Chiropractic CPT and ICD-10 Coding for Dummies

Presented by Evan M. Gwilliam, DC MBA BS
CPC CCPC QCC CPC-I  MCS-P CPMA CMHP AAPC Fellow
Clinical Director
evan.gwilliam@paydc.com

Dr. Evan Gwilliam

• Education
  • Bachelor’s of Science, Accounting - Brigham Young University
  • Master’s of Business Administration - Broadview University
  • Doctor of Chiropractic, Valedictorian - Palmer College of Chiropractic

• Certifications
  • Certified Professional Coder (CPC) - AAPC
  • Certified Chiropractic Professional Coder (CCPC) - AAPC
  • Qualified Chiropractic Coder (QCC) - ChiroCode
  • Certified Professional Coder – Instructor (CPC-I) - AAPC
  • Medical Compliance Specialist – Physician (MCS-P) - MCS
  • Certified Professional Medical Auditor (CPMA) – AAPC, NAMAS
  • Certified ICD-10 Trainer – AAPC
  • Certified MIPS Healthcare Professional (CMHP)– 4Med
  • AAPC Fellow
Audit Your Own Evaluation and Management Encounter

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Take Away

• Get familiar with the basics of E/M
• Understand how auditors and coders look at E/M codes
Evaluation & Management

• 1992 Evaluation and Management (E/M) codes introduced by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA).

• 1995 Documentation Guidelines (DGs)
  • Exam scored by number of different systems
  • Works better for general practitioners

• 1997 Documentation Guidelines (DGs)
  • Single organ system exam bullet lists
  • Works better for specialists

Evaluation & Management

Office/Outpatient

<table>
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<tr>
<th>New Patient</th>
<th>Office/Outpatient</th>
<th>Established Patient</th>
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<tbody>
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*A new patient is one who has not received any professional services from the physician....within the past three years.*
Evaluation & Management

Three Key Components:
• History
• Physical Examination
• Medical Decision Making

Contributing Factors:
• Nature of Presenting Problem
• Time
• Counseling
• Coordination of Care

Nature of the Presenting Problem

Medical necessity is the overarching criterion for payment.

“The correct code for an E&M visit should be chosen based on the complexity of the visit. This is determined by the number of problems and the extent that the problems are addressed and documented in the record. The amount of documentation should not be the primary factor for what level of service is billed.”

-BCBS
A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

**Minimal**: A problem that may not require the presence of the physician or other qualified health care professional, but service is provided under the physician’s or other qualified health care professional’s supervision.

**Self-limited or minor**: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

**Low severity**: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

**Moderate severity**: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

**High severity**: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.
### Nature of the Presenting Problem

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### Three Key Components

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<th>Exam</th>
<th>MDM</th>
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### New Patient E/M Matrix (3 of 3)

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**Evaluation & Management:**

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Clinical Example

**Chief Complaint:** Neck pain with right arm tingling.

**History of present illness:**
- **Location:** central C4-C6 radiating to right posterior arm and elbow
- **Quality:** tingling and shooting pain
- **Severity:** 6-8/10 on the VAS
- **Timing:** constant
- **Duration:** two days
- **Context:** MVA, driver of vehicle struck from behind when at stop light
- **Modifying:** Feels better with rest
- **Associated signs and symptoms:** n/a

**Review of systems:**
- **Cardiovascular:** no past issues
- **Neurological:** no past issues
- **Endocrine:** Type II diabetic
- **Musculoskeletal:** Knee replaced, 2007

**Past history:** He takes oral medication for his diabetes, and was hospitalized for knee replacement in 2007. He was treated at this clinic for LBP in 2014.

**Family history:** Father and one sibling have type II diabetes.

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**History — HPI**

### History of Present Illness Elements

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<td>Modifying factors</td>
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<td>Associated signs &amp; symptoms</td>
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</table>

“HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present.” ‘97 DGs

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### History — ROS

**Review of Systems Elements**

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**GENITOURINARY:** Patient DENIES any Burning with urination, Urinary frequency, Blood in urine, Incontinence, Nocturia, Dyspareunia, Vaginal discharge, Vaginal itching, Testicular pain, Testicular mass, Penile discharge, Erection difficulties, Genital sores.
Clinical Example

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<td>6-11</td>
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<tr>
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<td>Y 4+ 2-9 1-2</td>
<td>2x-7x</td>
<td>12 in 2</td>
</tr>
<tr>
<td>99204</td>
<td>Y 4+ 10+ 3</td>
<td>8+</td>
<td>18 in 9</td>
</tr>
<tr>
<td>99205</td>
<td>Y 4+ 10+ 3</td>
<td>8+</td>
<td>18 in 9</td>
</tr>
</tbody>
</table>

- **CC**: Chief Complaint
- **HPI**: History of Present Illness
- **ROS**: Review of Systems
- **PFSH**: Past, Family, and Social History
- **’95 DGs**: Disease Group 1
- **’97 DGs**: Disease Group 2
- **Dx**: Diagnosis
- **Data**: Data
- **Risk**: Risk
Exam: BP 128/84, pulse 76, weight 176 pounds

Cardiovascular: No evidence of swelling in the extremities, pulses and temperatures same.

Musculoskeletal: Palpable swelling and spasticity in cervical paraspinals at C5/C6, pain with active and passive ROM, which is limited 50% in all directions.

Neurological: Pinwheel testing, deep tendon reflexes normal bilaterally in the upper extremities, but cervical compression reproduces symptoms in right arm.
## New Patient E/M Matrix (3 of 3)

<table>
<thead>
<tr>
<th>History (3 of 3)</th>
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<th>MDM (2 of 3)</th>
</tr>
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<tbody>
<tr>
<td><strong>CC</strong></td>
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<td><strong>ROS</strong></td>
</tr>
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<tr>
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<tr>
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<td>4+</td>
</tr>
<tr>
<td>99205</td>
<td>Y</td>
<td>4+</td>
</tr>
</tbody>
</table>

## General Multi-System Examination

### Elements of Examination

#### Constitutional
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

#### Cardiovascular
- Palpation of heart (e.g., location, size, thrills)
- Auscultation of heart with notation of abnormal sounds and murmurs

Examination of:
- carotid arteries (e.g., pulse amplitude, bruits)
- abdominal aorta (e.g., size, bruits)
- femoral arteries (e.g., pulse amplitude, bruits)
- pedal pulses (e.g., pulse amplitude)
- extremities for edema and/or varicosities
**Clinical Example**

**Exam:** BP 128/84, pulse 76, weight 176 pounds

**Cardiovascular:** No evidence of swelling in the extremities, pulses and temperatures same.

**Musculoskeletal:** Palpable swelling and spasticity in cervical paraspinals at C5/C6, pain with active and passive ROM, which is limited 50% in all directions.

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<th>Dx</th>
<th>Data</th>
<th>Risk</th>
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<td>1-5</td>
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<td>1</td>
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<tr>
<td>99204</td>
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<td>10+</td>
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<td>8+</td>
<td>18 in 9</td>
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</tr>
<tr>
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### Established Patient E/M Matrix (2 of 3)

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<tr>
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<th>'97 DGs</th>
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<th>Risk</th>
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<td>Minimal (0-1)</td>
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<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple (3)</td>
<td>Moderate (3)</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
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<tr>
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<td>Extensive (4)</td>
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<td>High Complexity</td>
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### MDM — Diagnosis

#### Number of Diagnoses or Management Options

<table>
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<tr>
<th>Diagnosis</th>
<th>Points</th>
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<tr>
<td>Self-limited or minor problem (^{\text{max}=2})</td>
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</tr>
<tr>
<td>Established (to examiner) stable or improved problem</td>
<td>1 point</td>
</tr>
<tr>
<td>Established (to examiner) worsening problem</td>
<td>2 points</td>
</tr>
<tr>
<td>New (to examiner) problem, no additional work up (^{\text{max}=1})</td>
<td>3 points</td>
</tr>
<tr>
<td>New (to examiner) problem, with additional work up</td>
<td>4 points</td>
</tr>
</tbody>
</table>
Clinical Example

**Assessment:** Sprain of ligaments of the cervical spine (S13.4XXA) and strain of muscles at neck level (S16.1XXA) with cervical radiculopathy to right posterior arm (M54.12). Segmental dysfunction C5/C6 (M99.01).

**Plan:** Davis x-ray series taken to assess for ligamentous instability. See attached report. Initial treatment plan includes treatment three times/week with ultrasound and massage as needed, and gentle spinal manipulation. When able, patient will begin rehabilitation exercises. Reassess after trial of two weeks, and consider MRI for possible disc injury if progress is unsatisfactory.

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<tr>
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<td>High Complexity</td>
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### MDM — Data

**Amount and/or Complexity of Data Reviewed**

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<tr>
<td>Review and/or order of tests in the laboratory section (80000)</td>
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</tr>
<tr>
<td>Review and/or order of tests in the radiology section (70000)</td>
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</tr>
<tr>
<td>Review and/or order of tests in the medicine section (90000)</td>
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</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1 point</td>
</tr>
<tr>
<td>Decision to obtain old records or history from someone other than the patient</td>
<td>1 point</td>
</tr>
<tr>
<td>Review of old records w/document summary or obtain history from someone other than patient</td>
<td>2 points</td>
</tr>
<tr>
<td>Independent/second visualization of tests with documented summary</td>
<td>2 points</td>
</tr>
</tbody>
</table>
Clinical Example

**Assessment:** Sprain of ligaments of the cervical spine (S13.4XXA) and strain of muscles at neck level (S16.1XXA) with cervical radiculopathy to right posterior arm (M54.12). Segmental dysfunction C5/C6 (M99.01).

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Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, eg. cold, insect bite, linea corporis</td>
<td>Laboratory tests requiring urinanalysis, chest x-rays, complete blood count, urinalysis</td>
<td>Rest, saline drip, aspirin, ibuprofen, antihistamines</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not unlike those in uncomplicated illness, eg. urinalysis, chest x-rays</td>
<td>Oral antibiotics, tetanus toxoid, tetanus antitoxin, tetanus antiserum</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors</td>
<td>Surgical treatment of complications of chronic illness, medical management of chronic illness, home health care</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast and identified risk factors</td>
<td>Surgical intervention, medical management of chronic illness, home health care, palliative care</td>
</tr>
</tbody>
</table>

9/9/2019
Assessment: Sprain of ligaments of the cervical spine (S13.4XXA) and strain of muscles at neck level (S16.1XXA) with cervical radiculopathy to right posterior arm (M54.12). Segmental dysfunction C5/C6 (M99.01).

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<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>One self-limited or minor problem, eg, cold, insect bite, linea corporis</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Diet, Cargers, Elastic bandages, Superficial dressings.</td>
</tr>
<tr>
<td></td>
<td>Two or more self-limited or minor problems</td>
<td>Physical tests not under stress, eg, pulmonary function tests</td>
<td>Non-cardiovascular imaging studies with contrast, eg, barium swallow, EGD, CT scan.</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, eg, well controlled hypertension, normotensive dependent</td>
<td></td>
<td>Over-the-counter drugs, little surgery with no identified risk factors.</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, eg, sprain, fracture, laceration, mild cellulitis</td>
<td></td>
<td>Superficial needle biopsies, Clinical laboratory tests requiring arterial puncture.</td>
</tr>
<tr>
<td></td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td></td>
<td>Minor surgery with identified risk factors.</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td></td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors.</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncorrected, eg, lung nodule</td>
<td></td>
<td>Prescription drug management.</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, eg, pneumonia, peritonitis, otitis media</td>
<td></td>
<td>Therapeutic nuclear medicine for fluids with additives.</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, eg, head injury with brief loss of consciousness</td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation.</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td></td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors.</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or injuries that pose a threat to life of body function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, severe respiratory distress, progressive severe rheumatic arthritis, psychiatric illness with potential threat to self or others, dementia, acute renal failure</td>
<td></td>
<td>Emergency major surgery (open, percutaneous, or endoscopic).</td>
</tr>
<tr>
<td></td>
<td>Acute illness with potential threat to self or others, pneumonia, acute respiratory failure, acute renal failure, acute neurologic status, eg, seizure, TIA, weakness, sensory loss</td>
<td></td>
<td>Parenteral controlled substances.</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td></td>
<td>Drug therapy requiring intensive monitoring for toxicity.</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or injuries that pose a threat to life or body function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, severe respiratory distress, progressive severe rheumatic arthritis, psychiatric illness with potential threat to self or others, dementia, acute renal failure</td>
<td></td>
<td>Decision not to resuscitate or to discontinue care because of poor prognosis.</td>
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### Unofficial Chiropractic Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Examples</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>Self limited problem, one non invasive test (x-ray), simple management.</td>
<td>Symptomatic complaints without a definitive diagnosis, such as minor neck pain (maybe &lt;6 chiro visits).</td>
<td>Diet, Cargers, Elastic bandages, Superficial dressings.</td>
</tr>
<tr>
<td></td>
<td>Two or more self-limited problems (eg, chronic mildly invasive test (blood work), OTC drugs</td>
<td>Arthritis, degenerative joint disease, radiculopathy with no identified risk factors.</td>
<td>Non-cardiovascular imaging studies with contrast, eg, barium swallow, EGD, CT scan.</td>
</tr>
<tr>
<td></td>
<td>Multiple chronic, or systemic acute problems, more invasive tests (incl. labs), major surgery with risks, prescription drug reg, IV fluids.</td>
<td>MVA with loss of consciousness, fracture, neurological complications (maybe &gt;24 chiro visits).</td>
<td>Non-cardiovascular imaging studies with contrast, eg, barium swallow, EGD, CT scan.</td>
</tr>
<tr>
<td></td>
<td>Severe chronic or acute problems, imaging with contrast (discography), emergency surgery</td>
<td>Acute MI, seizure, stroke, abrupt change in neurologic status – weakness, sensory loss (refer to emergency room).</td>
<td>Non-cardiovascular imaging studies with contrast, eg, barium swallow, EGD, CT scan.</td>
</tr>
</tbody>
</table>
### Medical Decision Making (MDM)

<table>
<thead>
<tr>
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<th>Data</th>
<th>Risk</th>
<th>Type of MDM</th>
</tr>
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<tbody>
<tr>
<td>Minimal (1)</td>
<td>Minimal (1)</td>
<td>Minimal</td>
<td>Straightforward</td>
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<tr>
<td>Limited (2)</td>
<td>Limited (2)</td>
<td>Low</td>
<td>Low Complexity</td>
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<tr>
<td>Multiple</td>
<td>Moderate (3)</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive (4)</td>
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<td>High Complexity</td>
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### New Patient E/M Matrix (3 of 3)

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<thead>
<tr>
<th>CC</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>'95 DGs</th>
<th>'97 DGs</th>
<th>Dx</th>
<th>Data</th>
<th>Risk</th>
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</thead>
<tbody>
<tr>
<td>99201</td>
<td>Y</td>
<td>1-3</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>1-5</td>
<td>1</td>
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</tr>
<tr>
<td>99202</td>
<td>Y</td>
<td>1-3</td>
<td>1</td>
<td>n/a</td>
<td>2-7</td>
<td>6-11</td>
<td>1</td>
<td>0-1</td>
</tr>
<tr>
<td>99203</td>
<td>Y</td>
<td>4+</td>
<td>2-9</td>
<td>1-2</td>
<td>2x-7x</td>
<td>12 in 2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>99204</td>
<td>Y</td>
<td>4+</td>
<td>10+</td>
<td>3</td>
<td>8+</td>
<td>18 in 9</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99205</td>
<td>Y</td>
<td>4+</td>
<td>10+</td>
<td>3</td>
<td>8+</td>
<td>18 in 9</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
### New Patient E/M (3 of 3)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

### Established Patient E/M Matrix (2 of 3)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Y</td>
<td>Reason for encounter</td>
<td>Vital signs or tests</td>
</tr>
<tr>
<td>99212</td>
<td>Y</td>
<td>1-3</td>
<td>n/a</td>
</tr>
<tr>
<td>99213</td>
<td>Y</td>
<td>1-3</td>
<td>1</td>
</tr>
<tr>
<td>99214</td>
<td>Y</td>
<td>4+</td>
<td>2-9</td>
</tr>
<tr>
<td>99215</td>
<td>Y</td>
<td>4+</td>
<td>10+</td>
</tr>
</tbody>
</table>
### Established Patient E/M 2 of 3

<table>
<thead>
<tr>
<th></th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Reason for encounter</td>
<td>Vital signs or tests</td>
<td>Instructions</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

#### Evaluation & Management:

Time and other special circumstances
If counseling and/or coordination of care dominates (more than 50%) of the encounter, time is the key controlling factor.

<table>
<thead>
<tr>
<th>New Pt. code</th>
<th>Time</th>
<th>Est. Pt. code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 min.</td>
<td>99211</td>
<td>5 min.</td>
</tr>
<tr>
<td>99202</td>
<td>20 min.</td>
<td>99212</td>
<td>10 min.</td>
</tr>
<tr>
<td>99203</td>
<td>30 min.</td>
<td>99213</td>
<td>15 min.</td>
</tr>
<tr>
<td>99204</td>
<td>45 min.</td>
<td>99214</td>
<td>25 min.</td>
</tr>
<tr>
<td>99205</td>
<td>60 min.</td>
<td>99215</td>
<td>40 min.</td>
</tr>
</tbody>
</table>
Time Override

Counseling--discussion with patient or family
- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management options
- Instructions for management and follow up
- Importance of compliance with chosen management options
- Risk factor reduction
- Patient and family education

Time Override

Create a form that records the time and lists the seven counseling items as subheadings.

Then fill in the blanks to show a coder / auditor exactly what they are looking for.
Evaluation and Management Counseling Record

The following information was discussed with the patient:

**Diagnostic results / impressions:** Sprain of ligaments of cervical spine, strain of muscles at neck level. Cervical radiculopathy to right arm. Segmental dysfunction (subluxation) C5/C6.

**Prognosis:** Patient is expected to respond favorably to treatment.

**Risks and benefits:** Patient understands that there is a possible disc injury which may require surgery, which carries significant risk. Chiropractic care is relatively safe, by comparison. Data suggests better long term recovery with chiropractic.

**Instructions for management / follow up:** Three times per week for two weeks, with re-exam, then possibly three or two per week for up to four more weeks.

**Importance of compliance with management options:** Patient informed that rehabilitation exercises are critical to long term recovery.

**Risk factor reduction:** Patient instructed to avoid strenuous activities, including heavy lifting for 4-6 weeks.

**Patient education:** Soft tissue healing and remodeling models explained, as well as the nature and physiology of disc herniations.

---

**Time Override**

**Start time:** 3:40pm  **Stop time:** 3:58pm  **Face-to-face:** 16 minutes

---

**New Pt. code** | **Time** | **Est. Pt. code** | **Time**
--- | --- | --- | ---
99201 | 10 min. | 99211 | 5 min.
99202 | 20 min. | 99212 | 10 min.
99203 | 30 min. | 99213 | 15 min.
99204 | 45 min. | 99214 | 25 min.
99205 | 60 min. | 99215 | 40 min.
Do you bill level 4 and level 5 exams?
If your practice profile is significantly different from this, you could be on the radar.
### Medical Decision Making (MDM) (2 of 3)

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Data</th>
<th>Risk</th>
<th>Type of MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (1)</td>
<td>Minimal (0-1)</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited (2)</td>
<td>Limited (2)</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple (3)</td>
<td>Moderate(3)</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive (4)</td>
<td>Extensive (4)</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

### Unofficial Chiropractic Table of Risk

<table>
<thead>
<tr>
<th>MDM — Risk</th>
<th>Unofficial Chiropractic Table of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Self limited problem, one non invasive test (x-ray), simple management. Examples: Symptomatic complaints without a definitive diagnosis, such as minor neck pain (maybe &lt;5 chiro visits).</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited problems or one stable chronic, mildly invasive test (blood work), OTC drug mg, physical therapy, minor surgery. Examples: Sprain/strain, degenerative joint disease, radiculopathy without complications (maybe 7-24 chiro visits)</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple chronic, or systemic acute problems, more invasive tests (inclinations), major surgery with risks, prescription drug mg, IV fluids. Examples: MVA with loss of consciousness, fracture, neurological complications (maybe &gt;24 chiro visits)</td>
</tr>
<tr>
<td>High</td>
<td>Combinations of acute problems, imaging with contrast (discography). Examples: Acute H2 axis dysfunction, trauma in neurologic status, weakness, sensory, reflex, imaging and functionality.</td>
</tr>
</tbody>
</table>
### Established Patient E/M Matrix

#### History (3 of 3) vs. Exam MDM (2 of 3)

<table>
<thead>
<tr>
<th>CC</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>'95 DGs</th>
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<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Y</td>
<td>1-3</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>1-5</td>
<td>1</td>
<td>0-1</td>
</tr>
<tr>
<td>99212</td>
<td>Y</td>
<td>1-3</td>
<td>1</td>
<td>n/a</td>
<td>2-7</td>
<td>6-11</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>99213</td>
<td>Y</td>
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<td>2-9</td>
<td>1</td>
<td>2x-7x</td>
<td>12 in 2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99214</td>
<td>Y</td>
<td>4+</td>
<td>10+</td>
<td>2+</td>
<td>8+</td>
<td>18 in 9</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### Consultations

**99241-99245:** Office outpatient consultations

- RVU higher by 20-60%
- Must receive a written request from a referring physician (or appropriate source) and enter the information in box 17 on CMS 1500
- "Appropriate sources" include physicians, mid-levels, social workers, lawyers, and insurance companies (add modifier 32 if mandated)
- Must send a report (and attach a copy to the claim for good measure) to the referring physician, who still manages the patient
Modifier 25

According to the CPT manual:
- “CMT codes include a pre-manipulation assessment. Additional E/M services….may be reported separately using modifier 25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.”

- Modifier 25 tells the payer that the E/M service is not part of the CMT service and should be paid separately.
- It is unnecessary if CMT is not also billed that day.

These situations might be “significant and separately identifiable:”
- Periodic re-evaluation (2 weeks, then every 4 weeks)
- New condition
- Exacerbation or re-injury
- Return after lapse in care
- Counseling (using the time override)
- Release/discharge from active care
Take Away

• Get familiar with the basics of E/M

• Understand how auditors and coders look at E/M codes

Documenting Diagnoses Like a Peer Reviewer

Presented by Evan M. Gwilliam, DC MBA BS
CPC CCPC QCC CPC-I MCS-P CPMA CMHP AAPC Fellow
Clinical Director
evang@paydc.com
Take-away

For the top conditions treated by DCs, learn:

1. Code options
2. Code detail considerations
3. Common objective findings
4. Top procedure code linkage
5. Subjective and Objective sample documentation

Muscles, discs, headaches, pain, radiculopathy, sprain/strain, subluxations

Diagnosis Hierarchy

1. Nerve-related disorders (e.g. radiculopathy)
2. Acute injuries (e.g. sprains and strains)
3. Structural diagnoses (e.g. degenerative disc disease)
4. Functional diagnoses (e.g. difficulty with walking)
5. Symptoms (e.g. neck pain)
6. Comorbidities (e.g. diabetes)
7. External causes (e.g. place and activity)
ICD-10-CM Updates

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>New codes</td>
<td>1,943</td>
<td>363</td>
<td>279</td>
</tr>
<tr>
<td>Revised codes</td>
<td>422</td>
<td>252</td>
<td>143</td>
</tr>
<tr>
<td>Deleted codes</td>
<td>302</td>
<td>142</td>
<td>51</td>
</tr>
</tbody>
</table>

Deleted Oct. 1, 2016:
- M50.12 Cervical disc disorder with radiculopathy, mid-cervical region

New Oct. 1, 2016:
- M50.120 Mid-cervical disc disorder, unspecified
- M50.121 Cervical disc disorder at C4-C5 level with radiculopathy
- M50.122 Cervical disc disorder at C5-C6 level with radiculopathy
- M50.123 Cervical disc disorder at C6-C7 level with radiculopathy
ICD-10-CM Updates

Deleted Oct. 1 2017:
• M48.06 Spinal stenosis, lumbar region

New Oct. 1, 2017:
• M48.061 Spinal stenosis, lumbar region without neurogenic claudication
• M48.062 Spinal stenosis, lumbar region with neurogenic claudication

ICD-10-CM Updates

As of October 1, 2018, there will be 71,932 active ICD-10 CM codes.

Deleted Oct. 1, 2018:
• M79.1 — Myalgia

New Oct. 1, 2018:
• M79.10 — Myalgia, unspecified site
• M79.11 — Myalgia of mastication muscle
• M79.12 — Myalgia of auxiliary muscles, head and neck
• M79.18 — Myalgia, other site
Sprain/strain
1. Code options

Sprain/Strain (Spinal)

<table>
<thead>
<tr>
<th>Code Options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S13.4xx. Sprain of ligaments of cervical spine</td>
<td>Example: Stretching or tearing of ligaments</td>
</tr>
<tr>
<td>S16.1xx. Strain of muscle, fascia, and tendon at neck level</td>
<td></td>
</tr>
<tr>
<td>S23.3xx. Sprain of ligaments of thoracic spine</td>
<td>Example: Stretching or tearing of ligaments</td>
</tr>
<tr>
<td>S29.012. Strain of muscle, fascia, and tendon of back wall of thorax</td>
<td>Example: Stretching or tearing of muscle or tendon</td>
</tr>
<tr>
<td>S33.5xx. Sprain of ligaments of lumbar spine</td>
<td>Example: Stretching or tearing of ligaments</td>
</tr>
<tr>
<td>S33.6xx. Sprain of muscle, fascia, and tendon of lower back</td>
<td>Example: Stretching or tearing of ligaments</td>
</tr>
<tr>
<td>S39.012. Strain of muscle, fascia, and tendon of lower back</td>
<td>Example: Stretching or tearing of muscle or tendon</td>
</tr>
<tr>
<td>S39.013. Strain of muscle, fascia, and tendon of pelvis</td>
<td>Example: Stretching or tearing of muscle or tendon</td>
</tr>
</tbody>
</table>
Sprain/strain

2. Coding considerations

• Though they commonly occur simultaneously, sprains and strains must be coded separately if both are documented.

Seventh character
• The seventh character “A, initial encounter” is the most likely choice for these codes, as long as the patient is undergoing “active treatment.”

Extremities
• Sprains and strains for extremities follow a similar pattern. They begin with the letter “S,” the second character designates the anatomic location (e.g. “6” for wrist, “9” for ankle). The third character is “3” for sprains and “6” or “9” for strains.

Symptoms
• Many conditions, such as strains of muscles, include pain. Signs and symptoms that are associated routinely with a condition should not be assigned as additional codes.

Sprain/strain

3. Objective findings

Sprain
• Palpation
• Pain with passive assisted motion
• Flexion/extension or digital motion x-rays,
• Possible MRI

Strain
• Palpation
• Pain during muscle contraction
• Possible MRI

Sprain/strain

4. CPT linkage

• 97140 Manual therapy
• 97124 Massage therapy
• 97110 Therapeutic exercise
• 97014 Electrical stimulation

• 97012 Mechanical traction
• 97035 Ultrasound
• 97010 Hot/cold pack
Sprain/strain
5. Sample documentation

S13.4XXA Sprain of ligaments of cervical spine, initial encounter

Subjective: Following a rear-end collision, patient reports pain at the back of the neck and headache that began a day after the accident. She also reports some vertigo and difficulty sleeping.

Objective: Examination reveals forward head posture, rounded shoulders, rigidity and spasm with tenderness and edema in the neck bilaterally. Passive ROM is decreased in all planes. DTRs normal. Spurlings negative for radiculopathy.

Segmental dysfunction
1. Code options

<table>
<thead>
<tr>
<th>Subluxation</th>
<th>Segmental and Somatic Dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>M99.00</td>
<td>Head region</td>
</tr>
<tr>
<td>M99.01</td>
<td>Cervical region</td>
</tr>
<tr>
<td>M99.02</td>
<td>Thoracic region</td>
</tr>
<tr>
<td>M99.03</td>
<td>Lumbar region</td>
</tr>
<tr>
<td>M99.04</td>
<td>Sacral region</td>
</tr>
<tr>
<td>M99.05</td>
<td>Pelvic region</td>
</tr>
<tr>
<td>M99.06</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>M99.07</td>
<td>Upper extremity</td>
</tr>
<tr>
<td>M99.08</td>
<td>Rib cage</td>
</tr>
</tbody>
</table>
2. Coding considerations

“Subluxation”
• Other ICD-10-CM codes include the word “subluxation,” but it appears that they are not recognized by payers as indications to justify chiropractic manipulative treatment.
• Document “segmental dysfunction” to match the code description.

Trauma
• The so-called traumatic subluxation codes, S13.1 - Cervical, S23.1 - Thoracic, S33.1 - Lumbar include “sprain,” and therefore would not be reported on the same claim as sprains.

PART
• Note that the sample documentation follows the Medicare principle of P.A.R.T., which should suffice for all payers and regulators.

3. Objective findings

• Static palpation
• Motion palpation
• Observation
• Range of motion
• X-ray

4. CPT linkage

• 98940-98943 Chiropractic Manipulative Treatment
**Segmental dysfunction**

5. Sample documentation

M99.03 Segmental and somatic dysfunction, lumbar region

**Subjective:** Patient reports lumbar spinal pain during regular activities.

**Objective:**
- **P:** Pain is reproduced when the L3/L4 region is palpated.
- **A:** The L3 spinous process is rotated to the right, and the L4 spinous is rotated left. The right hip appears higher than the left.
- **R:** Right lumbar lateral bending and flexion are reduced as recorded by inclinometry.
- **T:** Hypertonicity is palpated in the lumbar paraspinal region.

---

**Muscles**

1. Code options

<table>
<thead>
<tr>
<th>Muscle Conditions</th>
<th>Code Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>M50.8 Other myositis</td>
<td>Example: Inflammation of muscles, but documented detail does not match other myositis codes</td>
</tr>
<tr>
<td>M62.4 Contracture of muscle</td>
<td>Example: Shortening and hardening of muscle, leading to rigidity</td>
</tr>
<tr>
<td>M62.81 Muscle weakness (generalized)</td>
<td>Example: Measurable loss of muscle function</td>
</tr>
<tr>
<td>M62.83 Muscle spasm</td>
<td>Example: Involuntary muscle contractions</td>
</tr>
<tr>
<td>M79.1 Myalgia, myofascial pain syndrome</td>
<td>Example: Pain in muscle, trigger points</td>
</tr>
<tr>
<td>M79.7 Fibromyalgia</td>
<td>Example: Disorder characterized by widespread musculoskeletal pain and fatigue, sleep, memory and mood issues</td>
</tr>
</tbody>
</table>
Muscles

2. Coding considerations

Myositis:
- M60.8- Other myositis documentation should include weakness and signs of inflammation, such as heat, redness, or swelling.
- The other subcategories (fourth characters) for myositis are “infective,” “interstitial,” and “foreign body granuloma;” therefore “other” is most likely to be used in a chiropractic setting.
- The fifth character describes the anatomic location of the involved muscles.

Contracture:
- The fifth and sixth characters for M62.4- Contracture of muscle provide detail about the anatomic location.

Weakness:
- The description for M62.81 includes “generalized” in parenthesis. This is a non-essential modifier, so it is not a required part of the code. (i.e. this code works for localized weakness too.)

Spasm:
- Three options for the sixth character for M62.83- Muscle spasm. It designates the location of the spasm (back, calf, or “other”).

Myalgia:
- M79.1 Myalgia cannot be coded along with M79.7 Fibromyalgia or M60. - Myositis. It is already included in those conditions.

Muscles

3. Objective findings

- Muscle strength
- Palpation
- Algometry

Muscles

4. CPT linkage

- 97140 Manual therapy (especially M79.1, M62.4-)
- 97124 Massage therapy (especially M62.83-, M62.4-)
- 97112 Neuromuscular reeducation (M62.81)
- 97014 Electrical stimulation
- 97012 Mechanical traction
- 97035 Ultrasound
- 97010 Hot/cold pack
Muscles
5. Sample documentation

M62.83Ø Muscle spasm of the back

Subjective: Patient complains of hard, tight muscles in the mid back. He is a 55 year old sedentary male whose symptoms began after 36 holes of golf last weekend.

Objective: Palpation reveals tight and rigid fibers in the thoraco-lumbar paraspinals bilaterally. ROM limited 50% in all directions. Consider x-ray to evaluate for spinal arthritis.

Disc disorders
1. Code options

<table>
<thead>
<tr>
<th>Disc Disorders (M50-., M51-.)</th>
<th>Code Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERVICAL DISC DISORDERS</td>
<td>Code Options</td>
</tr>
<tr>
<td>M50.0- With myelopathy</td>
<td>Example: Neurologic deficit to spinal cord</td>
</tr>
<tr>
<td>M50.1- With radiculopathy</td>
<td>Example: Neurologic deficit to nerve roots</td>
</tr>
<tr>
<td>M50.2- Other disc displacement</td>
<td>Example: No neurological complications</td>
</tr>
<tr>
<td>M50.3- Degeneration</td>
<td>Example: Only x-ray findings, no neurological complications</td>
</tr>
<tr>
<td>M50.8- Other disc disorders</td>
<td>Example: Documented detail does not match the other options</td>
</tr>
<tr>
<td>M50.9- Unspecified</td>
<td>Example: None of the above details are documented</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THORACIC, THORACOLUMBAR, AND LUMBOSacral INTERVERTEBRAL DISC DISORDERS</th>
<th>Code Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>M51.0- With myelopathy</td>
<td>Example: Neurologic deficit to spinal cord</td>
</tr>
<tr>
<td>M51.1- With radiculopathy</td>
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<tr>
<td>M51.3- Degeneration</td>
<td>Example: Only x-ray findings, no neurological complications</td>
</tr>
<tr>
<td>M51.4- Schmor's nodes</td>
<td>Example: As seen on x-ray</td>
</tr>
<tr>
<td>M51.8- Other disc disorders</td>
<td>Example: Documented detail does not match the other options</td>
</tr>
<tr>
<td>M51.9- Unspecified</td>
<td>Example: None of the above details are documented</td>
</tr>
</tbody>
</table>
The fifth character for all of these codes designates the specific anatomic location. See the Tabular List for details.

Symptoms:
- M54.2 Cervicalgia would not be coded along with M5Ø - Cervical disc disorders codes because it is already included.
- M54.5 Low back pain would not be coded along with M51.2 - Other disc displacement because it is already included.
- M54.1- Radiculopathy would not be coded with M5Ø.1- or M51.1 - Disc disorders with radiculopathy because it is already included.
- M54.3- or M54.4 - Sciatica would not be coded with M51.1 - Disc disorder with radiculopathy because it is already included.

Disc disorders
2. Coding considerations

Disc disorders
3. Objective findings
- Deep tendon reflexes
- Muscle strength
- Pinwheel testing
- Orthopedic tests
- X-ray
- MRI scan
- CT scan with myelography
- Electromyelogram

Disc disorders
4. CPT linkage
- 98940-98942 Chiropractic Manipulative Therapy
- 97140 Manual therapy (includes traction)
- 97012 Mechanical traction
**Subjective:** Patient is a 37 year male who complains of neck pain and weakness in the right biceps and wrist extensor muscles, as well as numbness, tingling, and pain radiating to the thumb side of the hand. It began following a hyperextension injury.

**Objective:** Examination reveals that the patient tilts his head to the left, and has decreased extension and right lateral bending and rotation. Hypertonicity and tenderness is palpated on the right side of the neck. Elbow flexion and wrist extension strength are 4/5. Foraminal compression test reproduces the symptoms.

### Pain/stiffness
#### 1. Code options

<table>
<thead>
<tr>
<th>Code Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>M25.5- Pain in joint</td>
</tr>
<tr>
<td>M25.6- Stiffness of joint, not elsewhere classified</td>
</tr>
<tr>
<td>M54.2 Cervicalgia</td>
</tr>
<tr>
<td>M54.5 Low back pain</td>
</tr>
<tr>
<td>M54.6 Pain in thoracic spine</td>
</tr>
<tr>
<td>M79.6- Pain in limb, hand, foot, fingers and toes</td>
</tr>
</tbody>
</table>

*Example: Discomfort in an extremity joint*

*Example: Stiffness in an extremity joint*

*Example: Discomfort in the neck region*

*Example: Lumbalgia or lumbago*

*Example: Thoracalgia*

*Example: Discomfort in hands or feet*
Pain/stiffness
2. Coding considerations

Spinal
• The spinal pain codes are a restatement of the patient’s subjective complaint. It does not require any clinical skill to provide these diagnoses. When using them, try to add more detail by stating “due to…” and finish the sentence. More definitive diagnoses will better communicate medical necessity to third party payers.
• Many conditions, such as strains of muscles, include pain. Signs and symptoms that are associated routinely with a condition should not be assigned as additional codes.
• The spinal pain codes should not be coded with certain disc disorder codes because they are included.
• Even though there are codes for “joint stiffness,” there are none for “spinal stiffness.” That information should still be documented and may support the selection of M99.0- Segmental and somatic dysfunction codes.

Extraspinal
• The fifth and sixth characters for M25.5- Pain in joint describe the anatomic location of the pain, but do not include hands and fingers, feet and toes, or spinal joints. Those codes begin with M79.6-.
• M25.6- Stiffness of joint, NEC is to be used if the documented cause of the stiffness does not include ankylosis (M24.6-), or contracture (M24.5-).

Pain/stiffness
3. Objective findings
• Palpation
• Range of motion

Pain/stiffness
4. CPT linkage
• 97014 Electrical stimulation
• 97035 Ultrasound
• 97010 Hot/cold pack
Pain/stiffness
5. Sample documentation

M54.1 Cervicalgia

**Subjective:** Patient complains of generalized neck pain and stiffness with no radiation to the upper extremities. Sharp pain is noticed with rotation, but it goes away with rest.

**Objective:** Examination findings include a visible kyphosis and tenderness to palpation in the neck region and upper trapezius bilaterally. ROM is slightly limited in all ranges. X-rays are negative for significant findings.

Radiculopathy
1. Code options

**Radiculopathy and Sciatica (M54.-)**

<table>
<thead>
<tr>
<th>Code Options</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.1-</td>
<td>Radiculopathy, neuritis or radiculitis</td>
</tr>
<tr>
<td>M54.3-</td>
<td>Sciatica</td>
</tr>
<tr>
<td>M54.4-</td>
<td>Lumbago with sciatica</td>
</tr>
</tbody>
</table>

More definitive diagnoses:
- M50.1 - Cervical disc disorder with radiculopathy
- M51.1 - Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy
- M47.2 - Other spondylosis with radiculopathy.
Definitions

• Neuritis or neuropathy is inflammation of a peripheral nerve. (Included in M54.1-)
• Radiculitis is inflammation of a spinal nerve along its path of travel (dermatome). (Included in M54.1-)
• Radiculopathy is a general term for the condition of spinal nerve root problems, including paresthesia, hyporeflexia, motor loss, and pain. (Included in M54.1-).
• Sciatica definitions vary, but it is generally defined as numbness, tingling, weakness, and leg pain that originates in the buttock and travels down the path of the sciatic nerve in the back of the leg.

Laterality

• The fifth character for M54.1- Radiculopathy designates the spinal level. Laterality is not an option for these codes. Document it anyway.
• The fifth character for M54.3- Sciatica and M54.4- Lumbago with sciatica designates the laterality.

Combo

• M54.4- Lumbago with sciatica is a combination code. Multiple codes should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.

2. Coding considerations

3. Objective findings

• Deep tendon reflexes
• Muscle strength
• Pinwheel testing
• Straight leg raiser
• Bragard’s
• Laségue’s
• MRI scan
• CT scan with myelography
• Electromyelogram
• Needle EMG
• Nerve conduction velocity tests

4. CPT linkage

• 98940-98942 Chiropractic manipulative therapy
• 97140 Manual therapy (includes traction)
• 97012 Mechanical traction
M54.17 Lumbosacral radiculopathy

Subjective: Patient is a 55 year old male who has worked on the docks, engaged in heavy labor, for 25 years. He reports numbness and shooting pain from the right buttock to the right posterior thigh and lateral ankle/foot which increases with sneezing or coughing.

Objective: Decreased sensation via pinwheel testing along right S1 dermatome. Lasegue’s test reproduces the symptoms. Ankle plantar flexion and eversion is 4 out of 5 on the right. Achilles reflex is absent on the right.

Headaches
1. Code options

<table>
<thead>
<tr>
<th>Headaches (G43.-, G44.-)</th>
<th>Code Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>G43.- MIGRAINES</td>
<td>Example: Severe headaches, usually one side of head, with nausea, vomiting, and extreme sensitivity to light and sound</td>
</tr>
<tr>
<td>G43.0 Migraine without aura</td>
<td>Example: No visual or other disturbance noticed before headache</td>
</tr>
<tr>
<td>G43.1 Migraine with aura</td>
<td>Example: Visual or other disturbance noticed before headache</td>
</tr>
<tr>
<td>G43.7 Chronic migraine without aura</td>
<td>Example: 15 or more days per month, for at least three months</td>
</tr>
<tr>
<td>G43.8 Migraine, other</td>
<td>Example: Documented detail does not match the other options</td>
</tr>
<tr>
<td>G43.9 Migraine, unspecified</td>
<td>Example: None of the above details are documented</td>
</tr>
<tr>
<td>G44.- OTHER HEADACHES</td>
<td>Example: Non-migraines</td>
</tr>
<tr>
<td>G44.0 Cluster headaches</td>
<td>Example: Recurrent, cyclical severe headaches</td>
</tr>
<tr>
<td>G44.1 Vascular headache, not elsewhere classified</td>
<td>Example: Documented detail does not match the other options</td>
</tr>
<tr>
<td>G44.2 Tension-type headache</td>
<td>Example: Hat-band pattern, often with muscle involvement</td>
</tr>
<tr>
<td>G44.3 Post-traumatic headache</td>
<td>Example: Follows brain injury, such as concussion</td>
</tr>
<tr>
<td>G44.4 Drug-induced headache</td>
<td>Example: Worsens with medication use</td>
</tr>
</tbody>
</table>
**Headaches**

2. Coding considerations

**Definition:**
- For most headache codes, the fifth or sixth character identifies whether or not the headache is intractable.
- This is defined in the code set as pharmaco-resistant, treatment resistant, refractory, and poorly controlled.

**Symptoms:**
- R51 *Headache* is the symptom code for headaches that do not have a definitive diagnosis.
- This would be used only when the provider has not documented one of the headaches from G43.- or G44.-.

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**Headaches**

3. Objective findings

- Cranial nerve evaluation
- MRI scan
- CT scan

**Headaches**

4. CPT linkage

- 98940-98942 *Chiropractic Manipulative Therapy*
- ???
G44.221 Chronic tension-type headache, intractable

**Subjective:** Patient is a middle aged female who complains of dull ache and tightness in a hat band pattern, with muscle rigidity in the neck and shoulders. Headaches occur more than 15 days per month, for the last six months. It does not respond to over the counter medication.

**Objective:** Cranial nerve tests within normal limits, consider MRI or CT scan to rule out tumors.

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**Take-away**

For the top conditions treated by DCs, learn:

1. Code options
2. Code detail considerations
3. Common objective findings
4. Top procedure code linkage
5. Subjective and Objective sample documentation

Muscles, discs, headaches, pain, radiculopathy, sprain/strain, subluxations
Coding and Documenting Physical Therapy Procedures

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  • Master’s of Business Administration - Broadview University
  • Doctor of Chiropractic, Valedictorian - Palmer College of Chiropractic

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  • Qualified Chiropractic Coder (QCC) - ChiroCode
  • Certified Professional Coder – Instructor (CPC-I) - AAPC
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  • Certified Professional Medical Auditor (CPMA) – AAPC, NAMAS
  • Certified ICD-10 Trainer – AAPC
  • Certified MIPS Healthcare Professional (CMHP)– 4Med
  • AAPC Fellow
Take Away

For the top therapeutic procedure and modality CPT codes for chiropractors
  o Get a handle on the fundamentals and coding rules
  o Identify the right modifiers and diagnosis codes
  o Nail the documentation requirements
  o Eliminate denials

References

  o 2019 ChiroCode DeskBook
  o American Medical Association
    • Current Procedural Terminology, 2019
    • CPT Assistant articles
  o Centers for Medicare and Medicaid Services
    • Local Coverage Determination – Physical Therapy, outpatient (L30009), Cahaba Government Benefit Administrators
  o FindACode.com
  o CMS National Correct Coding Initiative
  o Anthem Payer Policies
Therapeutic Procedure Coding for Chiropractic

Most commonly used codes by chiropractors:
1. 97140 Manual therapy techniques
2. 97110 Therapeutic exercises
3. 97124 Massage
4. 97112 Neuromuscular reeducation
5. 97530 Therapeutic activities, direct patient contact
6. 97150 Therapeutic procedure(s), group
7. 97139 Unlisted therapeutic procedure
Therapeutic Procedures

“A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” –CPT manual

“...procedures that attempt to reduce impairments and restore function through the application of clinical skills and/or services.” –CMS LCD

Indications

• “Rehabilitative services are intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer medically necessary and the individual stops progressing toward those goals.”
  • –Anthem Medical Policy Guideline CG-REHAB-04
Indications

• “Physical therapy may be indicated for treatment of muscle weakness, limitations in the range of motion, neuromuscular conditions, musculoskeletal conditions, lymphedema and for selected training of patients in specific techniques and exercises for their own continued use at home.”

• – Aetna Clinical Policy Bulletin 0325

Medically Necessary

Rehabilitative physical therapy (PT) services are considered medically necessary when ALL the following criteria are met:

1. The therapy is aimed at improving, adapting or restoring functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality; and

2. The therapy is for conditions that require the unique knowledge, skills, and judgment of a physical therapist for education and training that is part of an active skilled plan of treatment; and

3. There is an expectation that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time; and
Rehabilitative PT services are considered **not medically necessary** if **any** of the following is determined:

1. The therapy is **not** aimed at improving, adapting or restoring functions, which have been impaired or permanently lost as a result of **illness, injury, loss of a body part, or congenital abnormality**.
2. The therapy is for conditions for which therapy would be considered routine **educational, training, conditioning, or fitness**. This includes treatments or activities that require only routine supervision.
3. The expectation does not exist that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.
   1. If function could reasonably be expected to improve as the individual gradually resumes normal activities, then the therapy is considered **not medically necessary**.
   2. If an individual’s expected restoration potential would be insignificant in relation to the extent and duration of the therapy service required to achieve such potential, the therapy would be considered **not medically necessary**.
   3. The therapy documentation fails to objectively verify functional progress over a reasonable period of time.

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Anthem Medical Policy Guideline CG-REHAB-04

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4. The physical modalities are not preparatory to other skilled treatment procedures.
5. Treatments that do not generally require the skills of a licensed provider of PT services are considered **not medically necessary**. Examples include palliative massages, palliative Jacuzzi /whirlpools, hot or cold packs in the absence of complicating factors, general range of motion or exercise programs, maintenance therapy, repetitive gait or other activities that an individual can self-practice independently or with a caregiver, swimming and routine water aerobics programs, general fitness and training, and general public education/instruction sessions.
6. Routine reevaluations not meeting the above criteria.
7. Treatments that are not supported in peer-reviewed literature.

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Anthem Medical Policy Guideline CG-REHAB-04
Therapeutic Procedures

• These codes are not limited to any particular specialty group.
• Delegation to clinical staff is governed by state licensure, and often a source of contention with payers.
• The expectation is that timed services average fifteen minutes, not eight.

Documentation

First visit
• History and objective findings which support the correlating diagnosis
• Functional limitations/deficits, if appropriate
  o Motion (degrees), strength (grades), balance (assistance required), coordination (deficits), mobility
• Plan for the service:
  o Description of machine settings, or exercise procedures and their purpose (i.e. effect on function)
  o Areas treated
  o Frequency/duration, goals with outcome expected*
**Documentation**

**During typical treatment visits**
- Relevant subjective and/or objective changes
- Time
- Any variation from original plan
- Response of patient

**At the re-assessment**
- Update functional progress
- Evaluate whether or not goals were met
- If appropriate, suggest alternate treatment strategies

**15 minutes**

CPT editorial approach to time-based services:
- 50% of required time
  - 7.5 minutes or more would be reported as the 1st unit of a fifteen minute service
  - Any less is not reportable, and can’t be bypassed with the 52 modifier (incomplete service)—*CPT Assistant March 2014*
- Includes all necessary pre, intra, and post service work associated with the service
CMS approach to time-based services:

- **8 minute rule**
  - Less than 8 minutes = no billable units
  - 8-22 minutes = 1 fifteen minute unit
  - 23-37 minutes = 2 fifteen minute units
  - 38-52 minutes = 3 fifteen minute units

- Includes only the actual time involved in performance of the service (intra-service time). Pre and post service work does not count. Time should be face-to-face.

CMS approach to time-based services:

- Less than 8 minutes
  - Can’t be billed, but save the time

- **Bundling services of the same time**
  - Lower value bundles to higher value. Bill the higher value service.

- **Bundling services of different times**
  - Lower time bundles to higher time. Bill the higher timed service.
15 minutes

Suppose you perform the following:

• 97110 10 minutes
• 97140 12 minutes

CPT example:
97110 1 unit
97140 1 unit

CMS example:
22 total minutes
97140 1 unit

If 5 minutes of 97035 were also performed, the CPT example would not change, but 1 unit of 97110 would be billable under the CMS example.

15 minutes

• One more example:
  • 24 minutes of NMR 97112
  • 23 minutes of exercise 97110
  …would be coded as
    o 2 units of 97112
    o 1 unit of 97110
  …because total time is 47 minutes, which equals 3 units (38-52 minutes)
Therapeutic Procedures

• Physician or other qualified health care professional (i.e. therapist) is required to have direct (one-on-one) patient contact.
• Clinical skill is necessary to achieve the specific therapeutic change and must be applied during the entirety of the service; hence, the direct one-on-one contact requirement.
• Supervision of a previously taught exercise is not covered.
• Exercise using equipment that does not require the intervention/skills of a therapist are not covered.

Therapeutic Procedures

• There is no separate coverage for educational components of treatment or time spent on documentation.
• Improvement of limitations/deficits must be expected in a reasonable and generally predictable period of time.
• Medicare Secondary Payers (MSPs) often require the GP modifier
RVU = 0.77
1. Manual traction for cervical radiculopathy
2. Joint mobilization for restricted joint motion *
3. Myofascial release for restricted motion of soft tissue*
4. Manipulation for spasm or restricted motion of soft tissue*
5. Lymphatic drainage for lymphedema
   *Adjunct to 97110, 97112, or 97530

- Considered medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk
- There is insufficient evidence to support the effectiveness of Instrument Assisted Soft Tissue Mobilization (IASTM) – Per Aetna
- May be indicated instead of CMT in a body area when CMT is too difficult to administer or contraindicated (severe spasm, swelling, tenderness)
- Some payers approve of this code for dry needling
97140

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), each 15 minutes

• “Manual” therapy requires that providers use their hands, not a machine
• Number of regions treated is irrelevant
• 3-6 visits typical, 12-18 visits max, 4-6 weeks
• 97140 is not interchangeable with 98940-2 (CMT) or 97124

Modifiers:
• 97124 (massage) in not covered on same visit date unless related to a different area of the body, but NCCI edits say no modifier will bypass the edit.
• 97530 should have 59 or X{EPSU} modifier attached if billed with 97140
• 97140 should have 59 or X{EPSU} modifier attached if billed with 97012 or 97150 or 98940-2
• “Different body region” has different definitions
Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), each 15 minutes

Modifiers:

- **XE Separate Encounter**, a service that is distinct because it occurred during a separate encounter,
- **XS Separate Structure**, a service that is distinct because it was performed on a separate organ/structure,
- **XP Separate Practitioner**, a service that is distinct because it was performed by a different practitioner, and
- **XU Unusual Non-Overlapping Service**, the use of a service that is distinct because it does not overlap usual components of the main service.

According to Optum, when reporting the CPT code 97140 in conjunction with CMT codes, there are six criteria that must be documented to validate the service:

1. Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous
2. The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
3. Description of the manual therapy technique(s)
4. Location e.g., spinal region(s), shoulder, thigh, etc.
5. Time i.e., number of minutes spent in performing the services associated with this procedure meets the timed-therapy services requirement
6. CPT code 97140 is appended with modifier 59 or the appropriate “X” modifier (XS separate structure)
**97140**

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), each 15 minutes

**Indications:**
- Trigger points (M79.1-)
- Myositis (M60.8-)
- Limited range of motion:
  - Adhesive capsulitis, shoulder (M75.0-)
  - Stiffness of joint (M25.6-), tissue adherence
- Muscle spasm (M62.8-)
- Contracted tissue (M62.4- Contracture of muscle)
- Soft tissue swelling, pain (R60.0 localized edema)
- Contracture of joint (M24.5-)

**97110**

Therapeutic exercises to develop strength and endurance, range of motion and flexibility, each 15 minutes

RVU = 0.84

- Considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury.
- Examples include treadmill (endurance), isokinetic exercise (ROM), lumbar stabilization exercise (flexibility), and gymnastic ball (stretch/strengthen)
- Exercising done subsequently without a physician or therapist present and supervising = Not Covered
97110
Therapeutic exercises to develop strength and endurance, range of motion and flexibility, each 15 minutes

• Use 97112 to rehabilitate movement, coordination, or balance, not 97110
• 3-6 visits typical, 12-18 visits max, 4-6 weeks, transition to Home Exercise Program (HEP)
• If passive, then 2-4 visits
• 97110 should have 59 modifier attached if billed with 97150

Indications:
• Loss or restriction of joint motion, strength, flexibility, functional capacity or mobility from a specific disease or injury.
• If used for pain, include pain rating, location of pain, and effect of pain on function
• Not covered for exercises to promote overall fitness, flexibility, endurance enhancing, aerobic conditioning, and weight reduction.
• Not covered for maintenance of ROM or strength unless a skilled therapist is needed
97124
Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion), each 15 minutes

- Designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm.
- Considered medically necessary as adjunctive treatment to another therapeutic procedure on the same day.
- Often not considered medically necessary for prolonged periods.
- Should be limited to the initial or acute phase of an injury or illness (i.e., an initial 2-week period).

RVU = 0.83
- Must be performed by hand, not with a device.
- May not be covered as an isolated treatment, or for more than 30 minutes.
- 97140 not covered on same visit unless related to a different area of the body.
- Maximum 6-8 visits generally.
- Maximum of 1-2 units is easiest to defend as medically necessary.
97124
Massage, including effleurage, petrissage and/or tapotement
(stroking, compression, percussion), each 15 minutes

Note must be signed by licensed provider

Modifiers:
• 97124 should have 59 modifier attached if billed with 97150 or 98940-2
• 97124 (massage) is not covered on same visit date as 97140 unless related to a different area of the body, but NCCI edits say no modifier will bypass the edit.

Indications:
- Restore muscle function
- Relieve muscle spasm (M62.8-)
- Improve joint motion, mobilize stiff or scarred tissue (M62.4-)
- Reduce edema (R60.0)
- Increase blood flow
RVU: 0.96

- Examples include PNF, Feldenkrais, Bobath, BAP’s boards, and desensitization techniques
- Use 97110 (rather than 97112) for strength, ROM, and flexibility
- Max 12-18 visits within 4-6 weeks
- 97112 should have 59 modifier attached if billed with 97150 or 98940-2

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has had muscle paralysis and is undergoing recovery or regeneration. Goal is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity) that may result from disease or injury such as severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. -Aetna CPB 0325 - Emphasis Added
97112
Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, each 15 minutes

**Indications:**

- Loss of DTRs and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers
- Nerve palsy (i.e. foot drop)
- Nerve injury or disease leading to muscle weakness or flaccidity
- Inability to sit or stand unassisted
- Loss of gross and fine motor coordination
- Hypo/hypertonicity

97530
Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

**RVU = 1.1**

- Dynamic activities include the use of **multiple parameters**, such as balance, strength, and range of motion, for a functional activity.
- Procedure involves the use of functional activities (e.g. bending lifting, carrying, reaching, catching, transfers, and overhead activities) to restore functional performance in a progressive manner.
97530
Therapeutic activities, direct (one-on-one) patient contact
(use of dynamic activities to improve functional performance), each 15 minutes

• Requires the professional skills of a provider and are designed to address a specific functional need
• May be appropriate after a patient has completed exercises focused on strengthening and range of motion, but need to be progressed to more function-based activities
• Dynamic activities must be part of an active treatment plan and directed at a specific outcome

97530
Therapeutic activities, direct (one-on-one) patient contact
(use of dynamic activities to improve functional performance), each 15 minutes

• 97110 focuses on a single parameter via exercise, 97530 focuses on multiple parameters via activities.
• 97530 requires the skill of the therapist to design the activities to address a specific functional need and instruct the patient.
• If more than 12 visits, documentation must support need.
• 97530 should have 59 modifier attached if billed with 97140 or 97150
97530
Therapeutic activities, direct (one-on-one) patient contact
(use of dynamic activities to improve functional performance), each 15 minutes

Indications:
• Patient must have a condition for which 97530 will improve function, such as loss or restriction of mobility, strength, balance, and/or coordination
• Exercise must correlate with patient’s condition
• Patient must be unable to perform the activities without the skilled intervention of the therapist

97150
Therapeutic procedure(s), group (2 or more individuals)

RVU = 0.51
• If 97110-97139 are performed with two or more individuals, 97150 is reported instead. Do not code the specific type of therapy in addition to 97150
• Group therapy procedures involve constant attendance of the physician or other qualified health care professional [ie, therapist], but by definition do not require one-on-one patient contact by the same physician or other qualified health care professional
• Patients may or may not be doing the same activity
• 97150 is not time based, therefore it is reported once per session, regardless of the time involved
• 97150 is reported for each individual receiving group therapy
• 97110-97530 need modifier 59 or X{ESPU} when performed one-on-one separate in time from the group.

• Group therapy is typically only billable once per patient per day
• Groups should not exceed 4 individuals
• Supervising patients who are exercising independently or on exercise equipment is not a skilled service and may not be billable as group or individual therapeutic procedures
97150

Therapeutic procedure(s),
group (2 or more individuals)

Indications:
- Functional loss (same as for 97110-97530)

Document:
1. As part of care plan:
   - Specific skilled treatments used
   - Functional loss, frequency/duration, goals
2. At each encounter:
   - Size of group
   - Any variation from plan and response of patient
3. At re-evaluation, show progress towards goals

97139

Unlisted therapeutic procedure
(constant attendance)

RVU = none
- Should be used when no accurate code exists
- Direct one on one contact is required
- May be a timed code
- Only once per day
- Requires a “special report”
  - Description of the nature, extent, and need for the procedure
  - Time, effort, and equipment necessary to provide the service
Document:

1. As part of care plan:
   • Rationale and description of the procedure, area treated, functional deficits, frequency/duration, goals

2. At each encounter:
   • Time, if applicable
   • Relevant subjective and objective findings
   • Variations from treatment plan and response of patient

3. At reassessment, show functional progress

Modality Coding for Chiropractic
Modalities vs. Procedures

Modality defined:
“Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.” –CPT 4th edition

Code is selected based on the physical agent used to cause the change.

Modalities vs. Procedures

Therapeutic procedures defined: “A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” -CPT

Code is selected based on the primary therapeutic outcome desired.
Modalities vs. Procedures

Is the service a modality or procedure?
Look at what is causing the therapeutic change.

- A physical agent?
  - Light, sound, thermal, electrical, mechanical force, etc.
- The clinical skill of the physician or therapist?
  - Evidence that clinical direction is necessary to achieve a particular therapeutic result.

Modalities

Most commonly used codes by chiropractors:

1. 97014/G0283 electrical stimulation (unattended)
2. 97012 traction, mechanical
3. 97035 ultrasound, each fifteen minutes
4. 97010 hot or cold packs
5. 97032 electrical stimulation (manual), each fifteen minutes
6. 97026 infrared
7. 97024 diathermy
8. 97039 unlisted modality
9. 97016 vasopneumatic devices
10. 97022 whirlpool
Modalities

Level of contact:

- **Supervised**: does not require direct contact (97010-97028), bill once per encounter
- **Constant attendance**: direct (one-on-one) patient contact (97032-97036), bill once per each 15 minutes
  - “one-on-one” is defined as “Visual, verbal, and/or manual contact with the patient” – *CPT Assistant July 2004*
  - Doesn’t count if you are just lonely. Must be a clinical need to stay with the patient to deliver the service.

"Chiropractic care and adjunct modalities may be considered medically necessary when ALL of the following criteria are met:

- The neuromusculoskeletal condition/diagnosis may improve or resolve with chiropractic treatment. (i.e. neuromusculoskeletal conditions include, but are not limited to, spondylosis, osteoarthritis, sprains and strains, headaches, degenerative conditions of the joints, repetitive motion injuries) AND
- A patient-specific, goal-oriented treatment plan is documented (see Documentation Requirements) AND
- The diagnostic procedures and treatment interventions are directly related to the patient’s symptoms."

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Premera Medical Policy 8.03.501 Chiropractic Services
Modalities

• “Passive modalities are most effective during the acute phase of treatment, as they are typically directed at reducing pain and swelling.”
• “They may also be used during the acute phase of an exacerbation or a chronic condition.”
• “The optimal duration of a course of passive modalities is a maximum of one to two months, after which their effectiveness diminishes, and patient dependency may develop.”

– CIGNA Chiropractic Coverage Policy 0267

Modalities

• Passive modalities should lead to active procedures.
• After no more lasting physiologic benefit can be attained, modalities are included in the CMT.
• Research indicates that manipulation with active care is most effective.

• “One or more areas” - CPT
  o Each modality may only be billed once per encounter, regardless of number body regions or length of time.
  o No modifier 51 (multiple procedures)
Modalities

• Usually not indicated as the sole treatment, unless patient cannot tolerate exercise or activities
  o If allowed by state scope, then modalities alone should not exceed 2-4 treatments

• Medical necessity limits the number of modalities that can be provided on a single date of service

• Multiple heating modalities should not be used on the same day

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Electrical Stimulation (supervised)

RVU = 0.42

• TENS training for pain, 1-2 visits
  o “…considered experimental and investigational for acute and chronic headaches, adhesive capsulitis (frozen shoulder), chronic low back pain,…TMJ” –CPB 0011

• Muscle stimulation (visible contraction), up to 12 visits, transitioning to home use

• IFC for spasm, swelling and/or pain, 6-12 visits
  o “Aetna considers interferential stimulation (e.g., RS-4i Sequential Stimulator) experimental and investigational for the reduction of pain and edema and all other indications because its effectiveness has not been established.” -CPB 0011

• For acupuncture with e-stim, use 97813, 97814
97014

Electrical Stimulation
(supervised)

- Medicare, along with some private payers, accept the HCPCS code G0283 in place of 97014.
- Two disposable electrodes are included in the RBRVS payment methodology for this code.
- Modalities should lead to active therapeutic procedures
  - If provided as the sole treatment, consider only 2-4 visits

Indications:
- Spinal pain** (M54.2, M54.5, M54.6)
- Myalgia (M79.1)
- Muscle spasms (M62.83-)
- Inability to contract muscles, weakness or denervation (M62.81)
- Poor muscle coordination
- Peripheral edema** (R60.0)
- Inflammation (M60.88)

**considered investigational by some payers
Electrical Stimulation (supervised)

Document:

1. As part of care plan:
   • Rationale, type of stimulation, area treated, applicable functional deficits, frequency/duration, goals

2. At each encounter:
   • For muscle weakness: objective strength rating
   • For swelling/edema: location and description
   • For pain: rating, location
     • Variations from treatment plan and response of patient

3. At re-evaluation, show progress towards goals

Traction, mechanical (supervised)

RVU = 0.41

• Force applied to separate joint surfaces
• Specify whether traction is:
  o Static
  o Intermittent
  o Auto traction (using body’s own weight)
• May be considered medically necessary for chronic back or neck pain
Traction, mechanical (supervised)

- Typically used in conjunction with therapeutic procedures, not as an isolated treatment
- Standard treatment is to provide supervised mechanical traction up to 4 sessions per week
- For cervical radiculopathy, treatment beyond 1 month can usually be accomplished by self-administered mechanical traction in the home.
- CMS says 3-4 visits max in office, then teach home care

Roller tables are not considered true mechanical traction by some payers.
- Some payers require FDA cleared devices
- 97140 needs the 59 modifier if billed at the same encounter (NCCI edits)
- Flexion-distraction should be billed as CMT
- VAX-D should be billed as S9090
97012
*Traction, mechanical*  
*(supervised)*

**Indications:**
- cervicalgia (M54.2)
- lumbago (M54.5)
- radiculopathy (M54.1-)
- disc herniation (M50-, M51-)
- sciatica (M54.3-)
- consider also adhesions, stiffness, inflexibility, arthritis, compression

**Document:**

1. As part of care plan:
   - Rationale, part of the body, force applied, angle, time, frequency/duration, goals
2. At each encounter:
   - Any variation from plan and response of patient
3. At re-evaluation, show progress towards goals
97035

Ultrasound, each 15 minutes
(constant attendance)

RVU = 0.37

- Deep heating modality that produces a sound wave of 0.8 to 3.0 MHz.
- Increased blood flow reduces swelling/edema, massages muscles, tendons, ligaments without straining tissue.
- Ultrasound is an ideal modality for increasing ROM.

97035

Ultrasound, each 15 minutes
(constant attendance)

- 52 modifier cannot be used for < 8 minutes
- 6-12 visits is generally sufficient
- If performed with simultaneous e-stim (combo unit), code only 97035
- “hands free” ultrasound should be reported with 97039
- Should be used with, or transition to, active therapeutic procedures
97035

Ultrasound, each 15 minutes
(constant attendance)

Indications:
• pain (M54-)
• spasm (M62.83-)
• joint stiffness and inflexibility
• soft tissue calcification (M61-)
• Neuromas (G57-, T87-)

Document:
1. As part of care plan:
   • Rationale, area treated, US frequency/intensity, time, functional
deficits, frequency/duration, goals
2. At each encounter:
   • Subjective findings: pain ratings, location, and effect on function
   • Objective measurements of strength, ROM, and functional
     limitations
   • Variations from treatment plan and response of patient
3. At re-evaluation, show progress towards goals
97010
Hot or cold packs
(supervised)

RVU = 0.17

- Bundled by many payers since skills are not required for its application
- Long term or routine application should be avoided
- Examples: hydro-collator, cryotherapy

Cold:
- Causes vasoconstriction (shrinkage of blood vessels), decreases blood flow to an area, and slows the body’s metabolism and its demand for oxygen.
- The therapeutic goals include: reduce edema, ease inflammation, and block pain receptors.
- Cold application is more effective than heat for sprains or other soft tissue injuries and is the preferred treatment within the first 48 hours after injury.
Heat:
- Heat causes vasodilation increasing blood flow to a specific area.
- Increases the oxygen, nutrients, and various blood cells delivered to body tissues
- Relieves local pain, stiffness, or aching, particularly of muscles and joints
- Aids in removal of wastes from injured tissues, such as debris from phagocytosis

Indications:
1. Heat: sub-acute or chronic.
   - scar tissue (L90.5)
   - muscle spasms (M62.83-)
   - inflexibility, poor circulation, nerve damage
2. Cold: acute trauma or severe spasticity
   - inflammation, pain, and swelling
97010
*Hot or cold packs (supervised)*

Document:
1. As part of care plan:
   - Areas treated, frequency/duration, goals
2. At each encounter:
   - Any variation from plan and response of patient
3. At re-evaluation, show progress towards goals

97032
*Electrical Stimulation, manual, attended, 15 minutes, one or more areas (constant attendance)*

RVU = 0.43
- Requires direct contact by the provider or other qualified health care professional
- More than one unit can be billed based on time, but not # of areas treated
Electrical Stimulation, manual, attended, one or more areas
(constant attendance)

• Attended e-stim is also called manual e-stim
• May be appropriate if the stim must be adjusted and monitored during the course of treatment
• Shooting the breeze about sports while the patient gets passive e-stim, such as IFC is 97014.

Quiz

The provider does interferential e-stim in the lumbar region for twelve minutes, then the left shoulder region for six minutes, and the right shoulder and neck for eight minutes each. The correct code(s) would be

A. 97014
B. 97032 x2
C. 97014-51 x2
D. 97032-52 x2

Hint: .52 means “reduced services”
.51 means “multiple procedures”
97039

Unlisted Modality
(constant attendance)

RVU = none
- Should be used when no accurate code exists
- Not to be used routinely or on a recurring basis
- Not necessarily a timed code
- Only once per day

Requires a “special report”
- Description of the nature, extent, and need for the procedure
  - Time, effort, and equipment necessary to provide the service.

1. As part of care plan:
   - Rationale and description of the modality, area treated, functional deficits, frequency/duration, goals

2. At each encounter:
   - Time, if applicable
   - Relevant subjective and objective findings
   - Variations from treatment plan and response of patient

3. At re-evaluation, show progress towards goals
Modalities

What about these?

• Therapeutic Magnetic Resonance Treatment
• Percutaneous Electric Nerve Stimulation
• Class I-II light therapy (LED)
• Class III (cold laser)
• Class IV (hot laser)
• Hands free ultrasound
• E-stim, US combo
• Phonopheresis
• Posture pump
• Vibratory massage/massage chairs

• Did you bring about a therapeutic change to biologic tissue?
Take Away

For the top modality and therapeutic procedure CPT codes for Chiropractors

- Get a handle on the fundamentals and coding rules
- Identify the right modifiers and diagnosis codes
- Nail the documentation requirements
- Eliminate denials