforts.[4] The NPP for your office, the forms shown in the following list, and your implementation procedures will be your first line of defense in demonstrating your compliance to HIPAA. Determine how you will respond to and manage patient requests and develop and implement the following forms for patients to use:

- Acknowledgment of Notification of Privacy Practices—This form shows patients' signatures acknowledging that they have received your privacy practices and have read them.
- Patient Communication Form—HIPAA grants the patient a right to request and receive records through an unsecure email account so long as the practitioner warns the patient that it's probably a bad idea. Practitioners should use a form that advises patients of appropriate means of communication with the practitioner, provide secure alternatives when available, and document patient preferences and contact information.
- Patient Privacy Complaint Form.
- Request for Record Amendment.
- Request for an Accounting of Disclosures.
- Request for Alternative Communication.
- Request for Restricted Disclosure.
- Request for Restriction of Disclosure to Insurers when patient pays for services in full.

- Request for Use of Patient Information in Marketing—Many practitioners make the mistake of allowing patient comments or reviews on the practitioner Web site, which constitutes the use of patient information for marketing and must be specifically authorized.
- Request for Patient's own records—HHS has differing standards for records requested by a patient versus requests made by others and authorized by the patient. Practitioners must accommodate a wider range of requests for access by patients and must make reasonable efforts to satisfy the methods by which the patient requests access.
- Patient Authorization for the Use and Disclosure of Protected Information—This form is very specific to the kind of information that may be shared, with whom and for what purpose. The authorization has a short life span and typically expires in 90–120 days, which should be stated on the form.
- Revocation of Authorization—You must provide patients with explicit instructions on how they may revoke their authorization to release medical information.

Finally, determine how you will protect your patients' rights. After you have conducted the required HIPAA risk assessment and included the report in your HIPAA records, outline the steps you will take to protect against these risk to patient privacy. It could be as simple as printing a confidential statement on fax cover sheets, tracking who you share information with and why (use the insurance verification form to log and monitor this information), and using the suggested forms to obtain your patients' consent or authorization to share their PHI. Whatever your plan, write it down and follow it.

Here is a sample statement to print on the bottom of your fax cover sheet:

The documents accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or covered entities named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted by law or regulation.

If you are not the intended recipient, you are hereby notified that any use, disclosure, copying, or distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Protect transmitted information further by verifying the accuracy of all fax numbers before sending documents. Some states impose requirements that practitioners periodically verify fax numbers before use. For example, Washington state law provides a stricter standard for fax communication by a HCP.

> When health care information is transmitted electronically to a recipient who is not regularly transmitted health care information from the health care provider, the health care provider shall verify that the number is accurate prior to transmission.
>
> **RCW 70.02.150**

Some incidental use and disclosure of health information is permitted. For example, discussions can take place to coordinate care in person or on the phone if you speak in a low voice and away from listeners. You can leave messages on patients' answering machines or with family members if you only provide the minimum information necessary. You may ask patients to sign in, and you may call their name in the waiting area as long as the reason for the visit is not disclosed.

Safeguard your patients' PHI—you cannot have privacy without security. Take the necessary precautions, such as locking your cabinets and doors and limiting access to patient records. Review your privacy practices and forms annually. Evaluate the status of patients' rights. Stay abreast of the updates by accessing HIPAA Web sites regularly and making changes as necessary.

HIPAA SECURITY ISSUES

Security and privacy go hand in hand. The HIPAA security regulations are about controlling access to electronically transmitted PHI, and privacy is about controlling how electronic, oral, and written PHI is used and disclosed.[4] The biggest difference between these rules is that security only applies to electronic PHI. However, practitioners often forget that even when the HIPAA security regulations do not apply, the privacy rules have a standard for protecting paper records—"a covered entity must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information."[5] HHS fined Parkview Health System $800,000 after an employee left 71 cardboard boxes of medical records of a retiring physician in the driveway of his home.

In addition, states have been enacting a wide range of privacy laws that require everyone maintaining personal financial and health information to implement security safeguards and report breaches.

These are the types of safeguards you must have in place to be compliant with HIPAA:

- Physical safeguards—rooms and storage facilities with locks or other safeguards to control access
- Administrative safeguards—policies and procedures that define authorized access to information, including user IDs and passwords and actions that will be taken if violations occur.
- Technical safeguards—encryption of electronic data and use of passwords to verify use and to track users who have logged onto the system.[4]

Just because you practice alone or have a small staff, don't ignore the risk of unauthorized access and your responsibilities to lower risk and report certain unauthorized use or disclosure. For example, purchase and install security software for your electronic devices and secure all access to your computer, phone, and tablets.

Fees and Policies

CONTENT

Fees and policies include a fee schedule, payment options, and miscellaneous office policies. Publish your fees and policies and distribute them to all patients. Determine the policies that allow you to be financially sound and that provide clear boundaries. You can always be more lenient later (if special circumstances arise), but it is difficult to get tough after the fact. Decrease the possibility of frustrations by defining the patient behavior necessary for you to relax and enjoy your practice.

Fee Schedules

Fee schedules describe the various services you offer and the costs associated with them. Fees may be delineated by techniques and modalities, such as manual lymphatic drainage or hot/cold packs; by style or intent, such as wellness care or curative care; or by service codes, such as 97124 for massage therapy. If you are billing for your services using current procedural treatment (CPT) codes, such as 97124, break down your fees on your fee schedule according to the time specified in the service description. For example, CPT codes designate most physical medicine procedures to 15-minute units, so your fee schedule should delineate your rates in 15-minute increments (see Figure 5-6). Exam codes (97161-97164) and some modality codes (for example, hot/cold packs—97010) do not designate units of service. These services are considered single application services.

TALES FROM EXPERIENCE

Massage Therapists Consulted in CPT Code Changes!

The American Medical Association (AMA) convened a consultation panel to review and update the existing CPT codes for physical medicine and rehabilitation. The goal of the panel was to create codes that reflected the varying degrees of complexity patients present with, providing variable reimbursement rates that recognize the level of effort and skill required to deliver care. Included were representatives from various manual therapy professions: massage therapy, physical therapy, occupational therapy, and athletic trainers. The American Massage Therapy Associate (AMTA) was asked to send representatives to sit on the panel. Susan Rosen, LMT, was the longest standing representative from the AMTA on this panel, her volunteer service spanning nearly two decades.

FIGURE 5-6. Fees and Policies—Fee Schedule

A. Fee Schedule

Fees for services are as follows:

• Evaluation	$30 initial session
• Re-Evaluation	$15 per session
• CranioSacral/Lymph Drainage (97140)	$100 per hour ($25 per 15 minute unit)
• Feldenkrais (97112)	$100 per hour ($25 per 15 minute unit)
• Hot and Cold Packs (97010)	$15 per session ($15 per session)
• Therapeutic Massage (97124)	$80 Per Hour ($20 per 15 minute unit)

Evaluation codes changed recently (effective January 1, 2017). Treatment codes have yet to be released, although the intention is similar: create codes that reflect the skill level required to treat based on the complexity of the patient's condition. The new evaluation codes distinguish between low (97161), medium (96162), and high (97163) levels of complexity for initial evaluations, with one reevaluation code (97164). Create a fee schedule that includes the levels of evaluation within your scope of practice.[6] (see Chapter 8, Insurance Billing, for definitions of the levels of evaluation codes.) Define your services clearly, both to explain what you offer to your patients (so they may choose appropriately based on their goals for health) and for the purpose of insurance reimbursement (so they can pay you accurately based on the services you provide). If you submit claims to insurance companies, you may need to define your services according to insurance standards to ensure reimbursement. For example, the *Current Procedural Terminology (CPT) codebook*—a set of codes created and published by the AMA—defines standard therapeutic procedures and modalities, assigns time frames for the purposes of insurance billing and reimbursement, and designates all health care services by categorizing like techniques, such as 97124—defined as massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion). The code 97140 is defined as manual therapy techniques, such as mobilization/manipulation, manual lymphatic drainage, manual traction, including myofascial release. The code 97112 is defined as neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception, for sitting and/or standing activities.[7] When describing your services to your patients, use specific terms rather than general categories or codes, such as deep tissue massage instead of 97124, myofascial release instead of 97140, or Feldenkrais instead of 97112 (see online, Appendix E for billing codes).

However, it is important to note that there is no standard terminology in the CPT codebook defining the intent or style of massage such as sports, wellness, treatment, therapeutic, or medical massage. If you submit claims using CPT codes and you choose to delineate different fees for these "styles" of massage, do so with a clear definition in mind and make sure that specific techniques and modalities do not overlap. In other words, if you differentiate between wellness care and curative care on your fee schedule, the techniques and modalities you use should be unique to the type of service provided—Swedish massage for wellness care and structural integration for curative care.

When establishing your fees, keep in mind that it is discriminatory and fraudulent to charge different rates for the same service. In other words, you cannot have one rate for cash patients and another rate for insurance patients when the service you provide is the same. You must charge the same rate for a service regardless of how the patient is paying. If an insurance auditor finds that you used myofascial release and lymph drainage on a patient who paid cash at the time of service but you charged the individual a lesser fee than you are charging the insurance company for the same techniques and modalities, you may be required to refund the difference (payment-at-time-of-service discounts will be taken into consideration). If an auditor determines that your billing practices are fraudulent, you could be asked to reimburse the company for overcharges—retroactive to 7 years. Owing to HIPAA regulations, fraudulent billing is now a federal crime enforceable by the FBI. In addition to reimbursing the insurance company, federal penalties may include jail time and extensive fines.

TALES FROM EXPERIENCE

Chiropractors Jailed for Fraudulent Billing

A chiropractic office was reported by an insurance company and underwent an investigation for fraudulent billing practices. The result: In addition to reimbursing the insurance company for overcharges, the two chiropractors were jailed for 6 months and each was fined $200,000.

The insurance company suspected that the doctors were treating family members and billing the insurance company for the services. This was indeed true. The doctors neglected to read the fine print of the insurance contract signed when applying for preferred provider status that restricted reimbursement for the treatment of family members. When the insurance company began the investigations, the FBI was alerted. Once the FBI arrived on the premises, they locked the doors to the practice and went through every file in the office, looking for breaches of contract and laws. They compared chart notes with billing dates; every date of treatment billed without a corresponding chart note—cash or insurance—was tallied as one felony. Over 100 counts of federal infractions were noted owing to missing chart notes, in addition to the 20+ counts of unlawful billing for the treatment of family members.

After the investigations were complete, the jail time was served, and the fines were paid, it was 2 years before the chiropractors were back in business.

In many states, it is legal to offer discounts to patients who pay at the time service is rendered. Discounts are allowed within reason as long as they apply to insurance patients as well as to cash-paying patients. A payment-at-time-of-service discount may not seem applicable to insurance patients, but it is increasingly popular for patients to pay for uncovered health care benefits up-front and then seek reimbursement from their health savings account. Publish all discounts on your fee schedule, including prepaid package discounts and financial hardship discounts, as well as discounts that apply when payment is made at the time of service. Check your local laws and abide by any requirements and exceptions (see Chapter 9, Ethics, for a discussion on the ethics of fee schedules).

Another method for setting your fee schedule is to charge by time rather than by modality. This method is known as bundling services. A flat fee includes any manual therapy applied that can be billed under one procedural code. For example, you may use Swedish massage, myofascial release, lymph drainage, trigger point therapy, acupressure, and muscle energy techniques in varying combinations but find it difficult to break everything down into time per modality. You may choose to bill using the general massage therapy procedural code and not bother with four different procedure codes and four different rates. Bundling service is common in cash practices and can be used with a billing practice as long as you do not bundle procedures that would be reimbursed at a lower rate than the one under which you are billing. This is a fraudulent practice known as upcoding.

Payment Policies

The payment policies section states the payment methods available and clarifies the type of insurance reimbursement you will accept and under what circumstances. Insurance reimbursement arrangements vary from manual therapist to manual therapist, from state

to state, and from country to country, depending on the scope of practice of the individual therapies and the insurance climate of the region. Inform yourself about the specific risks and benefits of insurance billing for your unique situation before setting a policy.

Office Policies

Provide written statements of your office policies. Make sure your patients read them and agree to abide by them. Require a signature demonstrating that the patient has read and understood your fees and policies. It is generally easier to enforce a policy statement when it is in writing and has been signed and dated. Keep the signed form in your patients' files. You may have to remind patients of these policies should something arise at a later date.

Cancellation policies are common in practices in which one session makes up a significant percentage of the daily income. Set a cancellation fee or charge the full price of the session whenever the patient fails to cancel within a specified number of hours before the scheduled time. Consider abiding by your own cancellation policy. For example, offer a similar discount to those patients whose appointments you cancel without a 24-hour notice. Demonstrate that you value their time, particularly when you are asking them to value your time. When you need to cancel without a 24-hour notice, give the patient a certificate for a free "no-show" or late cancellation, or forgive the occasional emergency cancellation.

Right of refusal is another common office policy. This policy can be helpful for turning away people who are impaired by alcohol or drugs, have an infectious illness, push for treatment outside your scope of practice, or behave inappropriately. It is important to set boundaries, to feel safe in your practice, and to take care of yourself. Use this policy any time you have a gut instinct to do so.

REFINE YOUR SKILLS

Create a List of Fee Schedules and Office Polices

As a class or at a professional networking meeting, divide into groups according to target market preferences (treatment, wellness, sports and recreation, for example). As a group, determine what the market might bear for entry-level manual therapists (students) or provide a range given experience and continuing education (practitioners). Discuss the value of experience and additional credentialing on fee schedules. Keep in mind that price-fixing is illegal—do not agree to all charge, a set price, unless you are working in the same clinic. Next, discuss the benefits of office policies, such as late cancellation fees, right of refusal, and how to handle practitioner cancellations. Combine ideas and create office policies (excluding fee schedules) that might work for all of you.

TIMING AND APPLICATION

The patient should read and sign your fees and policies form before the first session begins. Include the policy statement with the health information form and any other intake forms completed by the patient at the initial visit. Post your fees and policies clearly to reinforce what you are requiring the patients to agree to and to demonstrate your professionalism toward potential patients who walk in off the street. Revisit your fees and policies annually and update them as necessary.

Health Report

CONTENT

The health report provides a snapshot of the patient's health (see online, Appendix B for a blank form). In just a few minutes, the patient can chart the location of pain, stiffness, and numbness—by writing the letters P for pain, S for stiffness, and N for numbness—on the human figures and can rate his or her pain and loss of function by placing a dash on the lines of the analog scales. The drawings provide a map of the patient's symptoms that is accurate and easy to read. Below the figures are two analog scales or lines of continuum: one denoting pain, and the other, activity level. The mark on the line is measured, and a numerical score is calculated and recorded, making references to progress quick and easy.

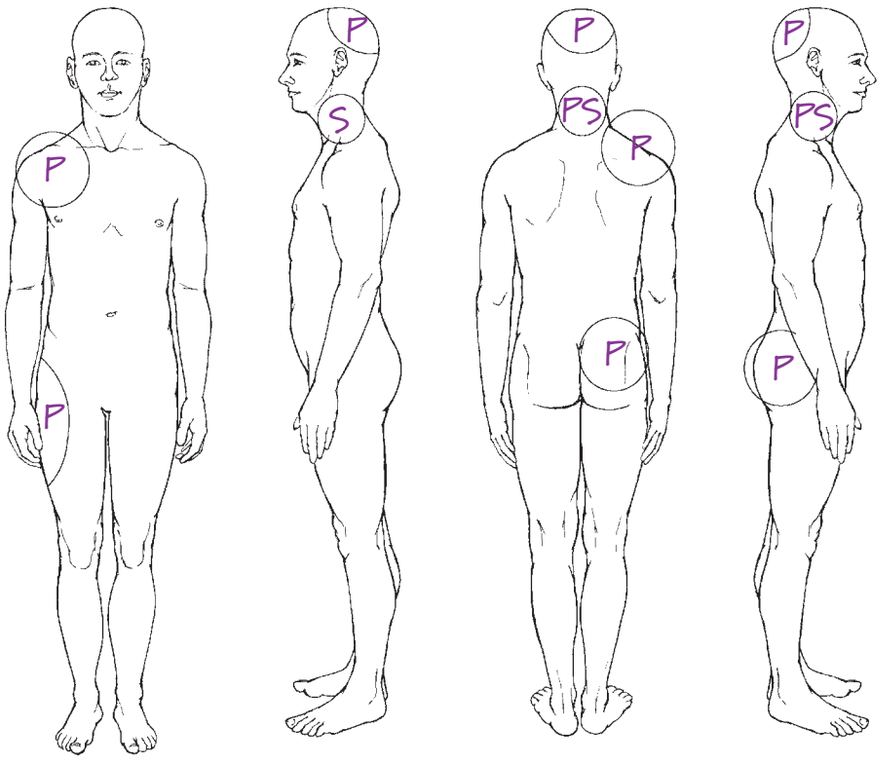
The health report is the form mentioned in the opening case study of Sandee in Chapter 4, Why Document? The benefits of paper version of this form are significant for the patient and the practitioner. Progress is recorded in the patient's own handwriting, convincing even the most frustrated patients of their health improvements. The manual therapist can use this form to support the health history interview, gathering pertinent information from tentative patients and streamlining the discussion with the chatty ones (see Figure 5-7).

FIGURE 5-7. Health Report—Figures

A. Draw today's symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

Key
P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



Diversity in learning styles is widely recognized in today's classrooms. Visual, auditory, and tactile learners have different ways of processing and storing information. The same is true of patients. Some enjoy filling out forms, whereas others would rather tell you about themselves (and often do so in story format). Still others can draw images more easily than filling in blanks on a form or talking. Provide a variety of ways to gather information, including multiple choice forms, one-on-one communication, and pictures to draw on, such as the ones on the health report.

Coaxing information from some patients can feel like pulling teeth. May be they were taught not to complain or they are just not comfortable speaking to people they do not know well. For those patients, drawing symptoms on pictures may be easier than having to talk about their pain or disability.

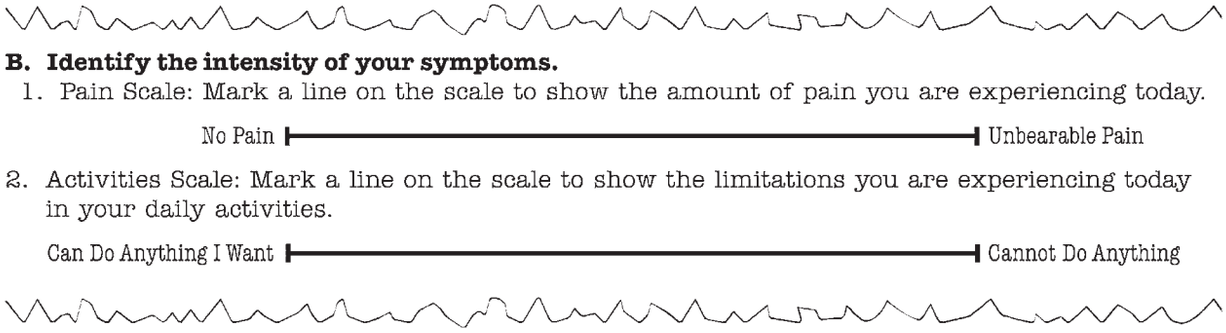
With other patients, trying to keep the interview less than 10 minutes is challenging. Some would rather talk about their problems than solve them. Others chatter when they get nervous. Gather the salient pieces of information on a form every 30 days or as needed to update you on the details of their health. Once the current information is recorded and reviewed, a few brief questions may suffice to assess their progress and prepare for the session.

Analog Scales

An analog scale is a method of measurement that omits numbers or words as measures and instead uses a line of continuum, with one extreme on one end and the opposite extreme on the other end. According to the research, analog scales are considered more reliable and accurate than numerical rating scales, such as 0–10. The literature suggests that numbers can be remembered from session to session, which decreases the validity of the responses. A malingerer may remember a previous response and manipulate the answer accordingly.[1]

The paper version of the health report uses analog scales to measure patients' pain and loss of function. On the line of continuum, for example, pain-free is at one end and debilitating pain is at the other end. The patient places a mark at a point between the two extremes that best represents how he or she feels at the moment (see Figure 5-8). The line is 10 cm long, making it possible to blind the patient to the numerical number and still score the patient's mark between 0 and 10. On a scale of pain-free to unbearable pain, for example, pain-free is given the value 0 and unbearable pain is given the value 10. The mark is placed between the two values. After the session, measure the mark on the line and record the number in the comments section. That number, or score, can then be used to populate a graph, as seen later in the chapter.

FIGURE 5-8. Health Report—Analog Scales



One drawback to an analog scale is the extra steps required to measure the mark on the line, record the score, and create the graph to show progress. For ease and speed of use, the EHR uses numerical scales to measure pain, function, and stress, before and after sessions. The system automatically populates a graph with each session, making it possible to note progress at any point in the treatment series, comparing before and after therapy changes as well as changes over time (see Figures 5-9A and 5-9B). It is also possible to skip the measures and simply lock the session note, if the client is relatively healthy and measures are not necessary as frequently. The graph only populates the pertinent results.

It is unnecessary to use an electronic or paper scale with every subjective complaint or objective finding that comes up during a session, such as trigger point pain or limited range of motion. A verbal response is indicated during the session using a number scale (0–10) or use word *values* (mild, moderate, severe), and the results can be recorded in the body of the session note.

FIGURE 5-9A. Electronic Health Record (EHR)—Presession Measurement Scales

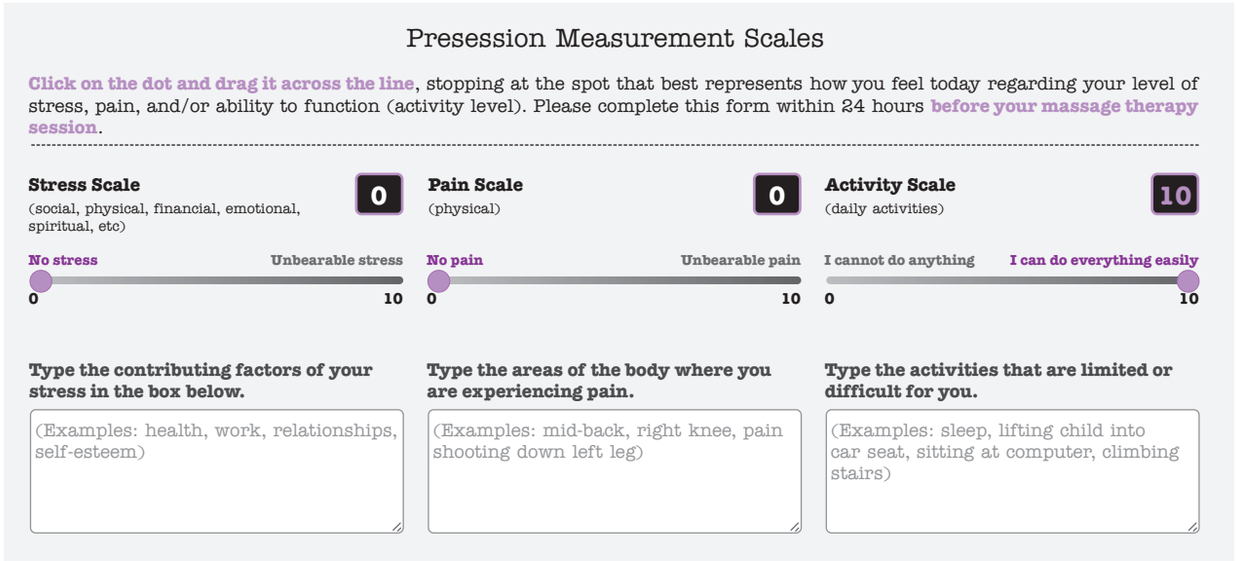
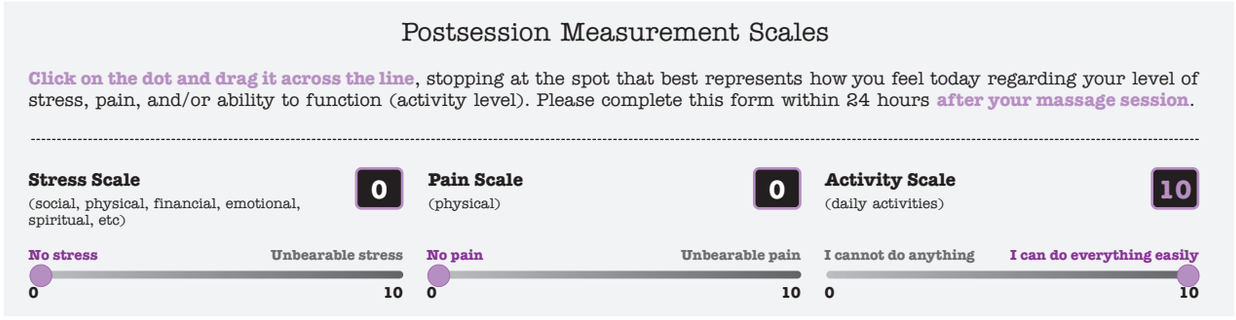


FIGURE 5-9B. Electronic Health Record (EHR)—Postsession Measurement Scales



REFINE YOUR SKILLS

Creating a Patient File

Create a file on yourself, one to take to exchange sessions with other students or to treatment sessions when seeing different manual therapy providers. Complete one health information form (the extended version) per year and a health report every month. Secure those to the left-hand side of the file folder in consecutive order.

In addition to the intake forms, the chart will contain the original of every SOAP (Subjective, Objective, Assessment, Plan) or Wellness chart completed for every session received during the school year. Secure those to the right-hand side of the file folder.

The student who provides the massage may need to turn in the chart for credit. If so, a copy can be made so that the original stays in the student's file, just as it would in practice. The "patient"/student takes the file to every student exchange to prevent redundancy in gathering intake information and to model clinical practices.

In cases where the "patient" is not a student, use the file to make life easier for all members of your health care team: make copies of the most current health information form and health report and deliver them to your HCPs at the initial visit. Consider updating them with future health reports at subsequent visits.

TIMING AND APPLICATION

Patients with injuries or chronic conditions should complete the health report at the initial session and at a minimum with each reevaluation session—about every 30 days or every 6–8 sessions. If the patient has no subjective complaints, such as pain, loss of function, stiff joints, or neuropathies, have them complete the report periodically. At a minimum, include the health report with the annual updates and ensure that you have all the health information you need to be safe and skillful in your work.

REFINE YOUR SKILLS

Have the Patient Chart for You!

If motivating yourself to chart is an issue, the EHR presession and postsession measurement scales will ease you into the habit of regular documentation. The patient does most of the charting for you! Simply fill out what you did, where you did it, and for how long in the EHR Wellness note in addition to the clients completing the scales. Or, if you are charting on paper, use a two-sided copy of the health report. Before the session, have the patient draw on the human figures and mark the analog scale on the front side of the form. Use the comments section to record your treatment notes. After the session, have the patient draw on the figures and mark the analog scale on the back of the form. Use the comments section on the back to record self-care exercises for the patient and any notes regarding a treatment plan for the next session. This shortcut is not recommended for insurance patients or for long-term care, but it is a good way to get started. As you proceed through this book, you will discover the limitations of using this form for all your daily charting needs, but if necessary, begin with the online presession and postsession scales or the two-sided paper version of the health report for your daily note-taking.

Pain and Disability Outcome Measures

Research shows that pain and disability outcome measures are reliable and effective tools for measuring the extent and nature of a patient's injury and improvement with treatment (refer to Wise One Speaks: The Reliability of Pain Questionnaires, later in this chapter). Proof of significant injury is provided through the disability percentage. The treatment plan is justifiable with ongoing use of the questionnaires.

Pain and disability questionnaires consist of questions regarding the patient's ability to sit, stand, wash, dress, walk, sleep, read, drive, travel, work, concentrate, and participate in recreation. The patient answers the questions by checking one of six options provided (Revised Oswestry and Vernon–Mior) or by circling one of five numbers (Functional Rating Index, FRI). The Patient-Specific Functional and Pain Scale (PSFS) varies in use, allowing the patient and practitioner to identify and rate (0–10) the limitation of important activities, unique to the patient. Those specific, self-identified activities are scored repeatedly over time and tracked on one form. Each of the four forms discussed here can be scored, by using either a disability percentage scale or the numbers between 1–5 and 0–10. Over time, the scores can be compared and progress can be concluded based on the change in scores.

Many pain and disability questionnaires are available. The most comprehensive and applicable list of outcome measurement tools are available through the International Society for Complementary Research at http://www.iscmr.org/domain/physical, where you can learn about over 50 different physical outcome measurement tools.[8] Three are presented in this text: (1) the Revised Oswestry Low Back Pain and Disability Index, (2) the Vernon–Mior Neck Pain and Disability Index, and (3) the Patient-Specific Functional and Pain Scale (see online, Appendix B for blank forms). An additional form (Functional Rating Index, FRI) was included in previous editions of this text but is now only available online. (To access a PDF of the FRI instrument, go to http://www.chiroevidence.com/FRI_license.html and accept the limited license agreement before downloading. The license will permit you to use the form in clinical practice, for teaching at an educational institution, or for research purposes and restricts you from modifying the form in any way.)

All four indices are backed by strong research (see the following Wise One Speaks, which discusses three of the four tools). Two are almost identical in content and format but focus on different areas of the body—Oswestry on the low back and Vernon–Mior on the neck. Both can be used creatively for other areas of dysfunction—the Vernon–Mior for the upper extremities and the Oswestry for the lower extremities. The FRI combines the content of the Oswestry and the Vernon–Mior in a format that reduces the need for multiple instruments for spine-related conditions and is much less text-heavy. The PSFS is favored over the other three, according to a different study comparing these and other commonly used measurement tools, owing to its internal and external responsiveness: it is easy to use, and it can be personalized to the patient.[9]

The FRI is for general use and does not ask questions specific to areas of the body. It takes the patient about 1 minute to complete the form and the practitioner about 20 seconds to score it. After its debut in 2001, it quickly became the preferred instrument for measuring pain and function. Based on the initial research, FRI demonstrates excellent reliability, validity, and responsiveness and significantly reduces administrative burden.[9,10] After seeing the results of a later study comparing these four measurement tools, alongside the bothersomeness scale and the Copenhagen scale, the PSFS is fast becoming the preferred scale (see Figure 5-10).[9]

FIGURE 5-10. Patient Specific Functional and Pain Scales (PSFS)

PATIENT SPECIFIC FUNCTIONAL AND PAIN SCALES (PSFS)

Manual Therapist

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

Clinician Instructions: Complete after the history and before the exam.

Initial Assessment:
We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem. Please list and score at least 3 activities that you are unable to perform, or having the most difficulty performing, because of your chief problem.

Follow-up Assessment:
When you were assessed on _____, you told us that you had difficulty with the following activities. Please score these activities that you told us previously you were unable to perform, or were having the most difficulty performing, because of your chief problem.

Patient Specific Activity Scoring scheme (Score one number for each activity for each date):

0=Unable to perform activity	0 1 2 3 4 5 6 7 8 9 10	10=Able to perform activity at same level as before injury or problem

Activity	Date:	Date:	Date	Date:	Date:
1.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
3.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
4.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
5.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
Totals:					

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

pl051607

When used throughout a treatment series, pain questionnaires can demonstrate functional progress. A progressive increase in functional abilities throughout the treatment assists in establishing that the treatment is reasonable and necessary. Functional progress reassures the patient, the referring HCP, and the medical–legal team that the treatment is returning the patient to preinjury status.

Based on the research, these forms are all highly effective. It simply comes down to personal preference. Select a form appropriate for the individual patient to use in addition to the pain, function, and stress 0–10 scales and increase your ability to justify care in challenging cases, such as motor vehicle crashes.

FROM THE LITERATURE

The Reliability of Pain and Disability Outcome Measures

Traditionally, objective measurements of soft tissue injury, such as palpable spasm and loss of lordotic curve on X-ray, have been thought reliable as "hard" evidence when measuring the extent of injury and the effectiveness of treatment. At the same time, subjective pain and function assessments were criticized as "soft" evidence. However, subjective pain assessments as measured through time-tested pain questionnaires have gained substantial acceptance in use and are now considered "hard evidence."[10,11,12,13,14]

A pain questionnaire, when used together with objective physical measurements, is considered the most reliable assessment of function and disability in the area in which there is no universal norm. One such pain questionnaire is the Oswestry Index, which was developed in 1976 in a hospital unit in Oswestry, Shropshire, England. It scores patients' disability in 10 different areas including intensity of pain; ability to lift, walk, sit, and stand; ability for self-care; and impact on social interactions, sex life, sleep, and travel.

Studies have confirmed that the Oswestry Index has good validity (scores improve as patient disability lessens) and reliability (scores are consistent when answered on different occasions by a patient remaining in the same condition).[15] After many refinements, this questionnaire is widely used in both research and clinical practice in Britain. Self-rating disability questionnaires are also in wide use in North America.

The FRI is a relatively new pain outcome measure and is getting recognition as a reliable, valid, and responsive instrument. Moreover, some claim that it is superior to other instruments with regard to clinical use.[11]

As HCPs know, all tools that assist in documenting the nature and extent of a patient's injury and the patient's improvement with treatment are vital. A well-formatted and consistently used pain questionnaire offers many benefits, including the following:

- **Provides a reliable means to measure change in the patient's physical condition**
- **Assists in documenting the nature and extent of injury and need for care**
- **Illustrates improvements in function resulting from treatment**
- **Supports the reasonableness and necessity of treatment**
- **Satisfies the provider's duty to monitor changes in subjective and objective findings**
- **Aids the provider in writing reports or testifying at depositions or trial**
- **Aids the provider in assessing residual limitations related to activities of daily living**

TIMING AND APPLICATION

Pain questionnaires and rating scales are easy to use and involve a minimal time commitment. There is no need to use all three; simply choose the one most appropriate for the patient's presenting condition. You or your staff may provide the questionnaire to patients at the initial session and again at every reevaluation session—every 30 days or 6–8 sessions. The online 0–10 scales can be used with every session or skipped and used at a similar interval. The patient fills it out before the session begins. You collect the form, check it for completeness, score it, and file it in the patient's chart.

To use the pain and disability questionnaires, instruct your patient to read the instructions at the top and to fill out the form completely. If a section is left incomplete, return it to the patient for completion. Avoid discussing with the patient the reason for using the pain and disability questionnaire. Advising patients on how the process works may influence responses on subsequent questionnaires. You may reiterate that the questions should be answered according to the patient's current condition—how they feel right now. Remember, timing can be a factor when filling out these forms. For example, if the form is completed on a Friday after a long work week, the answers may be different than if the form is completed on a Monday after a relaxing weekend. Keep this in mind when scheduling your reevaluation sessions.

Score, review, and look for areas of impaired function. If there is no loss of function indicated on the health information form, you may choose to omit the pain questionnaire from the pack of reevaluation forms for that particular patient. If the patient has no functional limitations, simply include a questionnaire in the packet of intake forms at the initial visit and at the annual updates to ensure that you have all the health information you need.

REFINE YOUR SKILLS

Practice Scoring Different Measurement Tools

Try all four of the pain and disability rating instruments discussed in the book. Test them for ease of use and applicability. After completing each one and scoring them, pick the one you feel most of your patients would benefit from and fill it out monthly on yourself for several consecutive months. (Scoring for the PSFS, Oswestry, and Vernon–Mior is available below. To obtain scoring protocols for the FRI, request a complementary copy online at http://www.chiroevidence.com/FRI_license.html.)

Create a chart of the results. To create a chart for the Visual Analog Scale (VAS) scale on the health report, for example, mark spaces for 0–10 on the vertical axis. On the horizontal axis, mark the dates the form was completed. Mark your scores with an X over the series of months and connect the X's. The chart will graph your pain over time and can demonstrate progress as a result of treatment. In the EHR, the completed scale results automatically populate the graphs (see Figure 5-11).

SCORING THE PAIN QUESTIONNAIRES

To score the Vernon–Mior and Oswestry questionnaires, a value is assigned to each answer. There are 10 sections per questionnaire and 6 possible answers in each section. The top answer has a pain value of 0. The bottom answer has a pain value of 5. Assign each section a score of 0–5, depending on the answer.

Add all 10 scores together. The highest possible score (worst pain) would be 5 for each section or a total score of 50 (510 = 50). Multiply this number by two to reach the overall rating of disability or (502 = 100%). This number is your disability percentage (see Figure 5-12).

The rating scale is as follows:

0–20%	Minimal disability
20–40%	Moderate disability
40–60%	Severe disability
60–80%	Crippled
80–100%	Bedbound or exaggerating

The PSFS uses a 0–10 scale, making scoring easy: simply fill in the score between 0 and 10 for each activity. Each can be compared for progress individually.

Injury Information Form

CONTENT

The health information form is sufficient for wellness care and most illnesses or injuries. Additional information is necessary when a patient has been involved in an on-the-job injury or a car collision. Different types of insurance cover different kinds of injuries or benefits. Workers' compensation covers on-the-job injuries and illnesses. Private and group insurance (through an employer) cover general injuries and illnesses. Personal injury protection (PIP) coverage includes injuries related to MVCs. In-depth documentation is recommended to address the specific needs of litigation and of federal and state workers' compensation regulations.

As with any insurance case, documentation is vital. The primary difference between record-keeping for cash-paying patients and for patients with insurance reimbursement is that care can be discontinued and payment can be reversed or even denied by the insurance company based on the documentation.[1] The injury information form (see online, Appendix B for a blank form) records specific data that may assist in

FIGURE 5-11. Electronic Health Record (EHR)—Progress Graphs

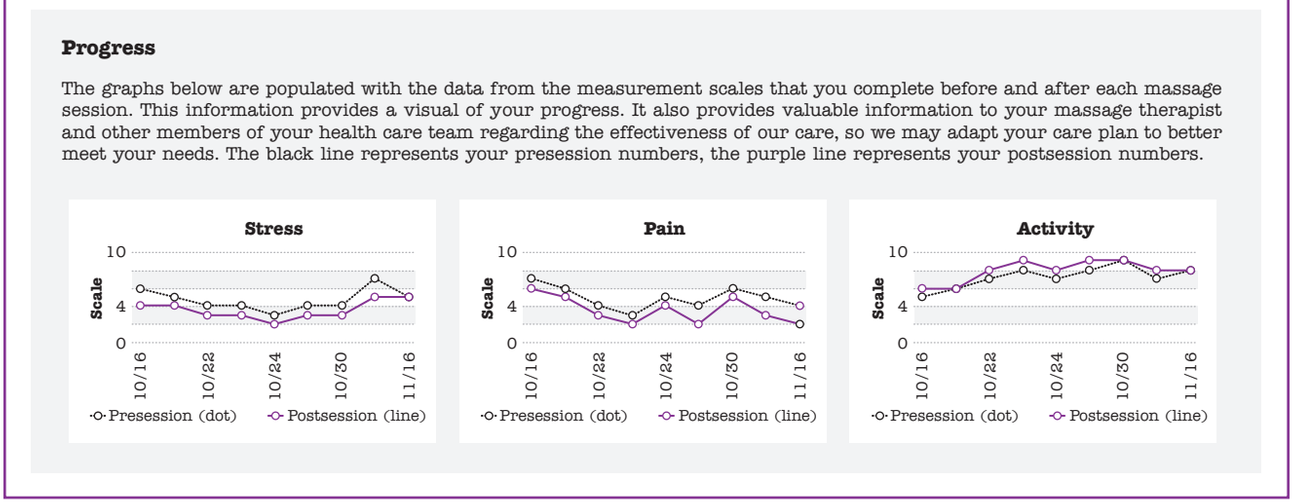


FIGURE 5-12. Pain Questionnaire with Disability Percentage

Helena LaLuna, CR
123 Sun Moon and Stars Drive
Capitol Hill, WA 98119
PHONE 206 555 4446
EMAIL LaLuna@email.com

® shoulder (revised Vernon-Mior)

NECK PAIN & DISABILITY INDEX

Patient Name Zamora Hostetter Date 4-4-17

Date of Injury 3-31-17 ID#/DOB C98-7654321

This questionnaire has been designed to give the health care provider information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem today.

3 **Section 1 - Pain Intensity**
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☒ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

3 **Section 2 - Personal Care (washing, dressing, etc.)**
- ☐ I can look after myself normally without causing pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☒ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash myself with difficulty and I stay in bed.

5 **Section 3 - Lifting**
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☒ I cannot lift or carry anything at all.

1 **Section 4 - Reading**
- ☐ I can read as much as I want to with no pain in my neck.
- ☒ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want to because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

3 **Section 5 - Headaches**
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☒ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

1 **Section 6 - Concentration**
- ☐ I can concentrate fully when I want to with no difficulty.
- ☒ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

5 **Section 7 - Work**
- ☐ I can do as much work as I want to.
- ☐ I can do my usual work but no more.
- ☐ I can do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☒ I can't do any work at all.

1 **Section 8 - Driving**
- ☐ I can drive my car without any neck pain.
- ☒ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

4 **Section 9 - Sleeping**
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1–2 hours sleepless).
- ☐ My sleep is moderately disturbed (2–3 hours sleepless).
- ☒ My sleep is greatly disturbed (3–5 hours sleepless).
- ☐ My sleep is completely disturbed (5–7 hours sleepless).

30 x 2 = 60%

4 **Section 10 - Recreation**
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☒ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do recreational activities at all.

Signature Zamora Hostetter Date 4-4-17

substantiating patients' claims and providing information required by insurance companies to continue coverage for your services. The mechanics of the injury, symptoms, daily activities affected by the injuries, and any possible health complications resulting from the incident must be documented. The goal is to gather information to substantiate that the injuries are significant and were incurred as a result of the incident and, thus, help justify care.

Personal Identification and Contact Information

The five identifiers—name, date, date of birth, insurance identification or claim number, and DOI—are collected on each form to verify patient identity. The address and phone numbers are not necessary, as this form is always used in conjunction with the intake—health information—form.

General Injury Information

The first page of the injury information form is filled out by people with any of the three types of injuries: on-the-job, MVCs, and other personal injuries. The second page is only for people involved in MVCs. For a personal injury case, differentiate between an MVC and other types of injury. Examples of a personal injury case other than a car collision include patients injured after falling off the roof of a house while cleaning the gutters, slipping on a commercial premise, or being impaled by debris flying from a construction site while walking nearby.

Type of Injury

On-the-job injuries and MVCs typically result in musculoskeletal dysfunction and, therefore, are common in manual therapy practices. Musculoskeletal complaints are the primary reason people seek manual therapy.[16] Differentiate between workers' compensation claims and personal injury cases on the injury information form.

Establish whether a record of the incident is on file somewhere other than in your patient's chart. Such records are helpful in substantiating particulars surrounding the injury. For example, a person involved in an MVC might have a police report on file, or someone injured on the job may have filed an incident report. Both may apply if the person had an MVC while on the job. If a police report has been filed, request a copy from the patient.

Description of the Injury

Information provided by the patient about the onset of the injury might explain the presence and severity of symptoms and functional limitations (see Figure 5-13). On-the-job injuries and personal injuries other than car collisions vary widely, making it impossible to standardize the questions about onset. Prompt those patients to be as specific as possible when describing how the injury or injuries occurred.

The second page of this form provides a list of standard questions for recording specific information about the mechanics of MVCs. However, it is important to focus on how the patient got hurt rather than how the collision occurred. The questions on the injury information form must be stated clearly, and you need to review the answers thoroughly with the patient to ensure that the answers are accurate and suitable.

FIGURE 5-13. Injury Information—Description of Injury

3. Describe your injury and how it occurred:
slipped on banana peel, carrying 25 lb. bag of rice over left shoulder, fell backwards onto right arm, then right hip, head bounced on tile floor, rice landed on top of me.

TALES FROM EXPERIENCE

Mechanisms of Injury

Describing the mechanisms of injury helps explain the type and extent of injury. In the example presented in Figure 5-13, Zamora fell on a hard surface. This injury is more damaging than if she had fallen on grass or other bags of rice. As a result, the severity of her injuries may be substantial. Her arms, hips, back, and head hit an unforgiving tile floor, complicating the overall injury. How she made contact with the ground may explain the location of her shoulder injury. Encourage the patient to describe the details about how the injury took place, including the environment and the interplay between the body and the objects involved, in addition to the obvious symptoms or physical expressions of the injury.

Describe the details of the injury, but avoid documenting the events that led up to the injury. At the massage clinic, we treated a patient who had been hit by a car while riding her bicycle. She was meticulous on the injury information form in describing the collision. Something that occurred in a fraction of a second seemed to happen in slow motion from the patient's perspective. She described it as it had appeared to her, with no reference to actual time. Unfortunately, the way in which she recorded her description of the accident made it appear that she had time to prevent it. This impression complicated her personal injury case, making it difficult to receive reimbursement for her health care. Her case went to court.

The lesson in this experience was to let the police report speak to the incident and use the injury information form to describe the injury itself. Had she focused on the mechanics of the injury—how she fell and what body parts hit the pavement—rather than on how the car approached her and what went through her mind leading up to the impact, she might have been able to settle out of court quickly and without disruption in medical payments.

Symptoms

Have the patient record all symptoms since the incident. Establish a time line for the onset of the injuries. Not all symptoms surface immediately, and some patients take weeks to seek manual therapy. The time line will help chart the progression of the injuries and the healing (see Figure 5-14).

FIGURE 5-14. Injury Information—Symptom Time Line

4. Describe how you felt during and immediately after the injury:
shoulder "popped"–immediate pain, head throbbing

Later that same day: backache

The next day: neck stiff, back stiff, can't use right arm at all

The next week: N/A

The next month: N/A

Describe any bruises, cuts, or abrasions as a result of the injury:
bruise on right hip

FIGURE 5-15. Injury Information—Functional Limitations

7. What are your work responsibilities?
cooking, prep, stocking supplies

Which work activities are affected by this injury? everything

Have your work responsibilities changed as a result of this injury? ☒ Yes ☐ No
Explain unable to work

What other daily activities are affected by this injury? everything using my right arm

Effect of Injuries on Daily Activities

An easy way to determine whether an injury is affecting the patient's quality of life is to look at the patient's ability to function in day-to-day activities (see Figure 5-15). If the patient's ability to earn a living is impaired, the injury is significant. Such an impairment may include loss of time at work, restrictions of responsibilities (such as assignment to

light duty), and loss of productivity. Documentation of changes in work-related activities is critical with many claims, particularly ones involving on-the-job injuries.

Activities other than work are also important to one's quality of life. Inability to participate normally in exercise, self-care, childcare, and household responsibilities should be recorded. Anything that detracts from the patient's quality of life may be included for personal injuries and for injuries covered by major medical plans. Focus on work-related impairments for workers' compensation cases. Follow up with a pain questionnaire every 30 days or 6–8 sessions to note changes in the patient's ability to function at work and home.

Adjunctive Care

Have the patient list all care received for the injury (see Figure 5-16). This is helpful information for communicating with the health care team and assists in reducing the chance of duplicating treatment and in coordinating treatment plans. Record the primary HCP's diagnosis. You can then refer to the diagnosis in your charts.

Typically, insurance peer reviewers red-flag a case whenever manual therapy is the only source of treatment, unless the manual therapist has primary care status. The combination of biomedical and complementary care is more acceptable. Noting additional care may help justify the treatment and speed up claims processing.

Preexisting Conditions

Establish the presence of preexisting conditions right away. Avoid the unpleasant surprise of the insurance company disallowing payment for services because the symptoms treated were present before the accident.

The information recorded here and on the health information form can help establish that current symptoms, even when associated with preexisting conditions, are related to the collision (see Figure 5-17). The information in this section will be compiled with the information in the health history section of the health information form. If the documents state that none of the symptoms were present before or that the preexisting symptoms were exacerbated by the current injury, it is easier for the attorney or claims adjuster to conclude that the symptoms were a direct result of the collision or work injury.

FIGURE 5-16. Injury Information—Adjunctive Care

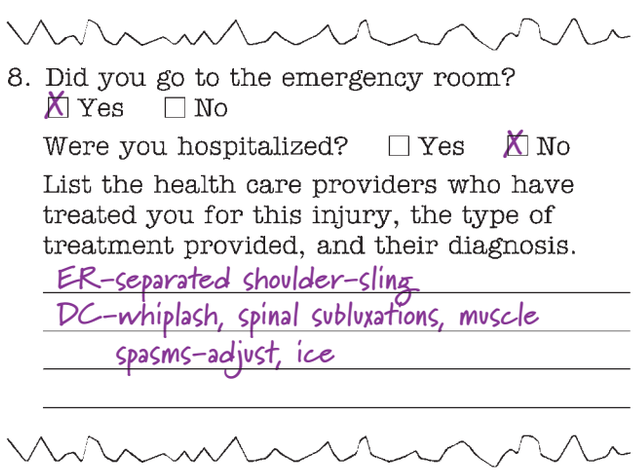

8. Did you go to the emergency room?
☒ Yes ☐ No
Were you hospitalized? ☐ Yes ☒ No
List the health care providers who have treated you for this injury, the type of treatment provided, and their diagnosis.
ER–separated shoulder–sling
DC–whiplash, spinal subluxations, muscle spasms–adjust, ice

FIGURE 5-17. Injury Information—Preexisting Conditions

9. Have you ever had this type of injury before? ☐ Yes ☒ No
Explain _____

Did you have any physical complaints before the injury? ☐ Yes ☒ No
Explain _____

Do you have any illnesses or previous injuries that may have been affected by this injury? ☐ Yes ☒ No
Explain _____

MVC Information

Mechanisms of Whiplash

The second page of the injury information form highlights the mechanisms that influence the severity of a whiplash injury (see Figure 5-18). Severity of injury is critical for establishing whether extensive, ongoing treatment is required to return the patient to preinjury status. Some research studies suggest that people heal from MVCs in 6–8 weeks, regardless of treatment. This may be true for minor soft tissue injuries but not for more complex sprain–strain syndromes or injuries presenting with neurologic dysfunction.[1]

Symptoms

Symptoms are gathered on several intake forms. The symptoms listed in the checklist on page 2 of the injury information form are specific to head trauma sustained in whiplash injuries and may indicate neurologic damage. This information influences the type of care you provide and the type of referrals you suggest, but it generally does not come up in an interview unless specifically asked. Loss of memory is not as obvious as the pounding headache or the bruises. The patient may forget to tell you about them unless prompted on the form.

Other questions about symptoms are more general than the head injury questions, but they also concern symptoms common with whiplash trauma. Breathing difficulties are often associated with seatbelt trauma. Sleeping comfort may be used later in the SOAP charts as a tool for mapping progress. Track the number of hours of restful sleep, the number of times waking (and why), and how the patient feels on rising to show the progression of health.

External proof of impact is concrete data. Record any visible trauma. Take pictures of bruises, cuts, and abrasions.

TALES FROM EXPERIENCE

Take a Picture

At the massage clinic, we had a patient who, after 5 car accidents in 8 years, began taking public transportation. When she stepped off the bus one day, the bus hit her. Bruises marked by the headlights were imprinted on her chest and abdomen. Some pictures are worth a thousand words.

FIGURE 5-18. Injury Information—Motor Vehicle Collision

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HANDS HEAL

INJURY INFORMATION page 2

B. Motor Vehicle Collision Information

1. Did the police arrive at the crash site?
   ☒ Yes ☐ No
2. How was your vehicle hit?
   ☒ Rear end ☐ Head on ☐ Side swipe
   OR Did your vehicle hit another vehicle/object?
   ☐ Rear end ☐ Head on ☐ Side swipe
   If you were hit from behind, was your vehicle pushed forward upon impact?
   ☒ Yes ☐ No If yes, how much?
   about 50 feet
   Did your vehicle hit anything else after the initial impact? ☐ Yes ☐ No
   Explain _____
3. Were you at a stop or moving at the time of impact? ☐ Stopped ☒ Moving
   If you were stopped, was your foot on the brake? ☐ Yes ☐ No
   If you were moving, were you:
   ☐ Increasing speed
   ☒ Decreasing speed
   ☐ Traveling at a steady speed
   Was the other vehicle moving at the time of impact? ☒ Yes ☐ No
   If yes, was it: ☒ Increasing speed ☐ Decreasing speed ☐ Traveling at a steady speed
4. Where were you seated in the vehicle?
   passenger side–front seat
5. Which way was your head facing upon impact?
   facing nephew–driver, we were talking
6. Were you aware of the approaching vehicle or did the impact catch you by surprise?
   ☐ Aware ☒ Surprise
7. Did you lose consciousness?
   ☐ Yes ☒ No
8. Were you wearing a seat belt? ☐ No
   ☐ Lap belt ☐ Shoulder harness ☒ Both
9. Is your vehicle equipped with an airbag?
   ☐ Yes ☒ No
   Did it activate? ☐ Yes ☐ No
10. Is the top of your head rest:
    ☐ Above your head ☒ Below your head
    Does your head touch the head rest?
    ☐ Yes ☒ No
    If no, how far in front of the head rest is your head?
    a few inches
11. What were the road conditions?
    ☐ Wet ☐ Dry ☒ Icy ☐ Oily
12. What type of vehicle were you in? (make, model, year)
    '98 Honda Accord
    What type of vehicle hit you? (make, model, year)
    '07 Ford F250 Truck
13. Did any part of your body come into contact with the vehicle? ☐ Yes ☒ No
    Explain _____
    Did any parts of the vehicle break?
    ☒ Yes ☐ No
    Explain fender damage
14. Check all of the following symptoms that you have experienced since the collision:
    ☐ Loss of memory _____
    ☐ Loss of balance _____
    ☒ Visual disturbances eye strain
    ☐ Hearing difficulties _____
    ☒ Difficulty breathing tight & painful
    ☒ Sleep disturbances pain keeps me up
15. Anything else you want to tell me about the accident or how you feel?

Patient Signature Darnel G. Washington Date 2-6-17

Space is left at the end of the form for the patient to add comments. It is impossible to cover all possibilities in a standardized form. Additional pertinent information unique to the individual may be written in this space.

TIMING AND APPLICATION

The patient completes this form before the initial session begins. The injury information form may accompany the ealth information form in a packet of intake forms sent to the patient the week before the first treatment session. The patient fills out the forms at home and brings them to the office. The injury information form needs to be completed only once per incident.

All patients fill out a health information form. Personal injury and workers' compensation patients also fill out the injury information form, but only those involved in an MVC need to fill out the second page of the injury information form. Keep the health information and the injury information forms separate, so other patients are not burdened with unnecessary paperwork.

Injury information is useful in the interview and in the development of a treatment plan. The information recorded is vital to workers' compensation and personal injury cases and is used to substantiate the injury and justify the treatment.

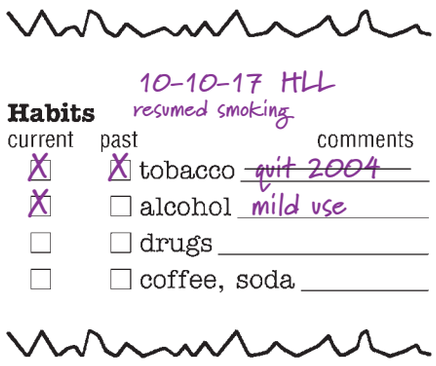
The variety of intake forms available are not always available in EHR systems. Continue to use the forms you prefer and simply scan those into the documents folder of the patient's online chart to make them a part of their permanent record.

Amending the Forms

You may want to make slight changes, additions, or corrections to the information recorded on any of the forms in the patient's file without asking the patient to complete an entirely new form. The patient's perspective may change or he or she may wish to include new perceptions. Changes can be made by either the patient or the practitioner, regardless of who filled out the form originally. There are two options for updating the existing form:

1. Write the new information on the original form. If you are replacing existing information, draw a single line through the outdated information, making sure that the previous information is still legible. Date and initial all changes and additions. Never use correction fluid or an eraser to delete information (see Figure 5-19).
2. Attach an amendment to the document. Write the new information on a separate sheet of paper and staple it to the original. Date and initial the attachment.

FIGURE 5-19. Amending Forms



All medical documents may be amended or updated as needed. Patients have a right to access their files and to make sure the information recorded is accurate. Make a habit of recording information in the presence of the patient. Avoid giving misinformation or interpreting information incorrectly. Reiterate the information provided to you and verbally confirm your interpretation of the patient's history and current status.

Summary

A variety of intake forms are used to document the therapeutic relationship. All of these forms are completed before the first treatment, and some are completed before every session or periodically to evaluate progress.

Every patient fills out a health information form and reads and signs a fee schedule and office policy form. Patients who have health concerns and are seeking treatment for injuries or illnesses are to fill out a health report and pain questionnaire periodically to document subjective data and to assist the manual therapist in evaluating progress. Patients seeking insurance reimbursement complete a billing information form, both initially and when the insurance coverage changes. The injury information form is completed by patients injured on the job or in a MVC—filled out once per incident.

HCPs who transmit confidential patient information electronically or who use a third-party billing service or clearinghouse to transmit information electronically are required to comply with HIPAA regulations. If you conduct all of your business activities and health care transactions on paper, by phone, or by a dedicated fax (as opposed to faxing from a computer), HIPAA does not apply to you. However, you may be required to comply with state regulations that dictate health care privacy standards.

Regardless of state and federal law, it is good business to protect your patients' confidential health information. Inform your patients of their rights regarding their health information, explain your privacy practices, and describe how you intend to use and disclose their health information. Secure patient information in your office so that only you and authorized staff members have access to it.

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