Quality Improvement Guide to Clinical Record Keeping

Massage Therapy

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Clinical Record Quality Improvement Program

Welcome to the Heraya Health (Heraya) Clinical Record Quality Improvement Program. The information in this Quality Improvement Guide is intended to help you and your office maintain member records that meet and exceed professional standards established by peers in your profession and by state and national regulatory agencies such as licensing boards and the National Committee for Quality Assurance.

These recommendations and practice tips reflect “best practices” in clinical record keeping in the peer community. They also address the specific opportunities for improvement that have been identified in your chart sample that was submitted for review.

Questions?

We hope this information is useful to you. If you have questions, please feel free to contact the Clinical Services Department at 503-203-8333 ext. 106.

Best Practices in Clinical Record Keeping: The Basics

Introduction

Since its inception many years ago, Heraya has engaged panel providers in developing "Best Practices" in clinical record keeping. Clinician advisors from each discipline have contributed their expertise and experience to information collected from authoritative sources to develop record keeping policy, procedures and resources to guide and assist Heraya providers. High-quality clinical records support high quality member care.

Why Keep Clinical Records?

The art and science of clinical record keeping deserves, but often does not get, as much attention as the art and science of delivering quality health care to members. The dictum that "if it didn't get written down, it didn't occur" is one that all health care providers must respect. Heraya is committed to enabling providers to maintain excellent clinical records. There are many reasons why documenting member care is a critical function in any health care setting, e.g. quality member care, malpractice risk assessment.

Professional and Legal Standards

Health care records include both clinical and legal (medico-legal) document requirements, e.g. HIPAA, informed consent. Failure to document member care adequately can be considered evidence of negligence and/or unprofessional conduct and can result in licensing board review.

Quality Member Care

Good clinical records support member care in several ways:

- Memory is not infallible. Keeping track of each member's unique clinical presentation, treatment plan, progress, precautions and outcomes would be impossible without a systematic and organized written record.
- Clinical decision-making hinges on good documentation. Decisions about how to best help a member; what works and what doesn't as treatment proceeds is dependent on a comprehensive record of the member's condition (symptoms, signs, examination, etc.). This should include what was done, how the member responded to the care, comparative status from visit to visit, and documented treatment plan.
- Continuity of care is enhanced by good clinical records. Whether a member's care is shared among different providers in one facility, or is transferred from one office to another, legible, understandable and accurate clinical information saves time and helps members get the care they need.
- Member safety can be maximized with consistent documentation and prominent display of warnings and contraindications to treatment.
- Clinical justification for care documented with good clinical records can help limit payment denials and delays by many insurance carriers.

Malpractice Risk Management

The importance of excellent clinical records is perhaps never appreciated so much as in malpractice actions. While we all strive to produce the best outcomes for our members, untoward events do occur and members do sue their health care providers alleging malpractice. In those unfortunate instances, complete, thorough and accurate clinical records often help with a successful defense.

Documenting Medical Necessity

Generally speaking, medically necessary care includes the following:

- is in accordance with the generally accepted standards of good care
- clinically appropriate and effective for the condition
- for the benefit of the member, not the caregiver.

Quality clinical documentation can demonstrate all these elements and assure compliance with requirements of payers.

Medical Record Keeping System and Standards for Availability

- Records must be organized and stored in a manner that allows easy retrieval by authorized personnel only.
- Each member will have a centralized medical record with all clinical records for that member in dated order.
- The record will be opened at the time of the first visit and all entries into the record will be contemporaneous with the encounter.
- Records will be maintained for such a period consistent with applicable state and federal law.
- Records will be maintained in an appropriate Electronic Health Record (EHR) system or written in ink.
- The record should also include correspondence from external sources, e.g. referring and/or other providers, attorneys, etc. as well as correspondence sent from the treating provider's office, e.g. requests for treatment notes.

Best Practices in Clinical Record Keeping: Identification

Introduction

One of the most basic elements of a clinical record is full and complete identification on each page of the chart, whether it is an intake form, a member health history, HIPAA, informed consent, examination form, daily chart or treatment notes.

Chart Identification: Each side of each page of the clinical record should include the following:

- Member name with unique identifier or date of birth.
- Provider name and clinic of origin by name, physical address, and phone number.
- Each entry is dated by month, day and year.
    - The author of each entry is identified by name. Services that are provided or ordered must be authenticated for each entry by the provider of or ordering provider using a valid signature. Signatures are handwritten, electronic, or stamped (only permitted where author has physical disability who can provide proof of an inability to sign due to a disability).
        - **Handwritten Clinical Record**: For a signature to be valid it must be legible. Alternatives include an illegible signature or initials over a typed/printed legible identification of the author; illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory; where multiple providers are listed the author of record is specifically identified;
        - **Electronic Clinical Record**: For a signature to be valid systems and software products must include protections against modification (e.g. time and date stamp), and administrative safeguards should be applied that correspond to standards and laws, e.g. using signature and secure login functions appropriately. Best practice would include the following elements:
            - full printed name of the author at the end of the entry,
            - date,
            - time,
            - digitized signature or signature statement, e.g. electronically signed by, signed by, authenticated by, reviewed by, etc.

Best Practices in Clinical Record Keeping: Informed Consent

Introduction

Informed consent is the process by which fully informed members can participate in choices about their health care. It originates from the legal and ethical right each member has, to direct what happens to their body and from the ethical duty of a provider to involve the member in his or her health care. Fully informed members have adequate foreknowledge or understanding of the recommended treatment, the anticipated outcomes and alternatives to it. It is the process of effectively communicating with members in terms they understand, and then allowing them the opportunity to ask questions.

An informed consent should be included in the clinical record. A written contract and verbal discussion should include these elements and is often referred to as, 'PARQ' conference:

- (P) **P**rocedures or treatment explained in general terms.
- (A) **A**lternatives to massage explained. If massage is not effective, they may also seek alternatives with a chiropractor, primary care or other healthcare provider.
- (R) **R**isks explained: skin sensitivity to oils or aroma therapy, side effects associated with high blood pressure, check with PCP before massage, if diagnosed with cancer, etc.
- (Q) **Q**uestions? Give the client/member time for questions, especially if massage is a new experience for them.

This can be documented in the clinical record as PARQ. If the member requests further information or has specific questions, the provider can underline PARQ. In addition, they should note the question(s) asked and the more detailed information provided.

It is also recommended to include the following in a document acknowledging the member has been part of the informed consent process:

- the material risks have been disclosed including a description of those risks
- the member has agreed to the procedures understanding those risks
- viable alternatives mentioned
- the opportunity to ask questions has been provided

This could be accomplished using a prepared written consent form or other format that must be signed by the member and provider. It is important that providers have a discussion directly with the member and not rely exclusively on these forms.

There may be additional written informed consent documentation requirements specific to individual states providers must be familiar with, e.g. Washington State, breast and perineal area massage.

THE MINOR MEMBER

As with all members, informed consent is required for minor members. For the purposes of Best Practices, it is recommended that the massage provider review the specific statutes or rules regarding obtaining informed consent from a parent/legal guardian or the minor member, whichever is appropriate, that applies to the services rendered in the state in which they practice.

Best Practices in Clinical Record Keeping: SOAP Notes

Introduction

There are many styles of clinical record keeping that can describe the critical elements of a properly documented member encounter, however narrative notes in the SOAP format are the standard. Proper record keeping using the SOAP method limits the most common source of board actions, improves member care and enhances communication between the provider of care and other parties: claims personnel, peer reviewers, case managers, attorneys, and other providers who may assume the care of your members or that refer to you. There are a number of shortcut methods for documenting daily visit notes designed to improve efficiency, e.g. check boxes, computer generated "same as last time" (SALTED/canned/cut and paste). Use of these shortcuts however generally produce a clinical record with little clinical content and often the outcome does not meet professional standards for clinical record keeping.

The Basics

Chart notes must be legible, or preferably, typed. Allow enough space on each page to ensure legibility. The provider's identification (name, address and phone) and the member's name and unique identifier, such as date of birth (DOB) or record number, must be indicated on each side of each page of notes. Every chart entry must be dated and signed by the person entering the note. This includes contacts, such as phone calls and entries from other office personnel who may have contact with the member. Standard abbreviations are acceptable as long as they are easily understandable and interpretable by others and should include a key. Avoid using colored paper or shaded areas on forms as they do not copy well.

Properly documented daily visit notes are necessary and must include the following elements on every date of service:

1. Subjective complaints that are consistent with a lesion, injury, or condition. This is further described below under "S".
2. The examination must confirm the existence of a lesion, injury, or condition that is consistent with the member's complaints and the exam findings must be documented in the chart. This is further described below under "O".
3. The management of the case or treatment rendered must be considered appropriate for the condition. This is further described below under "A".
4. The plan for further treatments or care, as well as a follow-up timeframe. This is further described below under "P".
5. The member chart should reflect overall improvement over time both subjectively (in the member's own words) and by clinical examination findings.

The provider must document visit specific findings on every date of service. Avoid cut and paste 'repeats' or whole note cloning with the constant appearance of 'Same As Last Time' or "SALTED" notes. Notes that appear 'canned' or SALT may trigger audits or complaints from insurers, payment denials or delays and state board action for unprofessional conduct or negligence.

The Anatomy of "SOAP"

S = Subjective or symptoms reflects the history and interval history of the condition. The specifics of the member's complaints should be described in some detail in the notes of each office visit. Using the member's own words is best and should include all relevant symptoms such as pain, fatigue, stress, etc. The symptoms should further be qualified and quantified where possible. For the initial visit further details of the following elements; Onset, Provocation/Palliation, Quality, Radiation, Severity, and Timing (OPQRST) should all be documented.

- **O** = Onset, when and how did the problem start?
- **P** = Provoking or Palliative, record what makes the problem better or worse. Include **A**ctivities of **D**aily **L**iving (ADL's) with comments that show how the complaint affects them, e.g., sleep, hobbies, work, etc.
- **Q** = Quality of Pain or Symptom: dull, sharp, tingling, numb, weakness, etc.
- **R**= Radiating, describe any radiation of pain. Describe where it radiates from and to.
- **S** = Severity, quantify all complaints and the effects. This may include using a pain scale (e.g. 0-10), as well as documenting duration, intensity, and frequency which can be re-evaluated at each visit. Example: *"Mary says her neck has been 6/10 sore and burns on the right side since she gardened for 6 hours last Saturday. She only sleeps for 2 hours before pain awakens her. She's been so tired from the pain and lack of sleep that work and social activities are now affected."* Additional methods of measuring changes in severity of symptoms and their effects on clinically meaningful functional capacity has led to the development and use of OAT's., an acronym for (O) Outcome (A) Assessment (T) Tools. This would include items like the Neck Disability Index, Oswestry, DASH, Pain Disability Questionnaire, etc. and should be recorded in this section.
- **T** = Timing is related to time of day. Example: *"The pain is worse in the morning."*

Interval changes: In follow-up notes at each visit, "S" is a reiteration of the chief complaints elicited during the initial evaluation or subsequent visits of the member with some detail of their response to care. Routine use of one-word entries or short phrases such as "better", "same", "worse", "headache", "back pain" is not sufficient. The complaints should reflect measurable change over time, e.g. duration, intensity and frequency of pain or other symptoms as well as responses to the previous treatment, resumption of daily or occupational activities (ADL's), intervening injuries, and exacerbations, Example: *"Mary's 8/10 prolong sitting pain reduced to 4/10 over the last 3 massages. However, she spent 6 hours gardening and flared the condition to 6/10."*. This change can be measured using a pain scale (0-10), OAT's, or other qualified and quantified method, e.g. moderately stiff and tight to mildly stiff and tight. "S" should also describe any changes in the member's activities and physical capacities in the interim between treatments, and the member's compliance with recommended home care instructions, e.g. stretching. Also included in this section are explanations for any hiatus in treatment, Example: *"Mary's last massage was 6 months ago. She was pain free, but after running a marathon, has returned to have her leg muscles massaged due to 3/10 soreness."*.

O = Objective findings or Observations by the provider. The specifics of these findings should be described in some detail at each visit. They should be qualified and quantified where possible with appropriate interval changes noted in order to determine response to care.

- Observation/Inspection: includes posture, skin appearance, movement patterns/mobility/range of motion (ROM) in general terms. Example: *"Mary winces when she moves R shoulder to take her coat off as she gets ready for massage today. She was unable to use the R arm to put hair up in a ponytail for massage due to 7/10 pain."*
- Palpation findings should list specific muscles or muscle groups with qualifiers and quantifiers, e.g. moderately tight and moderately tender bilateral trapezius.
- Objective indicators for treatment should always be included to document necessity of the treatment provided.

A = Assessment is a clinical impression based on the "**S"** and "**O"** components of SOAP, e.g. tightness or spasm of the trapezius muscle from postural stress or strain. Traditionally massage therapists use a documentation system where **"A"** also includes Action and the specific procedures of treatment. The assessment and action (if documented in this section) should be included and updated in some detail at each visit where appropriate. Following are some elements that may be included in A:

- Clinical impression and may include associated ICD-10 codes
- Treatment outcomes, e.g. immediate response to care (decreased pain level from x/10 to y/10)
- Treatment Procedures: (may also be documented under "P" for Procedure) specific descriptions of treatment can also be included in this section and should include the following:
    - Name of massage type used, e.g. Swedish, pin and stretch, deep tissue, etc.
    - Specifics of muscles or body areas where massage was performed. This may be documented using a list. Alternatively, reference to the list of muscles palpated in the **"O"** section of the note may be made if this is stated to be all inclusive or there is delineation otherwise.
    - List time factors/duration of massage.
    - Member tolerance of the procedure.
    - Example: *"Massage to all muscles palpated in 'objective' findings was done using Swedish lymphatic technique for 60 minutes. Tolerated moderate pressure without complaint."*

P = Plan or Procedure. The plan for treatment/return/follow-up should be included in this section, and when procedures are also documented here, they both should be updated in some detail at each visit.

- Treatment Plan/Return/Follow-Up: ranges from member determined to prescribed care by another provider.

- Where the member is determining when to return, documentation using the standard notation, PRN for Member to Return as Needed or other similar verbiage is appropriate.
- Any suggested referrals, exercises, actions should be noted in this section e.g. *Suggested some neck stretches to help increase ROM, referral to PCP.*
- Where there is a mutually agreed upon plan, this can be documented using language indicating the frequency and duration, e.g. 1x/week x 4 weeks.
- Where there is a referral with a prescribed treatment plan, state the plan and be specific with appropriate updates at each visit, e.g. member to return in 1 week for 2nd of 4 visits at 1x/week. Updating this at each visit will also provide a reminder of the status of the plan and assist in the overall care coordination for future treatment requirements. Avoid using phrases such as, "*Return as prescribed or per physician rx*".
    - This would also be an appropriate place to include comments regarding member compliance, Example: "*Of the total 6 visits scheduled, this member has never missed an appointment without re-scheduling or calling ahead."* or *"This member missed the last 3 massages due to a death in the family."* These types of comments may help to explain the need for additional massage prescriptions or extensions, why a member may not be improving as expected, etc.

Amending the Clinical Record

The patient record should never be backdated, erased, deleted or altered in any way. In the case of electronic patient records, corrections or amendments should be made using an addendum that is signed or initialed and dated. If corrections need to be made or addendums added to a written record, a line should be drawn through the original entry, the correction made or the addendum inserted, and the change initialed and dated. In both cases, the original record should be preserved.

Best Practices in Clinical Record Keeping: Documenting Procedures

Introduction

Massage Therapists need to accurately record clinical information when providing or performing massage therapy services/procedures. Standards for Best Practices rely on these records to establish the clinical necessity and effectiveness of any given procedure, aid in the determination of member outcomes management, help with continuity of member care, and aid in the reduction of malpractice risk.

These services primarily include the following two CPT codes which are both time-based codes and require direct member-provider interaction:

- **97124 = Massage:** This code signifies a basic massage done by most massage therapists. It includes effleurage, petrissage and/or tapotement (stroking, compression, percussion). Skeletal adjusting in the same area on the same day may be denied unless modifier-59 is used. Even then, many insurance plans deny payment. The rule is often misused by insurance plans when a denial is made. Because 97124 may be considered a form of 'manual' therapy and so is skeletal manipulation, many insurers categorically deny both services when billed together considering it a 'duplication of service'.
    - This code must have time factors and should include location and specific type of massage performed.

- **97140 = Manual Therapy Techniques:** This code signifies a more complex type of soft tissue or manual therapy technique and may be performed by a DC, ND, LAc or a more experienced massage therapist. This code should not be combined with skeletal manipulation in the same area. This code may include but is not limited to the following: mobilization/manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization, myofascial release, and trigger point therapy. Using this billing code requires documentation of the following 3 items:
    - Technique used must be clearly described, e.g. manual traction, myofascial release, soft tissue mobilization, active resistance, trigger point, etc.
    - Location of massage must be defined, e.g. with cervical, thoracic, lumbar, extraspinal muscles listed.
    - Time factors must be included.

Clinical documentation for these services should include a brief explanation of the necessity of the service, the nature of the procedure, e.g. massage, myofascial release, etc., location of application by region or segment (as specific as possible), duration and result.

In the event the CPT codes 97124 and 97140 are submitted for the same date of service, only 97140 will be reimbursed. A modifier is not allowed, as there are no circumstances in which both procedures should be paid for the same member on the same day by the same provider.

When billing any time-based modality or procedure, certain rules apply. While the AMA CPT Code Book defines time as a 15-minute unit, actual practice does not always fit such rigid parameters. Billing methods for time-based services, including these types of procedures allow for some flexibility, e.g. while one unit of time is 15 minutes, the individual service can vary between 8 minutes (just above the midpoint between 0 and 15) to 22 minutes (just below the midpoint between 15 and 30). Thus, a single unit of service may be billed when the involved time reaches 8 minutes. When multiple units of service are billed, only the last unit of service is subject to the range of time adjustment. All other units billed are based on the 15-minute definition. Two units of service would require 15 minutes for the first unit; the second unit could range between 8 and 22 minutes (total time of service would be from a low of 23 to a high of 37 minutes). Three units of service would require 30 minutes for the first two units; the third unit could range between 8 and 22 minutes (total time of service would be from a low of 38 minutes to a high of 52 minutes). The same method of calculation is used as additional units of modalities or procedures are added.

It is incumbent on the provider to document the time elements described above in such a manner that allows easy determination of when threshold parameters are met. Best Practice is to document both the start and stop times of the hands-on portion of treatment.

De-Identifying Clinical Records for Quality Improvement

Introduction

Heraya sometimes requires you to submit clinical records for various purposes such as record keeping quality improvement. When responding to these requests, it is imperative that you are compliant with Federal rules that protect member confidentiality. **Note: These rules do not apply to clinical records submitted to support billing, for Treatment Extension Requests, appeals and other aspects of payment.**

Why do I need to de-identify my clinical records?

The Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to protect member-specific health information, known as Protected Health Information (PHI). However HIPAA permits the use or disclosure of properly de-identified health information, as it is no longer considered PHI.

What does "de-identify" mean?

The term "de-identify" is from HIPAA and refers to redacting clinical record so that no one can tell who the information is about. PHI is considered to be properly de-identified if all of the 18 specified identifiers are redacted. These 18 identifiers are listed on the next page.

If I am not a covered entity as defined by HIPAA, do I still need to de-identify my clinical records sent to Heraya?

While you may or may not be a "covered entity," Heraya recommends that you take this precautionary measure when responding to requests for clinical records for quality management purposes.

Where can I obtain more information on de-identifying PHI?

The Department of Health and Human Services is the federal agency responsible for administering HIPAA. Below is a link to their website which speaks specifically to this topic:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html

If I have questions, who can I call at Heraya?

The Clinical Services Department may be contacted at 503-203-8333, extension 106.

The following are the 18 identifiers that create the definition of “individually identifiable” and can be used to identify a specific individual.

1. Names of members, spouses, relatives
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of a ZIP code if, according to the current publicly available data from the Bureau of the Census (a) the geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (b) the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. Day and month elements of dates directly related to an individual, such as birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of “age 90 or older.” **Note: this does not apply to dates of service in chart notes.**
4. Telephone numbers
5. Fax numbers
6. Email addresses
7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) addresses
16. Biometric identifiers, including finger and voice prints
17. Full-face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code