Course Title: Personal Injury for the 21st Century

Instructor: Dr. Michael Robertson, D.C.

Total Hours: 16 hours

Summary: In this course you will learn the most common mechanisms of injury in motor vehicle collision cases. We will review the process of tissue healing and timeline of healing and relate this information to appropriate methods of care for these cases. You will review appropriate examination procedures with emphasis on special testing and follow up care including referrals to other providers. Dr. Robertson will also review a concise treatment protocol utilizing low tech rehab, consistent re-examination and special testing and appropriate documentation that will improve the medlegal foundation for your care.

Learning Outcomes:

By the end of the seminar, participants will be better able to:

• Accurately and appropriately diagnose injuries related to motor vehicle collisions
• Identify key indicators for referral to other medical professionals
• Justify a course of care related to an MVC utilizing multiple accepted guidelines
• Document injuries and progression of improvement throughout care for MVC injuries
• Create individualized treatment plans for patients who were involved in MVC

Teaching Methods:

Lecture, slides, Q & A, Sample Cases/Case Studies

Course Outline:

<table>
<thead>
<tr>
<th>Hour</th>
<th>Content</th>
<th>Format</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hour 1</td>
<td>Key components of good documentation</td>
<td>Lecture,</td>
<td>Documentation/Record Keeping</td>
</tr>
<tr>
<td></td>
<td>• Standards for all records as it applies to Examination visits, and treatment visits</td>
<td>Slides</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Informed consent/record keeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Legal requirements of IC, critical elements of IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proper record keeping &amp; record keeping pitfalls to avoid (Do’s &amp; Don’ts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review NCQA record keeping guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Daily Chart Note requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• SOAP format -</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Subjective - quantity/quality of pain, severity, tools for outcome based care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Objective – inspections, PARTS system, AIR S-M</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assessment – diagnosis, goals (short/long)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Plan – frequency/duration, HEP, therapies (time/supervision), goals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Postgraduate & Continuing Education
25001 Industrial Blvd, Hayward, CA 94545 USA
P +1 (510) 780-4508  F +1 (510) 780-4518  E conted@lifewest.edu  ce.lifewest.edu
• CMT coding
  o Descriptors of CMT, 4 codes for CMT, 3 components of CMT

**Hour 2**

- **E/M code guidelines**
  o 3 categories of E/M codes
    • 2 categories of office visits (new vs established)
  o 5 levels of E/M codes
    • Documentation requirements for each level of code (new & established)

- **Determining level of service**
  o 7 components of level of service (3 key components)
  o History – (4 levels)
    • History of present illness
    • Review of systems
    • Past, family, social history
    • Selecting level of history

- **Examination**
  o 2 categories – general multisystem (MD/DO)/Single organ system (DC)
    • Single organ system exam-musculoskeletal exam (4 levels)
      • Review of exam components
      • Selecting level of exam

- **Medical decision making/coordination of care/Time**
  o Key considerations for decision making
  o 4 levels of decision making
  o Selecting level of decision making
  o Counseling/coordination of care
  o Time
    • Time requirements of E/M codes
    • Selecting Appropriate level of E/M

**Hour 3**

- **Discussion of ethical pitfalls and board complaints**
  o Boundaries (sexual/nonsexual)
  o Billing
  o Confidentiality
  o Impaired Physician

- **Expanded discussion on impaired physician**
  o Types of impairments
    • Discussion of psychological impairments and affect on practice

- **Treating patients with history of sexual abuse and Drug dependence**
  o Likelihood of encountering these populations
  o Practical tools to better help with these populations
  o Consideration for victims of abuse vs general population
  o Cage assessment

- **Solutions to prevent ethical pitfalls**
  o Documentation, listening, understanding, analyzing consequences, action steps
  o Review of recent board disciplinary actions and probable causes and solutions
### Hour 4

- Avoiding patient abandonment
- What constitutes doctor/patient relationship
  - Components of relationship
  - Call to office for care
  - Party situations
- Rules of advertising
  - No making claims of cures, promises of success
  - Telemarketing rules
  - What is bait-n-switch
- Informed consent
  - Components
  - Examples-Case Study

### Saturday

12:00pm - 1:00pm

<table>
<thead>
<tr>
<th>Lecture, Slides, Case Study</th>
<th>Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>STE</td>
<td></td>
</tr>
<tr>
<td>PTE</td>
<td></td>
</tr>
<tr>
<td>RPE</td>
<td></td>
</tr>
<tr>
<td>SPE</td>
<td></td>
</tr>
<tr>
<td>FPE</td>
<td></td>
</tr>
<tr>
<td>EPE</td>
<td></td>
</tr>
</tbody>
</table>

### Hour 5

- Impact Physics/Vector of Collision
  - Sample physics for frontal impact (with/without seatbelt)
    - G forces required for types of injuries-citations from European spine journal
  - No correlation between vehicle damage & human damage
    - Does not typically matter in terms of settlement
      - Insurance carriers correlate $ vehicle damage to value of care
  - Frontal impact – common injuries
  - Rear impact – common injuries
    - Introduction to facet injuries
  - Side impact – common injuries
  - Complex multi-vector impacts
  - Exploring 3 most common types of injuries
    - Facet joint injuries
      - Change in IAR from CAD events
      - Clinical presentations of facet joint pain
    - TBI
      - Common symptoms
      - Likely causes from collisions
      - Potential detriment to longevity-multiple studies (review & cite)
    - Ligament subfailure injuries
      - X-ray analysis techniques for detection
        - Griffith’s fanning technique
        - Posture Ray/software techniques
      - Functional evaluation via dynamic motion sEMG
    - More injuries not detectable by x-ray
      - Opportunites for other imaging techniques
  - Ligament subfailure injuries and their impact on long term outcomes
    - Panjabi’s model for subfailure injury
    - Review upper & lower cross syndromes
    - Long term outcomes for MVC patients
      - Pain probability
      - Degeneration
      - Susceptibility to injury

### Hours 6-7

- Working with Attorneys
  - What makes a strong case for your patient

---

Robertson - Personal Injury - page 3

Postgraduate & Continuing Education
25001 Industrial Blvd, Hayward, CA 94545 USA

P +1 (510) 780-4508  F +1 (510) 780-4518  E conted@lifewest.edu  ce.lifewest.edu
Saturday
2:30pm-3:45pm

- Visits to other providers
  - Priority of doctors from insurance carrier perspective
- Care from different perspectives
  - Patient’s perspective - Carriers - Doctors - Attorneys
- Tips for working with attorneys
- Points that weaken your patient’s case from Carriers perspective
- Mistakes to avoid in your cases

- Patient referrals
  - Re-examining the role of DC in care of PI patients
  - Referral coordinator to other providers when appropriate
  - We can be more than just another therapy
  - Referring to other providers
    - Common provider types who may need to help on your PI cases
    - Advantages of referring to other providers
  - Referring patient to attorney
    - Ethical considerations in attorney referral process
      - Give multiple choices
      - It is patient’s decision
      - Know your attorneys
  - PI practice pitfalls to avoid
    - No direct soliciting to accident victims (police lists, door-to-door, etc)
    - Can advertise within state rules (online)
    - Referrals from other medical providers, attorneys, MDs, etc

- Types of Insurance coverage and how it affects your patient
  - 1st Party
    - PIP
    - State requirements
    - Statute of limitations
    - What it pays for
    - Medpay
      - PIP vs Medpay
    - UM/UIM
  - 3rd party/LOP
    - Commercial Limits
    - Bodily Damage
  - Subrogation of claims
  - Health Insurance

Hour 7
(conclusion)

- ICD-10
  - Rules for coding with ICD-10
    - S-codes format
    - Use of “X”, “A”, “D”, and “S”
    - Initial vs subsequent as applied to PI cases
  - Common to use many different codes to describe injuries

Lecture, Slides, Coding and Diagnosis

Saturday
3:45pm-4:30pm
• Compare/contrast sprain/strain ICD-10 vs ICD-9
  • M & G codes
  • Specify laterality
    o Meaning of 0,9,1,2
    o Exceptions – foot codes, hand/wrist codes
  • Indicating spinal level
  • Sample codes for common c/s, t/s, l/s conditions
    o CPT codes that require clarification
      • 97140 Manual Therapy
      • 97112 NMR
      • 97014 EMS unattended
• Other consideration
  o Diagnostic testing
  o Gaps in care
  o Colosus
  o Concurrent cases
  o Dropped cases
  o Clinical peer reviews

Hour 8
Saturday
4:30pm-5:30pm
Lecture, Slides
Record Keeping: Guidelines for care

• Utilizing documentation to strengthen your patient’s case
  o Documenting risk factors for poor outcome
    • Head turned, awareness, prior injuries, head restraint position problems, Mechanism of injury, ligament injury
    • How to document patient education regarding ligament injury so it can be used in court to strengthen your case
      • Picture of ligament injury with reference – sign and date
      • Using references from the A.A.O.S. (American Academy of Orthopedic Surgeons)
    • Healing time frames
      • Use to justify care protocols
      • Phase 1
      • Phase 2
      • Phase 3
  o Documenting potential complicating factors
  o Frequently missed injuries
    • TBI, TMJD, Shoulder impingement, 1st rib, anterior ribcage, talar injuries, wrist injuries, tooth fracture (review common mechanism of injuries for each)
  o The importance of photographic documentation
    • Pictures of vehicle damage, on scene if possible, use ruler for perspective
    • Patient in care for headrest position
    • Contusions – make sure you can tell it is patient

• Review of different Guidelines for care
  o Croft Guidelines (NGC-ACA guideline) vs ODG
  o Croft Guidelines
    • Grading Severity of injury (review table)
    • Treatment frequency and duration (review table)
• Based on Grade for severity of injury
  o ODG Guidelines
    ▪ Cervical Guidelines
    ▪ Chiropractic
    ▪ PT
    ▪ Similarities/differences
    ▪ Lumbar Guidelines
    ▪ Chiropractic
    ▪ PT
    ▪ Similarities/differences

Hour 9
Sunday
9:00am-10:00am

• Automobile Accident Summary
  o Patient Vehicle details – Type and size, patient location, what vehicle was doing, damage sustained
  o First vehicle to strike details – type and size, how it struck/impact vector, damage sustained
  o Conditions at time of accident – time of day, road conditions, visibility
  o Patient positioning at moment of impact – preparation for accident, brake pedal usage, use of restraints, body position/thrown, head & neck position/thrown & motion
  o Results of impact – what body parts struck against

• Accident Injury summary
  o Date & time of accident/injury
  o Description of accident/injury
  o Immediately after accident/injury – LoC, patient felt, immediate pain, other significant injuries, emergency care at site of impact, destination after accident, transportation after accident (self, spouse, ambulance)
  o Following accident injury – when did additional symptoms develop, what additional symptoms (document appropriately), Other affects since accident not listed (difficulty with ADLs, sleeping, etc.), work restrictions, self treatment, other treatment

• Initial Patient history
  o Patient complaints
    ▪ Headaches – description, onset, frequency, aggravating factors, ameliorating factors, VAS, sleep interruptions, brought on by:, duration, sequelae, imaging
    ▪ Spine symptoms – Neck left/right, UBP left/right, MBP left/right, LBP left/right
    ▪ Severity, quality, aggravating, relieving, changes in intensity
    ▪ Spine related information – VAS, onset, sleep/ADL affects, timing (when worse), aggravating/relieving factors, previous treatment (details for each provider-records request for every provider listed), pre-existing conditions
    ▪ Extremity complaints – which extremity, which part of that extremity, quality of pain, onset of symptom, previous care, aggravating/relieving

Robertson - Personal Injury - page 6
• Medical, Family, Social History & ROS
  o Medical History
    ▪ Medical care details for this condition, hospitalizations, surgeries, previous accidents, conditions/illnesses, medications (prescribed by)
  o Family History – unchanged from typical exam
    ▪ Diabetes, heart disease, hbp
  o Social History – unchanged from typical exam
    ▪ Dob, sec, marital status, children, resides with, dexterity
  o Activities/habits
    ▪ Exercise, alcohol, smoking
  o Occupational information
    ▪ Employment – status, time at work per day, length of employment, complaints from accident and how they affect ability to perform job duties
    ▪ Job involves – lifting, movements, location, computer hours
    ▪ Work – stress level, affect on complaints (aggravates which symptoms with which specific activities)
  o ROS – unchanged from typical exam

Hour 10 Sunday 10:00am – 11:00am
• Overview of Exam
  o The Foundation of your justification of care
    ▪ CPRs put greatest emphasis on examinations vs daily treatment notes
    ▪ Look for referral opportunities when necessary – spasm/trigger points (PCP)
      ▪ PCP involvement creates referral opportunity and goodwill for profession
      ▪ Always get all medical records from referrals
      ▪ Avoid ordering negative tests (unnecessary MRIs) decrease case value and may compromise patient’s ability to continue necessary care due to finances
        ▪ Document clinical rationale for ordering additional test/imaging

• Neurological exam
  o Cranial Nerves – review tests and nerves associated with tests
  o Cerebellar functional tests – finger-to-finger, finger-to-nose, rapidly alternating movements, point-to-point movement, Romberg’s, heel-to-shin, tandem walk
  o ULE, LLE reflexes, motor strength, sensation
  o Heel walk, toe walk

• Orthopedic Exam
  o Go through each test to ensure it is done properly
  o Correlate each test with possible diagnosis codes

Robertson - Personal Injury - page 7
Cervical Ortho Exam
- Active ROM, Passive ROM, Compression tests – neutral, LLF, RLF, Max compression, valsalva, shoulder depression, Soto Hall, distraction

Lumbar Ortho Exam
- Active ROM, Valsalve, Kemp’s, Yeoman’s, Hibb’s, Nachlas, Sitting leg raise, Ely’s, Slump test

Positive Ortho/Neuro findings are foundation for future special testing, referrals, and necessity for continued care

Hour 11
- Most prevalent outcome Assessments in PI Cases (review each OA)
  - R36
  - NDI
  - Revised Oswestry
  - Rivermead Post Concussion Questionaire
    - Acute Concussion Evaluation – from the CDC

Sunday
11:00am
- Revised Oswestry
11:15am
- Rivermead Post Concussion Questionaire
  - Acute Concussion Evaluation – from the CDC

Sunday
11:15am
- In-office vs Referral to facility
  - Review by radiologist much stronger in court
  - Often radiologists do not document ligament subfailure injury (double edged sword)

Cervical Views – minimum 5 views
- Additional views – swimmer when can’t visualize lower c/s
- Obliques-must have documented evidence of radiculopathy
- APOM lateral flexion – stability of upper cervical ligament complex

Thoracic – 2 views
- Check for rib fracture

Lumbar – 2/3 views
- Flex/ext – not very often needed

Analysis methods for identifying whiplash/ligament subfailure injuries
- Griffiths Analysis-Musculoskeletal Radiology by Harry Griffiths
  - Embraced by DO/DC communities to determine whiplash injury
  - Demonstrates change in IAR
    - Explanation from Griffiths book of his methods
    - Illustrations of drawings from Griffiths book
      - Go through sample x-ray and practice this method

Posture Ray instability Analysis
- Better documented references in the literature than Griffiths
- Indicates areas of ligament subfailure
  - These injuries may allow permanent impairment ratings of 25%
- Go through sample analysis with this method

Compare/contrast the 2 methods

Robertson - Personal Injury - page 8
(advantage/disadvantages and strength in court)
  o Review other analysis options – online spinemetrics.us

Hour 12  
Sunday  
12:00pm -1:00pm

  • General Principles of rehabilitation programs  
    o Phase 1 treatment summary  
      • Up to 30 days post-injury  
        • Adjust and reduce inflammation to support growth of Type II collagen
    o Therapies need to make sense based on patient's phase of healing
    o Rehabilitation demonstrates progression
    o Protocols in place simplify this process for staff
  • Phase 1 Rehabilitation possibilities
    o For each modality discuss clinical rationale, times, codes
      • Passive ROM/traction/axial traction
      • Massage modalities
      • Cold laser
      • Ultrasound
      • IF
  • Home exercise program Phase 1 Care
    o Discuss rationale and coding for HEP protocols
      • Range of motion exercises
        • 15 reps each direction b.i.d.
      • Hot/Cold Therapies
        • Ice for acute inflammatory phase
        • 15 minutes following ROM exercises
      • Switch to contrast therapy after 72 hours
        • 4 min intervals cold-hot-cold-hot-cold
    o Heat
      • PRN for strained/spamming muscles
    o Brace
      • Rare-only for lumbar disc injuries
        • DME opportunity
  • TBI Home Care Protocol
    o Special considerations for concussion patients
      • Helping the patient understand symptoms of concussion
        • Mood, fatigue, headache, personality, irritability, forgetfulness
      • Review ACE protocols per CDC
      • Healing time frame for mTBI
    o Nutritional support
      • Supplementation and dietary considerations
    o Home activities to promote dendritic growth
      • Discussion of possible activities patient can do at home for low cost
        • Phone apps, music, ambidexterity exercises

Hour 13  
Sunday

  • History components  
    o Key points to follow up from initial history
      • Neuro findings and progression

Robertson - Personal Injury - page 9
1:30pm-2:30pm

- Mood/demeanor
- Level of fatigue
- ADLs/work difficulties
- FUNCTIONAL CHANGES—massive importance for justification of continued care
  - What constitutes functional improvement
    - Samples

- Examination components
  - Repeat previous positive tests
  - Determine necessity of additional exam components based on lack of improvement or worsening of symptoms or development of new symptoms sets

- OA components
  - Which tests should be better and which could get worse
    - Relate these results to phase of healing timeline from AAOS

- Special tests in office
  - GOAL=demonstrate proprioceptive loss
    - Clinical objective evidence of injury as per Punjabi model of sub failure of ligaments
  - CROM
    - Review test procedure
    - Rationale—most cases this is appropriate at 30 days
  - Single leg stance test
    - Review test procedure
    - Rationale for test

- Key decision points for co-management
  - MRI
    - If any neuro signs persist @ this point
    - 30 days gives tissues chance to heal & inflammation time to reduce
      - Reduces incidence of negative MRIs
    - Review ODG guidelines for MRI
      - Cervical
      - Lumbar
    - ODG guidelines for CT and other imaging
  - Orthopedic Consultation
    - Pain present in any extremity 30 days after DOI
      - Huge value driver for case
  - Neuro surgical consultation
    - IF MRI findings come back positive
      - Disc bulge, stenosis, encroachment
    - Disc reduction surgery guidelines from ODG

---

Hour 14

Sunday 2:30pm-3:00pm

- General Principles of rehabilitation programs
  - Phase 2 and early phase 3 treatment summary
    - Care appropriate at 30-60 days post injury
      - Adjust, support growth of Type II collagen, begin active therapy to restructure Type II collagen fibers
  - Transitioning to active therapies is necessary to demonstrates patient progressing as expected
Protocols in place simplify this process for staff
  ▪ Rehabilitative protocols should progress in difficulty as patient improves
  ▪ Every 2-3 weeks therapies should change

• Phase 2 and early phase 3 Rehabilitation possibilities
  o For each modality discuss clinical rationale, times, codes
    ▪ Traction (sagittal plane for collagen alignment)/axial traction (if confirmed disc bulge on MRI)
    ▪ Therapeutic Exercises /NMR/Therapeutic activities
      • Pros/cons of the different codes-audit flags
      • Vibration plate
      • Rocker board
      • Wobble board, exercise ball therapy, wobble chair
    ▪ Cold laser-justifiable because of healing cascade as tissues restructure

• Home exercise program Phase 2 and early phase 3 Care
  o Discuss rationale and coding for HEP protocols
    ▪ Range of motion exercises transitions to stretching
    ▪ Stiffness is expected around this point in care due to new type II collagen alignment limiting normal range of motion
      • 15 reps each direction b.i.d.
    o Posture based home exercises to reduce loss of cervical lordosis/anterior head translation from neck injuries
  o Heat
    • PRN for continued muscle pain

### Hours
**Sunday 3:00pm-3:45pm**

• History components
  o Should have significant improvement in symptoms by now
  o Key points to follow up from 30 day history
    ▪ Neuro findings and progression
    ▪ Mood/demeanor
    ▪ Level of fatigue
    ▪ ADLs/work difficulties
    ▪ FUNCTIONAL CHANGES-massive importance for justification of continued care
      • What constitutes functional improvement
        o Samples

• Examination components
  o Repeat previous positive tests
  o Determine necessity of additional exam components based on lack of improvement or worsening of symptoms or development of new symptoms sets

• OA components
  ▪ Repeat previous OAs
    • If there is no improvement in OAs

Robertson - Personal Injury - page 11
at this point a referral is expected or discontinuation of care due to patient plateau
- Any point where patient progress is static for 2 weeks is plateau and rationale for discontinuation of care
- At minimum therapies performed (including cnt) should be reassessed and altered

- Special tests in office
  - GOAL=demonstrate failure/weakness of deep stabilization muscles of spine
    - As inflammation has passed and collagen is mostly laid down the function of deep stabilization muscles may now be accurately assessed for injury
  - Cervical: Jules test vs craniocervical flexion test
    - Jules Test
      - procedure
      - Therapies appropriate to correct this weakness
        - Blue halo band head weights while performing cervical ROM
        - Wearing head weights while standing on vibration plate
        - Head weights while performing ROM on vibration plate
    - Craniocervical flexion test
      - Procedure
      - Therapies to resolve positive findings same as for Jules test
      - These 2 tests give same clinical information regarding cervical deep stabilizers
  - Lumbar tests: Side bridge endurance test vs Sorensen’s test
    - Side bridge endurance test (easier to administer)
      - Procedure
      - Therapies to correct positive finding
        - ½ side bridge exercises for 2 weeks progressing to full side bridge
        - Planking
        - Burpees for exceptionally rapidly progressing patients
    - Sorensen’s test (harder to administer)
      - Procedure
      - Same therapies as side bridge

- Key decision points for co-management
  - Chiropractic Referral/Consultation
    - Lack of improvement/progression
    - Make some change in treatment of patient
Neurologist consultation
- If TBI signs are persistent and not improving (not time for neuropsych consult yet)
- Rule out other significant and not yet documented brain injuries and get appropriate treatment outside of office when needed

**Hour 15**
(conclusion)

**Sunday**
3:45pm-4:00pm

- General Principles of rehabilitation programs
  - Phase 3 treatment summary
    - Care appropriate at 60+ days post injury
      - Adjust, direct therapy to restructure Type II collagen fibers allowing for greater long term range of motion and tissue more similar to original undamaged structure
  - Active therapies are expected
    - Protocols in place simplify this process for staff
    - Rehabilitative protocols should progress in difficulty as patient improves
    - Every 2-3 weeks therapies should change
  - Care should be focused on moving the patient to home exercise program and preparing for release from care
- Phase 3 Rehabilitation possibilities
  - For each modality discuss clinical rationale, times, codes
    - Traction (sagittal plane for collagen alignment)/axial traction (if confirmed disc bulge on MRI is still symptomatic and surgical consult has been performed)
    - Therapeutic Exercises/NMR/Therapeutic activities
      - Focus of therapies should be on strengthening protocol for deep neck flexors and lumbar intrinsic musculature
      - Pros/cons of the different codes-audit flags
      - C-Spine
        - ROM with head weights
        - Pro lordotic active traction bands
      - L-Spine
        - Wobble Chair – Pettibon exercises
  - Home exercise program Phase 3 Care
    - Discuss rationale and coding for HEP protocols
      - Strengthening exercises
        - Handouts from your software
        - Web Exercise programs
    - Posture based home exercises to reduce loss of cervical lordosis/anterior head translation from neck injuries
• History components
  o Should have near complete resolution of symptoms at this point
  o Key points to follow up from 60 day history
    ▪ Neuro findings and progression
    ▪ ADLs/work difficulties
    ▪ FUNCTIONAL CHANGES-massive importance for justification of continued care
      ▪ What constitutes functional improvement
        o Samples

• Examination components
  o Repeat previous positive tests
  o Determine necessity of additional exam components based on lack of improvement or worsening of symptoms or development of new symptoms sets

• OA components
  o Repeat previous abnormal OAs
    ▪ If there is no significant improvement in OAs at this point a referral is expected at minimum, discontinuation of care due to patient plateau is more likely
    ▪ These will be the most useful indicators for patient’s success with care and completion of care

• Special tests in office
  o Repeat any previously abnormal tests and document percent improvement
    ▪ GOAL=demonstrate resolution of symptoms and return to pre-accident status

CARE BEYOND 90 DAYS
• Vast majority of cases should be done treating with you at this point
  o Croft guidelines support care beyond this – Unfortunately it is harder to win settlements with care extending beyond 90 days. Argument for continued care as part of settlement is an option.
  o AAOS says it takes 1 year to complete restructuring – these exercises can be performed at home
    ▪ All of this can go in exit report
  o Still in pain at 90 days referral to pain management is standard of care

• May continue to see a few extreme cases beyond 90 days
  o Role of primary provider at this point is making sure home exercise program is being utilized
  o performing re-examinations to determine progress and plateau for release of care
  o Coordinating referrals and continued care with other providers

• Exception to 90 days of care
  o Cases which have resulted in surgery
    ▪ Continue treatment for surgical rehabilitation using physical medicine/rehab and following the ODG guidelines for post-surgical rehab
- If TBI/concussion signs persist without significant improvement at 120 days referral to neuropsych is appropriate

Hour 16 (conclusion)

Sunday 4:30pm-5:30pm

- Components of a complete patient file
  - Document Summary
  - Police Report
  - Records from any other provider who has treated patient
  - Photographs
  - Your complete file
    - Exam notes
    - Chart notes
    - OAs
    - Letters (work restrictions, accommodations, etc.)
    - Exit report
    - X-ray analysis

- Closing report
  - Instead of MMI say they have hit static MMI – this leaves room for regression
  - Your opportunity to justify the necessity of continued care to increase the value of the patient’s settlement
  - Easiest to build this off of document summaries

- Creating Document Summaries
  - Do it from the perspective of an independent reviewer
  - The basics that you need to know:
    - Report only what you have, be concise, and don’t add any information that you do not see (so do not include findings/diagnoses from other documents)
      - This includes all pertinent positive and negative findings
      - This includes info given for all body regions
  - What documents to summarize:
    - All medical documents with clinical information
      - Examples include SOAP notes, progress reports, narrative reports, and diagnostic testing reports
    - Chart Notes:
      - Examples: Physical therapy notes, chiropractic treatment notes, daily SOAP notes, hospital notes, etc.
      - In general, chart notes do not need to be summarized unless they contain significant clinical information.
      - If summarized, it is only necessary to summarize the clinically significant information that is not available in other reporting.
  - Diagnostic Report:

Robertson - Personal Injury - page 15

Postgraduate & Continuing Education
25001 Industrial Blvd, Hayward, CA 94545 USA
P +1 (510) 780-4508  F +1 (510) 780-4518  E conted@lifewest.edu  ce.lifewest.edu
• List the type of report, body region, and all impressions as well as any clinically significant findings (not included in the impressions) in the OBJ field only:
  o Template: [body region][report type]: [significant impressions and/or findings]
  o Example: “lumbar MRI: normal”

- Clinical Photos:
  - Examples: photos of patient’s injury/condition
  - Just indicate what photos are included in the MISC/OTHER field.

- Narrative Report:
  - Examples: Orthopedic/Neurologic/Psychiatric consultation; basically any clinical reporting in narrative format other than progress reports or medical-legal reports

- Progress Report:
  - Examples: Interim report, Progress Note, Monthly Note, Re-Evaluation, Follow-up visit, Primary Treating Physician’s Progress Report, physical therapy/chiropractic/acupuncture progress note
  o General format of document summaries:
    - Content for summary form fields:
      - SUB field include:
      - OBJ field include:
      - DX field:
      - TX field:
      - MISC/OTHER field:

Recommended/Background Readings

• Official Disability Guidelines: http://www.odg-twc.com/