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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE ETHNICITY  COHORT  AGE | Patient SSN  FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill no change  Pre-fill no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: **can change**  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Calculate age at indchirodt if valchirdt=1, else if valchirdt=2, calculate age at indchirdt2 |  |
| **#** | **Name** | **Question** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| **Patient Presentation & Diagnosis** | | | | |
| 1 | indchirodt | **Computer will pre-fill** the date of the index outpatient encounter with a Chiropractor at this VAMC. | mm/dd/yyyy  **Computer will pre-fill**  **Cannot modify**   |  | | --- | | >= 10/01/2022 and <= 12/31/2022 | | **Computer will pre-fill** the index date of the outpatient encounter with a Chiropractor during the specified time frame.  This date will come from the pull list provided by the VHA Office of Analytics and Performance Integration-Performance Measurement (API-PM). |

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| 2 | valchirdt | On (computer to display indchirodt) is there documentation of an outpatient encounter with a Chiropractor at this VAMC?   1. Yes 2. No | 1, 2  If 2, go to indchirdt2 | If there is a Chiropractor encounter on the date displayed in the question, select value 1.  If there is no documentation in the medical record indicating that there was an encounter with a Chiropractor on the date displayed in the question, select value 2. |
| 3 | indexicd1  indexicd2  indexicd3  indexicd4  indexicd5  indexicd6 | **Computer will pre-fill** the primary and other Chiropractic ICD-10-CM diagnosis codes documented in the record for the encounter on (computer to display indchirodt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  **Pre-filled: cannot be modified**  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters) | **Pre-filled; cannot be modified.**  The computer pre-fills the primary and other ICD-10-CM diagnosis codes for chiropractic care documented in the record from the pull list. |
| 4 | chircpt1  chircpt2  chircpt3  chircpt4 | **Computer will pre-fill** the Chiropractic CPT codes documented in the record for the encounter on (computer to display indchirodt). | **­­\_\_ \_\_ \_\_ \_\_ \_\_**  **Pre-filled: cannot be modified**   |  | | --- | | **If valchirdt is 1, go to missapt** | | **Pre-filled; cannot be modified.**  The computer pre-fills the CPT codes documented in the record from the pull list. |
| 5 | indchirdt2 | Enter the date of the earliest outpatient encounter with a Chiropractor at this VAMC during the time frame from 10/01/2022 to 12/31/2022. | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | >= 10/01/2022 and <= 12/31/2022 |   **If 99/99/9999, the case is excluded** | Enter the date of the earliest outpatient encounter with a Chiropractor at this VAMC.  If there is no Chiropractic visit during the specified study period, enter 99/99/9999 and the case will be excluded.  **Exclusion statement**: Although the sample information indicated the patient had a Chiropractor visit during the study time frame, review of medical record documentation did not find evidence of an encounter. |

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| 6 | ind2dx1  ind2dx2  ind2dx3  ind2dx4  ind2dx5  ind2dx6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display indchirdt2). | ­­\_\_ \_\_ \_\_.\_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | **Warning if xxx.xxxx** | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 7 | ind2cpt1  ind2cpt2  ind2cpt3  ind2cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display indchirdt2). | **­­­­**\_\_ \_\_ \_\_ \_\_ \_\_  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |
| **If valchirdt = 1, IndexEncounterDate = indchirodt; else IndexEncounterDate = indchirdt2** | | | | |
| 8 | missapt | During the time frame from (Computer to display IndexEncounterDate + 1 day and IndexEncounterDate + 6 months), were any follow-up visits lost (or not kept) due to a missed opportunity?   1. Yes 2. No | 1,2  If 2, go to chiefcplt1 | **Identify any interruptions to the chiropractic appointments during the specified period. Look for documentation that specifies:**   * The clinic cancelled the visit * The patient cancelled the visit * The patient did not show for the visit   **Review the clinic appointment information in Clinical Reports🡪Visits/Admissions🡪Past Clinic Visits or Patient Care Encounters🡪Past Clinic Visits to determine if any appointments were missed during the specified period.**  **For example:**   * **11/01/2022 09:00 Chiropractor Cancelled by Patient** * **11/15/2022 10:30 Chiropractor** * **12/01/2022 09:00 No-Show**   **Select value 1 as two appointments were missed.** |

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| 9 | misapt1  numiss1  misapt2  numiss2  misapt3  numiss3 | During the time frame from (Computer to display IndexEncounterDate + 1 day and IndexEncounterDate + 6 months), indicate the reason for the missed appointment(s) and the number of appointments missed for each reason.   |  |  |  | | --- | --- | --- | | **Reason** | **1,2**  **If any misapt1, 2, or 3 = 2, auto-fill respective numiss1, 2, or 3 = 95** | **Number of missed appointments**  **1,2,3,4,5,95**  **Will be auto-filled as 95 if respective misapt1, 2, or 3 = 2** | | 1. Appointment canceled by patient | 1. Yes 2. No | 1. 1 2. 2 3. 3 4. 4 5. 5 or more   95. Not applicable | | 2. Appointment canceled by clinic | 1. Yes  2. No | 1. 1  2. 2  3. 3  4. 4  5. 5 or more  95. Not applicable | | 1. Patient was a no show | 1. Yes 2. No | 1. 1 2. 2 3. 3 4. 4 5. 5 or more   95. Not applicable | | | **Review the clinic appointment information in Clinical Reports🡪Visits/Admissions🡪Past Clinic Visits or Patient Care Encounters🡪Past Clinic Visits to determine the reason for any missed appointment(s) and the total number of the appointments missed for each reason during the specified period.**   * For example, Past Clinic Visits shows that two (2) appointments were canceled by the patient. Select value 1 for MISAPT1 and value 2 for NUMISS1. * If appointments were not canceled for the specified reason, select value 2 for the reason question. For example, a review of Past Clinic Visits does not show any appointments were canceled by the patient, select value 2 for MISAPT1. |
| **Index Chiropractor Visit** | | | | |
| 10 | chiefcplt1  chiefcplt2  chiefcplt3  chiefcplt4  chiefcplt5  chiefcplt6  chiefcplt7  chiefcplt8  chiefcplt9  chiefcplt10  chiefcplt99 | During the encounter on (computer to display IndexEncounterDate), did the Chiropractor document what the chief complaint or working/differential diagnosis/impression in the note?  **Select all that apply:**   1. General low back (e.g., lumbar, coccyx, pelvic, sacral, sacroiliac) pain 2. Low back pain (LBP) with radiculopathy (radiating pain) 3. Neck (cervical) pain 4. Neck (cervical) pain with radiculopathy (radiating pain) 5. Thoracic pain 6. Headache 7. Upper extremity (arm) pain or condition 8. Lower extremity (leg) pain or condition 9. Generalized syndrome   10. Other impression documented  99. No working/differential diagnosis/impression documented in the Chiropractor’s note | 1,2,3,4,5,6,7,8,9,10,99  Cannot select 99 with other values | **Review the Chiropractor’s note and select the chief complaint and/or each working/differential diagnosis/impression documented in the note.**   * For example, in the assessment/plan section of the note, the Chiropractor documents: Neck pain with radiation down left arm, headache; and fibromyalgia. Select values 4, 6 and 9.   **Value “1”, general low back (lumbar) pain (LBP) also includes:**   |  |  | | --- | --- | | Coccyx pain | Lumbar strain | | Lumbago | Pelvic pain | | Lumbar dysfunction | Sacral pain | | Lumbar segmental dysfunction | Sacrococcygeal pain | | Lumbar sprain | Sacroiliac joint pain |   **Value “2”, low back (lumbar) pain with radiculopathy (radiating pain into leg) also includes:**   |  |  | | --- | --- | | Low back pain with leg or nerve pain | Sciatica | | Lumbar disc herniation with nerve impingement | Symptomatic spinal stenosis | | Lumbar radiculopathy |  |   **Value “3”, neck (cervical) pain also includes:**   |  |  | | --- | --- | | Cervicalgia | Cervical sprain | | Cervical dysfunction | Cervical strain | | Cervical segmental dysfunction |  |   **Cont’d next page**  **Value “4”, neck (cervical) pain with radiculopathy (radiating pain into arm) also includes:**   |  |  | | --- | --- | | Cervical disc herniation with nerve impingement | Cervical spinal stenosis | | Cervical radiculopathy | Neck pain with arm or nerve pain |   **Value “5”, thoracic (middle or upper back) pain also includes:**   |  |  | | --- | --- | | Thoracic dysfunction | Thoracic sprain | | Thoracic segmental dysfunction | Thoracic strain | | Thoracic spine pain |  |   **Value “6”, headache also includes:**   |  |  | | --- | --- | | Cervicogenic headache | Tension type headache | | Migraine |  |   **Value “7”, upper extremity (arm) pain or condition also includes:**   |  |  | | --- | --- | | Carpal tunnel syndrome | Shoulder pain | | Cubital tunnel syndrome | Tendinopathy | | Elbow pain | Tendonitis of upper extremity | | Hand pain | Tennis elbow | | Rotator cuff dysfunction | Thoracic outlet syndrome | | Sprain of upper extremity | Upper extremity dysfunction | | Strain of upper extremity | Wrist pain |   **Cont’d next page.**  **Value “8”, lower extremity (leg) pain or condition also includes:**   |  |  | | --- | --- | | Achilles tendonitis | Knee pain | | Ankle pain | Lower extremity dysfunction | | Ankle sprain | Sprain of lower extremity | | Foot pain | Strain of lower extremity | | Hip pain | Tendonitis of lower extremity | | Iliotibial (IT) band tendonitis | Tendinopathy of lower extremity | | Jumper’s knee |  |   **Value “9”, generalized syndrome includes:**   |  |  | | --- | --- | | Chronic pain syndrome | Muscle spasm | | Fibromyalgia | Muscle tension | | Myalgia | Stiffness | | Muscle ache | Unspecified location of pain/dysfunction | | Muscle pain | Unspecified pain |  * **Select value “10” if any other working/differential diagnosis/impression not listed above is documented in the Chiropractor’s note.** * **Select value “99” if no diagnosis/impression is documented.** |

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| 11 | ccpltm | During the encounter on (computer to display IndexEncounterDate), what was the length of time the chiropractor documented for the chief complaint.   1. Less than 4 weeks 2. 4 to 12 weeks 3. Greater than 12 weeks to 1 year 4. Greater than 1 year to 5 years 5. Greater than 5 years   99. Length of time not documented | 1,2,3,4,5,99 | **Choose the best response based on the documentation in the Chiropractor’s note for this encounter date.**  If the Chiropractor documents the days and weeks listed, calculate the length of time into the corresponding weeks, months or years and select the best response based on the Chiropractor’s documentation.  **For example:**   * If patient presents to clinic and states, “My back has been hurting for 6 weeks”; select value 2. * If patient presents to clinic and states, “My back has been hurting for the past 2 years, but it’s been really bad for the past week”; select value 4. |
| 12 | ccsymdur | During the encounter on (computer to display IndexEncounterDate), did the Chiropractor document the symptom duration category of the chief complaint?   1. Acute 2. Sub-Acute 3. Chronic 4. None of the above | 1,2,3,99 | Review the documentation in the Chiropractor’s note to determine the acuity of the patient’s chief complaint (condition for which the patient is primarily being seen). Acuity of the primary condition may be described as:   * Acute * Sub-acute * Chronic   Select the appropriate value for acute, sub-acute, or chronic, based on the documentation present in the Chiropractors encounter note(s).  If the acuity category (i.e.,acute, subacute, or chronic) is not documented, select value 99. |

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| 13 | txplnvisit | During the encounter on (computer to display IndexEncounterDate), what was the total count of required additional visits specified in the treatment plan?  1. 1  2. 2  3. 3  4. 4  5. 5  6. 6  7. 7-10  8. 11 or greater  9. Documented no additional visits needed  99. Number of additional visits not documented | 1,2,3,4,5,6,7,8,9,99  If 9, go to totaddvis | The Treatment Plan refers to the number of visits and frequency (in weeks, months, etc.) in which follow-up visits are set to occur after the initial visit.  Choose the appropriate answer to correspond with the total count of required additional visits specified in the treatment plan documented by the Chiropractor.  For example, the Chiropractor notes that the patient is to return for 4 follow-up visits every 2 weeks; select value 4. |
| 14 | nextvis | During the encounter on (computer to display IndexEncounterDate), what was the frequency in which these visits were stated to occur?   1. Weekly 2. Every 2 weeks 3. Every 3-4 weeks 4. Greater than 1 and less than 2 months 5. Greater than 2 months to 6 months 6. Greater than 6 months   7. Combination of frequencies  99. Not specified / unclear | 1,2,3,4,5,6,7,99 | Review the encounter note to identify the frequency in which the follow-up visits were stated to occur.  For example, Chiropractor notes that patient is to return to Chiropractic Clinic every week for 4 weeks, select value 1.  If provider documents more than one desired frequency, such as: “1x per week for 2 visits, then 1x every 2 weeks for 2 more visits,” select value 7.  If unable to identify the frequency, in which the follow-up visits were to occur, select value 99. |

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| 15 | folneed | During the encounter on (computer to display IndexEncounterDate), when was the first follow-up visit noted to occur?   1. Within 1 week 2. Greater than 1 week to 2 weeks 3. Greater than 2 weeks to 3 weeks 4. Greater than 3 weeks to 4 weeks 5. Greater than 1 month to 2 months 6. Greater than 2 months to 3 months 7. Greater than 3 months to 6 months 8. Greater than 6 months   99. Not specified / unclear | 1,2,3,4,5,6,7,8,99 | Review the encounter note on the specified date to identify when the first follow-up visit was to occur.  For example, Chiropractor notes, “Patient to return in 2 weeks”, select value 2. |

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|  | addvis | The intent of the next set of questions are to determine the total number of Chiropractic visits and review additional visits occurring after the Index Visit during the time frame (Computer to display IndexEncounterDate + 1 day and IndexEncounterDate + 6 months). |  | **Number of Total Visits Abstraction Guidelines: If the patient has greater than 10 visits during the time frame specified in question TOTADDVIS, review the first six (6) visits and the last three (3) visits for the following questions.**  **Example:**  Index Encounter: 11/01/2022  Encounter # 2: 11/06/2022 Encounter # 3: 11/09/2022  Encounter # 4: 11/12/2022 Encounter # 5: 11/14/2022  Encounter # 6: 11/16/2022 Encounter # 7: 11/20/2022  Encounter # 8: 11/28/2022 Encounter # 9: 12/01/2022  Encounter # 10: 12/05/2022 Encounter # 11: 12/10/2022  Encounter # 12: 12/15/2022 Encounter # 13: 12/19/2022  Total Visits: 12  Will use: Encounters 2, 3, 4, 5, 6, 7, 11, 12, 13 |
| 16 | totaddvis | Enter the total number of additional chiropractic visits that occurred during the time frame from (Computer IndexEncounterDate + 1 day and IndexEncounterDate + 6 months) at this VAMC. | \_\_\_\_\_\_  Numerical value   |  | | --- | | Warning if 0 or > 10 |   **If 0, go to end** | Review all scheduled visits that occurred after the Index Visit Encounter and up to 6 months after the Index Visit Encounter.  Enter the total number of Chiropractic encounters documented within the time frame.  **Do not count the Index Encounter Visit in the total number of additional Chiropractic visits.**  **Example:**  Index Encounter: 11/01/2022  Encounter # 2: 11/06/2022  Encounter # 3: 11/09/2022  Total Visits: 2 |
| **Number of Total Visits Abstraction Guidelines: If the patient has greater than 10 visits during the time frame specified in question TOTADDVIS, review the first six (6) visits and the last three (3) visits for the following questions.** | | | | |
| **Second Visit** | | | | |
| 17 | chirvst2dt | Enter the date of the second visit with a Chiropractor at this VAMC during the time frame from (Computer IndexEncounterDate + 1 day and IndexEncounterDate + 6 months) | mm/dd/yyyy   |  | | --- | | > IndexEncounterDate and <= 6 months after IndexEncounterDate | | Enter the date of the second visit with a Chiropractor at this VAMC during the specified time frame. |
| 18 | chir2icd1  chir2icd2  chir2icd3  chir2icd4  chir2icd5  chir2icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display chirvst2dt). | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_­­  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | **Warning if xxx.xxxx** | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 19 | chir2cpt1  chir2cpt2  chir2cpt3  chir2cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chirvst2dt). | **­­­­**\_\_ \_\_ \_\_ \_\_ \_\_  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT codes are documented in the medical record on the date of the encounter, add xxxxx. |

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| 20 | chirotc2 | During the encounter on (computer to display chirvst2dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the second chiropractic visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, the chiropractor notes, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |
| 21 | chirex2 | During the encounter on (computer to display chirvst2dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |

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| 22 | chirchg2 | During the encounter on (computer to display chirvst2dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom2 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **Example: Previous note states, “trial of chiropractic care once a week for 4 weeks.” NEW plan on this dates states, “patient responding well to care, patient will return in 3 weeks.”**  **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number of visits or time frame in which visits were set to occur is documented, select value 1.** |
| 23 | chgreas2 | During the encounter on (computer to display chirvst2dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5, 99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**   * **Some examples are:** Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the second visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1.   **Cont’d next page**   * Patient presented to clinic on the second visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |
| 24 | chirvstcom2 | During the encounter on (computer to display chirvst2dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst3dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 25 | disp2case1  disp2case2  disp2case3  disp2case99 | At the end of the encounter on (computer to display chirvst2dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply:**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed) 4. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis =1, go to end** | | | | |
| **Third Visit1** | | | | |
| 26 | chirvst3dt | Enter the date of the third visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst2dt +1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | **>** chirvst2dt and <= 6 months after IndexEncounterDate | | Enter the date of the third visit with a Chiropractor at this VAMC during the specified time frame. |

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| 27 | chir3icd1  chir3icd2  chir3icd3  chir3icd4  chir3icd5  chir3icd6 | Enter all the Chiropractic ICD-10-CM diagnosis codes documented in the medical record for the Chiropractic encounter on (computer display chirvst3dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx, xxxx**  May enter up to six codes   |  | | --- | | Warning if  xxx, xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record on the date of encounter enter xxx.xxxx.  **Suggested data sources:** Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 28 | chir3cpt1  chir3cpt2  chir3cpt3  chir3cpt4 | Enter the CPT codes documented in the record the Chiropractic encounter on **(**computer display chirvst3dt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes**.** | Enter the CPT codes for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |

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| 29 | chirotc3 | During the encounter on (computer to display chirvst3dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the third visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. | |
| 30 | chirex3 | During the encounter on (computer to display chirvst3dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) | |
| 31 | chirchg3 | During the encounter on (computer to display chirvst3dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom3 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note.**  **The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  If any change in number or time frame in which visits were set to occur is documented, select value 1. | |
| 32 | chgreas3 | During the encounter on (computer to display chirvst3dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5, 99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the third visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on third visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** | |
| 33 | chirvstcom3 | During the encounter on (computer to display chirvst3dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst4dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 34 | disp3case1  disp3case2  disp3case3  disp3case99 | At the end of the encounter on (computer to display chirvst3dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply:**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed) 4. None of the above | 1,2,3,99  Cannot select 99 with other values. | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 2, go to end** | | | | |
| **Fourth Visit** | | | | |
| 35 | chirvst4dt | **Enter** the date of the fourth chiropractic visit at this VAMC during the time frame from (computer to display chirvst3dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | > chirvst3dt and < =6 months after IndexEncounterDate | | **Enter the date of the fourth visit with a Chiropractor ~~visit~~ at this VAMC during the specified time frame.** |
| 36 | chir4icd1  chir4icd2  chir4icd3  chir4icd4  chir4icd5  chir4icd6 | Enter all the Chiropractic ICD-10-CM diagnosis codes documented in the record for the encounter on (computer display chirvst4dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter**  **xxx, xxxx**   |  | | --- | | Warning if  xxx, xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record on the date of encounter enter xxx.xxxx.  **Suggested data sources:** Problem List, Health Summaries, Adhoc Reports, Progress notes |

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| 37 | chir4cpt1  chir4cpt2  chir4cpt3  chir4cpt4 | Enter the CPT codes documented in the medical record for the Chiropractic encounter on (computer display chirvst4dt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |
| 38 | chirotc4 | During the encounter on (computer to display chirvst4dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the fourth visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |

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| 39 | chirex4 | During the encounter on (computer to display chirvst4dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |
| 40 | chirchg4 | During the encounter on (computer to display chirvst4dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom4 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note.**  **The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  If any change in number or time frame in which visits were set to occur is documented, select value 1. |
| 41 | chgreas4 | During the encounter on (computer to display chirvst4dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5, 99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the fourth visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on fourth visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |

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| 42 | chirvstcom4 | During the encounter on (computer to display chirvst4dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst5dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 43 | disp4case1  disp4case2  disp4case3  disp4case99 | At the end of the encounter on (computer to displaychirvst4dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed) 4. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 3, go to end** | | | | |
| **Fifth Visit** | | | | |
| 44 | chirvst5dt | Enter the date of the fifth visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst4dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | **>chirvst4dt and < = 6 months after IndexEncounterDate** | | **Enter the date of the fifth visit with a Chiropractor at this VAMC during the specified time frame.** |
| 45 | chir5icd1  chir5icd2  chir5icd3  chir5icd4  chir5icd5  chir5icd6 | **Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on** (computer display chirvst5dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter**  **xxx.xxxx**  May enter up to six codes   |  | | --- | | **Warning if**  **xxx, xxxx** | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10 CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10 CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 46 | chir5cpt1  chir5cpt2  chir5cpt3  chir5cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on(computer display chir5vstdt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |

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| 47 | chirotc5 | During the encounter on (computer to display chirvst5dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the fifth visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |

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| 48 | chirex5 | During the encounter on (computer to display chirvst5dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |

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| 49 | chirchg5 | During the encounter on (computer to display chirvst5dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom5 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |
| 50 | chgreas5 | During the encounter on (computer to display chirvst5dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5, 99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the fifth visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on fifth visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |
| 51 | chirvstcom5 | During the encounter on (computer to display chirvst5dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst6dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 52 | disp5case1  disp5case2  disp5case3  disp5case99 | At the end of the encounter on (computer to display chirvst5dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to  chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 4, go to end** | | | | |
| **Sixth Visit** | | | | |
| 53 | chirvst6dt | **Enter** the date of the sixth visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst5dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | **> chirvst5dt and <= 6 months after IndexEncounterDate** | | **Enter the date of the sixth visit with a Chiropractor at this VAMC during the specified time frame.** |
| 54 | chir6icd1  chir6icd2  chir6icd3  chir6icd4  chir6icd5  chir6icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer display chirvst6dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx, xxxx**  **May enter up to six codes**   |  | | --- | | **Warning if**  **xxx, xxxx** | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 55 | chir6cpt1  chir6cpt2  chir6cpt3  chir6cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chirvst6dt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx |

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| 56 | chirotc6 | During the encounter on (computer to display chirvst6dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the sixth visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |
| 57 | chirex6 | During the encounter on (computer to display chirvst6dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |
| 58 | chirchg6 | During the encounter on (computer to display chirvst6dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom6 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |

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| 59 | chgreas6 | During the encounter on (computer to display chirvst6dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons 6. Not documented | 1,2,3,4,5, 99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the fourth visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on first follow-up (second) visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |
| 60 | chirvstcom6 | During the encounter on (computer to display chirvst6dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst7dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Cont’d next page**  **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 61 | disp6case1  disp6case2  disp6case3  disp6case99 | At the end of the encounter on (computer to display chirvst6dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 5, go to end** | | | | |

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| **Seventh Visit** | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 62 | chirvst7dt | Enter the date of the seventh visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst6dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | > chirvst6dt and < = 6 months after IndexEncounterDate | | **Enter** the date of the seventh visit with a Chiropractor at this VAMC during the specified time frame.  **Remember:**  **Number of Total Visits Abstraction Guidelines: If the patient has greater than 10 visits during the time frame specified in question TOTADDVIS, review the first six (6) visits and the last three (3) visits for the following questions.** | | 63 | chir7icd1  chir7icd2  chir7icd3  chir7icd4  chir7icd5  chir7icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display chirvst7dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | Warning if  xxx, xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes | | 64 | chir7cpt1  chir7cpt2  chir7cpt3  chir7cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chir7vstdt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. | | | | | |
| 65 | chirotc7 | During the encounter on (computer to display chirvst7dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the seventh visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |
| 66 | chirex7 | During the encounter on (computer to display chirvst7dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |
| 67 | chirchg7 | During the encounter on (computer to display chirvst7dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom7 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |
| 68 | chgreas7 | During the encounter on (computer to display chirvst7dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5,99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the seventh visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on seventh visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |

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| 69 | chirvstcom7 | During the encounter on (computer to display chirvst7dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go chirvst8dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |

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| 70 | disp7case1  disp7case2  disp7case3  disp7case99 | At the end of the encounter on (computer to display chirvst7dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 6, go to end** | | | | |
| **Eighth Visit** | | | | |
| 71 | chirvst8dt | Enter the date of the eighth visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst7dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | > chirvst7dt and < = 6 months after IndexEncounterDate | | Enter the date of the eighth visit with a Chiropractor at this VAMC during the specified time frame. |
| 72 | chir8icd1  chir8icd2  chir8icd3  chir8icd4  chir8icd5  chir8icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display chirvst8dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | Warning if  xxx, xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx.  **Suggested data sources**: Problem List, Health Summaries, Adhoc Reports, Progress notes |
| 73 | chir8cpt1  chir8cpt2  chir8cpt3  chir8cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chir8vstdt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |
| 74 | chirotc8 | During the encounter on (computer to display chirvst8dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the eight visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |

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| 75 | chirex8 | During the encounter on (computer to display chirvst8dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |
| 76 | chirchg8 | During the encounter on (computer to display chirvst8dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom8 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |
| 77 | chgreas8 | During the encounter on (computer to display chirvst8dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5,99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the seventh visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on seventh visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |
| 78 | chirvstcom8 | During the encounter on (computer to display chirvst8dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst9dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 79 | disp8case1  disp8case2  disp8case3  disp8case99 | At the end of the encounter on (computer to display chirvst8dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 7, go to end** | | | | |
| **Ninth Visit** | | | | |
| 80 | chirvst9dt | Enter the date of the ninth visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst8dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | > chirvst8dt and < = 6 months after IndexEncounterDate | | Enter the date of the ninth visit with a Chiropractor at this VAMC during the specified time frame. |

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| 81 | chir9icd1  chir9icd2  chir9icd3  chir9icd4  chir9icd5  chir9icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display chirvst9dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | Warning if  xxx, xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx. |
| 82 | chir9cpt1  chir9cpt2  chir9cpt3  chir9cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chirvst9dt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |
| 83 | chirotc9 | During the encounter on (computer to display chirvstdt9), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the ninth visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1.  **Cont’d next page** |
| 84 | chirex9 | During the encounter on (computer to display chirvst9dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment) |

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| 85 | chirchg9 | During the encounter on (computer to display chirvst9dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3 go to chirvstcom9 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |
| 86 | chgreas9 | During the encounter on (computer to display chirvst9dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5,99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the seventh visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on seventh visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |

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| 87 | chirvstcom9 | During the encounter on (computer to display chirvst9dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  If 6, go to chirvst10dt as applicable | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 88 | disp9case1  disp9case2  disp9case3  disp9case99 | At the end of the encounter on (computer to display chirvst9dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |
| **If totaddvis = 8, go to end** | | | | |
| **Tenth Visit** | | | | |
| 89 | chirvst10dt | Enter the date of the tenth visit with a Chiropractor at this VAMC during the time frame from (computer to display chirvst9dt + 1 day and IndexEncounterDate + 6 months). | mm/dd/yyyy   |  | | --- | | > chirvst9dt and < = 6 months after IndexEncounterDate | | Enter the date of the tenth visit with a Chiropractor at this VAMC during the specified time frame. |
| 90 | chir10icd1  chir10icd2  chir10icd3  chir10icd4  chir10icd5  chir10icd6 | Enter all the ICD-10-CM Chiropractic diagnosis code(s) documented in the medical record for the Chiropractic encounter on (computer to display chirvst10dt). | \_\_ \_\_ \_\_ . \_\_ \_\_ \_\_ \_\_  ( 3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Abstractor can enter xxx.xxxx**  May enter up to six codes   |  | | --- | | Warning if  xxx,xxxx | | Enter the Chiropractic diagnosis code(s) documented on the date of the encounter.  A reference list of most common Chiropractic ICD-10-CM diagnosis codes can be found in Table 1.  If no Chiropractic ICD-10-CM diagnosis codes are documented in the medical record, on the date of the encounter enter xxx.xxxx. |
| 91 | chir10cpt1  chir10cpt2  chir10cpt3  chir10cpt4 | Enter the CPT codes documented in the record for the Chiropractic encounter on (computer to display chirvst10dt). | **\_\_ \_\_ \_\_ \_\_ \_\_**  5 alpha-numeric or numeric characters  **Abstractor can enter**  **xxxxx**  May enter up to four codes | Enter the CPT codes documented in the record for the Chiropractic encounter on the specified date.  If no Chiropractic CPT Codes are documented in the medical record on the date of the encounter, enter xxxxx. |

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| 92 | chirotc10 | During the encounter on (computer to display chirvst10dt), what was the documented outcome to care?   1. Overall favorable (reports of patient pain decrease, functional increase, satisfaction, or other.) 2. Overall no change 3. Overall worsened 4. Overall mixed (reporting improvement and others worsening with no clear overall direction)   99. No outcome of care documented or unable to determine outcome | 1,2,3,4,99 | Review the Chiropractor’s documentation to determine the overall outcome to care for the tenth visit.  The pain scale can be used to determine the outcome if it clearly shows a change in number and the change is documented in the note on the date of the encounter. For example, “Patient is ambulating without difficulty today. He reported he has been busy. Patient reported his pain level today is a 3/10. Last week the patient reported his pain level was 5/10.” Select value 1. |

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| 93 | chirex10 | During the encounter on (computer to display chirvst10dt), did the Chiropractor document that a re-examination was performed?   * + - 1. Yes       2. No | 1,2 | **Read the Chiropractor’s note on the date specified and if at least three (3) or more of the below are documented, a re-examination has occurred:**   * Time spent in medical decision making * Orthopedic tests (examples could include straight leg raise, Spurling’s Test, Jackson’s compression test, etc.) * Neurologic tests (reflexes, myotomes, dermatomes) * Observation of patient (ROM/gait analysis/posture) * Functional assessment (back extension/Sorenson Test/Functional Movement Screen/dynamometer strength testing) * Manual assessment (joint and/or soft tissue palpation or assessment |
| 94 | chirchg10 | During the encounter on (computer to display chirvst10dt), did the Chiropractor document a change in the plan for the frequency or scheduling of additional visits?   1. Yes 2. No 3. Not applicable because treatment plan was not documented | 1, 2, 3  If 2 or 3, go to chirvstcom10 | **A change in the Chiropractor’s plan of care may include:**   * Change in number of visits * Change in the time frame in which these visits will occur (days, weeks, months)   **In order to answer this question, please compare the overall planned visit number and scheduling frequency with the previous note. The intent of this question is to determine if there was any significant change in the total number of visits stated to be needed, and/or the time frame in which those visits should occur.**  **If any change in number or time frame in which visits were set to occur is documented, select value 1.** |
| 95 | chgreas10 | During the encounter on (computer to display chirvst10dt), what reason for the change in the plan for frequency or scheduling of additional visits was documented by the Chiropractor?   1. Resolution or substantial improvement of initial complaint 2. Maximum medical benefit reached 3. No improvement of initial complaint 4. Worsening of initial complaint 5. Non-clinical reasons   99. Not documented /unclear | 1,2,3,4,5,99 | **Review the chiropractic note on the specified date to determine the reason for the change in the plan for frequency or scheduling of additional visits.**  **Some examples are:**   * Chiropractor specifies in the index visit that they would like to see the patient once a week for the next 4 to 5 weeks; however, at the end of the seventh visit the Chiropractor discharged the patient due to resolution of complaint. Select value 1. * Patient presented to clinic on seventh visit with flare up of pain; provider decides to extend the trial of care for an additional four (4) visits**.** Select value 4.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.** |

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| 96 | chirvstcom10 | During the encounter on (computer to display chirvst10dt), did the Chiropractor document that the episode of care for this patient was completed?   1. Yes, resolution or substantial improvement of complaint 2. Yes, maximum medical benefit reached 3. Yes, no improvement of complaint 4. Yes, worsening of complaint 5. Yes, non-clinical reasons 6. No documentation that the episode of care was completed | 1,2,3,4,5,6  **If 6, go to end** | **The intent of this question is to determine if there is documentation by the Chiropractor that the planned episode of care was completed at this encounter.**  **Some examples:**   * The Chiropractor documents that the patient has not had any back pain since the last visit and physical exam is normal. Recommends patient to return if symptoms recur. Select value 1.   + - * The Chiropractor notes that the patient reports decreased back pain and is able to walk without issues. The Chiropractor and patient agree that patient should continue exercises at home and further visits are not needed. Select value 2.   **Examples of non-clinical reasons (value 5) include documentation that the patient is moving out of state or patient lives too far away to come back for treatment.**  **If there is no documentation by the Chiropractor that the episode of care was completed at this encounter, select value 6.** |
| 97 | disp10case1  disp10case2  disp10case3  disp10case99 | At the end of the encounter on (computer to display chirvst10dt), what did the Chiropractor document regarding disposition of this patient’s case?  **Select all that apply:**   1. Patient recommended to see primary care 2. Patient referred to another provider 3. Patient recommended to return to chiropractic clinic PRN (or as needed)   99. None of the above | 1,2,3,99  Cannot select 99 with other values | **Review the Chiropractor’s note on the specified date for documentation regarding disposition of patient’s case.**  For example, Chiropractor notes, “Patient’s low back pain has resolved. Recommended patient to return to chiropractic clinic as needed.” Select value 3. |