SOUTH DAKOTA CHIROPRACTIC PEER REVIEW

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PEER REVIEW CASE DOCUMENTATION
SDCPR Form #100

Please use additional paper if there is not enough space on this form Send completed for to address listed above.

Date: _____

PATIENT INFORMATION

Insurance Company: _____
Address: _____
Representative: _____ Title: _____

Patient Name: _____ Case #: _____
Patient's Age _____ Occupation: _____
Patient's Height: _____ Weight: _____ Sex: _____

PROVIDER'S INFORMATION

Provider's Name: _____
Address: _____
Telephone #: ( ) _____ Office Hours: _____

CLINICAL OVERVIEW

Chief and Secondary Complaints: _____
Date of Onset: _____
First Visit: _____ Last Visit: _____
History of Onset: _____
_____
_____
_____
_____

Past History: _____

Seen Prior to Current Problem? _____ Dates & Outcome of Prior Care (e.g. condition resolved, chronic recurring problems, etc.) _____
_____

SELECTION OF EVALUATION & MANAGEMENT CODES:

Initial Examination CPT code: _____. Re-examination CPT codes _____
_____

Selection of Evaluation and Mgt code is based upon level of service provided in three key component areas (1.history, 2. exam, and 3. clinical decision making). According to the criteria established in the CPT code book, does your selection of the Evaluation & Mgt code meet or exceed CPT code requirements for each of the three key component areas? Yes____ No _____

Did you bill for any Counseling time? _____ If so, where is time documented?

_____

DIAGNOSIS: _____

_____

_____

GOALS OF CARE:

Please explain the goals of your care (e.g. eliminate pain; normalize ROM; allow patient to return to full & normal activities of daily living).

_____

_____

_____

Are your goals documented in the case file? Yes _____ No _____ Where? _____

_____

Please list any activity intolerances demonstrated by your patient (e.g. carrying items, dressing, driving, getting in and out of bed, overhead reaching, lifting, pushing, pulling, rising from chair, etc).

_____

_____

Do established goals relate to activity intolerances? _____ If so, please briefly explain:

_____

_____

USE OF OUTCOME TOOLS

The Mercy document indicates there should be positive response to care within two weeks. If there is not, treatment should be changed and a second two-week trial implemented.

Does your documentation show the patient is responding favorably:

after the first 2 weeks? Yes _____ No _____
after the first 4 weeks? Yes _____ No _____

The use of outcome tools in clinical practice provides the mechanism by which the health care provider, the patient, and the payer are able to assess the efficacy (effectiveness) of care.

Please list the "outcome tools" you used to measure patient progress:

for example, (1) visual analog scale to assess pain; (2) inclinometer to measure ROM; (3) Oswestry questionnaire to measure low back-related disability; and (4) a SF-36 questionnaire to measure changes in general health status.

Please list the outcome tools you used (one tool per line) and the dates each was used:

Outcome Tool	**Date Outcome Tool was Used**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FREQUENCY & DURATION OF CARE

Please describe any complicating factors that in your opinion have increased the frequency or duration of care beyond usual (e.g. patient compliance and motivation; comorbidities; exacerbations; personal problems such as alcohol, marital, or financial; structural pathology or skeletal anomaly related to current problem; illness behavior; > 4 prior episodes of current problem; activity intolerance, reduced trunk strength & endurance, etc.)

_____
_____
_____
_____

Please List Dates of Documented Exacerbations:

Mild _____
Moderate _____
Severe _____

Previous Health Care: _____

When: _____ Where: _____

Loss of Time: Yes _____ No _____ If yes, how much: _____

Present Chiropractic Care (List All Services): _____
_____
_____
_____

Length of Visit: _____ Direct contact time with Doctor: _____

RADIOGRAPHIC EXAMINATION:

Where Performed: _____ Date: _____
Areas X-Rayed: _____Number: _____
Findings: _____
_____
_____

(Kindly submit all x-rays to committee office. All films will be returned.)

ORTHOPEDIC FINDINGS: (List tests and results, I.E. Babinski, Laseque, etc.)

_____
_____

_____
_____

NEUROLOGICAL FINDINGS: (List tests and results, I.E. patella, biceps, etc.)

_____
_____
_____
_____
_____

OTHER FINDINGS:

_____
_____
_____
_____

REHAB – IF APPLICABLE, SEE ATTACHED

PROGNOSIS:

Has patient been discharged? Yes _____ No _____ If yes, when: _____
If no, when is anticipated date of discharge? _____

Any additional information you believe would be helpful to the committee to fairly evaluate this case may be added below or on additional sheets.

_____
_____
_____
_____

NO FEES WILL BE PAID FOR COMPLETION OF THIS FORM.

Form 100-Rehab Supplement

Drs. Name_____ Patient's Name_____

1. Please explain the clinical indications for rehab.
   _____
   _____
   _____

2. Was functional assessment performed? Yes_____ No _____

   a. Type (MedX, Cybex, McKenzie, QBFC, etc.) _____

3. What were the results?
   _____
   _____

4. What deficit(s) did functional assessment reveal? (e.g. loss of strength, endurance, flexibility, aerobic capacity, movement pattern, etc.).
   _____
   _____

5. How does functional assessment data compare to normative data?
   _____
   _____

   a. Is normative data available in the medical record? Yes _____ No_____

6. What are goals of rehab?
   _____
   _____
   _____

7. Please explain how goals are related to activity intolerances.
   _____
   _____
   _____

8. Is the rehabilitation prescription (treatment) clinically appropriate to treat the patient's functional deficits (e.g. if goal is to increase low back strength, are the therapeutic exercise variables of frequency, duration, intensity and volume clinically appropriate for low back strengthening?). Yes_____ No _____

9. Is reassessment performed in a timely manner? Yes _____ No _____

10. Please explain how reassessment data effected your clinical decisions (e.g. continue with rehab, change rehab, discharge, etc).

_____
_____

_____

11. Does reassessment data reflect improvement. Yes _____ No _____

    a. Are goals being accomplished? Yes _____ No _____

    b. If not, please explain.

_____
_____

12. Does the medical record document time spent for all time-dependent CPT codes?
Yes _____ No _____

13. Is home exercise a component of the overall rehab case management? Yes ____ No _____
    a. If not, please explain.

_____
_____
_____

14. When is maximum therapeutic benefit anticipated?

_____

15. Anything else to consider?

_____