

Documentation Best Practices for Washington State Workers' Compensation

Table of Contents

Contents

Summary: Practical Application Points	3
Clinical Workflows and Documentation Needs across the Episode of Care	4
L&I Documentation Requirements	4
Initiation of a Claim	5
Activity Prescription Form	5
Work Ability Issues	6
Authorized Treatment.....	6
Charting and Progress	7
Objective Medical Findings	9
Consultation	10
Documentation Reference	11
Clinical Record Keeping Best Practices	13
Occupational Healthcare.....	13
Problem Oriented Record Keeping	14
Initial History Documentation.....	18
Patient Presentation	18
Occupational History.....	19
Past History	19
Initial Clinical Examination Documentation.....	20
Regional Examination.....	20
Functional Deficit	21
General Systems.....	21
Special Studies.....	22
Treatment Plan Documentation (Initial SOAP Note)	25

Purpose and Intended Use

This resource was developed by the Industrial Insurance Chiropractic Advisory Committee (IICAC) of the Washington State Department of Labor & Industries (L&I). It provides concise summaries regarding documentation standards and practices based on published clinical and health education literature as well as key legal documentation and reporting requirements for treating injured workers in Washington State.

Specific documentation requirements exist for coding and billing purposes for various procedures and are found in the Medical Aid Rules and Fee Schedule ([MARFS](#)). Note that example chart entries included in this document illustrate documentation of clinical information; they do not imply nor reflect specific documentation requirements for coding and billing purposes. This practice resource does not change L&I coverage or payment.

This and other practice resources are in the public domain and are available for download on L&I's website. Contact information for public input and submission of studies for future revisions is available on the website:

[Lni.wa.gov Practice Resources](https://lni.wa.gov)

Treatment Plan Documentation (Follow-up SOAP Notes).....	26
Non Face-to-Face Care (Phone Calls, e-mail, Peer Consultation)	28
Workers’ Compensation Issues Documentation	28
Evidence and Methodology	31
Citations	32
Appendix A: Work-related Terminology and Glossary.....	33
Appendix B: Lifting Calculator for Workers with Mild to Moderate Low Back Sprain/Strain	35
Appendix C: State Laws Relevant for L&I Documentation.....	36
Appendix D: Checklists and Guides.....	37
L&I Documentation Checklist and self-review	38
Work Relatedness Information Checklist.....	39
Documenting Work Ability Worksheet	40
Appendix E: Additional Resource Links	41
Appendix F: Documentation Examples	42
History, Examination, Problem List and Treatment Plan	42
Documentation Examples – Acceptable Chart Notes	52
Documentation Examples – Discharge SOAP Note / Final Report.....	53
Appendix G: L&I Basics section	55
Concurrent Treatment	55
Protected Health Information.....	55
Record Sharing and Retention	56
Electronic Health Information.....	56

Summary: Practical Application Points

- In addition to typical clinical documentation requirements, Washington State workers' compensation has requirements that are central to the care of workers and must be reflected in documentation. These components are:
 - work ability and RTW focus
 - functional status and activity
 - clinical rationale for the work-relatedness of the patient's condition
 - progress demonstrating that care is curative and rehabilitative
- Reports of findings and interpretation of special studies must be included in the chart, including written reports of in-office studies such as X-rays.

Occupational Healthcare Documentation

Clinical documentation serves several basic roles including: 1. It codifies the clinical rationale for making a patient's diagnosis, documents what interventions are done, and how well they worked. 2. It reveals why a provider does what she does reflecting both clinical logic and procedural components of care which are critical for professional liability purposes. 3. It provides an explicit log of what was done which is increasingly necessary for billing accuracy in third party reimbursement. 4. Additionally, unique to workers' compensation, clinical documentation becomes the basis for determinations of benefits that workers receive.

General Documentation Standards and Requirements

- L&I requirements are generally consistent with standard clinical teaching and practice, licensure, and medico-legal expectations. The [Medical Aid Rules and Fee Schedule \(MARFS\)](#) includes documentation requirements for coding and billing purposes.
- L&I additional information involves work issues (such as work-relatedness, functional improvement)
- Templates in some electronic medical records (EMR) may improve quality, however, the use of "copy forward" and auto-fill features can be problematic and hazardous in accurately reflecting work performed, or progress attained over time.
- Test and imaging results require full reports of findings and interpretation in the chart.
- Charting must be chronological and completely capture all issues relevant to and/or under care.
- Clinical elements are prescribed, but specific format terminology has flexibility. Problem-oriented records approaches are flexible enough for nearly all documentation needs.
- All providers who treat workers are required follow the agency's documentation and reporting requirements in order to remain in the network.

Problem-Oriented Records (POR)

- POR format has become a standard clinical documentation format that is required for workers' compensation documentation.^[1, 2]
- Elements include clinical findings and interventions in a "SOAP" format (Subjective, Objective, Assessment, Plan & Progress) and a problem list summarizing all of the patient's conditions being monitored or cared for in the practice.
- The SOAP format aligns well with inpatient or outpatient practices, can be tailored to any type of condition, evaluation, and intervention.
- A POR approach satisfied the needs of the patient for limited or continuing care and typically meets documentation requirements for payers and professional liability protection. Specific documentation requirements for coding and billing purposes may vary by payer and procedure.

Occupational Health Additions

- The claim number appear must appear in the upper right of every page of the clinical record due to the volume of medical records submitted for workers' compensation and to enhance proper entry into the Claims and Account Center (CAC)
- Copies of medical records are required to be submitted to L&I (or self-insured employer), but typically [must be sent to a different address than medical bills.](#)
- Work ability and activity must be addressed in the patient chart. Activity Prescription Forms (APF) capture the most essential information, however relevant issues should be address in subjective and assessment sections of SOAP notes, particularly any clinical issues that may be barriers to the patient's recovery and return to work.
- Some conventions have used SOAP-"ER" to emphasize a separate call out for "[Employment issues](#)" and "Restrictions to recovery") to address these occupational health specific issues.

Common Problems with Clinical Documentation

- Repetitive entries (such as EHR auto-fill, same findings and assessment at all visits) fail to justify need for continuing care.
- Inadequate or no documentation of functional improvement since care initiation makes it difficult to justify treatment plan.
- Documented objective findings, or lack of findings, do not support the accepted work-related condition.
- Entries not signed by the performing provider.
- Incorrect modification of records (such as latter additions or changes must have the date of entry of the addition).
- Failure to document all services performed in accordance with guidelines and policies including CPT ^[3] or [MARFS](#) can result in non-payment or recoupment of payment.

Clinical Workflows and Documentation Needs across the Episode of Care

Intake	Assessment and Care Plan	Provision of Care & Progress	Conclusion of Care
<p>Clinical Documentation</p> <ul style="list-style-type: none"> • History (CC, PI, ROS, PSFH). • Examination (regional and relevant physical examination). • Medical decision-making (such as diagnoses, systems involved). • Work-relatedness of condition(s). <p>Administrative</p> <ul style="list-style-type: none"> • Submit ROA (State or SIE). 	<p>Clinical</p> <ul style="list-style-type: none"> • Problem list. • Treatment plan. • Care rendered (SOAP notes). <p>Administrative</p> <ul style="list-style-type: none"> • Submit completed Activity Prescription Form (APF). • Submit copies of chart notes. 	<p>Clinical</p> <ul style="list-style-type: none"> • SOAPER Notes indicating: <ul style="list-style-type: none"> ○ Functional progress. ○ Work status. ○ Barriers to recovery. <p>Administrative</p> <ul style="list-style-type: none"> • 60 day/special report as appropriate. • New APF – <u>only</u> if work status changes since previous APF. 	<p>Clinical</p> <ul style="list-style-type: none"> • Closing Exam- assure initial positive physical examination findings are retested and other relevant objective measures of their functional ability is documented. • Discharge summary (inpatients). <p>Administrative</p> <ul style="list-style-type: none"> • Closing report including if there is or is not a need for an impairment rating.

L&I Documentation Requirements

This section comprehensively inventories provider documentation requirements called out in the laws and policies governing workers' compensation. [Appendix C](#) at the end of this document includes links to laws relevant to a provider's clinical record keeping. Providers are also referred to the [Medical Aid Rules and Fee Schedule](#) which addresses specific coding and reimbursement documentation requirements.

Ensure Clinical Documentation Reaches Claim File

Overview – Medical records for L&I claims are imaged as a graphic file in the electronic claims record. Due to the volume of documentation submitted it is essential that **EVERY PAGE** of each report and chart note has the **CLAIM NUMBER** in the **UPPER RIGHT HAND CORNER**. It may also be helpful to submit records from different claims separately to prevent confusion. Reports and chart notes must be submitted separately from medical bills as indicated below. Records without claim numbers in the upper right hand corner, or records sent to the wrong location are unlikely to be seen by the claim manager and may delay or result in denial for payment. Using your L&I provider number instead of your NPI will assist in claim processing efficiency.

L&I State Fund Claims documentation submission:

Report of Accident (ROA) Workplace Injury, Accident or Occupational Disease ([F242-130-000](#))

PO Box 44299
Olympia, WA 98504-4299 Fax: 800-941-2976 or 360-902-6690

Activity Prescription Form ([F242-385-000](#)), Correspondence, Reports, Chart notes

PO Box 44291
Olympia WA 98504-4291 Fax: 360-902-4567.

Information regarding billing, including billing online can be found at: lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI

Self-Insured Employers (SIE) have their own billing and submission processes that vary for each employer. Information and assistance can be found online at: lni.wa.gov/ClaimsIns/Providers/Billing/BillSIEmp/.

Initiation of a Claim

Overview – Providers who treat workers are required to inform them of their workers' compensation rights and assist them in making application for benefits. This carries with it the obligation of documenting the work-relatedness of the condition, completing and submitting a Report of Accident (ROA) Workplace Injury, Accident or Occupational Disease, documenting the history, positive physical exam findings, diagnoses, any barriers to recovery, and estimating the time off work that may be needed. This is submitted to L&I on a **ROA** form for [state fund claims](#). For self-insured claims, a **Provider's Initial Report** form is submitted to the self-insured employer. It is legally required to submit the ROA within 5 working days of the initial office visit with the worker. However, occupational health best practices and L&I's Centers for Occupational Health and Education (COHE) utilize a 48 hour turnaround which research has shown to be strongly associated with better outcomes and lower long-term disability.^[4] Using your LNI provider number instead of NPI can facilitate claim acceptance. Ensure that the diagnosis codes and descriptions are fully completed.

Additionally, all history, examination and testing findings **and** interpretation must be included in the chart. This includes providers who do in-office diagnostics such as plain film X-ray or laboratory studies. A **written** report for the study including what the findings are **and** their interpretation must be in the patient's clinical record in addition to clinical justification and appropriate patient information. An Activity Prescription Form is required to be submitted when there are work restrictions.

Report of Accident, Workplace Injury, Accident or Occupational Disease also referred to as **Report of Accident (ROA)** is required for initiation of all state fund claims and includes portions completed by the employer, worker, and the worker's attending provider. Nearly all claims are submitted by providers, with workers frequently completing their section in a provider's office. ROAs can be completed and submitted online Lni.wa.gov/FileFast with the capacity for the worker, employer, and provider to each complete their sections separately. Online filing speeds up claim processing by 5 days with faster payment of benefits.

The Provider's Initial Report (PIR), also billed as 1040M) is a slightly different form that serves as the ROA for self-insured employers. It covers the same information and is subject to the same requirements as the L&I state fund version, but is submitted directly to the self-insured employer. [Providers Initial Report](#)

Refer to the [Work-relatedness checklist](#) for more detailed information.

Clinical Record Documentation

- History and physical examination
- Special studies reports (such as X-ray, lab including findings and interpretation for each study)
- Problem list - diagnosis (such as problem list or assessment including ICD codes)
 - It should be clear in the problem list or assessment section of initial SOAP note which problems are directly a result of the work injury or exposure and the provider's reasoning for it)
- Treatment plan and prognosis

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or self-insured employer when appropriate)

- **State Fund Claims:** Report of Accident ("ROA") [Report of Workplace Injury, Accident or Occupational Disease \(F242-130-000\)](#).
- **Self-Insured Claims:** Provider's Initial Report ("[PIR](#)" [F207-028-000](#))

Examples of Relevant Laws and Rules

- [RCW 51.28.020](#) Worker's application for compensation — Physician to aid in.
- [WAC 296-20-025](#) Initiating treatment and submitting a claim for benefits.
- [WAC 296-20-020](#) Acceptance of rules and fees.
- [MARFS 26-7](#)

Activity Prescription Form

Overview - Providers who choose to treat injured workers are required to review these job demands and determine the worker's abilities and restrictions in performing them. Employers are entitled to know the provider's assessment of the worker's recovery and ability to perform work activities. [The Activity Prescription Form \(APF\)](#) is the most concise and complete way to document work status. This form should be completed and submitted with the ROA whenever work restriction are given. It should be updated and resubmitted only when there are changes in the patient's work status. More information is available online: <https://lni.wa.gov/claims/for-medical-providers/activity-prescription-form>

Refer to [APF Checklist](#) for more detailed information

Work Ability Issues

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or SIE)

- Activity Prescription Form ([F242-385-000](#)) (initially only when work restriction given and updated only when work status changes)

Overview – Unique to workers' compensation is the explicit attention required of providers to address work abilities and limitations. The determination of work abilities and restrictions documented by attending providers in the patient's clinical record and provider-completed forms are the basis for determination of various benefits for the worker.

Returning to work is an important outcome for workers and the system. Employers are required to furnish providers with information about what their work entails, what accommodations/modifications can be made including the physical activities involved.

There are a number of useful work ability and status terms referenced in workers' compensation law and policy that clinicians should be familiar with. A glossary of them is included in [Additional Materials](#).

Clinical Record Documentation

- Problem list and treatment plan
- Chart (Progress, SOAP) notes

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or SIE)

- Activity Prescription Form ([F242-385-000](#)) (initially only when work restriction given and updated only when work status changes)
- Job Analysis Summary ([F252-072-000](#)) (reviewed and signed by AP when sent by a vocational services provider)

Examples of Relevant Laws and Rules

- [RCW 51.32.090](#) Temporary total disability; Partial restoration of earning power; Return to available work; When employer continues wages; Limitations; Finding; Rules.
- [WAC 296-20-01002](#) Definitions: Modified Work Status; Regular Work Status; Temporary Total Disability; Temporary Permanent Disability; Total Permanent Disability.

Overview – Washington workers' compensation law prescribes several elements for care to be allowed:

- Care must be proper and necessary – this is operationalized as:
 - Care for an accepted work-related condition.
 - Care being curative and rehabilitative by objective documentation of functional improvement and other long term changes including return to work and normal activities.
 - Reflective of accepted standards of care under the provider's license.
 - Provided at the least cost and in the least invasive setting and not primarily for the convenience of the injured worker or providers.
 - Care provided until maximal medical improvement is reached, meaning changes are permanent, not temporary or transient.
- Care must be with an L&I network provider consistent with L&I policies and evidence-based guidelines.
- Initial diagnostic (plain film) X-rays do not require prior authorization.
- Routine blood and urine laboratory studies do not require prior authorization.
- Consultations for second opinions with specialist within a reasonable geographic area do not require prior authorization and should not be with a provider in the attending provider's own office or partnership. Consultations are not authorized if the claim manager has scheduled and independent examination, or if the worker has been under the active care of the consulting provider within the previous 3 years.
- Prior authorization by a claim manager is not required for up to 20 office visits within the first sixty days following the first visit. Care beyond that requires prior authorization by the claim manager.
- Prior authorization is not required for up to 12 visits for physical therapy.
- Prior authorization is required for certain kinds of tests and treatment (see WAC 296-20-03001) including:

Authorized Treatment

Proper and necessary

Curative and rehabilitative

Maximal medical improvement

- Conservative care beyond 20 office visits or 120 days beyond the initial office visit for the claim requires a second opinion consultation justifying need for further care.
- Physical therapy care beyond 12 visits and massage therapy beyond 6 visits.
- Diagnostic studies other than routine X-ray, blood, urinalysis studies.
- Diagnostic and therapeutic musculoskeletal system injections.

Clinical Record Documentation

- Chart notes, progress reports

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or self-insured employer)

- Specific written requests for authorization
- Web-based UR for advanced imaging requests

Examples of Relevant Laws and Rules

- [WAC 296-20-01002](#) Proper & Necessary, No Authorization, Authorization, imaging
- [WAC 296-20-121](#) X-rays
- [WAC 296-20-030](#) Treatment not requiring authorization for accepted conditions
- [WAC 296-20-03001](#) Treatment requiring authorization
- [WAC 296-20-035](#) Treatment in cases that remain open beyond sixty days
- [WAC 296-20-045](#) Consultation requirements
- [WAC 296-20-051](#) Consultation guidelines
- [WAC 296-20-01040](#) Health care provider network continuing requirements.

Charting and Progress

Overview – Consistent with standard clinical practice, licensure requirements, staff privileges, and medico-legal standards, workers' compensation law and policy prescribes that chart notes (aka, office notes, progress notes, SOAP or APSO notes) be maintained for care workers receive and that it be recorded in chronological order with each visit having its own chart entry.

Specifics of what the law prescribes be in a workers' chart (daily progress) notes include:

- Patient demographic information, date of service, name and title of individual(s) – provider or staff – who performed the service,
- Chief complaint at each visit
- Relevant patient history
- Examination findings
- Medications and/or equipment prescribed
- Description of the treatment provided
- X-rays/tests ordered or performed and their results
- Treatment plan and the outcome of treatment.

Refer to the L&I [Documentation checklist](#) for more detailed information

All of these elements specifically called out in law are routine components of standard problem-oriented record keeping practice and progress charting (that is Subjective findings, Objective findings, Assessment of patient, Prescribed care/Plan/Progress, aka, "SOAP" notes). A convention that has been used in workers' compensation chart notes included the addition of "E" employment factors and "R" workplace restrictions ("SOAPER"). It is important to routinely document functional ability, including work activity in usual SOAP notes. However, specific E & R components can be documented using an APF if work restrictions are given when a claim is initiated, and then completing an updated form when the patient's work status or abilities have changed.

Periodic written "60 Day" or "Special" Reports are required to be submitted to L&I that must include:

- The condition(s) being treated and its ICD diagnostic code(s)
- Subjective and objective findings (at the time of the report)
- The relationship of these findings to the industrial injury/exposure (directly caused by, indirectly associated with, and the rest)
- An outline of any proposed additional treatment, its duration and expected conclusion date (such as when recovery or stability is expected), and estimate of when return to work can be expected, and the probability of any expected permanent partial disability.
- An estimate of physical capacities in not back to work. A formal functional capacities evaluation can be requested if needed.

The attending provider is required to submit one at 60 days following their initial office visit, or whenever one is requested by L&I or the self-insured employer. The most important element to document in a 60-day report is how the patient's condition and functional ability has progressed since care began. If all of this information is clearly included in the patients chart notes, a separate 60 day report is not required.

Clinical Record Documentation

- Chart (daily progress) notes
- Written Reports

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or self-insured employer)

- Periodic written reports summarizing care, progress and further treatment plan

Examples of Relevant Laws and Rules

- WAC 296-20-01002 Definitions – Chart notes, Attending provider report

Objective Medical Findings

What are Objective Medical Findings (OMFs):

OMFs are described as a “finding” that can be seen, felt, heard, measured, or consistently reproduced by the examiner through examination or testing. This differs in context from what the patient states, rather these findings must be elicited by the examiner and independent of voluntary action versus what the provider elicited on examination. **NOTE:** The presence of OMFs alone doesn’t mean a person can’t work. The provider must explain how the OMFs prevent the worker from returning to the job of injury (JOI) or available modified duty.

Examples include:

- Physical examination (vital signs, inspection, palpation, percussion, orthopedic tests, lifting, ranges of motion,)
- Laboratory tests (blood chemistry, urinalysis)
- Diagnostic procedures (that is, X-ray, CT/MRI, pulmonary function, mental health testing)
- Outcome Assessment Tools (SPADI, Oswestry, [and others](#))

Usually, providers run into this issue when they aren’t particularly clear on tenderness to palpation as an elicited versus stated response, or the specific results of a positive test, or lack of outcome assessment tools. For example, subluxation findings must be linked back to how they impede the worker and are applied to their function. PARTS, in essence, but linking it to the injury and impairment. For example:

Insufficient information:

“worker has pain on palpation. MCC positive. Restricted c-sp rotation. Worker can’t do ADLs.”

Accurate and explanatory:

“Worker jumps due to pain when tight muscle fiber is palpated with moderate pressure. Maximum cervical compression is positive for local pain at C6 on the left. Lt rotation restricted at 15 deg, compared to 80 deg on Rt. Neck Disability Index shows 30% loss of function; improved from 40% 1wk ago.”

There are many times that the facts of the case and work the doctor does isn’t well documented in the notes and thus it appears further care would be less meaningful than what is actually occurring. This may create an inappropriate denial. The other common issue is when there is time-loss present and extra scrutiny is applied. Look at APF changes and ensure the measurement of and determination of these restrictions is present in your notes.

OMFs are used to substantiate the following:

- Allowance of an occupational disease claim
- Certification of time-loss benefits
- A time-limited, goal oriented treatment plan; or changes in the treatment plan
- Requests for further treatment and the estimated length of treatment
- Requests for additional testing or consultation
- Changes to work restrictions, modified duty, or time off work
- Aggravation or worsening of the condition
- Consistency with functional capacity evaluation (FCE) results
- Recommendation for permanent partial disability (PPD) rating
- Why an unrelated condition is retarding recovery

Levels of Service

Overview – Thorough clinical documentation provides justification for different types and levels of service that are billed. The adage “If it’s not documented, it didn’t happen” applies. Differences may exist between documentation requirements for coding and billing justification and usual practices for documentation for clinical management or medico-legal purposes. Detailed re-evaluation may exceed the time and medical decision making of a regular office visit and require use of an evaluation and management code. L&I providers should refer to the [Medical Aid Rules and Fee Schedule \(MARFS\)](#) paying attention to specific documentation coding and billing requirements for specific services they provide. Coding descriptions, including how services and services levels are defined can be found in Current Procedural Terminology,^[3] published and updated annually by the American Medical Association.

Relevant Laws and Rules

- [WAC 296-20-125](#) Billing procedures.
- [Medical Aid Rules and Fee Schedule \(MARFS\)](#)

Overview – A consultation referral may be made by any Attending Provider (AP) without prior authorization to obtain a second opinion (diagnostic assessment, identification of additional treatment options, reasons for stalled progress, necessity of further care, etc).

Consultations should be performed by a provider that is independent of the AP. A consulting provider may not bill for a consultation service if the patient has been under the consulting providers care within the prior three years. Use of the [AP's Referral Form](#) is recommended to clarify the need for the referral and documents all information a claim manager might need for any required authorizations. A consultation evaluation addressing the need for further care must be obtained and the report completed at or before 120 days of care or 20 office visits since care began. Consultations may happen at any time, and after 30-60-days of care may be a good opportunity to get input on challenging cases that have diagnostic uncertainty or lack of progress as expected by the AP.

The referring provider should provide the consulting provider with available records and reports prior to the worker's appointment with the consulting provider unless the consultant has access to the records otherwise (that is in the Claim & Account Center). A consultation may be obtained at any time during care, provided that L&I or the SIE has not already requested an Independent Medical Examination (IME).

Second opinion consultations are also required for non-emergent major surgery for patients with complicating conditions, for the use of allowable non-standard procedures, and if requested by L&I or the self-insured employer.

The Industrial Insurance Chiropractic Advisory Committee (IICAC) oversees a [chiropractic consultant program](#) of doctors of chiropractic with additional L&I training specific to workers' compensation particularly related to musculoskeletal injury diagnosis, conservative management options, functional improvement and maximal medical improvement.

The consulting provider must supply a written report within 15 days to the referring provider and L&I, that includes:

- An adequate history to establish the type and severity of the occupational condition.
- The patient's previous physical and mental health, and any social or emotional factors that may affect recovery.
- Compares their history to the one provided by the referring provider.
- An examination of all systems affected by the industrial injury or exposure.
- A complete diagnosis of all conditions the patient has (including ICD codes) with specific delineation of which ones were due solely to the occupational injury/exposure, which conditions pre-existed the injury/exposure that were aggravated by the injury/exposure, any conditions that were not impacted by the exposure/injury, but that may retard recovery, and any unrelated concurrent conditions.
- Conclusions about their evaluation including the type of treatment recommended for each condition and probable duration of that treatment, the expected degree of recovery from the occupational condition, probability of residual disability from the condition, and probability of returning to work.
- Recommendations for any appropriate additional diagnostic studies.

Clinical Record Documentation

- Chart notes
- Copy of written consultation report

Separate L&I Forms/Reports (Required to be completed and submitted to L&I or self-insured employer)

- Written consultation evaluation report
- [AP Referral Form](#)* (recommended, but not required for making consultation referrals)

Examples of Relevant Laws and Rules

- [WAC 296-20-01002](#) Definitions – Consultation examination report.
- [WAC 296-20-035](#) Treatment in cases that remain open beyond sixty days
- [WAC 296-20-045](#) Consultation requirements
- [WAC 296-20-051](#) Consultations

* Voluntary educational practice aid

Documentation Reference

Form or Written Documentation	When	Purpose(s)
Initiated By Attending Provider		
<p>Report of Accident (ROA) Workplace Injury, Accident or Occupational Disease (state fund) aka, "Report of Accident (ROA)"</p> <p><i>Form: F242-130-000</i></p> <p>Or Provider's Initial Report (self-insured)</p>	<p>Required within 5 days of initial visit (ideally within 48 hours)</p>	<ul style="list-style-type: none"> Documents worker's description of injury/exposure. Provider's initial assessment of work-related condition, its causation, and worker's clinical condition and estimated impact on ability to work. Provides essential information required for L&I or self-insured employer to determine if claim can be accepted.
<p>Activity Prescription Form</p> <p><i>Form: F242-385-000</i></p>	<p>At initial visit having work restrictions and when work status changes</p>	<ul style="list-style-type: none"> Documents patient's work status, estimate of physical abilities, return to work information. Provides essential information required for L&I or SEI to determine time-loss benefits eligibility.
<p>Sixty Day Report.</p> <p><i>Written Documentation: May be a letter to claim manager, or detailed documentation in submitted chart notes (the latter is not reimbursable as a separate report).</i></p>	<p>Every 60 Days after first visit</p>	<ul style="list-style-type: none"> Documents worker's clinical and functional progress since care began. Estimates and documents clinical need for further care, degree of expected recovery, any barriers to recovery, and estimated timeline.
<p>Consultation Report (May be requested by AP for second opinion without authorization)</p> <p><i>Written Narrative Report: To attending provider and required to be provided to L&I or SIE</i></p>	<p>At AP discretion but required at or before 20 visits or 120 days of conservative care if duration is expected to exceed that.</p>	<ul style="list-style-type: none"> Provides second independent opinion of worker's clinical and work status. Documents additional perspective of care progress. Identifies further care needs options. Assesses for maximal medical improvement (MMI). Predicts possibility of permanent partial impairment.
<p>Closing Examination Report</p> <p><i>Written Documentation: May be a letter, or detailed documentation in chart (the latter is not billable as a separate report).</i></p>	<p>At conclusion of care (MMI)</p>	<ul style="list-style-type: none"> Documents current complaints and disability (if any). Repeat of physical examination documenting what has objectively changed. Serves to inform impairment if any and baseline for possible future claim reopening. If a permanent impairment exist once a patient has reached MMI, the closing exam should include an impairment rating. Some attending providers may perform impairments ratings. See MARFS Chapter 12 for more information.
Initiated By L&I or Self-Insured Employer (SIE)		
<p>Special Report</p> <p><i>Written Narrative Report: To claim manager requesting the report</i></p>	<p>When requested by L&I or SIE</p>	<ul style="list-style-type: none"> Provides specific information a claim manager needs to adjudicate the worker's claim or authorize care Documents worker's clinical and functional progress since care began Estimates and documents clinical need for further care
<p>Independent Medical Examination (IME) conducted by a provider on L&I's Approved</p>	<p>At L&I or SIE request</p>	<ul style="list-style-type: none"> Review of patient's available clinical records and reports Independent examination of patient's clinical condition

<p>Examiner List aka, special commissioned examination</p> <p>Written Narrative Report: To claim manager requesting the Independent Medical Examination.</p>		<ul style="list-style-type: none"> Assessment of diagnostic status, physical and work abilities, progress to date, treatment options, any permanent impairment and any special questions from claim manager
<p>Attending Provider (AP) review of IME aka, concurrence report –</p> <p>Written Documentation: To claim manager, usually in a letter but may be documented in submitted chart notes.</p>	<p>At L&I or SIE request</p>	<ul style="list-style-type: none"> Documents AP review of IME findings and recommendations Requested at the discretion of the claim manager
<p>Miscellaneous Forms or Letters</p> <ul style="list-style-type: none"> Various correspondence Review of Job Analysis Loss of Earning Power (F242-208-000) 	<p>At L&I or SIE request</p>	<ul style="list-style-type: none"> Documents specific information needed from provider for adjudication of the claim or authorizing benefits.

Clinical Record Keeping Best Practices

Nearly all claims in Washington are initiated by providers, rather than employers. Acceptance of a worker's claim is an adjudication decision made by L&I or the self-insured employer. Documentation from the worker, the worker's employer and the provider form the basis for these decisions, with the provider's documentation being critical for determination of the condition's work-relatedness, allowance of time-loss benefits and appropriateness of care. Adequate documentation in the patient's chart notes (such as history, examination, objective medical findings, problem list, and plan-progress entries) and forms (such as initial reports of the injury, activity prescription forms) assures workers receive all benefits they are entitled to. Complete clinical documentation also reduces misunderstandings, delays, adversity in claims, and lowers the administrative burden on providers.

Occupational Healthcare

Workers' compensation cases involve unique administrative concerns in addition to clinical care of the work-related condition. Because workers' compensation is essentially a no-fault liability system owned both by employers and workers, health care services for injuries are specifically limited to care for the work-related condition(s) accepted on a claim. The provider's documentation is used by multiple parties for claim validity, benefits determination, dispute resolution and administrative uses in addition to more typical purposes of clinical management and verification of billing accuracy. Further, direct communication with employers and claim staff may be necessary for optimizing patient outcomes,^[5] something not typical of general health care practice.

There are many differences between general health care and occupational health care for which documentation is critical.^[5-7] The thoroughness of details surrounding condition onset, the impact of the condition on their ability to engage in specific physical activities and work tasks, the clinical rationale for treatment decisions, and importance of prognostic estimates for recovery exemplify where the role of an attending provider's documentation is important.^[7, 8] The magnitude of need for so many documentation specifics is reflected in the extensive volume of legislative, regulatory, and policy language specifically addressing documentation requirements (see [Additional Materials](#)).

Providers who choose to care for injured workers must meet these documentation requirements in addition to providing high quality care. It is particularly important that clinical reasoning patient-centered note-writing reflects relevance for work activities and functional abilities. Daily charting with work injuries should pay attention to factors such as breaks, loads, and task postures instead of generic function measures such as range of motion or activities of daily living.^[9]

Occupational health specialists receive training which incorporates such documentation needs, however most workers seek care from generalists for reasons of preference or access. Fortunately, it's well within most providers' expertise to address such issues, and requirements align well with usual clinical practice and documentation procedures. Assuring that documentation requirements are met not only speeds benefits to workers, it helps assure that care is effective in achieving functional improvement essential for the worker's livelihood. Attention to documentation up front also reduces unnecessary administrative burden of responding to requests for information or second opinions. It can also reduce reimbursement hassles.

Only a very small proportion of injured workers become chronically disabled in workers' compensation and these patients use the majority of system resources.^[7] Yet only a small fraction of these chronically disabled workers had catastrophic injuries; the vast majority become disabled from otherwise uncomplicated musculoskeletal injuries such as low back and extremity strains. Research has increasingly identified that factors directly under the provider's influence has substantial impact on whether or not a worker becomes chronically disabled.^[10, 11]

Problem Oriented Record Keeping

Problem-Oriented Medical Record (POMR) keeping is the standard across all health professions for the past 50 years.^[1] POMR addresses patient-centered care by systematically organizing patient data and provider assessments/interventions in a standardized fashion that works for any practice setting (from solo practice to hospital-based), all conditions (a simple single problem to multiple medically complex ones), and it works throughout a patient's lifetime. Requirements to document patient evaluation and management in this fashion have been adopted by provider groups, hospitals, regulatory and legislative bodies, as well as health purchasers and payers. When implemented well, POMR organizes clinical information that integrates patient and provider perspectives, assures accuracy, and provides comprehensive tracking and retrieval of crucial information by multiple providers.^[2]

There are 5 basic components to the problem-oriented record:

1. Data Base - History, Physical Exam and Laboratory Data
2. Complete Problem List
3. Initial Plans, aka Treatment Plan (for further diagnostic testing, monitoring and treatment interventions)
4. Daily Progress Notes
5. Final Chart/Progress Note or Discharge Summary

Although a number of variations of the theme exist, the central concepts of documenting the patient's perspectives of their condition (**Subjective**) as well as the provider's (**Objective**) are universal. POMR also includes the provider's overall summary of the patient's status (**Assessment**) which summarizes diagnostic and prognostic impressions initially into a Problem List. The final element of the POMR is documentation of the initial Treatment "**Plan**" and ongoing "**Progress**." These elements form the basis for the acronym "**SOAP**,"^[1, 2, 12, 13] Its principle advantage is enhanced usability of the patient's chart for managing multiple problems over time with the ability to easily identify and track refinements to problems and treatment plans. In Washington State, and nation-wide, this approach has been codified as a standard in several professions' licensing regulations and is specifically required in workers' compensation law. Thus, it is emphasized in this resource.

There is a tension between "too much" and "not enough" information in clinical documentation. Objective documentation of facts is central to quality record keeping.^[14] Optimally the medical record should serve the purpose of accurately recording the patient's status at the time of a visit, and the provider's clinical rationale for any interventions or further diagnostics, as well as the services performed that day. For professional liability reasons documentation must be comprehensive and accurate enough to allow external parties the ability to discern what was done and why. Third parties, including workers' compensation, serve as payers for health care and are accountable to their funders (employer, taxpayers, and premium payers). Complete clinical documentation has become the basis for determining what was done and the justification for it. The adage "If it's not documented, it didn't happen" applies. Conversely, avoid excessive documentation that does not reflect the visit, as happens regularly in copy/paste notes.

Chart entries generally should be concise and to the point. Clear summaries of actionable and relevant information that matters for clinical decision making (what to do or not do next) should be the focus.^[15] Excessively verbose documentation is neither necessary nor beneficial to facilitating patient-centered care. From an attending provider's standpoint, documenting specific functional improvement goals at the onset, and noting in subsequent assessments what specific functional improvements have been made will help keep care focused and prevent unnecessary administrative burden on your practice due to questions, information requests, or protests from claim and employer staff who are charged with assuring care is curative and rehabilitative.

Poor documentation contributes to multiple medical errors, including medication errors, wrong-side surgeries or other treatments, and missed follow-up when important studies are not acted upon.^[16] Establishing a culture of documentation expectations around quality over quantity requires recognition by clinical leadership that it is central to quality patient care. Too often, a culture of documentation being essentially for medico-legal protection or billing justification purposes exists. These problems can be particularly evident in small practices and business-centric institutions. Recognition of the clinical record as a critical tool for optimal patient centered care not only prevents medical errors, utilizing it for clinical goal setting, decision-making and progress tracking increases its relevance and reduces administrative "hassle." Training, reminders, and resources can improve SOAP note compliance in a clinical setting.^[17]

SOAP format may vary in the degree of detail based on factors such as time between visits, duration of care, or number of providers on a healthcare team. The following conceptualization may be most useful in settings that involve a series of frequent encounters over a period of time (such as rehabilitation from a musculoskeletal injury).^[18] The addition of Employment Issues and Restrictions to Recovery (E and R) often make occupational medicine documentation more clear and thorough, This is referenced as "SOAPER"

	Intake Evaluation Data Base, History and Physical	Follow-up Visits Progress/Chart Notes	Re-exams/Closing-exam Update Data/Discharge
Subjective	<ul style="list-style-type: none"> Chief Complaint and Presenting Illness (CC/PI). Past history (including medical, occupational, social). Review of Systems. 	<ul style="list-style-type: none"> Patient's perception of their CC/PI and or problem being address at the time of the patient follow-up visit (anchored numerical symptom scales are common). 	<ul style="list-style-type: none"> Patient's perception of their CC/PI and or problem being address at the time of the re-exam. Repeat of functional status questionnaire.
Objective	<ul style="list-style-type: none"> Complete initial and/or regional physical examination findings (including inspection and provocative testing). Written reports for laboratory, X-ray and other diagnostic studies (including findings and interpretation). Baseline functional status instrument (such as Oswestery, Quick-DASH). 	<ul style="list-style-type: none"> Typically includes physical findings on regional examination for area/condition addressed. 	<ul style="list-style-type: none"> Typically includes at least a repeat of previously positive exam findings.
Assessment	<ul style="list-style-type: none"> Written Problem List (best framed from patient's perspective, such as painful swollen ankle). Diagnoses (clinical conditions behind patient's problems such as Grade 2 ankle sprain). 	<ul style="list-style-type: none"> Basic summary of the condition is responding (such as no change since last visit, slight improvement, significant improvement). 	<ul style="list-style-type: none"> Comparison of how patient is at time of visit to how they were when care began. Functional improvement.
Plan/Progress	<ul style="list-style-type: none"> Written plan for each problem including anticipated diagnostics, passive, active and self-care. 	<ul style="list-style-type: none"> Documentation of all provided diagnostics, passive, active or self-care at that visit. Documentation of any counseling (including time if >50% of visit is spent counseling) 	<ul style="list-style-type: none"> Typical SOAP note for care provided at that visit, plus Any needed revision to Treatment Plan in chart.

Subjective (S) Entries

The S of the SOAP note documents the patient's report of their condition in their own words. It may be compressive when used as the intake record including work up of chief complaint of present illness, past history, review of systems, and the rest. Follow up encounters typically include their current state, and/or how they have been doing since their last visit. It may range from no complaint ("No pain in left leg this week") to a specific new problem ("My right shoulder started aching two days ago and is sharp and catches when I reach over my head"). The subjective report may capture an acute problem that resolved in the interim ("I had a headache Monday that lasted for two days"). Appropriate questioning about the patient's subjective reports should be documented as well (such as a full work up for a new problem), or perhaps clarifying exploration regarding a minor flare-up that resolved between visits (such as Has it happened again? or, Has this happened in the past?) with appropriate documentation of patient response. Compliance with previous instructions should be noted here as well ("John brought his fully completed activity diary today which indicated difficulty in increasing his walking distance for 2 days.")

Objective (O) Entries

Any clinical measurements or testing performed on a visit should be included. This can range from observation and palpation to provocative orthopedic tests or in office laboratory test. Vital signs are routinely included. The appropriate, problem-focused physical examination should be documented in the SOAP note (or may be referenced to a specific identically dated exam form in manual records). Specificity for each abnormal finding is critical to document (such as "Left cervical rotation and lateral bend were restricted and produced pain in lower left cervical region") but generalities for normal findings are adequate (such as "no pain or restriction was noted in all lumbar ranges of motion"). Variations in specificity based on the provider's practice area or specialty are to be expected. Legibility and understandability are crucial. Non-standard abbreviations and symbols should be avoided and all routine shorthand should have a legend included whenever charts are submitted to third parties.

Assessment (A) Entries

The assessment reflects the clinician's integration of the subjective and objective information into a concise statement of the patient's status at the time of the patient encounter. An infrequent or initial entry should be rather comprehensive: "A 48-year-old male construction worker presents today for evaluation of right-sided low back pain that began suddenly while lifting a heavy wooden beam at work yesterday afternoon. There are no signs of radiculopathy, but muscle tightness and tenderness in the right lumbar area suggests a minor low back sprain." Again detail and specificity variation is to be expected according to specialty and practice focus. For example, an osteopathic or chiropractic physician's assessment entry may include greater specificity related to vertebral levels that are dysfunctional, which muscle groups are involved, while an internist or occupational medicine specialist might be inclined to just note the general anatomic region.

Written Problem List

The problem list is effectively a table of contents for the entire chart and reflects all conditions being monitored or cared for in the practice overall. Typically it is a stand-alone section of the chart, but may be included in the Assessment section of SOAP notes for an initial visit and redone at significant re-evaluation visits. For each problem on the Problem List include:

- Date on which the problem was *entered onto the problem list* (not the date when the problem began for the patient; that should be included in the problem's description).
- Description of the problem, ideally from the patient's perspective (such as "lowers back and left leg pain to mid-calf" rather than "herniated nucleus pulposus with L5/S1 radiculopathy." Doing it this way facilitates chart management when complex conditions may involve multiple interventions and/or sub-problems which can change over time.
- Specific diagnoses (and their corresponding ICD Codes) believed to be responsible for the problem can be included as a sub-entry to the problem list, in a detailed initial SOAP note assessment on the date the problem is entered into the chart, or in some other dedicated location in the chart. When selecting a specific diagnosis, the most specific condition diagnosis possible should be used, rather than coding by symptoms (such as lumbar strain rather than low back pain).
- Dates and descriptions for any modifications to problems (such as resolution, recurrences).

Numbering each problem in the list (particularly in manual charts) facilitates referencing the problem(s) being addressed in a particular visit. Electronic records increasingly have conventions to create such linkages automatically. Often the diagnosis codes are used in the problem list. [The International Classification of Disease \(ICD\)](#), short for "International Statistical Classification of Diseases and Related Health Problems" is an international standard maintained by the World Health Organization to classify diseases, and delineate variations in symptoms, abnormal findings, social circumstances and causation primarily for epidemiological purposes (such as research, tracking disease, monitoring health status). It has also become a standard for data collection and reimbursement purposes in government and private sector health plans.

Prognosis

Prognosis is a provider's best estimate of how a specific condition will progress and/or resolve. This may be best noted as part of the Problem List, or in an Assessment entry in the chart on the date the problem was entered onto the Problem List. For example, with a moderate lumbar sprain/strain condition an assessment entry along the lines of "Barring any unforeseen complications, complete resolution of the problem can be expected with the proposed treatment plan within 6-8 weeks."

Written Treatment Plan (P)

Optimally, a written treatment plan can also be a stand-alone list summarizing the overall management approach and its modification as care progresses.^[18] More typically, and just as acceptable, the plan is included in the P section of each visit's SOAP note. The former approach is more useful for providers performing a high frequency of care for a period of time (such as chiropractors, physical therapists) while the latter make more sense when follow-up encounters are few in number and with longer intervals between them. The treatment plan should include a reference to all interventions and estimated timeframes for the problem's resolution:

- Anticipated additional diagnostics (such as "nerve conduction studies if carpal symptoms do not improve within 2 weeks").
- Planned passive care (such as "two week trial of spinal adjusting and myofascial release in the lower back then reassess progress").
- Planned active care (such as "PT referral for 2 weeks of ankle strengthening exercises then reassess progress").
- Specific medication prescribed or dispensed, including dosages and durations.
- Referrals or hospital admission instructions.
- Patient instruction and/or self-care (such as "activity diary given for daily incrementally increasing walking distances, review in 1 week").
- Anticipated resolution or expected problem status (such as 2 weeks of incrementally increasing mobility and strengthening knee exercises. Return for follow-up with full resolution and discharge expected).
- Date and frequency/duration of follow-up care).

Initial History Documentation

The history captures the patient's verbal communication about their experiences of the condition and their physical, emotional, and social state. These elements have been categorized under the umbrella conception of "Subjective" and are consistent with the "S" in the problem-oriented record keeping acronym of SOAP.^[10, 18]

The initial history is more comprehensive than this element in subsequent encounters. Typically only changes since an initial exam and or previous encounter would warrant documenting in subsequent entries.

Patient Presentation

Chief Complaint (Presenting Illness/Injury) – records the patient's characterization of what they are seeking care for.

History of Present Illness (Presenting Complaint) – refers to elements about how the chief complaint came about and how it behaves. These are obtained from interviewing the patient. A number of acronyms have been created that help remind of all the key elements to obtain in the patient interview. One common one is 'OPQRST':

- **O**nset of Condition – How did the symptoms/condition come about? Precisely when did symptoms start, what specific activities they were engaged in at the time (or occurred prior to onset), what biomechanics were in play (if traumatic or activity induced).
- **P**rovocation and **P**alliation – What exacerbates and/or relieves the symptoms? Direct provocation of the symptomatic part vs. distant body part, generalized exertion, and the rest.
- **Q**uality of Pain and Other Symptoms – The patients' experience of the pain or sensations (such as sharp, dull, burning, crushing, tearing, tingling, shooting, numbing) helps identify involved tissues (cutaneous, neurological, muscular) in musculoskeletal conditions. Corollary delineations can be helpful for respiratory and dermatological conditions.
- **R**egion and **R**adiation – Specificity in location of the symptoms
- **S**everity – Magnitude of the experience of the pain or sensation is most easily captured on an anchored scale (such as 0-10 where zero means no pain at all and 10 means the worst pain you have ever experienced or could imagine) and has the advantage of standardizing the endpoints for reference. Verbal categories such as mild, moderate, severe are also common.
- **T**iming – How long the symptoms have been going on since they started, how long they last for (if intermittent), if they ever stop, when symptoms may have changed.

Work-Relatedness – Although work-focused factors fit within the CC and HPI's organization, the occupational nuances are rarely highlighted in basic clinical training and warrant special attention.^{[6] [8]} Refer to our [work-relatedness checklist](#) for additional guidance.

Work-Relatedness Factors	Relevance
Do symptoms change between work and home? Do symptoms occur on days off (weekends, vacation)?	Symptoms that do not vary with work hours may indicate a non-work-related etiology.
Identify repetitions, duration, awkward positions, weights associated with onset.	Informs return to work strategies, needed activity or ergonomic modifications.
Have symptoms like this occurred at other jobs?	History of similar symptoms helps establish a functional baseline for pre-injury status, is helpful for determining treatment options, and informs if prior jobs contributed to problem (particularly relevant when detailed work history is needed for apportioning responsibility to past employers).
What environmental factors warrant consideration?	Exposure to liquids, aerosols, temperature extremes inform toxic exposures.
What safety and protective equipment was in use?	Availability and compliance with safety procedures and protective equipment (such as respiratory devices, lift assists) informs onset as well as prevention of recurrences.

Occupational History

Description of Current Job

A patient's description of their work environment helps identify potential factors that may have caused an injury or exposure. Chemicals in the workplace, use of safety and assistance equipment, nature of shift (breaks, volume/duration/posture of tasks), and the worker's experience are example of factors that may warrant documentation. Topics should include:

- Job title
- Length of time at current job
- Workplace details (shift duration, frequency and duration of breaks, safety procedures)
- Specific work activities/tasks
- Products made
- Potentially hazardous exposures (environmental, substances)
- Assistive devices/protective equipment used

Recent Workplace Changes

Document any changes in tasks that may have led to new exposures. Record changes in materials or products made and any of out-of-the-ordinary events that may have occurred. Similar symptoms among other employees may also help pinpoint a work-related etiology. ^[5, 8]

Work History

The work history routinely documents previous jobs and time of employment with each and should include part-time and secondary jobs as well. Conditions may be related to a job other than the worker's primary position. Additionally, a history of similar symptoms prior to the current episode establish a function baseline to compare progress to as well as identify useful treatment options that were effective in previous episodes. In Washington State, occupational diseases that may be a result of prolonged exposures may be adjudicated and apportioned across more than one employer. It can be particularly important to thoroughly record work activities and possible exposures in prior jobs. Conditions and recovery may be associated with factors other than current job requirements and activities.^[8]

Past History

Social History

In addition to general lifestyle factors, social issues related to the workplace should be addressed including relationships with supervisors, fellow employees, and customers. Stress at work and poor work relationships can affect return to work and recovery. The magnitude of stress, as well as overall attitudes and satisfaction with work and career may be informative to return-to-work and job accommodation strategies. Lifestyle, recreational, and athletic activities should be documented, and it may be appropriate to reference how non-work factors that may have contributed to their condition. Note: In Washington State, even if employment only contributes partially to a condition, the condition may be accepted as work-related. Hobbies (such as hunting, carpentry, and painting), sports activities, and home activities or projects (such as yard work, remodeling projects) should be documented. Alcohol and 'recreational' drug use should also be noted.

Of particular value in worker care and preventing disability is recognition of the worker's coping skill for the myriad of dimensions a worker may deal with. Uncertainties, anxieties, or fears about their recovery, how they are handling life obligations, degree of activity reflect examples of various avenues for exploration the attending provider should consider. Workers who exhibit low recovery expectations and/or fear-avoidance behavior are at greater risk of developing prolonged disability.^[20]

Examples – Social history entries

- *“Roger is concerned that his back condition will impact his ability to work at his job. He states that as a single parent of two grade schoolers, it is a challenge to fit in home obligations, especially since he also has to trade off with his sister as a caregiver for his father who has progressing dementia.”*
- *“Nancy is going through a divorce. She states that coping with this shoulder injury on top of that is very stressful.”*

Description of Similar Previous Conditions

A common source of contention and protest about a worker's claim can come from uncertainty if the current condition arose out of a work exposure or is actually a pre-existing problem that coincidentally was noticed at work. It is particularly important to carefully explore and document the patient's past history of any similar problems prior to the onset of the current condition. Although an aggravation or lighting up of a pre-existing condition can be considered work-related, many conditions may have natural and episodic flare-ups regardless of work activities. For example, with a former high school athlete with a history of chronic ankle sprain, it may be especially important to document how frequently and how severe past episodes of ankle pain have been for someone who just noticed it bothering her at work one day. Any differences between the current presentation and past episodes should be noted.

Examples – Similar past condition entries

- *“Patient experienced several right ankle sprains when on the tennis team in high school, but never on the left. Since she stopped playing tennis competitively she only reports one time in the past 5 years that her right ankle bothered her following a hike and it has not been a problem again until the current episode.”*
- *“Over the past 10 years, Mr. Jones has had multiple episodes of low back pain. The most recent episode was three years prior, after transferring firewood from a truck to a storage shed. That episode resolved without treatment and he has not had any low back pain until his recent work injury.”*

Initial Clinical Examination Documentation

Regional Examination

An adequate physical examination of the affected body regions or systems is required. The provider's observations about the patient physically, including observation/inspection, palpation, auscultation, and under provocation. Identifiable limitations, responses, deviations from normal (including compared to the patient's unaffected regions) are routine components. Although there are no uniform standards for what is contained in examination documentation, most institutions set quality standards.

The minimum expectation in documenting regional exam findings would include enough clarity to discern what deviates from normal and all relevant findings that would support the diagnosis are documented. Keep in mind that the information documented for a regional examination forms the basis for justifying the level of service that is reimbursable.

Standard templates and forms are commonly used for both paper and electronic records and usually reflect the practice's specialization. Such forms and templates are acceptable, however the chart must indicate that patient-filled out forms were reviewed by the clinician if the information contributes to the justification of a certain level of service for billing purposes. Cloning and copy forward features in electronic records may seem efficient, but they can be error prone.^[21] Repetitive entries may not only indicate that care is not leading to meaningful improvement but can increase the risk of audit of the providers' documentation and billing. Note that baseline examination findings usually serve as an objective starting point for determining how the condition progresses over time.

Examples – Regional examination finding entries

- Deep tendon stretch reflexes are tested in the nerves of the lumbar plexus, and are symmetrically active, rated 2+.
- There are no altered dermatome sensations reported in the lower extremities.
- No deficit is found strength testing of the muscles supplied by the lumbar nerve roots, rated symmetrically 5/5.
- Provocative maneuvers of the dorsolumbar spine are positive for producing mild to moderate local pain, right greater than left, without eliciting radicular symptoms. These include: Kemp's Test, Milgram's Sign, Ely's Heel to Buttocks Test, and Goldthwait's Sign bilaterally with movement of L4-5, and L5-S1.
- Straight Leg Raise produces increased lower back pain when performed on the right without radicular symptoms.
- Dorsolumbar Active Range of Motion observed: WNL with mild to moderate sore through entire range right > left.
- Intersegmental restriction is found: L4-5, L5-S1, Rt. Sacroiliac jt.
- Moderate tenderness to palpation pressure is noted: L4-5, L5-S1, right > left, as well as the Rt. Sacroiliac jt.
- Moderate hypertonicity is palpated: lumbar erectors, quadratus lumborum, gluteal muscles, right > left.
- Mild splinting to palpation pressure is found of the: Right L5-S1, and the Rt. Sacroiliac jt.

Functional Deficit

In Washington State, care for work injuries is required to be curative or rehabilitation, meaning that the treatment being provided resolves or meaningfully improves the patient's condition. Although palliative care may be appropriate for the initial healing process, ongoing care that only provides symptomatic relief is usually not allowed. Curative and rehabilitative care is characterized as care that improves the worker's ability to function, including return to work. The regional examination is the place to document physical findings that reflect the worker's pathoanatomic and physiologic states.

The worker's [ability to function at home and work](#) should be documented. At a minimum, initial history and examination should document how much the patient's condition interferes with their ability to perform normal activities (such as pain interference). Better yet, there are many easy to use validated instruments that a patient fills out that can more effectively objectify how the condition impacts their functional abilities and track how well function improves with care. An L&I Practice Resource for documenting functional improvement is available that summarizes and provides copies of several validated tools for this purpose on the [Treatment Guidelines and Resources](#) webpage.

General Systems

The extent and comprehensiveness of general and specialized physical examination is driven by the patient's presenting complaints, past health history, potential involvement of apparently related systems and a provider's specialty and the answers to a patient's Review of Systems (ROS). For example someone with an acute low back injury with lower extremity pain obviously warrants an adequate neurological assessment of the involved lower extremity. However if the presentation involved paresthesia across multiple dermatomes, a family history of diabetes, an overweight stature, and reports that sometimes his leg has felt numb in the past, a more comprehensive vascular exam of the involved leg may be needed as well as laboratory test to determine if the presenting complete may be due to an unrelated concurrent diabetic peripheral neuropathy.

Typically clinical evaluation for injuries is region and condition focused, with only basic physical exam and vital signs being routinely documented. With most sprain /strain type injuries, a statement of observed general physical ability is appropriate. Examples such as "patient ambulates freely," "patient freely moves from sitting to standing position," or, "patient ambulates slowly" could be expected. The extent of further general physical and body system examination that should be documented is expected to reflect the diagnostic complexity of the patient and their presenting condition. Comments on complete body systems would not be expected with a focused physical complaint and a clear consistent history.

Examples – General systems physical examination finding entries

- For a 47-year-old Hispanic female presents with sudden onset right elbow pain following pushing a file cabinet at work
VITAL SIGNS: Weight 191 lbs., blood pressure 154/104, pulse 94, temperature 98.2
HEENT: Conjunctivae pink. Sclerae anicteric. Oropharynx clear.
NECK: No lymphadenopathy or thyromegaly or JVD.
LUNGS: Clear to auscultation and percussion.
HEART: Regular rate and rhythm without murmur, rub or gallop.
ABDOMEN: Normal bowel sounds. Soft, nontender. No hepatosplenomegaly.
EXTREMITIES: No cyanosis, clubbing or edema. Tenderness noted over right lateral epicondyle. Patient grimaces when extending the affected extremity.
PSYCHIATRIC: Normal affect and behavior with seemingly good insight.
- For a 38-year-old borderline diabetic male smoker with acute onset low back pain following lifting 80 lb box at construction.
VITALS: Temp:99.1 F Pulse: 88 Resp. Rate: 24 BP: 114/78

GENERAL: Alert, calm, well-developed male. Height/weight proportionate. No acute distress when walking, however he has to position himself slowly and pushes his left hand against his leg when getting up from a seated position. .

HEENT: Pupils equal, round, reactive to light and accommodation. Extra-ocular movements intact. Moist mucous membranes in oropharynx. Some darkened teeth; possible caries. Small, reddened, raised area on left tonsillar pillar.

NECK: Supple, without lymphadenopathy or thyromegaly. No carotid bruits.

LYMPH: No axillary, cervical, supraclavicular, pre-auricular, submental, or occipital lymphadenopathy,

CARDIOVASCULAR: Regular rate and rhythm, with normal S1 and S2. No murmurs, rubs, or gallops. No JVD. 2+ pulses bilaterally – dorsalis pedis and radial.

LUNGS: Diffuse, bilateral crackles throughout lung fields. No wheezes. No accessory muscle use or cyanosis. Rhonchi from right lung base extending midway up lung field, very loud. No egophony. No tenderness to palpation.

ABDOMEN: Normoactive bowel sounds. Soft, flat, non-tender, and non-distended. No hepatosplenomegaly; liver span approximately 10 cm.

SKIN: Warm, dry, well-perfused. No rashes or other lesions. Some scattered freckles across arms and back. Tanned neck and forearms.

EXTREMITIES: 2+ pulses in upper and lower extremities. No lower extremity pain or edema; legs are symmetric in appearance.

RECTAL: Deferred.

NEURO: Alert and oriented to person, place, and time. Able to communicate well. Cranial nerves 2-12 grossly intact. 5/5 strength in all extremities bilaterally. Sensation intact in all extremities. Normal gait. 1+ DTR's in biceps, triceps, supinator, knee, ankle. No clonus.

PSYCH: Appropriate affect.

Special Studies

Laboratory Tests and other Special Studies

Copies of all special studies (such as laboratory tests, nerve conduction studies, electrocardiograms) ordered or performed by the attending provider must be in the patient's chart. At a minimum reports must include basic identifiers to the patient (such as name, claim number), tests and dates performed, findings, and their interpretation. This may vary by the type of test. For example, a lab report would also include the normal range for a particular test as well as what the patient's result was. A nerve conduction study or ECG study may include a copy of the actual tracing from the study, but must also include a written report of what the study found and what it means (findings and interpretation). Such reports are routine when conducted by a facility the patient's provider refers them to, however, such **written reports** are also required when such studies are conducted by the attending provider in their office.

Imaging Studies

Complete written documentation of imaging studies is required in a patient's chart, whether copies of a report from referral for radiological studies, or from plain films performed in-office. This holds true even if original study images are maintained in the office where the patient is treated. Essential elements of written documentation must include:

- **Demographics:** Patient's name, study identifier, date of service, patient's date of birth, patient's sex, name of examination, interpreting physician's name, interpreting physician's signature, and referring physician if applicable.
- **Clinical Information:** Indication(s) for the radiological examination, views taken, description of findings, limitations of exam (if applicable), clinical impression or conclusion, and any recommendations or suggestions for follow-up (if applicable).

A stand-alone radiology report with this information is standard practice in radiology practices; General and other specialty providers might best utilize a similar approach. Alternatively, a dated SOAP formatted entry can be utilized that starts with "[*Body region specified*] radiographs were taken on [*date films acquired*]. The study identifier is: [*number or code unique to the patient that is permanently exposed onto the films as well as used on any X-ray storage jacket, as well as a written report so original films or files can easily be located*] and the following views were acquired using standard techniques obtained from the radiographic factoring technique chart: [*list all views taken*]." This should be followed by a signed and dated SOAP entry including:

- **S:** Working diagnosis and any specifics regarding why the films were taken (such as low back pain, rule out spondylolisthesis). This should be supported by examination and history data to validate the importance and "realness" of the concerns leading to films being ordered.

- O:** Description of findings that would typically be in the body of a formal radiology report with significant detail. For example, if there is DJD, it should be listed by location and specific levels in the spine (such as "L4 facets bilaterally, worse on the left"). Postural changes should be specified, not just listed as "postural changes". If they are important enough to mention or if they will drive any aspect of care, they need to be specified.
- A:** Impressions or conclusions. These should be the diagnoses or probable diagnoses rendered from the film. They should be written in a "surgical sieve" format, which is to say contraindications or potential contraindications to care listed first, findings that will affect care second and DJD, postural changes, incidental findings or fascinating but unimportant variants last.
- P:** Recommendations for additional follow up studies should be listed under "P of the SOAP". If no additional studies are indicated, the P should note "no additional studies needed."

Facility documentation (not necessarily in the patient file) regarding radiological studies requires maintenance of an X-ray log that includes:

- Study date,
- Patient identifier number,
- Patient name,
- Views taken,
- Notes field entitled "Technical Factors or Positioning Changes" allowing notation of modifications from the standard series acquisition strategy that were required because the patient was large, deformed, unable to stand, sit or lay, and the rest.
- Notes field entitled "Repeat Films" with why the original film was unsatisfactory and what was changed to correct the problem on the repeat film.

Additionally, the facility must provide for and be able to demonstrate use of an environment-stable storage space that is HIPAA compliant for X-ray files to be stored.

Example 1 – Written sample radiology finding and impression entries

CERVICAL SPINE

- Degenerative changes are noted throughout the cervical spine, but are most severe between C4 and C7.
- Substantial spurring is seen bilaterally at the intervertebral foramina at these levels.
- No fracture or dislocation is identified.
- Long-standing and severe degenerative disc disease is noted at the C5-C6 level with significant spur formation bilaterally into the intervertebral foramina.
- No fracture or dislocation is observed.

THORACIC SPINE

- All vertebral bodies appear of normal alignment and height.
- Disc spaces are of normal width and pedicles and neural arches appear intact.

LUMBAR SPINE

- Comparing to a previous study from July 2001, progressive degenerative change is evident on the left side involving the first through fourth lumbar vertebrae.
- A slightly increased right scoliosis convexity (apex L3) is noted.
- No fractures are visualized.

CHEST

- The anterior portion of the right hemidiaphragm displays moderate eventration. There is a partial collapse of the right middle lobe observed as well as an atypical spherical density over the apex of the right hemidiaphragm on the PA projection. A follow-up examination in 10-14 days is highly recommended.
- Multiple small patchy areas suggestive of pneumonitis are visualized within the right middle lobe and ligula.
- No pleural effusion can be seen.
- The heart outline is normal and the hilar and mediastinal vessels are of normal appearance. No disease is seen in the lung fields or pleura.

RIGHT SHOULDER

- There is no evidence of soft tissue calcification observed.
- Slight widening of the acromioclavicular joint space is present.

- There is no indication of fracture or degenerative change in the AC area. This study may reflect a possible partial AC separation and follow-up stress films are recommended.

SACRUM AND SI JOINTS

- A healing fracture at the junction of the first and second sacral segments is demonstrated in this examination.
- No osseous destruction is seen which suggests this lesion would not be due to metastatic disease.
- Mild degenerative changes are seen within both sacroiliac joints.

RIGHT WRIST

- A 1.0 mm bony fragment is identified at the dorsal aspect of the carpal region which could indicate a small avulsion fracture from either the capitate or lunate bone.
- No evidence of any joint disease is seen.

Example 2 – Complete written radiology report

Patient: Smith, Johnathon T

Male

DOB: 04/27/74

Identifier: H 12345

Study: AP/Lat Lumbosacral spine

Exam Date: 01/20/16

Clinical History: Unresolved low back pain without radiculopathy following lifting incident at work in December 2015.

Findings

- No fractures seen; no evidence of blastic or lytic present.
- Anterolisthesis of L4 on L5 (Grade 1).
- Mild levoscoliosis noted with apex at L2.
- Severe multilevel degenerative changes associated with osteophytosis from L3 to S1 inclusive.
- Loss of disc space with end plate sclerosis seen at L3/4, L4/5 and L5/S1.
- Pedicles are intact and soft tissue structures are visualized normally.

Impressions

- Severe degenerative changes L3-S1.
- Mild levoscoliosis, apex at L2.
- Grade 1 anterolisthesis L4 on L5.

Follow-up: MRI may be warranted, particularly with worsening of symptoms and/or development of radiculopathy.

Treatment Plan Documentation (Initial SOAP Note)

A written treatment plan needs to be included in the patient chart at the onset of care. There is no single standard to format a treatment plan, however, key elements must be documented regarding what the provider will be orchestrating. In general, two options for documenting the treatment plan have been commonly employed: “Stand alone” or as part of an initial SOAP note. [1, 12, 18]

Common to either organizational approach is delineating the types of care being provided: patient education and counseling, “active” or “self” care the patient will engage in themselves, and “passive” care the patient will receive from providers. Anticipated frequency and duration of the treatment, expected outcomes from care, and when re-evaluations and assessment of progress will be performed should be included in the plan.

- **“Stand Alone” Initial Treatment Plan:** This approach creates a dedicated section in the patient chart (similar to, or as a part of, the Problem List). This may be as simple as a heading (such as Rx Plan, Tx Plan) at the beginning of the chart or as sophisticated as a dedicated page or section in the chart or EHR that functions as an ongoing “Table of Contents” for each problem throughout the patient’s course of care with the provider or clinic. The key advantage to this approach is there is a single location where any changes to the treatment plan can be documented, reducing the need to search individual chart notes over time to find out about changes to the treatment. Stand-alone treatment plans should be formatted in a way to include entry dates for any modifications made to the plan that correspond to follow-up SOAP note entries.
- **Treatment Plan as Part of Initial SOAP Note:** One can utilize the Plan and Progress (P) portion of the first visit’s SOAP note in an expanded fashion to capture all of the elements of a treatment plan. Updates to the plan are then recorded in subsequent SOAP note entries at the time the plan is modified. While this may be a little more convenient for entry at the time of a visit, rapid identification of what changes are made to treatment as the problem progresses can be harder to locate in either manual or electronic records. This can be especially true when entries get repetitive or minimalist in order to speed entry completion in busy practices.

Patient Education and Simple Self-care

Patient education involves instructions given to or provided for the patient. Common examples in work injuries might include: ergonomic instruction for proper lifting, how to determine a safe amount of weight to lift, a pamphlet of simple home exercises to try, timing or combining of medications, counseling of the patient about their recovery, changing bandages or dressings, or what to do to manage an increase in pain. Providers often put these kinds of common routine instructions in printed handouts and may briefly go over them (or have office staff go over them) before a patient leaves the office. If instructions are a durable standard office brochure, just referencing them in the notation may be adequate; however, if customized or individualized, a copy should also be attached or scanned into the record.

Examples – Self-care plan entries

- Routine wound care leaflet given. Return for PRN follow-up if redness/swelling worsens or pain does not diminish in 3 days.
- Home low back stretching exercise sheet reviewed and given. Bill was instructed to perform twice daily (upon arising and before bed) for 10 minutes. Increase to 15 minutes if tolerated for 3 days. If not tolerated call office, otherwise continue until return for follow up in one week.
- Instructed to apply ice 2-3 times per day for 10 minutes to relieve swelling. Maintain normal activity to tolerance. Avoid lifting over 25 lbs. from floor without assistance.
- Low back pain flyer on normal recovery given.
- Worked with patient to determine best options for materials handling under the lifting restrictions that I listed on the APF.

Active Care

Active care essentially involves dedicated participation of, and individualization to the patient. This is typically associated with more intense in-office involvement by the patient and provider. Although there may be overlap with self-care instruction, a review of exercises on a take-home sheet is best conceptualized as patient education while an office visit involving in-office training on specific exercises with them performing repetitions to demonstrate competence (or referral to a physical therapist for such rehabilitation work) is better characterized as active care.

Focused training on particular activities may also be best characterized as active (such as getting in and out of a wheel chair) as well as focused cognitive learning such as how to move awkwardly-shaped objects or develop safe lifting habits.

Passive Care

Example – Active care plan entry

- Active strengthening including 15 minutes of flexibility and core strengthening exercise incrementally increasing in difficulty and duration for at least 6 weeks with weekly in-office follow-up.

Any procedure performed “on” the patient by someone can be considered passive care. Examples include modalities (such as thermal, electrical, sonic, mechanical), manual care (such as joint manipulation/mobilization, soft tissue work), pain and inflammation control (such as medications, injections).

Potential exists for overlap with education and self-care, particularly when prescribing medication or supplements. Typically if a specific prescribed course of treatment is provided, it probably best fits into passive care.

Examples – Passive care plan entries

- Pain control including cryotherapy and gentle effleurage for 1 week. Increase intensity of paravertebral soft tissue work and add HVLA lumbosacral manipulation as spasm reduces up to 4 weeks, monitoring functional improvement on Oswestry score.
- Lidocaine injected into right subacromial space provided immediate relief of her shoulder pain. 4mg corticosteroid (Methylprednisolone acetate) was injected which can be expected to reduce inflammation to better tolerate physical therapy. One additional injection may be considered if symptoms return to the point of not tolerating therapy.

Opioids

For providers who prescribe, specific documentation is required whenever opioids are considered. The Washington State guidelines for [Prescribing Opioids to Treat Pain in Injured Workers](#) became effective July 1, 2013. There are several critical points to be followed:

- Chronic opiate therapy should be administered with caution with a full appreciation of both risks and benefits.
- Effective use of chronic opiates *must* result in clinically meaningful improvement in function otherwise therapy should be tapered and discontinued.
- Chronic opiate therapy should be avoided with an active substance abuse history and used with great care with a prior history of substance abuse.
- Chronic opiate therapy is complex to administer and the provider should consider consultation with a qualified pain management specialist particularly when doses reach or exceed 120 Morphine Equivalent Dose/day. Other sedating medications should not be prescribed with opiates.
- Key aspects of therapy include use of/adherence to opiate contracts, careful documentation of functional improvement, caution with comorbid conditions, monitoring for aberrant behavior to include periodic urine drug screening, and the use of Washington State’s [Prescription Monitoring Program](#).

Treatment Plan Documentation (Follow-up SOAP Notes)

Routine Care

Content of routine progress notes can vary greatly by specialty. However, regardless of practice focus, it is particularly important to document what is or is not progressing, with particular attention to the worker’s functional ability. When subjective and objective entries are repetitive with little meaningful change from visit to visit, it implies that the care is not contributing to recovery or that it is just temporary or palliative. This is especially important for practices where frequent encounters involve repeating treatments (such as physical therapy, chiropractic care). Electronic health records that auto-populate fields based on previous entries can be especially problematic in this regard. Assessment entries on each visit should clearly reflect what functional progress is being made. Plan entries for routine visits should simply reflect what interventions were performed or prescribed at that day’s encounter.

There is a convention in Washington State’s workers’ compensation documentation called “SOAPER” which adds “E” for employment factors and “R” for restrictions to the standard SOAP note, and to narrative progress reports. It is perfectly acceptable to use this convention as a reminder to attend to these issues with injured workers, but noting them as part of the assessment and specifically addressing them in written reports is acceptable. The

most important work-related factors are routinely addressed with Activity Prescription Forms which should be submitted whenever there is a change in work status.

Example – Routine SOAP note entry

- S:** Some relief with right knee pain since over the weekend rated 4/10 today. Reviewed activity diary, she indicated she could not reach goal of three times per day with theraband, but did twice most days this week. Knee stiffens up while standing at work but was able to get a small stool behind the counter and can change leg position regularly which is helping. Demonstrated resisted extension exercises, performed them well.
- O:** Rt. knee: Medial joint line tenderness. Appears less swollen. Apprehensive upon full passive extension, but no pain. Tender and tight right sartorius compared to left side.
- A:** Improving, albeit somewhat slower than hoped.
- P:** Today: deep tissue trigger point work right quads and hamstrings. Resisted contraction multi-position in flexion and extension. Instructed to take hourly break to walk and stretch.
- E:** Will call employer to discuss possibility of allowing longer morning and afternoon break to do stretching and resisted movement exercise in employee breakroom.
- R:** Compliant with strengthening and tracking exercises, but prolonged standing at work appears to lead to guarding and tightening. Circulation issues may be slowing recovery.

Reassessment

Although L&I payment policy requires (and will only reimburse for) a written stand-alone progress report every 60 days, competent clinical management and various workers' compensation requirements (such as WAC 296-20-01002) require ongoing assessment of functional improvement, operationalized as ability to engage in activities, including work tasks.

As described in the [SOAP table](#), a key characteristic of a re-examination (re-evaluation, re-assessment) patient encounter is comparison of both subjective and objective findings when care was first initiated for the accepted condition to the workers findings at the time of reassessment (as opposed to just considering the previous visit). This should also be considered in relationship to the original treatment plan and expected prognosis. Detailed re-evaluation may exceed the time and medical decision making of a regular office visit and require use of an evaluation and management code.

Example – Reassessment SOAP note entry

- S:** Mr. Cruise is re-assessed today at 4.5 weeks following his neck and left shoulder-area sprain and strain that followed from several heavy boxes coming down from an overhead shelf as he was trying to put a box up. He states he is still feeling stiff in the neck and trapezius area on the left, but overall the pain is much better, and only happens occasionally with sudden or extreme movement while reaching overhead. He has remained at full duty at work for 2 weeks without problem, but has made sure to get a coworker in the warehouse to assist when working with large or awkward materials overhead.
- O:** Neck Disability Index re-administered today is 12/100 compared to 27/100 at intake. His previously restricted left cervical rotation is now full and pain free, however, left lateral bend is reduced compared to the right side. Foraminal compression no longer produces pain. His left-sided grip strength has improved substantially to 32 pounds (compared to 8 on intake). The left trapezius region feels tight compared to the right and numerous trigger points are found in the left rotator cuff muscles.
- A:** Left cervical sprain-strain is resolving well, particularly related to discomfort when reaching above his head.
- P:** Today soft tissue work and resisted contraction exercise was done in the left shoulder region with 10 minutes devoted to the rotator cuff group. Lower cervical HVLA adjustment (PLS, C-6) given. Treatment was well tolerated and full left lateral bend was evident following care. Further care: I discussed increasing the repetitions with his home neck stretching and strengthening exercises, and will follow-up weekly for another 4 weeks. Anticipate discharge at that time barring no unexpected setbacks.

*Note that Employment Issues and Recovery are included in the body of this example.

Discharge

Thorough documentation of the patient's subjective and objective status at the patient's last visit is essential. This documentation contributes to determination of potential permanent impairment benefits the worker may be entitled to and serves as the baseline for determination of objective worsening should the worker ever apply to have their claim re-opened for any reason. It's recommended to submit a Final Report (1026M) summarizing the worker's progress since the injury and status at the time of care is being concluded. It is especially important to record all objective findings related to their condition or injured region at time of discharge. What is documented at the time the claim is closed serves as the basis for any

permanent impairment and future changes (or lack thereof) serve as the basis for making claim re-opening decisions should their condition worsen and need care at some point.

Example – Discharge SOAP note entries

- S:** Ms. Rodrigues presents today completely free of the right knee pain that began after pushing her desk to the other side of her office six weeks ago. She indicates she has no limitations to positions she puts her leg in and is able to get up from a chair and walk without it making any cracking noise.
- O:** Knee Flexion R = 140° L = 145°; Patellar tracking is full and pain free bilaterally. There is no anterior or posterior slippage (Drawer sign) on either knee. McMurray's click test is negative bilaterally. There is a minimal tenderness in the poster hamstring insertions on the left compared to the right.
- A:** Resolved moderate left knee strain.
- P:** Performed myofascial trigger point therapy in the left medial hamstring which did not immediately change the mild residual tenderness in the insertion area. Instructed patient to consider periodic (a few times a week) stretching of the leg, utilizing the exercises she was taught to help keep the muscles loose. No further care for this injury scheduled.

Transfer of Care

Workers in Washington State have the right to choose their Attending Provider (AP) so long as the provider is part of the L&I network. Only one attending provider of record is allowed on a workers comp claim in Washington at a time, and this must be authorized by the claim manger. Transfer of care may be requested by submitting a [Transfer of Care Form](#) signed by the patient, or [online](#) by the worker or provider.

Non Face-to-Face Care (Phone Calls, e-mail, Peer Consultation)

Any communication outside of an office visit with patients, employers, other providers, or office staff discussion for care planning, referrals, and the rest may be appropriately considered as case management and must also be documented in the patient's chart. A chronological dated note in the progress notes will often suffice, but specific documentation requirements can be found in [MARFS](#). A description of the content discussed and decisions made, along with individuals and time involved should be included. Return to work communication with employers is particularly important and specifics about options discussed, planned follow-up communication (such as a job description), the identity and contact information of the employer representative involved should be documented.

Workers' Compensation Issues Documentation

The Work-relatedness Information Checklist on Page 4 summarizes information required for documenting work-relatedness of a condition. Consistency and completeness in what appears in the patient and provider portions of the Report of Industrial Injury/Exposure (ROA) (or Providers Initial Report) as well as the history documented upon intake in the patient's chart will facilitate the decision to accept the claim or not.

If contradictory or incomplete information appears, claim acceptance becomes delayed in order for the claim manager to obtain the legally required information to support their decision. Some occupational health guidelines encourage objectively documenting facts (as opposed to provider opinion) in the patient charts regarding work relatedness.^[14] Documentation from the worker; the worker's employer; and the provider form the basis for these decisions. Nearly all claims are initiated by providers. Accurate and complete documentation in patient's history, examination, chart notes, and forms (such as ROA, APF) assure workers receive all benefits they are entitled to.

Avoiding terms such as "work-related," or "occupational" in the chart itself can enhance credibility as record reviews of past medical records frequently find that patient's denials of any pre-existing condition are incorrect.

Injury

A work injury arises proximally out of a distinctly identifiable event experienced during the course of employment. The condition may be immediately symptomatic (such as an acute ankle sprain) or emerge proximal to the event (such as low back pain the evening or next morning after a day of exceptionally heavy lifting). The connection and relationship between the worker's condition and the workplace exposure must be clearly documented in the chart and the provider's rationale and justification for that connection must also be clearly documented. There is no standard approach to documenting work-relatedness, however the Chief Complaint and Present Illness entries, or the initial visit SOAP entry are highly recommended locations to include relevant details. A detailed description of the work occurrence and the chronology of the development of symptoms or signs fits well under the subjective component.

Examples – Work-relatedness injury entries

S: Patient presented with left-sided lower back pain which has him listing to the right side. Onset began 3 nights ago and became worse by morning to the point of having difficulty getting out of bed. He stayed home and tried to walk it off, but it has not gone away and states it is getting more intense. He works as an auditor which usually involves desk work, but on Wednesday he changed offices having spent all day packing up books and files into boxes and stacking them up for facilities to move to the new building. He felt very tired and somewhat achy late in the day, but figured it would be fine but is now worried he did something to it. He states this is the first time he's had pain like this in low back.

HPI: The patient is a railroad track maintenance worker who was walking in the railroad yard this afternoon when he felt something go in his left eye. Nobody was hammering, welding or working nearby. It was immediately painful. He tried washing it out with a bottle of eyewash at the workplace but was unsuccessful. He could see a speck in his eye. He rates the discomfort at 1/10. He denies any photophobia or watering. He has never had a foreign body removed from his eye previously.

Specific criteria summarized on Page 4 must be met for a worker's condition to be accepted as an occupational disease. One of the reasons for this is that Washington State law requires that responsibility for a disease due to workplace exposures at different employers may be apportioned to each employer. This increases the complexity of the decision-making and necessitates a very comprehensive work history. When such apportionment happens, former employers have rights to appeal the decision which adds complexity and possibly delays adjudication. Clear and thorough documentation of work exposures that support that the occupational disease resulted naturally and proximately from distinctive conditions of employment and precisely documents what the activity or exposure was at work that caused or contributed to the condition. [RCW 51.08.140]

Occupational disease claims must be filed within **two years** following the date the worker receives **written notice from a provider** that the occupational disease exists and that a claim for benefits may be filed. [RCW 51.28.055]

[Occupational Disease History Forms](#) are available online.

An example of a completed occupational disease report for a carpal tunnel syndrome case can be found in Example 5 of the [Documentation Examples](#) appendix.

Return-to-Work

Returning the injured worker to work is a principal purpose of workers' compensation benefits. Patients' overall long term outcomes are best for workers who return to their same jobs with their same employers. Return-to-work should be as much an important 'clinical' outcome as it is a goal of workers' compensation systems. However, both administrative systems and providers usual documentation practices rarely identify or include elements central to return-to-work.^[22] Providers are in a key position to influence:

- Patient expectations for recovery.
- Communication/coordination with employer.
- Documentation of key occupation health issues.
- Assessment of impediments to return-to-work.
- Helping the worker and employer find transitional opportunities.

Physical Capacity and Work Restrictions

- Getting assistance from L&I in return to work.

In addition to usual clinical matters, it is important to document return-to-work issues in the chart. Although, ability to work, functional capacities, and work restrictions are rarely addressed in medical records, in Washington State, properly completed Activity Prescription Forms (APF) address issues needed to fairly adjudicate benefits for a worker. Attending providers should record in the chart specifics of job activities the worker is concerned about or specifics of work activities and/or light duty including communications with employers (record names and contact information of supervisors, safety and human resource staff).

Documentation of the worker's ability to do specific activities and tasks on the job is critical for employers bringing an injured worker back for light or regular duty. This is routinely documented by attending providers on an Activity Prescription Form. This form meets adjudicative needs of L&I, as well as providing useful information to employers for bringing the patient back to work. It is optimal to document goal-directed activities such as "limit moving more than 10 lbs. of materials at a time for the next 3 days, incrementally increasing by about 5 lbs. every three days until up to 25 lbs." Appropriate RTW, even in a limited capacity facilitates recovery and can prevent the patient from getting discouraged or feeling inappropriately disabled.

Attending Provider's Activity Prescription Form:

<https://lni.wa.gov/forms-publications/f242-385-000.pdf>

Functional Capacity Evaluators (such as PT, OT, VRC) Functional Capacity Form:

<https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Flni.wa.gov%2Fforms-publications%2Ff245-434-000.docx&wdOrigin=BROWSELINK>

IME Doctor's Estimate of Physical Capacities: <https://lni.wa.gov/forms-publications/f242-387-000.pdf>

Evidence and Methodology

Acknowledgements

IICAC and L&I thank Les White, DC, Sarah Martin OT, and Kristine Ostler for their contributions and assistance in reviewing drafts of this resource, but note that this assistance does not constitute an endorsement.

A comprehensive search of available literature on clinical documentation was conducted by the Practice, Education and Outreach (PEO) Subcommittee of the IICAC and L&I staff during the Spring of 2022. Additionally, relevant statutes, administrative rules, and department polices were identified and reviewed. Literature was reviewed and assessed for relevance and quality and summaries were drafted by consensus of the subcommittee with expert content input from consultants and reviewers, including L&I's Industrial Insurance Medical Advisory Committee. An updated draft was approved for distribution in July 2022 by the IICAC. This resource is expected to be updated periodically by the IICAC. Interested parties are encouraged to submit new published reports for consideration in future revisions.

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Appendix A: Work-related Terminology and Glossary

Modified work status – The worker is not able to return to their previous work, but is physically capable of carrying out work of a lighter nature. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self-confidence. Related terms and concepts include modified duty, light duty, workplace accommodation, work restrictions, physical capacity limitations.

Functional Capacity Evaluation (FCE) – Evaluation typically provided by a physical or occupational therapist. Used to assist the attending provider when more information is needed to make RTW and treatment decisions.

Job Analysis (Job Summary) – Report prepared by a VRC or VSS about the physical demands of a job. This may be the job of injury or a job being considered for an injured worker. This report or summary needs to be reviewed, approved and signed off on by the worker's attending provider as soon as possible.

Work restrictions – Specifically delineated limitations on tasks and activities an injured worker may perform, such as by task, frequency, duration, weight, or other modifications.

Regular work status – The injured worker is physically capable of returning to his/her regular work. It is the duty of the attending doctor to notify the worker and the department or self-insurer, as the case may be, of the specific date of release to return to regular work. Compensation will be terminated on the release date. Further treatment can be allowed as requested by the attending doctor if the condition is not stationary and such treatment is needed and otherwise in order.

Temporary partial disability – Also referred to as **Loss of Earning Power**. Partial time-loss compensation may be paid when the worker can return to work on a limited basis or return to a lesser paying job is necessitated by the accepted injury or condition. The worker must have a reduction in wages of more than five percent before consideration of partial time-loss can be made. No partial time-loss compensation can be paid after the worker's condition is stationary. All time-loss compensation must be certified by the attending doctor based on objective findings.

Temporary total disability (Time-loss) – Full time-loss compensation will be paid when the worker is unable to return to any type of reasonably continuous gainful employment as a direct result of an accepted industrial injury or exposure.

Total permanent disability – Loss of both legs and arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful employment. When the attending doctor feels a worker may be totally and permanently disabled, the attending doctor should communicate this information immediately to L&I or the self-insurer. A vocational evaluation and an independent rating of disability may be arranged prior to a determination of total permanent disability. Coverage for treatment does not usually continue after the date an injured worker is placed on pension.

Job Description – A document prepared by an employer that details all tasks and activities a worker is required to do for their job.

Return to Work (RTW) Decision – Attending providers who treat injured workers are required to determine, document and certify whether or not an injured worker may go back to work, including any temporary or permanent work restrictions.

Vocational Services – A number of services are available to assist workers, providers, and employers in determining work ability and effecting safe and sustainable return to work including:

- **Ability to Work Assessment (AWA)** – An assessment completed by a vocational provider to provide information necessary to make a decision regarding an injured worker's employability or eligibility for further vocational services. It may also help workers plan for the future by identifying their return-to-work options.
- **Early Return To Work (ERTW)** – A vocational support program at L&I that identifies workers who have not returned to work with a few weeks of their injury and works with the worker, employer, and provider to identify and obtain needed assistance and resources to facilitate return to work.
- **Release With No Restrictions** – A phrase that needs to be used by the worker's attending provider in clinical documents/notes/reports (such as an activity prescription form) once a final determination is made that an injured worker can return to full duty.

Abbreviations and Acronyms

ACHIEv	Advisory Committee on Healthcare Innovation and Evaluation	LEP	Loss of Earning Power
AP	Attending provider	MD	Medical Doctor
APF	Activity Prescription Form	MMI	Maximal Medical Improvement
APSO	Assessment, Plan, Subjective, Objective (Variant of SOAP note, reordering elements)	NCS	Nerve Conduction Study progress/plan (elements of routine chart note)
ARNP	Advanced Registered Nurse Practitioner	OMD	Office of the Medical Director (unit in L&I)
AWA	Ability to Work Assessment	OPQRTS	Pneumonic for elements included in chart note for chief complaint/present illness (Onset, Provocation/palliation, Quality of symptoms, Region/radiation, Severity, Timing)
CC/PI	Chief Complaint and Present Illness	OT	Occupational Therapist
CFR	Code of Federal Regulations	PCE	Physical Capacity Evaluation (outdated term for Functional Capacity Evaluation)
DC	Doctor of Chiropractic	PHI	Protected Health Information
DDS	Doctor of Dental Surgery	PIR	Providers Initial Report (report of accident form used with self-insured claims)
DMD	Doctor of Medical Dentistry	POMR	Problem Oriented Medical Record
DO	Doctor of Osteopathy	POR	Problem Oriented Record
DPM	Doctor of Podiatric Medicine	Pt	Patient
DPT	Doctor of Physical Therapy	PT	Physical Therapist
Dx	Diagnosis	RCW	Regulatory Code of Washington (laws promulgated by the State Legislature)
EHR	Electronic Health Record	ROA	Report of Accident (refers to Report of Accident, Workplace Injury, Accident or Occupational Disease for State Fund claims or Providers Initial Report for self-insured claims)
EMR	Electronic Medical Record	ROS	Review of Systems (component of patient history)
E/M	Evaluation and Management (refers to general office visit services providers may bill for)	RTW	Return to Work
FCE	Functional Capacity Evaluation (service performed by physical or occupational therapist)	Rx	Prescribed treatment
HSA	Health Services Analysis (unit in L&I)	SIE	Self-Insured Employer
IICAC	Industrial Insurance Chiropractic Advisory Committee	SOAP	Subjective, Objective, Assessment, Plan/Progress (systematic method for patient charting (see Page 13 for others)
IIMAC	Industrial Insurance Medical Advisory Committee	Tx	Treatment
IME	Independent Medical Examination	VSS	Vocational Services Specialist
ISD	Intersegmental Dysfunction	VRC	Vocational Rehabilitation Councilor
JA	Job Analysis (formal details of a job completed by a vocational provider)	WAC	Washington Administrative Code (laws promulgated by state agencies)
JD	Job Description (written details of a job from the employer)	WNL	Within Normal Limits
L&I (LNI)	Washington State Department of Labor and Industries		

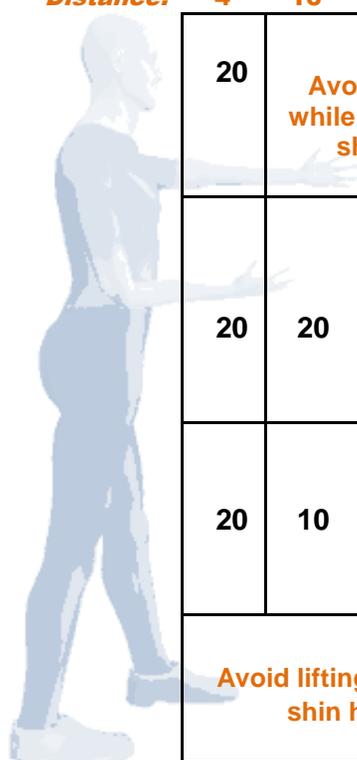
Appendix B: Lifting Calculator for Workers with Mild to Moderate Low Back Sprain/Strain



Step 1

Circle the number in the cell where the hands are at the beginning of the lift:

Reach Distance: 4" 16" 23"

	20	Avoid reaching while lifting above shoulders	
	20	20	Avoid long reaches while lifting
	20	10	
Avoid lifting below mid-shin height			

Step 2

Circle the number for the frequency and duration of lifting in a workday:

Lifts / Minute	Hours / Day	
	1 hr. or less	1 to 2 hrs.
1 lift every 2-5 mins.	1.0	1.0
1 lift every min.	0.95	0.95
2-3 lifts every min.	0.90	0.85

- Lifting more than **3 times per minute** or for more than **2 hours per day** is not recommended for workers with a low back disorder.
- Regularly lifting more than **70 lbs.** by oneself is not recommended, even for healthy workers.
- Gradually increasing amount of weight and/or repetitions can be helpful as worker recovers.
- Awkward positions and reaches should be corrected/minimized while lifting.

Step 3

Is there twisting $\geq 30^\circ$?

No = 1.0 Yes = 0.85

Total: _____ **X** _____ **X** _____ **=** _____ pounds

Step 1 Result
Step 2 Result
Step 3 Result
Recommended Lifting Limit

This calculator is intended for workers healthy enough to return to a job that has lifting duties. It is designed for mild to moderate low back sprain/strain injuries. Judgment should be used when setting restrictions for those with more severe conditions or involving other body areas.

Appendix C: State Laws Relevant for L&I Documentation

Providers' Responsibilities	Statutes (Regulatory Code of Washington – RCW) Rules (Washington Administrative Code – WAC)
Initiation of a Worker's Claim	<p>RCW 51.28.020 Worker's application for compensation – Physician to aid in. Instructions for workers and physicians on applying for compensation</p> <p>WAC 296-20-025 Initiating treatment and submitting a claim for benefits. Responsibilities for workers and providers when submitting a claim for benefits, including report of accident and continuing care.</p> <p>WAC 296-20-020 Acceptance of rules and fees. Responsibilities for workers and providers to accept all rules and fees when an accident report is filed or a treatment is administered.</p>
Work Ability.	<p>WAC 296-20-01002 Definitions Definitions involving work status and degrees of disability</p> <p>RCW 51.32.090 Temporary total disability – Partial restoration of earning power – Return to available work – When employer continues wages – Limitations – Finding – Rules Details on the benefits of returning to work and procedures if employers can provide available work outside of the workers usual work.</p>
Charting and Progress	<p>WAC 296-20-01002 Definitions Definitions and requirements involving chart notes and provider reports.</p>
Proper and Necessary Treatment Treatment Authorizations Maximal Medical Improvement	<p>WAC 296-20-01002 Definitions Definitions involving proper and necessary health care services and their coverage.</p> <p>WAC 296-20-030 Treatment not requiring authorization for accepted conditions. Outlines the types of treatments that do not require authorization for accepted conditions.</p> <p>WAC 296-20-03001 Treatment requiring authorization. Outlines the types of treatment which require authorization.</p> <p>WAC 296-20-03002 Treatment not authorized. Outlines the types of treatments that are not authorized and not allowed.</p> <p>WAC 296-20-035 Treatment in cases that remain open beyond sixty days. Outlines the conditions that must be met if treatment is required beyond sixty days.</p> <p>WAC 296-20-01040 Health care provider network continuing requirements. Outlines the necessary requirements for providers to continue to provide care and receive payment for services.</p>
Billing	<p>WAC 296-20-125 Billing procedures. Instructions on proper billing procedures.</p>
Consultation Evaluations	<p>WAC 296-20-01002 Definitions Requirements of a Consultation Examination Report</p> <p>WAC 296-20-045 Consultation requirements. Outlines conditions which require consultations and proper consultation arrangement.</p> <p>WAC 296-20-051 Consultations. Outlines correct consultation practices.</p>

Concurrent Treatment	WAC 296-20-071 Concurrent treatment. Instructions for providers requesting concurrent treatment.
X-rays	WAC 296-20-121 X rays. Policy regarding X-ray retention, custody, transfer and findings.
Protected Health Information	RCW 51.36.060 Duties of attending physician or licensed advanced registered nurse practitioner — Medical information Concerning the duties of providers to provide medical information.
Records Retention	WAC 296-20-02005 Keeping of records. Outlines records keeping practices for providers.

Appendix D: Checklists and Guides

L&I Documentation Checklist and Self-review

Clinical activity and required documentation		Typical Services Where Performed*	Limits/Notes
Initial Patient Visit with Worker	<input type="checkbox"/> Complete History and Examination <ul style="list-style-type: none"> Office forms, EHR, text, or dictation. Report of Industrial Injury/Exposure form (or Providers Initial Report), aka "ROA". 	New or established patient office visits Report of Industrial Injury/Exposure or Providers Initial Report.	<ul style="list-style-type: none"> ROA optimally submitted within 48hrs, at latest must be submitted within 5 days. Boxes 7-11 establish basis for claim adjudication – rationale for support must be discernable in chart.
	<input type="checkbox"/> Diagnosis and Diagnostic Plan <ul style="list-style-type: none"> Work-related DX(s) (including ICD codes). Concurrent DX(s) and impact on work-related DX. Clinical support and clear/legible rationale in chart. 	Report of Accident. Included in office visit services.	<ul style="list-style-type: none"> DXs included in written problem list. Written X-ray report including findings & interpretation. Special studies reports (labs, NCS, etc) including findings and interpretation.
	<input type="checkbox"/> Work Ability (in progress notes and on APF) <ul style="list-style-type: none"> Work status (in progress notes). Employer contact. 	Activity Prescription Form. Employer phone call. Employer e-mail.	<ul style="list-style-type: none"> APF submitted following initial visit with restrictions given. Document what worker can do. Document availability of modified duty if needed.
	<input type="checkbox"/> Written Treatment Plan	Included in office visit services.	<ul style="list-style-type: none"> Written summarized plan for self-care, passive and active care, patient education for each condition in problem list.
	<input type="checkbox"/> Initiation of Care <ul style="list-style-type: none"> Recorded in first chart note (such as SOAP). 	Included in office visit services.	<ul style="list-style-type: none"> Physician provided physical medicine initial care visit may be billed in addition to an initial office visit if service is distinct and supported in documentation.
Treatment & Progress	<input type="checkbox"/> Attending Provider Follow-up Office Visits <ul style="list-style-type: none"> Recorded in follow-up chart notes (SOAP-ER). Physical care services - AP provided services, chiropractic care services, osteopathic manipulation. Coordination of care - concurrent care, consultations, specialty referral, behavioral health services, activity coaching 	Established patient office visit services Provider specific physical medicine services. Provider specific behavioral health services	<ul style="list-style-type: none"> Document in standardized "SOAP" format and consider employment and return to work components. For DCs, after initial visit only a chiropractic care OR an established patient (E/M) service is payable per visit.
	<input type="checkbox"/> Work Ability Update <ul style="list-style-type: none"> Submit new APF only when work status changes. COHE Return To Work Impediments Assessment (1068M) 	Activity Prescription Form	<ul style="list-style-type: none"> Up to six APFs payable in 1st 60 days. Up to 4 APFs payable in next 60 days. RTW Impediments only to COHE providers 1x/claim.
	<input type="checkbox"/> Re-examination <ul style="list-style-type: none"> Usual chart forms/documentation. Special and 60 day reports. 	Established patient office visit services. Special report.	<ul style="list-style-type: none"> Assess functional progress since care began. Re-assessment of initial exam's findings and change. Progress report (SOAP and work ability) payable every 60 days or when requested by L&I or SIE.
	<input type="checkbox"/> Transfer of Care / Referral	Included in office visits	<ul style="list-style-type: none"> AP Referral Form and Transfer of Care card available Physical, Psychosocial or Behavioral Health referral
	<input type="checkbox"/> Discharge <ul style="list-style-type: none"> Usual chart forms/documentation. Final Report. 	AP Final Report.	<ul style="list-style-type: none"> When maximal medical improvement is reached. Documentation informs degree of impairment and serves as a baseline for future re-openings.

* see L&I's [Medical Aid Rules and Fee Schedule \(MARFS\)](#) for documentation and coding requirements for specific services

Issue	Needed Information
<p>Condition Causation</p>	<p>Clear delineation of specific work exposure(s) is essential for fair and timely adjudication in workers' compensation claims. Relevant points below need to be documented in the chief complaint and present illness portion of the history and appropriate sections of the past history and review of systems. Generally, pain and other manifestations of industrial injuries become evident within 3 months of an inciting event. In a situation where a condition is reported for the first time more than 3 months after a work incident or exposure occurred, it is important that the clinical rationale for its relationship to work be very clearly documented.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Where incident or exposure occurred <ul style="list-style-type: none"> ○ Physical location of occurrence. ○ Indication if location was regular worksite or other location. ○ If traveling, was that travel a requirement of job. <input type="checkbox"/> When incident occurred <ul style="list-style-type: none"> ○ Approximate time. ○ During regular shift, overtime, break, and the rest. <input type="checkbox"/> How the injury or exposure occurred <ul style="list-style-type: none"> ○ Description of specific activity at time of injury. ○ Doing a usual work task, or an out of the ordinary work activity. <input type="checkbox"/> When symptoms began <ul style="list-style-type: none"> ○ Immediately following a specific incident. ○ Soon after injury or accident. ○ Later that day. ○ The next day. ○ Gradually over a period of time. <input type="checkbox"/> Whether the current condition is <ul style="list-style-type: none"> ○ A new condition or an increase in symptoms of a pre-existing condition. ○ Likely to be temporary or permanent (provider's best estimate). <p>If a "new" suspected work-related condition is an increase in symptoms of a pre-existing condition the following terminology is typical:</p> <ul style="list-style-type: none"> • "objective worsening" is used for a previously accepted <u>work-related</u> condition (such as development of hallux rigidus years after an on-the-job toe injury). • "lighting-up" is used for a <u>pre-existing asymptomatic non-work-related</u> clinical condition (such as previously asymptomatic bilateral osteo-arthritis in the wrists becomes symptomatic in the right wrist after an assignment to assemble equipment involving extended manual use of a screwdriver). • "aggravation" is used for a <u>pre-existing symptomatic or disabling non-work-related condition</u> (such as previously occasionally bilateral osteo-arthritis in the wrists becomes constantly symptomatic in the right wrist after an assignment to assemble equipment involving extended manual use of a screwdriver). <p>Indication of which objective findings support the work-related condition(s)</p> <ul style="list-style-type: none"> • Easiest to note in an assessment section of a SOAP note. • Alternatives include summarizing with each work-related condition in problem list.
<p>Occupational Disease</p>	<p>Diagnoses of occupational diseases typically have distinct legal requirements for acceptance. It must be discernable from chart documentation that the occupational disease:</p> <ul style="list-style-type: none"> • Meets reasonable diagnostic criteria for an occupational disease such as those delineated in evidence-based guidelines. • Resulted <i>naturally and proximately</i> from distinctive conditions of employment. • Resulted from a specific activity(ies) or exposure(s) at work that caused or contributed to the condition (delineate which ones). <p>In other words, but for the distinctive conditions of employment, the worker would not have the current condition.</p>

Documenting Work Ability Worksheet

Initial Work Ability Issues	Actions	General Guidance
Can worker perform usual job duties without re-injury risk?	<p>Yes: Document <i>no restrictions</i> on APF</p> <p>No: Document restricted tasks (see APF) Note elements to restrict (chart and APF)</p> <ul style="list-style-type: none"> <input type="radio"/> Repetition <input type="radio"/> Weight <input type="radio"/> Duration <input type="radio"/> Awkward position <input type="radio"/> Specific tasks _____ <input type="radio"/> Other _____ 	<p>Numerous online resources can help determine how much is safe to lift and ideas to modify work activities and logistics. See the safe-lifting calculation worksheet for workers with a low back problem.</p> <ul style="list-style-type: none"> • L&I Evaluation Tools for workplace modifications • OSHA Technical Manual for lifting tasks • Oregon Lifting Calculator webpage • OSHA Ergonomic Tools for heavy lifting • UK Guide to Manual Handling and Lifting Techniques • Canadian Centre for Occupational Health and Safety fact sheets
<p>Accommodation Available Job restrictions given:</p> <p>(AP should contact employer and document if needed work restrictions and/or job modifications are possible).</p>	<p>Document available accommodations:</p> <ul style="list-style-type: none"> <input type="radio"/> Mechanical assistance <input type="radio"/> Weight reduction <input type="radio"/> Activity duration <input type="radio"/> Shift duration <input type="radio"/> Alternate job tasks <input type="radio"/> Co-worker assistance <input type="radio"/> Other: _____ 	<p>Employer Contact Resource for AP's Office captures essential elements needed for accommodation as an optional form</p> <p>Attending Provider Return To Work Desk Reference includes detailed instructions for completing the APF, resources for job modifications, and additional information for working with employers lni.wa.gov/IPUB/200-002-000.pdf.</p>
<p>Accommodation Not Available Job restrictions given:</p>	<p>Document in chart and note on APF.</p> <p>Contact claim manager to request early return-to-work (ERTW) assistance.</p>	<p>Employer RTW Assistance: Attending provider information for L&I's Stay At Work program can help speed your patient's return to work lni.wa.gov/StayAtWork.</p> <p>Consider referral for active exercise/conditioning to facilitate physical activity during recovery.</p>
Work Ability Reports	Who Typically Performs	What The Attending Provider Needs To Do and Document
Activity Prescription Form (APF)	Attending Provider (AP)	Complete all elements of the APF form and submit to L&I or self-insured employer (SIE) at initial visit and whenever work status changes.
Job Description	Employer	AP reviews for return-to-work decision. Document decision in progress note, employer questionnaire and/or APF.
Job Analysis (JA)	Vocational Rehabilitation Counselor (VRC) or Vocational Service Specialist (VSS)	AP reviews for return-to-work decision. Document decision by signing JA Summary Page or Signature Page and submit to vocational provider and L&I.
Therapy Progress/Discharge or Physical Medicine Progress Report Form	PT/OT	AP reviews functional improvement to assist in RTW determination and documents in progress note (and/or APF if work status changes).
Functional Capacity Evaluation	PT/OT	AP reviews to inform return-to-work determination and documents decision in progress note (and/or APF if work status changes).
Return-to-Work Resources	How To Access	More Information
Early Return-to-Work	AP request to claim manager	https://lni.wa.gov/claims/for-employers/help-your-employee-return-to-work
Stay At Work	AP request to claim manager	https://lni.wa.gov/claims/for-employers/employer-incentives/stay-at-work
Work Conditioning	AP referral to PT/OT (subject to overall PT limits)	https://lni.wa.gov/patient-care/treating-patients/helping-workers-get-back-to-work/physical-occupational-massage-therapy
Work Hardening	AP referral to PT/OT (PT/OT authorization needed)	https://lni.wa.gov/patient-care/treating-patients/helping-workers-get-back-to-work/work-hardening
Activity Coaching (pilot program)	AP referral to L&I program (see link)	https://lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/activity-coaching

Appendix E: Additional Resource Links

L&I Resource Material Links

<i>Hyperlinks</i>	
Attending Provider Resource Center	
Attending Provider's Return to Work Desk Reference	
Medical Examiners Handbook	
IICAC Best Practice Resources Web page	
Medical Aid Rules and Fee Schedule	
L&I Billing Information	
Self-Insured Employer Billing Information	

L&I Return-to-Work Support

<i>Hyperlinks</i>	
Return-to-Work Help	
Stay At Work Program	
Physical Therapy Services Information	
Work Hardening Program	
Activity Coaching Program	

Ergonomic and Work Modification Resource Links

<i>Hyperlinks</i>	
L&I Evaluation Tools for workplace modifications	
OSHA Technical Manual for lifting tasks	
Oregon Lifting Calculator	
OSHA Ergonomic Tools for heavy lifting	
UK Guide to Manual Handling and Lifting Techniques	
Canadian Centre for Occupational Health and Safety fact sheets	

Useful L&I Forms

<i>Hyperlinks</i>	<i>Web addresses</i>
State Fund Report of Accident	
Self-Insured Employer Report of Accident Order Form	
Activity Prescription Form	
AP's Referral Form	
PT / OT Referral Form	

Appendix F: Documentation Examples

History, Examination, Problem List and Treatment Plan

Example 1 – First Visit, Intake Chart Entry

Visit Date: 4/9/20xx

Onset: 04/05/20xx

SUBJECTIVE

Ms. Johnson, a 41-year-old grocery stocker, presents today reporting moderate to severe lower mid back and low back pain radiating into the left hip. She rates the discomfort at 6-8 on a 10 point scale and at times it is so sudden and sharp she has to stop whatever she's doing. She stated it first began at work last week immediately upon reaching overhead to lift a crate of bottled juice off the top of a stack of crates on a pallet. She said she felt an immediate "pop" in the middle of her lower back and experienced immediate, sudden, sharp pain. She says she told her supervisor about it and left work early on Friday.

She has been trying to take it easy over the weekend, but it continues to get worse. She also relates she has been taking OTC ibuprofen, but it has not helped. Ms. Johnson goes on to say she stayed home from work today because of the pain and the increasing difficulty with activities at home including getting up and down from a chair, reaching for and lifting objects such as a gallon of milk or even moving laundry from the washer to the dryer. She indicated that the discomfort is interfering with her sleep to the point she hardly got any last night.

She reports one prior episode of low back pain about 5 or 6 years ago that lasted about two weeks, responded to OTC ibuprofen and was not as painful as this condition.

OBJECTIVE

- Ms. Johnson is observed assuming a mild anterior antalgic standing posture and she grimaces when trying to straighten up or extend her back. Valsalva maneuver produces a sharp pain increase in left lower sacroiliac area.
- Minor's sign is observed as the patient rises to stand from a sitting position.
- Dorsolumbar Active Range of Motion observed: WNL with moderate pain through entire range on the left.
- Intersegmental restriction is found: T10, T11, T12, L4, L5, Sacrum, Lt. Sacroiliac jt.
- Moderate hypertonicity is seen: lumbar erectors, lower trapezius muscle, lower thoracic erectors, quadratus lumborum, gluteal muscles, left > right.
- Moderate trigger point tenderness is palpated: Left gluteal muscles.
- Mild to moderate splinting to palpation pressure found: Mid-lower lumbar erectors, with palpable spongy edema on the left PSIS.
- Moderate to severe tenderness to palpation pressure is noted: L4, L5, Sacrum, Lt. Sacroiliac jt. on the left.
- Deep tendon stretch reflexes are tested in the nerves of the lumbar plexus, and are symmetrically active, rated 2/2.
- There are no altered dermatome sensations reported in the lower extremities. No deficit is found strength testing of the muscles supplied by the lumbar nerve roots, rated symmetrically 5/5.
- Provocative maneuvers of the dorsolumbar spine produce moderate local lower lumbar spine pain, mostly on the left side without eliciting radicular symptoms. These include: Straight Leg Raise, Kemp's Test, Milgram's Sign, Goldthwait's Sign bilaterally with movement of L4-5, and L5-S1, and the left Sacroiliac joint, and Ely's Heel to Buttocks Test.
- Baseline Roland Morris (RM) Score: 46%

ASSESSMENT

Moderate low back sprain involving L4/5, L5/S1 and left SI joint associated with acute inflammation and mild extensor muscle splinting arising directly from overhead lifting of a large crate at work.

Diagnoses:

- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- S33.6XXA Sprain of sacroiliac joint, initial encounter
- S39.012A Strain of muscle, fascia and tendon of lower back, initial encounter

PLAN

Certify time-loss for 3 days to rest, and avoid aggravation of this currently acute phase of this injury. Anticipate RTW no later than Monday, 4/15/20xx. Will contact employer to determine availability of light duty if needed. Return tomorrow for evaluation and refinement of a course of soft tissue work, low back adjustments and incrementally increasing exercise. Initial follow up visit frequency of 3x weekly for 2 weeks with reassessment of RM score, and segmental movement and provocative low back tests. With expected improvement and sustained return-to-work, anticipate extending care another 2-4 weeks at 2-3 times per week attenuated by response and compliance with home exercise. Without complications or unanticipated aggravation, expect full recovery and discharge in 4-6 weeks.

Today's Care:

- EXAM: the thoracolumbar, lumbosacral, and sacroiliac region.
- PASSIVE: Initiated gentle mid and low back adjustments: T11, T12, L1 (anterior dorsal), L4, L5, Sacrum and Left Sacroiliac (Gonstead side posture). Patient tolerated treatment well.
- ACTIVE: Contract-relax muscle exercise (PNF) was performed to tolerance on the Gluteals, Hamstring, Piriformis. Immediate relief noted with back extension and observable increase in active range of motion.

After treatment she stated her back "loosened up a little."

INSTRUCTIONS TO PATIENT

- Recommend application of ice to affected area - maximum 20 min. ea. application and no more than once an hour, minimum 3 x day.
- Recommend prudent judgment in any and all activities next two weeks with light, incrementally increasing activity next three days. With any increased pain, patient is to stop and relax a few minutes before continuing. We spoke about the initial need to limit activity being only for a few days until sharpness of pain reduces. She was concerned about being off work, but I recommended definitely staying off tomorrow. I indicated I will contact her employer regarding light duty options, and call her this afternoon to see what is available. We spoke about the inflammation of the joints that is present, and this needs to settle down before stressing it too much. We also discussed the importance of incrementally increasing her activity and provided her with an activity diary that she will bring back each visit.

Reviewed and signed, R.J Smith, DC 4/09/20xx

4/09/20xx Addendum:

Spoke by phone with Ms. Johnson's supervisor, Anita Rockwell. She indicated the store has a light duty program and can be flexible with Ms. Johnson's abilities. Ms. Johnson can work in inventory for at least the next week with activities involving desk work, walking in the store room performing tablet entries, and ability to pace activities with rest. I called Ms. Johnson and relayed information. APF completed with time off and modified duty details.

Reviewed and signed, RJ Smith, DC 4/09/20xx

Example 2 – First Visit, Intake Chart Entry

SUBJECTIVE

Mr. Johnson reported the following today: moderate to severe neck and upper mid back pain, with right arm and right hand tingling and numbness. Moderate right shoulder pain. He states one week ago while at work, he was attempting to turn a connecting bolt on a car part using a four foot long pry bar as leverage. As he was pulling with all his strength, unbeknownst to him, a co-worker came over and helped push the bar from the opposite end. This rapid release sent Mr. Johnson falling backwards landing on the floor. He reported this injury the day it happened, although didn't want to make a "big deal about it." He has continued to work through this week, but his condition continued to get worse. Over the course of the past several days with continued use, he is now having moderate to severe intensity pain in the neck, upper mid back, and shoulder, with numbness and tingling radiating down into the right arm and hand. He is having difficulty with any physical activity due to the pain.

OBJECTIVE

A mild antalgic posture is observed, with guarding the right shoulder, the right slope of the shoulder elevated, and head tilt to the right. Valsalva maneuver is positive for producing a sharp increase of the right cervicodorsal pain.

Deep tendon stretch reflexes are tested of the cervicodorsal spine nerve roots, and are symmetrically active, rated 2/2. There are no altered dermatome sensations reported in the upper extremities. No strength deficit is found testing of the muscles supplied by the cervical nerve roots, rated symmetrically 5/5.

Provocative maneuvers of the cervicodorsal spine are positive for producing moderate to severe local pain, right > left. These include: Shoulder Depression, Soto Hall Test. Axial Compression Test elicits radicular symptoms into the upper right extremity. Cervical traction provides some relief of the neck and upper thoracic pain, and decreases the intensity of the radicular right upper extremity symptoms.

Cervicodorsal Active Range of Motion observed: mild to moderate restriction in all directions with moderate to severe pain produced at restricted end point. Intersegmental restriction is found: C5-6, C6-7, C7-T1, T1-2, T2-3, T3-4.

Moderate to severe tenderness to palpation pressure is noted: C4 through T6, right > left. Moderate hypertonicity is palpated: Mid-lower cervical erectors, levator scapulae, upper-mid thoracic erectors, upper-mid trapezius, upper and lower rhomboids, right > left. Moderate to severe trigger point tenderness is palpated: levator scapula, upper-mid trapezius, upper and lower rhomboids, at insertion on the superior vertebral angle and medial border of the right scapula into the slope of the shoulder.

Right glenohumeral Active Range of Motion observed: WNL with moderate to severe pain in all directions.

Moderate to severe tenderness is noted over the superior and anterior aspect of the right glenohumeral joint. Provocative maneuvers are positive for eliciting pain in the right shoulder; these include Apprehension test, Drop arm test, and Supraspinatus test.

ASSESSMENT

Mr. Johnson appears to have suffered muscular strain to his right upper cervical, mid back and shoulder area related to sustained muscle exertion followed by a sudden, unexpected change in load which created sudden reflex contractions irritating multiple cervical and thoracic joints and leading to sustained muscular dysfunction throughout the right shoulder girdle. This should respond rapidly to a short course of cervicothoracic joint manipulation, soft tissue work, and incrementally increasing home exercise.

PLAN

Recommended follow up care with a doctor closer to his home in Spokane, WA. Mr. Johnson will follow up Monday, and he is given a referral to see Dr. Tim Smith in Spokane. I will fax a referral note with today's chart notes to Dr. Smith.

TREATMENT

Segments adjusted: C5-6, C6-7 (gonstead), T1-2 (long axis traction), T2-3, T3-4 (anterior dorsal) and right shoulder mobilization. Patient tolerated treatment well. Manual traction was performed on the cervical region.

The following diagnostics were performed today: physical examination of the cervicodorsal spine and right shoulder; AP/lateral cervical, and AP/lateral thoracic radiographs were exposed utilizing routine weight bearing spinal projections.

COMMENTS/FUNCTIONAL TRACKING

Mr. Johnson presents today, and he is obviously uncomfortable. His head and neck are held in a mild antalgic leaning posture, and he supports his right arm to ease the weight of it - taking pressure off of his right shoulder. I think Mr. Johnson may have made a mild to moderate injury made moderate to severe by continuing to work through the week following this injury.

The patient was examined, and X-rays were taken of the cervical and upper thoracic spine today. Following examination and X-rays, we reviewed the findings, and he was treated to get the healing process started, and attempt to get some pain relief. It appears as Mr. Johnson may have injured both the cervicodorsal spine, and his right shoulder in this accident, as provocative testing indicates. He is to decrease all activity and rest for the next couple of days. I am recommending he begin application of ice to the affected areas, 20 min. each application, three to four times per day.

He drove to this office (in Seattle, WA) this afternoon from Spokane, WA for this appointment. He has recently moved his home to Spokane from Seattle, and he states he doesn't have a doctor yet in Spokane. I am recommending he follow up for care with Dr. Tim Smith in Spokane. We spoke about this current situation, and it is unrealistic to think he will get the quality of care he needs from so far away. He will most likely require regular follow up care and therapy for these injuries.

Mr. Johnson has been treated in this office on two separate occasions previous to today's visit. Both for work-related injuries; one in 2004, Claim number ABC000; and one in 2010, claim number XYZ000.

Example 3 – First Visit, Intake Chart Entry

SUBJECTIVE

History of Injury

Ms. N tripped while carrying a heavy box. She hit a table with her left elbow. She did not hit the floor. She noticed pain immediately in the left upper thoracic and cervical pain. It worsened over the next 24 hours. She went to an urgent care clinic. She was diagnosed with a "pulled muscle". She was prescribed muscle relaxers and other medication. It did not help.

CHIEF COMPLAINTS

She complains of a "knot" in her left thoracic region adjacent to the scapula. It is constant. The quality is "dull and achy". She rates the pain intensity as 4-5/10. It is worse with desk work and sleeping on her sides or back. She does not sleep soundly. Ice and stretching help. She is most comfortable prone on a massage table with the face cradle lowered. The pain can radiate to the left elbow. The left upper extremity feels heavy. She denies numbness and tingling. She also complains of left low cervical pain. The pain is worse with laying on a pillow, turning her head. The intensity is 3-4/10. It is described as "aching" and "throbbing". It can "twinge" with certain neck movements. The pain is focal.

WORK HISTORY

Ms. N works full time as a manager of a retail store. Her job is approximately half desk work and half manual labor.

SOCIAL HEALTH HISTORY

She walks daily 2.5 miles once per day. She was going to gym, but quit when her husband was recently laid off. She is considering doing water aerobics. She reports no loss of activities of daily living.

PAST HEALTH HISTORY

She denies prior injury to these regions. She reports losing over 100 lbs. since having gastric bypass surgery. The weight loss has improved her overall health greatly.

OBJECTIVE

Observation- Postural Analysis: high right shoulder, anterior head carriage and rounded shoulders

Observation- Antalgia: The patient did not display antalgia.

Musculoskeletal - Visualized Range of Motion - Cervical - Active

- Flexion: 30/60 degrees with pain - "pulling" into the left scapula
- Extension: 70/55 degrees without pain
- Left Lat. Flexion: 30/40 degrees with left neck pain
- Right Lat. Flexion: 40/40 degrees with pain - "pulling" into the left scapula
- Left Rotation: 60/80 degrees with pain - "pulling" into the left scapula
- Right Rotation: 80/80 degrees with pain - "pulling" into the left scapula

FUNCTIONAL TESTING

Wall Angle testing was performed. The patient's left wrist was two inches off the wall. The patient's right wrist was three inches off the wall. There was no pain.

Ortho-Maximum cervical foraminal compression (cervical compression with extension and lateral flexion) was performed bilaterally. On the left, there was not pain. On the right, there was pain in the left scapular region.

Ortho-Doorbell testing (digital goading of the cervical nerve roots) - On the left, there was pain to left scapular region.

Neuro-Mental Status: Evaluations performed and the patient was observed to be alert, oriented and cooperative.

Neuro-Light Touch: Evaluations performed and indicated light touch sensations were within normal limits at all upper extremity dermatomes.

Neuro-Deep Tendon Reflexes (normal 2+):

- Biceps Left 1+, Right 1+,
- Triceps Left 1+, Right 1+,
- Brachioradialis Left 1+, Right 2+,

Neuro-Upper extremity resistive isometric motor testing (normal 5/5):

- Deltoid: Left: 5 / 5 Right: 5 / 5
- Biceps: Left: 5 / 5 Right: 5 / 5
- Triceps: Left: 5 / 5 Right: 5 / 5
- Wrist flexors: Left: 5 / 5 Right: 5 / 5
- Wrist extensors: Left: 5 / 5 Right: 5 / 5
- Finger flexors: Left: 5 / 5 Right: 5 / 5
- Pronator teres: Left: 4 / 5 Right: 5 / 5

- Abductor digiti minimi: Left: 5 / 5 Right: 5 / 5

Neuro-Grip Strength Testing: I used the Jamar dynamometer and found the following strength with successive tests:

Left - 48, 46, and 46 pounds

Right - 55, 58, and 48 pounds

She is right hand dominant.

PALPATION

- Regions of decreased spinal intersegmental motion (fixation): atlanto-occipital, cervical, and thoracic
- Tenderness and hypertonicity: left upper thoracic and mid to lower left cervical, left levator scapula

ASSESSMENT

Ms. N appears to have radicular pain. Her persistent and continued pain is the result of episodic irritation of a cervical nerve root. Her signs and symptoms are very consistent with this. She is unlikely improve until she can avoid irritating the nerve root.

TREATMENT RECOMMENDATIONS

I recommend a multi-faceted approach to Ms. N's care. I think that she would benefit from chiropractic care. She is particularly fixed in the thoracic region; the more mobility she can gain there, the better. I think adjustments will help that. I recommend twice weekly care for 6-8 weeks.

I think massage therapy would also be helpful.

She was instructed to stop stretching her left cervicothoracic region. I understand that it feels tight and that a stretch would be helpful, but that appears to be irritating her nerve root. I instructed her to avoid doing anything that causes referred pain to the left scapula.

In order to enhance her thoracic mobility, I supervised her doing thoracic extension mobilization on a foam roll. We also did overhead reaching with an eight pound medicine ball on the foam roll. To induce more scapular stability, I had her perform a Dynamic Neuromuscular Stabilization exercise - tripod to bear crawl.

After the exercises, we retested her cervical active range of motion and it was improved and several directions did not induce scapular pain anymore.

I instructed her to perform the exercises twice per day. She purchased a foam roll and seemed enthusiastic about doing it. I will email her links to videos on how to perform the exercises.

If she does not respond to conservative care within the first 2-4 weeks, I will consider a referral for a cervical MRI to rule out an intra-spinal source, such as the disc to the radiculopathy and to a physiatrist for co-treatment.

She is released to the job of injury without restrictions.

Example 4 – First Visit, Intake Chart Entry

SUBJECTIVE

History of Injury

Mr. K was injured while working at NW Hospital. He was pushing a heavy bed around a corner on 24 July 20xx. He was pushing very hard to maneuver the bed to keep the patient from hitting the wall after the handrail came off the bed. He suddenly felt hot and was seeing stars. He asked for help. Afterwards, his neck felt stiff. He has had a lot of trouble sleeping because of the pain. His hands would get stiff and numb while sleeping.

Current Complaints

He has right neck pain that radiates to the right scapula and down the right upper extremity. He has numbness, tingling, and pain in his hand encompassing all of the digits. His thumb region can become edematous. He notices the upper extremity symptoms 75% of the day. He gets a pulsing pain into the upper extremity when he lifts objects. He gets a pulling pain in his ear. He rates his pain intensity as 10/10. He says that he protects his right upper extremity, because unguarded motion can cause a spike in his pain. He is right handed and finds himself using the right hand out of habit.

Treatment History

He has had a cervical MRI that shows a disc protrusion with stenosis at C6-7 on the right. Electrodiagnostic testing found a C7 motor radiculopathy.

Past Health History

He had a distinct injury where he was lifting bags of garbage and pushing a linen cart. The cart suddenly stopped (he thinks that his shoe hit one of the wheels). He was trying to turn the cart. He had pain in his right forearm and elbow afterwards. Eventually, he had surgery for the injury. It didn't help much. He complains that when he tries to make a fist with his right hand, his fingers tremble and shake. He has returned to the surgeon with these complaints, but the surgeon refuses to take any further action, declaring the surgery a success.

Work History

He had some time loss. He has been released to the job of injury without restrictions, but his employer has limited work for him and he has been placed on reserve. He gets work occasionally, but not consistently.

Past Health History

He denies any prior injury to his neck.

OBJECTIVE

He shook my right hand with his right hand and gave a good effort. He used his right upper extremity easily to get on and off the table and to turn over. During the history and examination, he preferred to keep his right upper extremity close to his torso. There is good development of the right upper extremity musculature, including in the hand with no signs of atrophy. The skin color, temperature, and hair patterning was symmetric between the upper extremities. He did not withdraw from my touch.

Observation- Postural Analysis: anterior head carriage, thoracic hyperkyphosis, anterior pelvic tilt, hyperlordosis of the lumbar spine, rounded shoulders and internally rotated upper extremities

Musculoskeletal - Visualized Range of Motion - Cervical - Active

- Flexion: 40/60 degrees with posterior head pain
- Extension: 30/55 degrees with discomfort
- Left Lat. Flexion: 30/40 degrees with right neck and scapular pain
- Right Lat. Flexion: 30/40 degrees with left neck pain
- Left Rotation: 60/80 degrees with right neck pain
- Right Rotation: 60/80 degrees with right neck pain

Ortho-Doorbell testing (digital goading of the cervical nerve roots) - On the right, there was local pain only.

Ortho-Maximum cervical foraminal compression (cervical compression with extension and lateral flexion) was performed bilaterally. On the left, there was no pain. On the right, there was pain in the cervical spine on the right with radiation to the right scapular region.

Neuro-Roo's (AER) testing: The patient was instructed to open and close his hands with his shoulder abducted to 90 degrees and fully externally rotated for up to 60 seconds. After 45 seconds, the patient complained of pain in the right cervicothoracic region and developing paresthesia in the right upper extremity.

Neuro-Mental Status: The patient was observed to be alert, oriented and cooperative, although his affect was blunted.

Neuro-Light Touch: Light touch sensation was decreased throughout the entire right upper extremity.

Neuro-Deep Tendon Reflexes (normal 2+):

- Biceps Left 1+, Right 0
- Triceps Left 1+, Right 1+
- Brachioradialis Left 1+, Right 1+

Neuro-Upper extremity resistive isometric motor testing (normal 5/5):

- Deltoid: Right: 4 / 5
- Biceps: Right: 4 / 5
- Triceps: Right: 4 / 5
- Wrist flexors: Right: 4 / 5
- Wrist extensors: Right: 4 / 5
- Finger flexors: Right: 4 / 5
- Pronator teres: Right: 4 / 5
- Abductor digiti minimi: Right: no effort

There was give way weakness of the right upper extremity muscles.

Palpation:

- Regions of decreased spinal intersegmental motion (fixation): atlanto-occipital, cervical, thoracic, lumbar, sacral and pelvic/sacroiliac
- Tenderness and hypertonicity: right cervical, right suboccipital, and right levator scapula

There was some edema in the right antecubital fossa. Several surgical scars are noted around the right elbow. He demonstrated limited right elbow flexion and extension - flexion to 110 degrees and extension to -15 degrees.

ASSESSMENT

Mr. K has objective evidence of a right sided disc protrusion at C6-7 with chronic radiculopathy.

He appears to be exaggerating his symptoms. His pain diagram shows pain on both upper extremities, throughout his back, and outside of the body. He rates his pain intensity as 10/10. I do not know the reason for this.

The differential diagnosis list could include neurogenic thoracic outlet syndrome and complex regional pain syndrome; the former is likely and the latter is less likely.

PLAN

Today's Treatment:

Primary Treatment: Manual Chiropractic Manipulative Therapy (CMT) to the atlanto-occipital, cervical, thoracic, lumbar, sacral and pelvic/sacroiliac region(s) and the following extremity joints: none.

Trigger point therapy: I performed trigger point therapy to the regions of hypertonicity and tenderness listed above.

I have recommended a trial of chiropractic care three times per week. I think it will be helpful. What is less clear is whether I will be able to elicit a straightforward report of his symptoms. I may have to rely more on examination tests to check his progress.

After the treatment, he stood more erect. He had increased cervical range of motion.

He has been released to the job of injury without restrictions by his attending physician.

cc: Richard R. Richards, MD (ACME Spine and Sports Medicine)

Example 5 – First Visit for a Supportable Occupational Disease Claim

CC: Bilateral hand numbness, sometimes painful at night.

HPI: The patient is a maintenance worker at ACME, Inc. who has had worsening numbness of both hands as well as muscle weakness and atrophy. He had onset of numbness in the fingers of both hands beginning in the early 1990s when he was a commercial fisherman. His symptoms remained minimal and intermittent for several years until he took his current job as a maintenance worker. He has been employed there 14 years, the first 7 years as a mechanic and the last 7 years as a maintenance worker. Approximately 5-6 years ago he saw a hand surgeon and was diagnosed with carpal tunnel syndrome and was told he needed surgery. A claim was filed but was denied because the IME determined that diabetes mellitus type II was responsible for his carpal tunnel syndrome. After he had recent electrodiagnostic studies, he wishes to file a new claim. Please refer to the Doctor's Assessment for Work-Relatedness for Occupational Diseases that I have completed today.

PMH: Reviewed in Epic. Type II diabetes mellitus treated for approximately 5 years with metformin. History of tobacco chewing for many years.

PHYSICAL EXAM: He is pleasant, well-nourished and in no distress. He weighs 232 pounds and is 68 inches tall. He has obvious severe muscle atrophy of the left thenar eminence, with mild atrophy of the right thenar eminence. He has profound light touch deficits in the thumb through ring fingers of the left hand, less so but diminished in the right hand. Tinel's test is positive at both wrists. Grip strength is weak in both hands, left more weak than right. Thumb opposition to index fingers is likewise weak in both hands. His Katz Hand diagram is consistent with bilateral median nerve involvement.

ADDITIONAL DATA: He had electrodiagnostic studies done on September 29, 20xx showing bilateral sensorimotor median neuropathy of the wrists. The EMG showed acute denervation and abnormalities and motor unit action potential in the left APB. The small amplitude acute denervation changes were more suggestive of chronic denervation than acute/active denervation. There was prolonged onset latency with decreased amplitudes and slowed conduction velocities.

ASSESSMENT: Bilateral carpal tunnel syndrome, pre-existing, permanently aggravated by occupation on a more probable than not basis. His non-occupational risk factors are more than overcome by a clear occupational connection related to prolonged, extensive gripping first as a commercial fisherman then as a mechanic, and now doing maintenance work.

PLAN: I strongly support this occupational disease claim. He will follow-up after determination of his claim for referral to a hand surgeon.

EMPLOYMENT ISSUES: He requests no work restrictions.

RESTRICTIONS TO RECOVERY: There are no barriers. He continues to work full time and has modified how he does things to minimize excessive or prolonged gripping.

DOCTOR'S ASSESSMENT OF WORK-RELATEDNESS FOR OCCUPATIONAL DISEASES

Source of Information for this Report: Injured Worker history, Occupational Disease and Employment History form, and medical record review.

Required Questions About Work Activities:

- 1) *Have you discussed with the injured worker the work activities of ALL jobs listed in the work history (including discussion of protective equipment and engineering controls)?*

Yes.

- 2) *What conditions have you diagnosed?*

Bilateral carpal tunnel syndrome (CTS), pre-existing, permanently-aggravated by occupation, on a more-probable-than-not basis.

- 3) *For each condition in Question #2 which is considered a disease (rather than an injury), which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition relative to the risks in everyday life, on a more probable than not basis? Which jobs did NOT create such a risk?*

His work in commercial fishing involved extensive gripping, pulling on and deployment of heavy netting. The job of maintenance worker created a recognizable risk of developing CTS that is greater than the risks of everyday life, on a more-probable-than-not basis.

- 4) *For each job that did create a recognizable risk, answer BOTH of the following questions:*

- a. *Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes).*
- b. *Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.*

Commercial fishing deckhand, early 1990's, job at time of symptom onset. Maintenance worker, 5 years ago, job at time of severe and permanent aggravation. In the deckhand job, he repeatedly grabbed individual fish and held them with wrists flexed. In the latter job, 5 years ago he repeatedly pressure-washed with defective wands that required him to exert extreme grip pressure on the trigger with the left hand, while simultaneously flexing and extending both wrists as he swept the wand back and forth. Throughout the maintenance job for the past 7 years, he has been required to repair pavement defects by applying a filler, then using a 30 pound steel tamper to compress the filler. Such activity required him to repeatedly flex and extend the wrists as he tamps up and down, simultaneously gripping the tamper with enough force to keep it under control.

- c. *Describe the basis for your opinion that the workplace activities contributed to the disease. Please include: A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.*

The worker's symptoms of CTS first developed when he was in commercial fishing, long prior to his diagnosis of type 2 diabetes mellitus. His symptoms remained minimal and intermittent until the pressure-washing activity described above. Thereafter he developed constant and worsening paresthesias left greater than right, as well as muscle weakness and atrophy in the left hand (now beginning in the right hand).

- d. *Any other information you deem relevant (such as supporting references from the medical literature).*

Not applicable.

- 5) *Describe non-work activities or conditions that may have an effect on the disease.*

Age, genetics, obesity, tobacco dependence.

- 6) *If you believe the disease was caused SOLELY by non-work activities or conditions, describe the basis for your opinion. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.*

Although the worker has non-occupational risk factors for carpal tunnel syndrome, clearly the occupational risk factors are predominant in his case. At the time of his employment with [redacted] as a maintenance worker, he was only intermittently and mildly symptomatic. After the pressure-washing incidents, his symptoms became constant, and they have continued to be aggravated by repeated wrist activities in ergonomically-unfavorable conditions. He now has marked muscle atrophy of the left thenar region and the onset of muscle atrophy of the right thenar region. I have indicated by an asterisk on the Occupational Disease and Employment History form that [redacted] is the sole responsible employer for the permanent aggravation.

Example 6 – Occupational Dermatitis

First visit

NEW INJURY, CLAIM number: JB 007

CC: Hand rash

HPI: The patient is a critical-care nurse at MI-6 who began work there in July 20xx. Immediately after starting work and using the foaming hand sanitizer provided in the unit, her hands broke out in an itchy red rash. This was the same rash she had experienced previously at another hospital in Colorado and she believes that the offending soap is exactly the same here as it was there. Her supervisor gave her a bottle of alcohol-based hand sanitizer to use instead as a temporary measure until she could see me. She tolerates this over-the-counter product fine. Since stopping the use of the hand sanitizer in the unit, as well as applying emollient creams her hands have gradually cleared and are almost back to normal. She has a history of allergy to pollen, mold and penicillin. She has no history of asthma. She has never had any problems with synthetic gloves.

PMH: Reviewed in Epic.

PHYSICAL EXAM: She is pleasant, well-nourished and in no distress. Examination of the hands reveals a faint, erythematous macular reticular rash around the right knuckles with no fissuring or eczema. The nails are normal. Fingers are well-perfused. Otherwise her hands and forearms are completely normal. Lungs are clear to auscultation bilaterally. Cardiac regular rate and rhythm without murmurs rubs or gallops.

ASSESSMENT: Allergic versus irritant contact dermatitis.

PLAN: A claim form was completed. She will follow up with me for patch testing. Until that time she can continue to use the over-the-counter hand sanitizer. When she comes back she will bring a container of the offending soap so that I may include it in my patch test panel. An activity prescription form is completed specifying no use of the offending soap. Employer worker's compensation coordinator [redacted] was notified of this plan by a secure email.

EMPLOYMENT ISSUES: She is working doing her normal duties with accommodation made by her supervisor.

RESTRICTIONS TO RECOVERY: There are no barriers.

Second visit

FOLLOW UP VISIT CLAIM number: JB 007

CC: Hand rash

INTERIM HX: The patient returns to begin patch testing. She brings in a bottle of the offending agent, [redacted] foam hand sanitizer, NDC [redacted], with listed ingredients as follows: ethanol 62%, water, PEG-10 dimethicone, ethylhexylglycerin, farnesol, bisabolol, tert-butyl alcohol, and denatonium benzoate. The last component is a known cause of allergic contact dermatitis and I have seen this cause in other patients. She has been using a different hand sanitizer without any untoward effects since I last saw her. Her symptoms have completely resolved.

PHYSICAL EXAM: She is pleasant, well-nourished and in no distress. The patch testing protocol is explained to her in detail. She understands that she cannot shower or exercise for the next 48 hours. She understands that she cannot take antihistamines or immune suppressing medications. On her upper back, the 3 True Test panels are placed, each consisting of 12 allergen patches. In addition, I formulated 4 Finn chambers containing undiluted [redacted] product, a 1:10 dilution of [redacted] product in normal saline, a blank disc moistened with normal saline, and a blank Finn chamber. All patches were secured with hypoallergenic tape. Tolerated well.

ASSESSMENT: Allergic versus irritant contact dermatitis.

PLAN: She will follow up with me in 2 days for removal of the patches and the initial reading. This was a 40 minute encounter greater than 50% of which was patch test preparation.

Third visit

FOLLOW UP VISIT CLAIM number: JB 007

CC: Hand rash

INTERIM HX: The patient returns for removal of the patch tests 48 hours after they were placed. She reports some itching initially under the patches as well as itching of her throat but no swelling of her throat or shortness of breath. She has been working doing her normal job.

PHYSICAL EXAM: She is pleasant, well-nourished and in no distress. All patches are removed and the skin is allowed to air dry for 25 minutes. There is redness surrounding a closed pustular comedone at patch #1, nickel sulfate. This is likely not a true reaction but time will tell. All other patches and controls are negative today.

ASSESSMENT: Allergic versus irritant contact dermatitis.

PLAN: She will follow up with me in 2 days for final reading of the patch tests. This was a 25 minute encounter.

Fourth visit

FOLLOW UP VISIT CLAIM number JB 007

CC: Hand rash

INTERIM HX: The patient returns for the final reading on her patch tests. She has no complaints.

PHYSICAL EXAM: She is pleasant, well-nourished and in no distress. All patch tests are negative.

ASSESSMENT: Occupational irritant contact dermatitis, resolved.

PLAN: She is given an APF permanently restricting her from the use of [redacted] foaming hand sanitizer. There're plenty of substitutes available and the employer is accommodating. This was a 10 minute encounter. A secure email was sent to [redacted] in the workers' compensation office advising her of this outcome.

Example 7 – An eye, foreign body case

CC: Left eye pain

HPI: Mr. N. is a railroad track maintenance worker who was walking in the railroad yard this afternoon when he felt something go in his left eye. Nobody was hammering, welding or working nearby. It was immediately painful. He tried washing it out with a bottle of eyewash at the workplace but was unsuccessful. He could see a speck in his eye. He rates the discomfort at 1/10. He denies any photophobia or watering. He has never had a foreign body removed from his eye previously.

PMH: Reviewed in Epic. He denies any allergy to anesthetics or other meds.

PHYSICAL EXAM: He is pleasant and in no acute distress. The left pupil reacts normally to light. Extraocular muscle movements are intact. No afferent pupillary defect. Visual examination of the left eye reveals a large corneal foreign body embedded at 9 o'clock very close to the limbus. Eversion of the upper and lower lids shows no trapped particles. There is no erythema or chemosis of the conjunctiva.

PROCEDURE: Under slit-lamp microscope examination, after anesthetizing the cornea with 2 drops of 0.5% proparacaine, I identified the foreign body as a large rust particle and removed the majority of it using fine point tweezers. An Optiburr was then used to remove the remaining rust ring. In a deeper layer of the cornea there remains a residual rust stain that is not removed due to proximity to the limbus. After removal, there was no fluorescein uptake viewed with the slit-lamp UV except where the rust had been removed. The patient tolerated the procedure well and feels much better.

ASSESSMENT: Left corneal foreign body, removed except for deep rust stain.

PLAN: Polytrim drops were prescribed, 1 drop OS every 3 hours while awake for the next 3 days. A Tdap was administered. I left a 1 minute voice mail with the patient's supervisor, Jim, advising him of the injury and of the need for a follow up appointment tomorrow with an eye doctor. An activity prescription form is completed releasing him to full duty except for the need to see the optometrist sometime tomorrow. He is referred to the [redacted] eye clinic for further evaluation of the deep stain. Our nurse scheduled an appointment tomorrow for him. He is discharged from our care unless he has problems such as increased pain, photophobia, drainage or decreased vision, and he understands to seek care immediately if those develop.

Example 8 – A laceration case

CC: Left thumb laceration

HPI: The patient is a right-hand dominant warehouse worker who about 4 p.m. today was using a box knife when he accidentally lacerated his left thumb. The cut was quite deep and he came immediately to the clinic after wrapping it in a towel. He has been able to move his thumb. He reports no numbness or tingling distal to the wound. He is not in much pain. The patient had a tetanus shot last year.

PMH: Reviewed in Epic. No meds or allergies. He is a one pack per day smoker.

PHYSICAL EXAM: He is pleasant and in no acute distress. Well-nourished. The left thumb has a deep laceration on the dorsal aspect of the proximal phalanx, slightly oblique to the finger axis, wound edges straight, 1.9 cm long, extending into the subcutaneous tissue. He has intact light touch sensation distal to the wound. Flexion and extension strength of the IPJ and the MCPJ are both 5/5. The wound is bleeding quite profusely but capillary refill at the tip is brisk.

PROCEDURE: The wound edges were anesthetized with a total of 2 mL of 2% lidocaine without epinephrine. Following further irrigation and cleansing of the surrounding skin with antiseptic swabs, an elastic thumb tourniquet was applied, hemostasis was obtained, and the wound was thoroughly explored. No tendons or neurovascular structures are visible except for a bulging vein from the proximal edge of the wound that was not sacrificed. Through sterile prep and drape, the wound was repaired in 2 layers, first the subcutaneous layer with a single horizontal 4-0 Biosyn suture that relieved wound tension. The skin layer was then repaired with four 4-0 Prolene vertical interrupted sutures. The total tourniquet time was 12 minutes, and the thumb pinked up nicely with transient bleeding from the wound edges after removal of the tourniquet. The patient tolerated the repair well. The wound was dressed with a bulky dressing. There was no bleeding through the dressing at discharge.

ASSESSMENT: Left thumb laceration, repaired.

PLAN: An activity prescription form was completed limiting use of the left thumb and advising to keep it clean and dry and not to cover it with a glove. I discussed these restrictions in person with Alex, the patient's supervisor, in a 3 minute discussion and light duty is available. I gave the patient instructions on changing the dressing daily and avoiding immersion underwater. He will follow up here in 3 days for a wound check and probably one week thereafter for suture removal. I advised him to stop smoking and explain the detrimental effect of nicotine on wound healing. I went over written wound precautions with him and he understands the need to seek care immediately if signs or symptoms of infection develop.

EMPLOYMENT ISSUES: The patient has been released to work effective today performing modified duty as delineated on the APF.

RESTRICTIONS TO RECOVERY: The temporary physical limitations that prevent return to work in the job of injury are inability to power grip with the left thumb. There are no unrelated conditions that prevent return to work. At this time there is no need for return-to-work assistance.

Documentation Examples – Acceptable Chart Notes

Example 1 – Improving

Subjective

Lynne presents today much improved. Overall the complaints that she is experiencing due to the industrial accident in question are relatively negligible. Those complaints include pain in the left SI region usually after sitting for greater than 15 minutes or so and getting out of the chair, or when she shifts in a chair as in going around a corner while driving to the right causing her to shift onto her left hip causing some discomfort. The pain is relatively short lived and goes away as soon as she obtains a neutral sitting posture. It does not affect her work to any degree. She completed a low back disability questionnaire (ODI) prior to care today, which was grade at 8/100. Functional losses were indicated with walking.

Objective

Vitals: 46 yrs. 9 months, 5'2", 195lbs, 115/86, with a pulse of 80 bpm.

Palpation today found some slight tenderness at the left sacroiliac joint, decreased joint motion with increased quadratus lumborum tone. Posterior fixation was determined with a slight anterior fixation determine on the right SI joint. Side posture manipulation was utilized today. Thoracolumbar junction was also manually manipulated due to increased paraspinal muscle tone and decreased joint motion at that level. Unrelated to the claim, T4 and T8 were also tender to joint provocation, with increased paraspinal muscle tone and decreased trunk motion noted. Manual manipulation employed with the patient supine. Cervical evaluation from C2 tender to joint provocation on the right, C7 on the left, demonstrating increased paraspinal muscle tone and decreased joint motion at these levels. Manual manipulation employed with the patient supine.

Assessment

Daily Assessment: showing improvement and modest improvement since previous visit as indicated in today's subjective.

Current Status: Improving because she is reporting less discomfort and is showing improved function. She has not reached maximal medical improvement because of continued discomfort in the affected joint on prolonged sitting; however she has been compliant with home exercise and is able to work unencumbered without restriction, performing all of her work duties in relation to the injury sustained in the industrial accident in question.

Plan

Today's Treatment:

Chief Complaint: right sacroiliac and left sacroiliac

Primary Treatment: Manual Chiropractic Manipulative Therapy (CMT) to the right pelvis, left sacrum and L1 spinal level(s). Treatment was well tolerated and response as expected.

Follow up: In 2-3 weeks, with expectation of reaching MMI. I find that the claim manager has scheduled her for an IME which at this point I don't feel is worthwhile, I will call the claim manager to advise of her current condition and expected discharge within the month. Next visit in 2-3 weeks.

Example 2 – 60 Day Progress Entry/Report

S: Initially the injured worker had lower back pain radiating into the posterior thigh and posterior right leg. He rated his low back pain at 8/10 and the right lower extremity pain at 5/10. These were aggravated by sitting greater than 30 minutes and standing greater than 45 minutes. Currently he rates his lower back pain at 3/10 and he no longer has right lower extremity pain. He is now able to sit for 1 hour and stand for 1 1/2 hours.

O: Initially he had an antalgic posture forward and to the left. Currently his posture is erect without analgia. He had guarded movements. He had difficulties arising from a chair and used his hands on his thighs to help achieve an upright posture. Dorsolumbar flexion was limited at 30° and right lateral flexion was limited at 5°, both causing lower back pain with radiating pain into the right lower extremity.

The straight leg raise test was positive on the right at 40° with radicular pain to the posterior knee. He is able to move without difficulties. Dorsolumbar flexion is now to 60° with lower back pain and right lateral flexion is 30° with no pain. The straight leg raise test is now negative for radicular pain at 60° but does produce mild lower back discomfort.

A: Improving from his lumbosacral dysfunction with strain. He is no longer showing signs of radiculopathy.

P: My plan is to continue with chiropractic manipulative therapy as well as Cox distraction for an additional 30 to 60 days on a decreasing frequency basis. He currently is in physical therapy and they are progressing with a walking and strengthening program.

E: Initially he was restricted to working four hours per day with restrictions on bending and lifting. He is currently working full time with no restrictions.

Documentation Examples – Discharge SOAP Note / Final Report

Example 1 – SOAP Format

Subjective

Lynn presents today noting primarily left SI region pain, subsequent to her work injury. Currently she notes little if any pain in that particular region. She does not note any difficulty performing any work activities or any home chores. When asked to grade how much pain interferes her ability to do any work activities, she rates it as 0-1 out of 10. The activity that tends to irritate this at all appears to be driving quickly around a curve or off ramp, where centripetal force will cause her to slide in her seat to the left. She completed a low back disability questionnaire (Oswestry) prior to care today, which was grade at 2/100. Functional losses were found with traveling.

Objective

Active range of motion of the lumbar spine revealed full and symmetrical planes of motion. Some tenderness was noted at end range of extension, indicating the L5/S1 region. She was able to perform a normal heel and toe walk. She was able to perform a normal squat to the ground and regain a standing posture without assistance. Supine orthopedic maneuvers to elicit long track signs or acetabular involvement were unremarkable. Double straight leg raise was unremarkable. Joint provocation, performed with the patient prone did not elicit tenderness of either SI joints. L1-L5 joint provocation also was relatively nontender with some slight muscle tightness noted on the right of L5 compared to the left.

(Unrelated to her L&I claim, tenderness was noted at T4 and T8 with increased paraspinal muscle tone and decreased joint motion primarily on the right. Manual manipulation was applied to this region with the patient in supine posture. Cervical evaluation from C7 tenderness on palpation on the right, C2 on the left. Increased paraspinal muscle tone decreased joint motion these levels were noted. Manual manipulation employed with patient supine. No impact on level of service provided).

Assessment

Meeting expectations and resolved as indicated in today's subjective.

Current Status: She appears to have reached maximum medical improvement because she is showing such improved function.

Plan

Today's Treatment: Manual Chiropractic Manipulative Therapy (CMT) to the right pelvis, left sacrum and L1 spinal level(s). Treatment was well tolerated without incident and response was as expected. Recommended she continue to regularly do the lower back range of motion exercises for a few more weeks.

Next Visit: None scheduled. She was instructed to call and return on an "as needed" basis. If no flare-ups, will discharge in 30 days considering today's visit as closing exam.

Example 2 – SOAP format

S: Since our last visit three weeks ago, Mr. Johnson states that he has had no back pain and no radiating pain into the right lower extremity. He can now sit and stand without restrictions.

O: Currently his posture is erect without antalgia. There are no guarded movements. He is able to flex to 90° and lateral flex to 30° bilaterally. All movements were accomplished with no pain complaints. The straight leg raise test is now negative bilaterally to 70° with no lower back or lower extremity complaints.

A: Mr. Johnson is at maximum medical improvement from his industrial lumbar spine injury.

P: No further care is scheduled.

E: He is currently working full time at his job as injury.

R: He is working with no restrictions.

Example 3 – Narrative letter format

Initial history: Richard Smith, a 34-year-old, 175 lb. male, presented to our office on November 8, 20xx with complaints of left arm pain and numbness following an incident at work 12 days prior where a coworker tossed him a 25 pound bag of seed corn off a loading dock. He lost his footing while trying to catch the bag and fell to the ground “scraping my elbow and forearm pretty bad.”

He reported that first aid to clean the scrape was done at the time and he finished the unloading job but left his shift early to visit to an urgent care clinic. The wound was cleaned and debris was removed. He was bandaged and given instructions for cleaning and changing the dressing and told to stay off work a few days. He stated he was also told to call or come back in if the problem redness or swelling increased.

Apparently an initial Report of Accident diagnosing left arm laceration was sent to L&I. Although the wound was healing, soreness persisted, including throbbing forearm pain, wrist pain and neck tightness that gradually increased and became painful and restricted and became “headaches” prompting his visit to our clinic. He denies any prior history of neck and head pain.

Initial examination: Demonstrated diminished left grip strength compared to the right (primarily due to what he described as cramping along the inner left forearm during gripping. Muscle tightness and tenderness throughout left arm and shoulder girdle, restricted and painful neck range of motion in left rotation and right lateral bend were also noted. Axial compression during left lateral bend produced sharp pain in the lower left neck and left trapezius region, and substantial tenderness could be elicited with spinous process pressure throughout the upper and mid thoracic region. Extreme tenderness to palpation was present over the left radial head. There was also scab formation over the proximal ulnar surface extending along the ulnar side of the forearm to 2 inches proximal to the ulnar styloid.

Although full shoulder abduction produced pain in the neck and mid-back, examination of the glenohumeral and acromioclavicular joints was unremarkable. No sensory disturbances were seen in the left arm.

I diagnosed this as

- 1) Resolving left forearm laceration.
- 2) Left radial head subluxation.
- 3) Mild cervico thoracic strain.
- 4) Cervicothoracic joint dysfunction/subluxation.

Although the initial report of this incident focused on the skin laceration, the mechanism of his fall, the location and nature of onset of his symptoms, and the lack of any prior complaint or history of treatment for neck and arm pain strongly support their causation as entirely the result of the fall at work.

Care to date has involved:

8 sessions of manual care including cervical and thoracic joint manipulation and myofascial trigger point work; 2 of those sessions also involved radial head adjustment. I also prescribed home activation including: cervical stretching, range of motion exercises, and resisted contraction exercises with which Richard has been very compliant. I also showed him how to locate and massage out trigger points in his forearm musculature if he notices return of pain or weakness when grasping with his left hand.

During the first two weeks of care, I arranged with his employer to reduce the number of hours he spent with the heavier lifting and loading tasks and instructed him on safer transferring of items off the loading dock, including having his employer dedicate a dolly to move the heavier items. As per the 2 APFs submitted to date, he returned to full duty on November 21.

Progress to date: At this stage he is asymptomatic. There is still some mild tenderness to spinous pressure in the mid thoracic spinal region, otherwise, all ranges of cervical motion are full, symmetrical and pain free. Hand grip strength is symmetrical and painless. Axial cervical compression is pain free in all positions. As of December 18, 20xx, he is released from care with instructions that it would be a good idea to continue with regular neck stretching exercises a couple times a week, and he is free to return for periodic care for general health and mobility. His work injury care is complete.

Appendix G: L&I Basics section

Concurrent Treatment

Overview – Only one provider at a time may be the Attending Provider (AP) of record on a workers' compensation claim. The AP is responsible to oversee all care, manage return to work, communication with the employer, other providers, as well as L&I or the SIE. With prior authorization by a claim manager, concurrent treatment by more than one provider (qualified to be an AP) may be allowed. The AP is required to request authorization for concurrent care from the claim manager by providing information about concurrent care provider, their role and assuring all reports and documentation are submitted. The AP Referral Form is the most efficient and complete way to document all aspects of concurrent care for all parties, as well as being useful to the provider and claim manager for any kind of specialist or second opinion referral.

Clinical Record Documentation

- Name and contact information of concurrent care provider, their role, duration of concurrent care.

Separate L&I Forms/Reports

- [AP Referral Form](#) (recommended, but not required for making consultation referral).

Examples of Relevant Laws and Rules

- [WAC 296-20-071](#) Concurrent treatment.

Protected Health Information

Overview – A patient's health information may contain sensitive material that providers appropriately have concerns about releasing to third parties. The Federal Health Information Portability and Accountability Act of 1996 (HIPAA) requires that providers protect patients' personal health information but specifically addresses workers' compensation:

“A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries without regard to fault.” (45 CFR 164.512 (I))

Washington State workers' compensation law describes what medical information must be released:

“... all medical information in the possession or control of any person and relevant to the particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the injured worker's representative, and the department upon request and no person shall incur any legal liability by reason of releasing such information.” (RCW 51.36.060)

Providers should let claim managers know about any sensitive information in a patient's chart that may need to be redacted if requested by other authorized parties. Additional information can be found online: [Lni.wa.gov/ClaimsIns/Providers/Claims/HIPAA/default.asp](http://lni.wa.gov/ClaimsIns/Providers/Claims/HIPAA/default.asp).

Record Sharing and Retention

Examples of Relevant Laws and Rules

[RCW 51.36.060](#) Duties of attending physician or licensed advanced registered nurse practitioner — Medical information.

Overview – L&I requires that clinical records be maintained and retrievable for a minimum of 5 years after the patient is last seen and X-rays for a minimum of 10 years from date of examination. Records must remain available for these periods even when a practice closes. State Department of Health laws may have additional requirements depending on licensure and facility regulations. Records must be made available for second opinion examiners and new attending providers in a timely fashion when requested and properly authorized.

Examples of Relevant Laws and Rules

[RCW 70.02](#) Medical Record – Health care information access and disclosure

[WAC 296-20-02005](#) Keeping of Records

[WAC 296-20-121](#) X-rays

[WAC 246-808-650](#) Records and X-rays and withdrawal from practice—Maintenance and retention of patient records

Electronic Health Information

Electronic health records (EHR) are becoming standard in health care delivery and expectations are that routine exchange of health information digitally will become the norm. Technology is rapidly changing and universal standards for submission to payers and government entities are emerging. Increasingly, health care institutions are developing ways to transfer health information electronically among providers and payers.

Billing and submission of reports of accident can be done electronically. Additionally, online access to claim information and secure electronic communication with claim managers can be done through L&I Claim and Account Center.

- [Provider Express Billing](#) for electronic billing:
- [FileFast](#) for online submission of Reports of Accident is:
- [L&I's Claim and Account Center](#) for reviewing a claim and electronically communicating with a claim manager: