

Writing a Progress Report for a Patient's Insurance Company

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When an insurance company sends a request for patient records, health care providers usually find themselves answering questions about medical necessity. In other words, is the given treatment medically necessary to either cure or relieve the patient's condition or chief complaint?

The patient's health care policy coverage, in the vast majority of instances, is to either cure the condition or bring the condition to a level of maximum medical improvement also known as MMI.

Maximum medical improvement (MMI) refers to the state in which the patient's clinical findings, both subjective and objective, have reached a plateau in improvement. The insurance company is looking for a reasonable treatment time in doing so with other treatment avenues or methods attempted. For example, many studies of recovery time from a soft tissue injury, such as a sprain and/or strain of muscles, ligament and tendons, usually resolves itself in three months. As a practitioner, your job is to reduce any residuals, get the patient back to normal activities of daily living in a shorter time. If your treatment has been ongoing for eight months and the records do not show an appreciable improvement from one visit to the next, then the medical necessity of the treatment you prescribed is called into question. Are you helping this patient or just MAINTAINING the condition? This is called maintenance care in the insurance industry vocabulary. Generally, the health insurance coverage does not include maintenance treatment; since it is not billable to the insurance company, the patient pays this directly to you.

A related term is Pre-injury Status. This refers to the patient's physical state when treatment subjective and objectives reach a particular level before the onset of the current condition or problem.

When you receive a request for records, your goal is to show there is medical necessity for your treatments. Use the records to demonstrate that there is a reasonable expectation to see improvement in the chief complaint or problem. The best way to support this is by sending copies of your patient records. DO NOT send in your original patient records, as you are the custodian of these records. Only provide chart record copies to the patient and those parties the patient authorizes, such as an insurance company. When sending chart notes, include the initial history of the condition, the initial examination forms, your daily progress notes showing changes in the subjective and objectives, copies of diagnostic test results (i.e., laboratory tests), and the summary of your care (use the progress report form below).



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By the time you finish looking at this, you may come to realize that the patient is at maximum medical improvement or the patient needs additional treatment, and you should argue a justification in your report.

The Progress Report sections are listed with what material is discussed in each and a sample report attached so you can get an idea of how a final report reads.

Chief Complaint:

List the patient's initial complaints in order of treatment priority with the first one being the one you primarily treated.

Subjective:

This is what the patient tells you about the chief complaint. Include the patient's history and if important, the past history. Note how the condition began, including the onset, symptoms, frequency, intensity and duration. What makes the chief complaint better or worse? Describe the quality or description of the pain if there is pain. Does the pain move, travel or radiate? If so describe from where to where and how often it does this and duration of it. Is there a difference in the condition with change in location? For example: work vs. home vs. athletic field, outside vs. inside, in the car, etc. Does the condition change with the time of day?

Then describe the most recent or last visits subjective complaints. Compare the most current subjective in each area to the first. What you are hopefully seeing is an improvement from the first visit or the last re-evaluation until now.

Note: If there is important system review history or past medical history like prior motor vehicle accidents, surgeries, hospitalizations, etc. that may be pertinent, include it in this section also.

To remember the components of a subjective history (H) for the chief complaint (CC), use the mnemonic OPQRST which stands for:

Onset/Occurrence
Palliative/Provocative
Quality/Quantity
Radiation/Region
Site
Time of Day

Objective:

This is what is observed by you the healthcare provider. It includes tests, measurements, observations, etc. Use the mnemonic listed below for a crutch. Keep in mind that not all of these areas will be done. It is dependant on the chief complaint and the subjective history as to what exam tests below that are done. To help you remember what to do when performing an exam, use the following mnemonic - IPPIRONEL.

I: In this section, include inspection of the area of the chief complaint and describe anything abnormal.

P: Palpate the area and describe what you find -- hardness, softness, pain, spasm, etc.

P: Percussion to the area listening for abnormalities or reproduction of the pain.

I: Use any necessary instrumentation like ear, nose and throat diagnostic kit, etc.

R: Do active, passive and resisted ranges of motion in all planes.

O: Conduct necessary orthopedic tests pertaining to the area of the chief complaint. For example: Straight Leg Raise (SLR), Kemps Test, etc.

N: Neurological evaluation to include cranial nerves, dermatomes, light touch, sharp vs. dull, temperature, position sense, graphism, etc. and reflexes. If needed do girth measurements of the extremities.

E: E stands for x-ray, MRI, CT scan, Bone Scan, etc. Include the name of the test, view taken, date done, and the interpretation. Include the radiologist name who interpreted the study.

L: Laboratory test ordered. Include the pertinent results to the patient care.

Assessment:

This is the diagnosis. Using the data from the chief complaint, patient subjective, and exam objectives arrive at a diagnosis. This is known as your best guess. It is allowed to be modified as you go along and other data reveals itself. You are not being graded here but it does need to be consistent with the chief complaint, patient subjective and exam objectives. The first diagnosis listed is the one you primarily are treating. However you may also be treating the other. Include the diagnosis in the International Classification of Diseases Volume 9 (ICD-9) code book. Do not include the Traditional Oriental Medicine diagnosis here because it will confuse the insurance company reviewer. If you wish to include diagnoses which are to be ruled out, say that next to the diagnosis. For example: Rule out lumbar spine disc herniation.

Discussion:

This is where you will summarize your initial findings, how the patient has progressed up to the last visit, what therapies were used, your overall strategy for the condition. If you need additional visits, list the number of additional visits over and the time interval these will be used. If the patient has been discharged or sent to another specialist, state this.

Print the progress report on your letterhead, sign and date it. Include a bill for your report, as some insurance companies will pay for it. Send it with a copy of the patient treatment notes. In thirty days, call the insurance company for their decision if you have not yet been contacted. This is not a fool proof, guaranteed payment strategy, but it gives you a fighting chance. More often than not, the reviewer is looking for reasons to pay you. Provide the data and hope for the best.

The following is a sample Insurance Company Progress Report. Use it as a model; copy and paste text into your report template or [download](#) this version now.

April 21, 2010
Jane Doe
Wonderful Insurance Company
123 Maple Street
Anywhere, MI 60128

PROGRESS REPORT

Re: John Smith
Claim: 57674584
DOI: February 1, 2010
Chief Complaint: 1. Neck Pain
2. Right Arm Pain

Subjective: John Smith was seen in my office on February 1, 2010 for history, examination and treatment for the above chief complaints. At the time of the initial examination, the neck pain began on February 1, 2010 when he was cutting trees in his back yard. The patient recalls lifting the saw above his head when he felt a snap and then a sharp stabbing pain in the right upper shoulder and neck area. Pain began to radiate down to the right hand. The pain was described as a constant, severe pain which increased with any head rotation. The arm radiation was also constant. The patient wife had to drive him to the office. He had no other treatment up to this point.

Past history showed he had a motor vehicle accident two years before which caused increased neck pain but resolved fully with only minimal neck pain which was occasional. It responded well to neck exercises, home ice and massage.

The patient was last seen in this office on March 16, 2010. At that time the patient had minimal neck pain with no arm pain.

Objective: The initial examination on February 1, 2010 showed a normally developed Caucasian male in severe distress. He was unable to rotate his head in any plane. His wife needed to assist him with movement around the office.

Inspection of the neck showed a right convex curve with visible muscle spasms of the upper trapezius region.

Palpation of the neck and upper extremities showed severe muscle spasms with swelling of the levator scapula, trapezius and moderate spasms of the teres minor

muscle on the right. There was trigger point radiation down the right arm with palpation that reproduced his symptoms.

Active and passive range of motion of the neck was painful in all planes and restricted 90% of normal. Resisted range of motion was painful in all planes.

Orthopedic tests including Spurlings was positive on the right for radiation to the right arm. Neck traction test was positive for increased pain.

Neurological evaluation of the upper extremity for light touch, sharp and dull, temperature was normal bilaterally. Reflexes of the upper extremities were 2+ bilaterally for the biceps, triceps and brachial radialis.

A five view radiograph of the neck done on February 1, 2010 which was read by radiologist, I. C. Everything, M.D. The results were 1. Right convex curvature of the cervical spine secondary to muscle spasm. 2. Clinical correlation for a cervical disc herniation is necessary. Consider MRI or CT scan. 3. No evidence of fractures, dislocations or bone pathology.

After a clinical course of treatment, the patient was re-evaluated on March 16, 2010. The patient's neck did not have a right lateral convexity but was now normal. The muscle spasms of the right upper back and neck were non-painful to palpation. Active and passive range of motion was full and non-painful. Spurlings and neck traction test were negative.

Assessment: 1. Cervical Sprain/Strain
 2. Myofascial Pain Syndrome
 3. Rule out Cervical Spine Disc Herniation

Plan & Discussion: The patient was initially seen on February 1, 2010 with neck and right arm pain which was described as a constant and severe, sharp stabbing pain. The objective tests showed muscle spasms and trigger points in the right shoulder cervical spine area with associated compensations. The neck range of motion was severely limited. The patient had x-rays done and was given a clinical course of treatment consisting of home ice therapy for the first 48 hours, acupuncture, massage and passive range of motion. As the inflammation decreased, moist heat was used prior to treatment with spinal manipulation and stretches being introduced followed by home ice therapy. As the patient's muscle spasms resolved, the neck curvature returned to normal, the trigger point in the teres minor muscle resolved and the patient's symptoms reduced significantly. The patient was discharged after 12 office visits on March 16, 2010 with mild neck pain which is managed with home therapies including ice, heat, and massage.

If you have any questions, please feel free to contact me.

Sincerely,

IM Terrific, D.C., L.Ac.

IM Terrific, D.C., L.Ac.
Dr. I. M . Terrific, D.C., L.Ac.

cc: patient file
John Smith



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