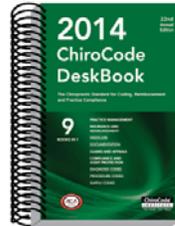
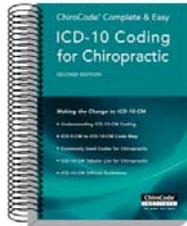


ChiroCode Institute Endorsement

Dr. Arkfeld and the material presented here have received ChiroCode Institute's Endorsement.



2014 Iowa Chiropractic Society

Session 2 – ICD-10-CM

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ADVANCED
COMPLIANCE TECHNOLOGIES
Physician Coding and Compliance Services



Where Do We Start?

History Essentials

- ✓ Chief Complaint of the patient
- ✓ Causation (mechanism of injury)
- ✓ Past Medical History
- ✓ Review of Systems
- ✓ Family and Social Histories

Disclaimer

Advanced Compliance Technologies, PLLC, denies responsibility or liability for any erroneous opinions, analysis, and coding misunderstandings on behalf of individuals undergoing this ICD-10-CM study program.

The coding topics taught here are for the sole purpose of the chiropractic profession, any transference to other healthcare disciplines are at the risk of the individual coder's discretion.

We have based the majority of this program on the guidelines set forth by the CPT Code Book, ICD-10-CM information found in the ChiroCode DeskBook, and in The Medicare Manual, as it relates to Chiropractic practice.

No legal advice is given in this presentation, and we encourage you to refer any such questions to your healthcare attorney.

History Documentation

There are two main references for history documentation :

1. The CPT Code Book
2. The Medicare Manual for Chiropractors



History

Obtaining a thorough history is arguably the most important component of a new or established patient encounter.

A good history is the best and most informative diagnostic tool a physician possesses.



History Documentation

Per the CPT code book the requirements are:

1. Chief Complaint
2. History of Present Illness
3. Review of Systems
4. Patient History including past medical, family, and social histories

History

History is also the starting point for determining the correct Evaluation and Management (E/M) level to bill and code .

And in today's healthcare, history takes on the more important role of determining **medical necessity** issues.

Chief Complaint

A chief complaint as a concise statement describing the symptoms, *problems, conditions, diagnoses, or other factors that are the reason for the patient encounter* (usually stated in the patient's own words)

The presenting chief complaint will determine the correct E/M code and is also necessary in order for the most specific diagnosis to be placed in box 21 of the CMS claim form.

ACT

11

History Documentation

Per Medicare the requirements are:

- ✓ Symptoms causing patient to seek treatment
- ✓ Family history (if relevant)
- ✓ Past health history (general health, prior illness, injuries, or hospitalizations, medications, surgical history)
- ✓ Quality and character of symptoms/ problem
- ✓ Onset, duration, intensity, frequency, location and radiation of symptoms
- ✓ Prior interventions, treatments, medications, secondary complaints
- ✓ Mechanism of trauma
- ✓ Aggravating or relieving factors

ACT

9

Chief Complaint



Once the chief complaint is solicited, next is the mechanism of injury or trauma .

ACT

12

E. Documentation Requirements: *Subsequent Visits.- the following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:*

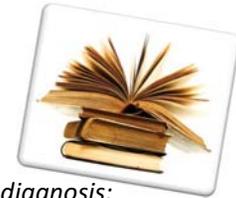
1. History

- Review of chief complaint;
- Changes since last visit;
- System review if relevant.

2. Physical exam

- Exam of area of spine involved in diagnosis;
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.



ACT

10

HPI

You must give the patient enough information on what you are trying to achieve with the history process, in order *for them to accurately describe their symptoms*.

Many patients do not equate stiffness or soreness with pain, so when you ask the question, "where does it hurt or where is the pain?" Many times the answer is, "I have no pain in that area." Simply put, if you don't ask the right questions, you won't get the right answers.

History of Present Illness (HPI)



1. Location
2. Quality
3. Severity
4. Duration
5. Timing
6. Context
7. Mod. Factors
8. Signs/Symptoms

Review of Systems (ROS)

The Review of Systems is often either not obtained or the relevance of information that was documented not problem pertinent.

For many offices the intake forms that have ROS information is lacking questions relating to the fourteen (14) systems recognized by the *AMA CPT Code Book*, or too many questions that do not provide any useful information to the provider.

Many times this portion of the history is considered to tedious and time consuming for the physician and is omitted even though **higher level E/M codes require a ROS**.

HPI

Psychosocial factors play a huge role in obtaining the quality of pain or discomfort from the patient.

The astute historian will pick up on any hesitation or reluctance by the patient to provide this information

PFSH

(Past Medical, Family & Social History)

Family History

A review of the patient's family history to include any conditions or cause of death of parents, siblings, or children. This should include asking about diabetes, hypertension, cancer, or any other disease related to or that may delay recovery of the chief complaint.

Review of Systems (ROS)

The 14 systems as per the AMA CPT Code Book:

- | | |
|------------------------------|---------------------------|
| 1. Constitutional | 8. Musculoskeletal |
| 2. Eyes | 9. Integumentary |
| 3. Ears, Nose, Mouth, Throat | 10. Neurological |
| 4. Cardiovascular | 11. Psychiatric |
| 5. Respiratory | 12. Endocrine |
| 6. Gastrointestinal | 13. Hematologic/Lymphatic |
| 7. Genitourinary | 14. Allergic/Immunologic |

Clinical Examination- Physical

Examination forms should be guides or templates for performing the evaluation, not crutches or a cookbook approach to the orthopedic assessment.

Orthopedic testing should be done in a flowchart differentiation manner with tests and counter test to lead the examiner to the real cause of the problem.

PFSH

(Past Medical, Family & Social History)

Past History

A review of the patient's past medical history should include information on previous occurrences of the chief complaint, surgeries, fractures, traumas, treatments, medications, and home therapies.

Examination Flow & Documenting Results

Check marks without explanations are an example of inaccurate documentation, that can lead you to incorrect diagnosis or treatment plans for your patients.

Clinical Examination- Physical

The purpose is to generate a problem specific diagnosis.

Examination Flow & Documenting Results

The same shortcuts lead to check box examinations for documentation, while chiropractic technique screenings begin to replace proper orthopedic and neurological evaluations.

Examination Flow & Documenting Results

In chiropractic college, we were taught to conduct an extensive orthopedic evaluation on every patient.

Upon entering private practice, it is simply not feasible or profitable to spend 2 hours examining each new patient.

Examination Flow & Documenting Results

Another example is a straight leg raise test where results are often inaccurately marked positive.

This test is designed to assess for sciatica, but too many physicians inadvertently mistake hamstring tightness for a positive finding.

ACT

27

Examination Flow & Documenting Results

In reviewing over 1000 chiropractic case files, the most common error found was the failure to properly indicate what a particular orthopedic or neurological test really elicited.

ACT

25

Examination Flow & Documenting Results

If this is occurring in your practice, I strongly recommend you go back and review the orthopedic and neurological tests that you commonly perform in your office.

ACT

28

Examination Flow & Documenting Results

For example, many doctors continue to mark positive on a cervical compression test if a patient states they felt pain in the cervical spine with no radiation into the extremities.

ACT

26

Tissue Differentiation

Tissue differentiation is a term for narrowing down or isolating the anatomical structure or structures causing the pain or symptoms experienced by the patient.

When physicians rush through the exam, often there is inadequate interpretation and documentation of the examination findings.

Physician Understanding

It is imperative that the physician understand what they are doing when applying specific provocative maneuvers.

Tissue Differentiation

Incorrect interpretation leads to inaccurate treatments.

Physician Understanding

1. The anatomy involved in the region of complaint.
2. The neuromuscular system, the biomechanics, and the reasoning behind each orthopedic/neurological test .
3. The knowledge of how to perform examinations in a flowchart differentiation manner . The main goal of each examination is to identify the anatomical structure or structures responsible for producing the patient's pain or symptoms

Orthopedic Testing & Counter Testing

When beginning the orthopedic section of the examination, it is important to determine what anatomical structure or structures are the pain producers. The examination will begin the process of tissue differentiation.

In order to do this , we must begin with soft tissue examination in which there are two types.

ACT

35

Examination Flow

The examination process actually begins during the history by evaluating a patient as they enter the exam room.

ACT

33

Contractile Tissue

Incorporates the muscle belly, musculotendinous junction, the body of the tendon, and the tenoperiosteal junction.

When testing for passive and contractile tissue injuries I recommend starting with O'Donahue's Test

ACT

36

Examination Flow

1. General appearance
2. Vital signs
3. Gait and Postural Analysis
4. Orthopedic testing
5. Neurological testing
6. Biomechanical Evaluation

ACT

34

O'Donahue's Test

Things to Note:

Pain that is present primarily upon passive ROM, especially at the ends of specific joint ROM, may indicate injury to a ligamentous structure .

ACT

39

Passive Tissue

Refers to that tissue which does not have contractile properties (i.e. ligaments, joint capsules, bursa, and fascia)

ACT

37

O'Donahue's Test

Things to Note:

The plane that produces the pain should be recorded, because active ROM stresses both contractile and passive tissues.

ACT

40

O'Donahue's Test

O'Donahue's Testing should be used in conjunction with ROM. Ranges of motion should be performed in the following sequence: active, passive, and resisted.

This method allows the physician to differentiate a strain (muscular)from a sprain (ligamentous) injury .

ACT

38

Range of Motion Reference Values

Range of motion of the cervical and lumbar spines will sometimes have references to normal by different sources siding different numeric values.

None of these texts take into account gender or age variations

ACT

43

O'Donahue's Test

Things to Note:

Pain that is produced during passive ROM, but is absent during resisted ROM, may indicate articular structures or posterior joint capsule injuries.

ACT

41

Range of Motion Reference Values

I recommend computerized range of motion measurements based on the "AMA Guides to The Evaluation of Permanent Impairment, sixth edition"

These protocols are the most objective and reliable parameters when utilizing digital inclinometers.

ACT

44

Diagnostically

Pain on resisted motion is considered musculogenic

- Pain on passive motion , especially end motion, is considered ligamentous
- Pain during active and passive motion, which is specifically not increased by resisted motion , is considered articular

ACT

42

Range of Motion Notations

Normal

Range of motion was performed actively, passively, and was visually assessed. All movements were unrestricted and pain free in the cervical and lumbar spines

ACT

47

Range of Motion Reference Values

The results will provide real numbers that can be used as baseline readings, and for follow up assessments to determine the functional progress of the patient .

Medicare , third party payers, auto and workers compensation insurance companies like to see objective measurements.

ACT

45

Range of Motion Notations

Abnormal

Range of motion was performed actively, passively, and was visually assessed. All planes of movements were restricted and painful in both the cervical and lumbar spines.

ACT

48

Range of Motion Reference Values

If you do not have digital inclinometers, then visualization of the active and passive range of motion is recommended.

Do not indicate in your documentation any numbers as percentages of abnormal motion if you do not have digital inclinometers.

ACT

46

Orthopedic Testing

Compression tests are designed to elicit radiating pain, but that does not mean a negative finding fails to deliver additional valuable diagnostic information.

Types of Orthopedic Tests

It is imperative that you, as the Physician, understand what reactions you're trying to elicit when applying specific provocative maneuvers.

A skilled examiner will perform the examination in a flowchart differentiation manner to pick and choose what is most appropriate for that patient.

Problem: Cervical Example

When performing a cervical or foraminal compression tests, there was not a radiating complaint from the patient, but they stated there was localized neck pain .

How would you document this?

Orthopedic Testing

The true value of orthopedic testing is in how you interpret and document the findings.

Compression tests should indicate if the pain producer is arthritis , dural irritation, intervertebral disc syndrome, facet, or nerve root mediated pain.

Correct Verbiage

The cervical compression test was found to be negative for radiating pain into the upper extremities, but did elicit localized pain in the C5 – C6 facet joints bilaterally.

ACT

55

Problem: Cervical Example

Marking this as positive is incorrect, due to the fact there were no radiating pain complaints.

However, marking this as a negative test would also be incorrect, because crucial information was left out indicating what may be the actual pain producer.

ACT

53

Orthopedic Testing

After performing a compression type of orthopedic tests, the next step is to do a distraction type and maneuver (a counter test).

If your compression tests continued to produce pain that either radiates into the extremities or remains localized, your distraction test results should decrease the symptoms.

ACT

56

Problem: Cervical Example

The pain producer could be the facet joints or the posterior aspect of the Intervertebral disc.

Noting this result only as a negative takes this factual information away. Further testing would allow you to narrow in on what the real pain producer is.

ACT

54

Problem: Lumbar Spine Example

The patient may well be experiencing pain as a result of this test, but you must document where and what type of pain is being elicited .

ACT

59

Correct Verbiage

Cervical distraction was positive for relieving the radiating pain into the upper extremities.

Cervical distraction was positive for relieving the localized pain felt in the C5-C6 facet joints bilaterally.

Cervical distraction was positive for muscular pain in the cervical spine.

ACT

57

Correct Verbiage

Kemp's test was positive for radiating pain into the right lower extremity

Kemp's test was negative for radicular component, but did elicit localized pain in the L4 – L5 facet joints on the right

Kemp's test was negative for a radicular a component, but did elicit localized pain in the L4- L5 facet joints on the right. When performing Kemp's Test on the left the localized pain felt in the right L4-L5 facet joints were diminished.

ACT

60

Problem: Lumbar Spine Example

The main compression test for the lumbar spine is Kemp's Test, which is also a prime source of improper test result interpretation.

As with the cervical compression tests, Kemp's Test has its share of noted false positives.

ACT

58

Clinical Impressions

The diagnosis must support the patient's subjective symptomatology, mechanism of injury, objective findings and radiographic evaluations (if necessary)

The diagnosis should be as accurate as possible and express the etiology of the patient's condition.

Clinical Examination- Neurological

Diagnosing without Neurological Testing

723.2 Cervicocranial Syndrome

The neurological dysfunction of the upper portion of the spinal cord, lower portion of the brain stem, or associated suboccipital nerve roots.

Caution: Do not use in place a common head and neck pain. This condition could be considered an advanced neurological disorder

Clinical Examination-Neurological

A thorough neurological examination is an absolute must on all new and established patient evaluations with complaints of radiating pain into the extremities, or with the history of trauma to the head

Diagnosing without Neurological Testing

724.4 Thoracic or Lumbosacral Neuritis or Radiculitis—

Inflammation of the thoracic or lumbar nerve roots

Caution: Do not use in place of leg pain. There must be neurological findings of motor weakness, sensory loss, and/or DTR abnormalities.

ACT

67

Diagnosing without Neurological Testing

723.3 Cervicobrachial Syndrome

The neurological dysfunction of the lower portion of the cervical spinal cord, upper portion of the thoracic spinal cord, and their associated spinal nerve roots

Caution: Do not use in place of neck and arm pain. This condition is also called Brachial Plexopathy

ACT

65

Motor & Sensory Evaluation

The motor and sensory aspects of the neurological examination are a crucial step in providing information to establish the most accurate diagnosis

ACT

68

Diagnosing without Neurological Testing

723.4 Brachial Neuritis or Radiculitis—Cervical Radiculitis

Inflammation of the cervical nerve roots

Caution: Do not use in place of arm pain. There must be neurological findings of motor weakness, sensory loss, and/or DTR abnormalities.

ACT

66

Lower Extremities

1. Quadriceps & Psoas Muscles (L2 & L3)
2. Tibialis Anterior (L4)
3. Extensor Hallucis (L5)
4. Gastrocnemius/Hamstrings (S1 & S2)

ACT

71

Motor Evaluation

The motor evaluation can be performed relatively quick and provide excellent details to determine if a motor deficit exists and what spinal nerve roots may be involved.

ACT

69

Dermatomal Assessment

Sensory evaluation is a necessary step in determining if the sensory component of the nerve root or dorsal root ganglion (DRG) is being irritated.

ACT

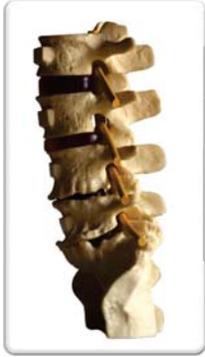
72

Upper Extremities

1. Middle Deltoid (C5)
2. Biceps (C6)
3. Triceps (C7)
4. Wrist Extensors (C6)
5. Wrist Flexors (C7)
6. Finger Flexors (C8)
7. Finger Abductors (T1)

ACT

70



The Vertebral Subluxation Complex

ACT

ACT

75

Dermatomal Assessment

Failing to perform the sensory portion will result in an incomplete examination.

ACT

73

The Vertebral Subluxation Complex

- ✓ Spinal Kinesiopathology
- ✓ Neuropathophysiology
- ✓ Myopathology
- ✓ Histopathology
- ✓ Pathophysiology

ACT

76

Dermatomal Assessment Terms

Anesthesia	No recognition of an external stimuli
Hypoesthesia	Decreased ability to recognize cutaneous stimulation caused by pressure made with a sharp point or a dull object
Paresthesia	Painful tingling, aching, and or burning along the course of the peripheral nerve that results from percussion of the involved nerve or stimulation of the skin
Hyperesthesia	Excess sensitivity, such as to touch or pinprick

ACT

74

739 Segmental Dysfunction

ICD-9	ICD-10
739.0 Head Region	M99.00 Segmental and somatic dysfunction of head region
739.1 Cervical Region	M99.01 Segmental and somatic dysfunction of cervical region
739.2 Thoracic Region	M99.02 Segmental and somatic dysfunction of thoracic region
739.3 Lumbar Region	M99.03 Segmental and somatic dysfunction of lumbar region
739.4 Sacral Region	M99.04 Segmental and somatic dysfunction of sacral region
739.5 Pelvic Region	M99.05 Segmental and somatic dysfunction of pelvic region
739.6 Lower Extremities	M99.06 Segmental and somatic dysfunction of lower extremity
739.7 Upper Extremities	M99.07 Segmental and somatic dysfunction of upper extremity
739.8 Rib Cage	M99.08 Segmental and somatic dysfunction of rib cage

Spinal Kinesiopathology



The Abnormal Movement or Position of a Vertebra

839 Subluxation (Cervical Spine)

ICD-9	ICD-10
839.00 Cervical Vertebra, unspecified	S13.101_ Dislocation of unspecified cervical vertebra
839.01 First Cervical	S13.111_ Dislocation of C0/C1 cervical vertebra
839.02 Second Cervical	S13.121_ Dislocation of C1/C2 cervical vertebra
839.03 Third Cervical	S13.131_ Dislocation of C2/C3 cervical vertebra
839.04 Fourth Cervical	S13.141_ Dislocation of C3/C4 cervical vertebra
839.05 Fifth Cervical	S13.151_ Dislocation of C4/C5 cervical vertebra
839.06 Sixth Cervical	S13.161_ Dislocation of C5/C6 cervical vertebra
839.07 Seventh Cervical	S13.171_ Dislocation of C6/C7 cervical vertebra
839.08 Multiple Cervical	S13.181_ Dislocation of C7/T1 cervical vertebra
	S13.101_ Dislocation of unspecified cervical vertebra

Spinal Kinesiopathology

Restricted ROM

- AROM and PROM
- Static/Motion Palpation
- Postural Analysis

Negative Compression Tests for radicular symptoms, but localized pain

- 739 Segmental Dysfunction
- 839 Subluxation
- 724.8 Facet Syndrome
- 728.85 Muscle Spasms
- 729.1 Myalgia
- 724.9 Stiff/Stiffness of Spine
- 719.58 Stiffness of Joint
- 723.5 Torticollis
- 333.83 Torticollis, Spasmodic
- 738.2 Acquired deformity of neck

839 Subluxation (Lumbar Spine)

ICD-9

839.20 Lumbar Vertebra

ICD-10

S33.101_ Dislocation of unspecified lumbar vertebra

ACT

83

What is __?

Add the appropriate 7th character to each code from category

A- initial encounter

D- subsequent encounter

S- sequela

Example: S13.101A Dislocation of Cervical Vertebrae initial encounter

ACT

81

839 Subluxation (Pelvic & Sacrum)

ICD-9

839.42 Sacrum

839.69 Other (pelvic)

ICD-10

S33.2xx_ Dislocation of sacroiliac & sacrococcygeal joint

S33.39x_ Dislocation of other parts of lumbar spine & pelvis

ACT

84

839 Subluxation (Thoracic Spine)

ICD-9

839.21 Thoracic Vertebra

ICD-10

S23.101_ Dislocation of unspecified thoracic vertebra

ACT

82

Neuropathophysiology

- Motor
- Sensory
- DTR

Muscle Weakness

Dermatomal Findings

Decreased Reflexes

Cervical

- 723.4 Brachial Neuritis/Radiculitis
- 723.3 Cervicobrachial Syndrome
- 723.2 CervicoCranial Syndrome

Lumbar

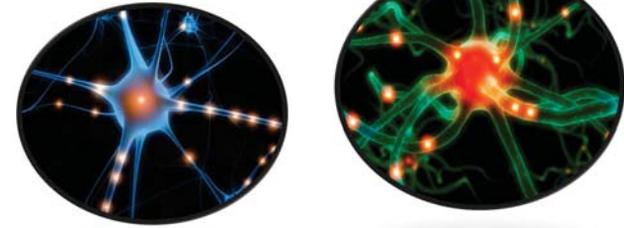
- 724.3 Sciatica
- 724.4 Thoracic or Lumbosacral neuritis or radiculitis

ACT

87

Neuropathophysiology

Abnormal Function of the Neurological System



ACT

85

Neurological Diagnosis

ICD-9

- 723.4 Brachial Neuritis
- 724.3 Sciatica
- 724.4 Thoracic or lumbosacral neuritis or radiculitis
- 782.0 Disturbance of skin

ICD-10

- M54.12 Radiculopathy, cervical region
- M54.13 Radiculopathy, cervicothoracic region
- M54.30 Sciatica, unspecified side
- M54.14 Radiculopathy, thoracic region
- M54.15 Radiculopathy, thoracolumbar region
- M54.16 Radiculopathy, lumbar region
- M54.17 Radiculopathy, lumbosacral region

ACT

88

Incorrect Diagnosis

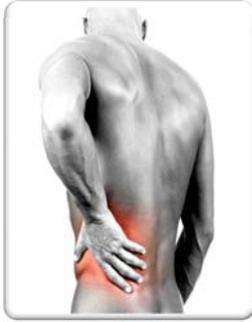
In the majority of cases where radicular pain was a subjective complaint, doctors are using an incorrect diagnosis of "radiculitis" or "neuritis".

This error is largely due to the fact that no neurological examination findings corroborate this diagnosis.

ACT

86

Myopathology



Pathological Changes
Occurring in the Spinal
Musculature

ACT

91

Neurological Diagnosis

ICD-9

782.0 Disturbance of skin sensation

ICD-10

R20.0 Anesthesia of skin

R20.1 Hypoesthesia of skin

R20.2 Paresthesia of skin

R20.3 Hyperesthesia

R20.8 Other disturbances of skin sensation

R20.9 Unspecified disturbance of skin sensation

ACT

89

Myopathology

Decrease AROM

Antalgia

Muscle Spasms

Muscle Hypertonicity

Muscle Wasting

Muscle Weakness

○ 728.1 Muscular Calcification &
Ossification

○ 728.2 Muscular Wasting &
Disuse Atrophy

○ 728.85 Muscle Spasm

○ 729.1 Myalgia

○ 728.87 Muscle Weakness
Generalized

○ 738.2 Acquired Deformity Neck

**(Review the 738 series of
deformities)**

ACT

92

Dermatomal Assessment Terms

Anesthesia

No recognition of an external stimuli

Hypoesthesia

Decreased ability to recognize cutaneous
stimulation caused by pressure made with a sharp point or a
dull object

Paresthesia

Painful tingling, aching, and or burning along the course of
the peripheral nerve that results from percussion of the
involved nerve or stimulation of the skin

Hyperesthesia

Excess sensitivity, such as to touch or pinprick

ACT

90

Histopathology

PROM

Orthopedic Tests (Disc Pathology)

X-ray

MRI

- 722.0 Cervical Disc
- 722.10 Lumbar Disc
- 722.11 Thoracic Disc
- 847 Sprains
- 724.8 Facet Syndrome
- 722.3 Schmorl's Nodes

ACT

95

Myopathology Diagnosis

ICD-9

- 728.10 Muscular Calcification & Ossification
- 728.2 Muscular Wasting & Disuse Atrophy
- 728.85 Muscle Spasm
- 729.1 Myalgia
- 728.87 Muscle Weakness Generalized
- 738.2 Acquired Deformity Neck

ICD-10

- M61.9 Calcification and ossification of muscle unspecified
- M62.50 Muscle Wasting and atrophy, not elsewhere classified, unspecified site
- M62.40 Contracture of muscle, unspecified site
- M62.838 Other muscle spasm
- M62.81 Muscle weakness (generalized)
- M95.3 Acquired deformity of neck

ACT

93

Histopathology Diagnosis

ICD-9

- 722.0 Cervical Disc
- 722.10 Lumbar Disc
- 722.11 Thoracic Disc
- 724.8 Facet Syndrome

ICD-10

- M50.20 Other cervical disc displacement, unspecified cervical region
- M51.26 Other intervertebral disc displacement, lumbar region
- M51.27 Other intervertebral disc displacement, lumbosacral region
- M51.24 Other intervertebral disc displacement, thoracic region
- M51.25 Other intervertebral disc displacement, thoracolumbar region
- M53.82 Other specified dorsopathies of cervical region (facet syndrome)

ACT

96

Histopathology

Abnormal Soft Tissue Function



ACT

94

Pathophysiology

- All Degenerative Processes

- All Arthritis

- Both need Validation by x-ray, MRI, or CT Scan

- 722.4 Degeneration of Cervical Disc
- 722.51 Degeneration Thoracic or thoracolumbar IVD
- 722.52 Degeneration of Lumbar IVD
- 721.0 Cervical Spondylosis w/out myelopathy
- 721.2 Thoracic Spondylosis w/out myelopathy
- 721.3 Lumbosacral Spondylosis w/out myelopathy

ACT

99

Histopathology Diagnosis

ICD-9

- 847.0 Neck
- 847.1 Thoracic
- 847.2 Lumbar
- 847.3 Sacrum
- 847.4 Coccyx

ICD-10

- S13.4xx_ Sprain of ligaments of cervical spine
- S13.8xx_ Sprain of joints and ligaments of other parts of neck
- S23.3xx_ Sprain of ligaments of thoracic spine
- S23.8xx_ Sprain of other specified parts of thorax
- S33.5xx_ Sprain of ligaments of lumbar spine
- S33.8xx_ Sprain of other parts of lumbar spine and pelvis

ACT

97

Pathophysiology Diagnosis

ICD-9

- 722.4 Degeneration of Cervical Disc
- 722.51 Degeneration Thoracic or thoracolumbar IVD
- 722.52 Degeneration of Lumbar IVD

ICD-10

- M50.30 Other cervical disc degeneration, unspecified cervical region
- M51.34 Other intervertebral disc degeneration, thorax region
- M51.35 Other intervertebral disc degeneration, thoracolumbar region
- M51.36 Other intervertebral disc degeneration, lumbar region
- M51.37 Other intervertebral disc degeneration, lumbosacral region

ACT

100

Pathophysiology



Abnormal Function of the Spine and Body

ACT

98

SUBJECTIVE:

The patient indicated today that he is experiencing constant moderate pain in the area of the cervical spine. This is restricted movement as well as stiffness, sore and tight pain neck. He finds that nothing makes his neck pain feel better and seems to be aggravated by repetitious movements, turning the head left and turning the head right.

He also reports he is experiencing constant moderate headache pain. He further describes it as throbbing and pounding pain generalized in the top of the head. Mr. Stafford related that resting gives him relief but finds that lights and fatigue causes more distress.

Mr. Stafford reported his neck pain at 6 and headache at 5, based on a 1 to 10 pain scale.

ACT

103

Spondylosis

ICD-9

- 721.0 Cervical Spondylosis w/out myelopathy
- 721.2 Thoracic Spondylosis w/out myelopathy
- 721.3 Lumbosacral Spondylosis w/out myelopathy

ICD-10

- M47.812 Spondylosis w/out myelopathy or radiculopathy, cervical region
- M47.12 Other spondylosis w/myelopathy, cervical region
- M47.814 Spondylosis w/out myelopathy or radiculopathy, thoracic region
- M47.817 Spondylosis w/out myelopathy or radiculopathy, lumbosacral region

ACT

101

REVIEW OF SYSTEMS:

General: Denies fever, chills, fatigue, and no major weight loss or gain.

Psych: DISTURBED SLEEP

Eyes: DOUBLE VISION

GI: NAUSEA

Past Medical Health: Denies past medical history

FAMILY HISTORY:

The patient has no family history of problems.

ACT

104

Mathew Stafford
01-3140

10/17/2013 E/M 3 Detailed

CAUSATION DETAILS:

This onset of the primary complaint started as follows:

The patient presents today with a chief complaint of neck pain and a secondary complaint of headaches.

He stated that while playing Sunday he was struck helmet to helmet by a very large defensive lineman. He felt immediate pain and was somewhat disoriented until he got to the sidelines. He also began to experience dizziness and mild nausea, but did not vomit. Since the game he has had constant neck pain and headaches.

ACT

102

GENERAL APPEARANCE:

This patient is a poorly-appearing 25 year old male in a moderate amount of distress. The patient was awake, alert and oriented and in moderate pain. Mathew showed good eye contact. The patient appeared comfortable and moderately depressed. The patient showed normal grooming and appropriate dress.

VITAL SIGNS:

Pulse Rate	72
Sitting Pressure/Systolic	L:120
Sitting Pressure/Diastolic	L:80
Height	6'3"
Weight	232
Body Mass Index	28.99

POSTURAL ANALYSIS:

Postural Analysis was evaluated on Mr. Stafford and the following was noted. This patient's posture while standing was generally fair. His posture while sitting seemed to be fair.

SOCIAL HISTORY

A social history was obtained from Mr. Mathew Stafford. Mr. Stafford's social history was reviewed and was found to be consistent with previous findings.

RANGE OF MOTION:

Spinal ROM: Range of motion actively and passively performed was visually assessed and revealed decreased movement and pain on all planes of motion.

Cervical:	
Flexion	Decreased
Extension	Decreased
Right Lateral Flexion	Decreased
Left Lateral Flexion	Decreased
Right Rotation	Decreased
Left Rotation	Decreased

NECK DISABILITY ASSESSMENTS:

The Neck Pain and Disability Index was used to indicate Mr. Stafford's perceived pain and disability. It is a valid indicator since the patient rated himself, thus avoiding interviewer interference. The patient related his capability in the activities of daily living as follows:

- Pain Intensity: "The pain is moderate at the moment."
- Personal Care: "It is painful to look after myself and I am slow and careful."
- Lifting: "Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)."
- Reading: "I can read as much as I want with moderate pain in my neck."
- Headaches: "I have moderate headaches which come frequently."
- Concentration: "I have a fair degree of difficulty in concentrating when I want to."
- Work: "I cannot do my usual work."
- Driving: "I can drive my car as long as I want with moderate pain in my neck."
- Sleeping: "My sleep is moderately disturbed (2-3 hours sleepless)."
- Recreation: "I can hardly do any recreational activities because of pain in my neck."

The patient's neck disability index on 10/17/2013 was 50. The patient's score fell into the 40 - 60% range indicates severe disability.

OBJECTIVE:

Spinal evaluation revealed severe joint restriction at C1, C2 and C5 - C7. On palpation of the spinal segments there was a strong pain level at C1, C2 and C5 - C7 bilaterally. Palpation revealed severe spasticity of the suboccipital muscles and cervical paraspinal muscles bilaterally.

ORTHO/NEURO:

Romberg Sign was absent. The patient was instructed to stand with their feet together and arm at their sides. The examiner stood close enough to catch the patient should they fall. Since the patient was able to do that pretty well, they were then instructed to close their eyes. The sign was absent due to the patient being able to retain their balance with minimal swaying.

Finger to Nose Test was positive bilaterally. While standing with their arms extended, the patient was instructed to touch their nose with one hand, then with the other, and then with both. The patient was then instructed to do this with their eyes closed. The test was positive since they were not able to do it either with eyes open, or with eyes closed, or both.

Maximum Cervical Compression Test was negative for a radicular component, but elicited localized neck pain. While seated, the patient laterally flexed their head and brought the chin of the involved side to the shoulder.

Jackson Compression Test was negative, but did reveal localized cervical spine pain. With the examiner behind the seated patient, the patient laterally flexed the head while the examiner clasped hands over the patient's head and pushed down.

Distraction Test was positive. The examiner placed the open palm of one hand under the patient's chin, and the other hand on the patient's occiput. Then, the patient's head was lifted to remove weight from the neck. The movement lessened the patient's degree of pain

ICD-9 DIAGNOSIS:

839.08 Closed Dislocation, Multiple Cervical Vertebrae

850.0 Concussion with No Loss of Consciousness

723.8 Other Syndromes affecting Cervical Region

728.85 Spasm of Muscle

723.1 Cervical Spine Pain

784.0 Headache

DEEP TENDON REFLEXES:

Biceps Reflex bilaterally was 2+/5.

Brachioradialis Reflex bilaterally was 2+/5.

CRANIAL NERVES:

Cranial nerve examination was performed on CN I - XII and no abnormalities were detected.

MUSCLE TESTING:

Deltoid (C5):	Right - 5/5	Left - 5/5
Biceps (C5, C6):	Right - 5/5	Left - 5/5
Wrist Extensors (C6):	Right - 5/5	Left - 5/5
Wrist Flexors (C7):	Right - 5/5	Left - 5/5
Finger Flexors (C8):	Right - 5/5	Left - 5/5
Finger Interossei (C8-T1):	Right - 5/5	Left - 5/5

DERMATOMES:

Evaluation of the dermatomes utilizing a pin wheel revealed all dermatomes tested were normal.

History

CAUSATION DETAILS:

The patient presents with full spine complaints of a gradual onset. She currently works as a bank teller and must stand on her feet for 4 to 6 hours at a time. The pain is worse at the end of the day.

SUBJECTIVE:

On today's appointment, Ms. Doe reported that she is feeling frequent moderate pain in the lower back. This is throbbing pain lower back. Additionally, she states that she has been feeling constant moderate pain in the upper back area. This is further described as throbbing pain. Ms. Doe stated that nothing makes her more comfortable but her upper back pain is a lot more uncomfortable due to exercising and repetitious movements.

This patient also reported that she has been feeling frequent moderate pain in the neck area. She further describes it as sore and stiffness pain neck. Repetitious movements, turning the head left and turning the head right causes the neck pain to be aggravated while nothing makes it better.

Ms. Doe was asked to determine her opinion of her current condition status. Based on a 1 to 10 pain scale, Ms. Doe estimated her low back pain at 5 and upper back pain at 5 and neck pain at 4.

ACT

115

ICD-10 Diagnosis

1. S13.101A Dislocation of Cervical Vertebrae initial encounter
2. S06.0x0A Concussion w/out loss of consciousness initial encounter
3. M53.82 Other specified dorsopathies of cervical region (facet syndrome)
4. M62.838 Other muscle spasms
5. M54.2 Cervicalgia
6. R51 Headache
7. W21.81A Striking against or struck by football helmet

ACT

113

ROS, PMSH, Family History

REVIEW OF SYSTEMS:

GU: Denies polyuria, nocturia, incontinence, or hematuria

GI: Denies nausea, vomiting, diarrhea, constipation, incontinence.

Medical Health: *Is significant for rollover motor vehicle accident in 2011 in which she injured her neck, upper back and lower back. She stated her car hit black ice and rolled and hit a tree.*

DRUGS: No medications

FAMILY HISTORY:

The patient has no family history of problems.

SOCIAL HISTORY

A review of Ms. Kimberly Doe's social history was obtained. Ms. Doe's social history was reviewed and was found to be consistent with previous findings.

ACT

116

Case 1

Fifty-eight year old male presents to ABC chiropractic for an initial visit. Patient is a long distance truck driver of 25 years. He complains of lower back pain and right leg paresthesia while sitting after he gets home from driving an 8 hour day.

Vital Signs—normal

Gait—normal

Lumbar ROM was restricted on all planes with pain more noticeable on extension and right lateral flexion. The RLF reproduced the pain radiating into his right leg.

Dermatome testing was positive for hypoesthesia in the L4 dermatome on the right. Left was negative.

Kemp's test was positive on the right and negative on the left.

Radiographs revealed spondylosis in the lumbar spine.

ICD-10- Diagnosis M47.26 Other spondylosis with radiculopathy, lumbar region

ACT

114

Lumbar ROM

Lumbar:

Flexion	Decreased
Extension	Decreased
Right lateral flexion	Decreased
Left Lateral Flexion	Decreased

ACT

119

Examination

GENERAL APPEARANCE:

The general appearance of Ms. Doe is normal.

VITAL SIGNS:

Pulse Rate	71
Sitting Pressure/Systolic	L:106
Sitting Pressure/Diastolic	L:67
Height	5'4"
Weight	145
Body Mass Index	24.89

ACT

117

Ortho/Neuro Testing

Maximum Cervical Compression Test was **negative bilaterally for radiating pain** into the upper extremities, but did **elicit pain in the C5-C7 facet joints bilaterally**. While seated, the patient laterally flexed their head and brought the chin of the involved side to the shoulder. This motion caused no radiating pain on the side of lateral flexion and rotation. The same result was obtained when the other side was tested.

Jackson Compression Test was **negative bilaterally for radiating pain into the upper extremities**, but did **elicit pain in the C5-C7 facet joints bilaterally**. With the examiner behind the seated patient, the patient laterally flexed the head while the examiner clasped hands over the patient's head and pushed down. This maneuver did not significantly increase the patient's amount of pain.

Kemp's Test was negative bilaterally. The examiner stood behind the patient and anchored the pelvis and sacrum with one hand while grasping the opposite shoulder with the other hand. The shoulder was then forced obliquely back, down, and medial.

Bechterew Sitting Test was negative bilaterally. With the patient seated and legs dangling over the edge of the table, the examiner instructed the patient to extend one knee straight out then repeat with the other knee. Then, the patient repeated the maneuver with both knees. The patient was able to do this without any pain and without leaning backwards.

ACT

120

Range of Motion

RANGE OF MOTION: Range of motion was visually performed both actively and passively, and elicited pain on extension and rotation in the cervical and lumbar spines.

Cervical:

Flexion	Decreased
Extension	Decreased
Right Lateral Flexion	Decreased
Left Lateral Flexion	Decreased
Right Rotation	Decreased
Left Rotation	Decreased

ACT

118

Neurological Testing

Biceps Reflex bilaterally was 2+/5.

Brachioradialis Reflex bilaterally was 2+/5.

Triceps Reflex bilaterally was 2+/5.

Patella Reflex bilaterally was 2+/5.

Achilles Reflex done bilaterally was a 2+/5.

All dermatomes were normal

Muscle testing of the upper and lower extremity were bilaterally 5/5

ACT

123

Ortho/Neuro Testing

Ely Heel To Buttock Test was positive on the left, negative on the right. This two stage test was performed with the patient lying prone. The examiner flexed the patient's knee approximating the heel to the opposite buttock. From this position, the examiner hyperextended the patient's thigh. The test was positive if the patient was unable to do the test, unable to extend the thigh, if femoral radicular pain was produced, and/or if upper lumbar discomfort was present. The test was negative on the right as the patient was able to perform this test without any difficulty.

Nachlas Test was positive on the left, negative on the right. The examiner stood on the side of the patient ipsilateral to the pain while the patient lay prone. With one hand, the examiner raised the foot of the involved side and maximally flexed the knee. With the other hand, the examiner pushed downward on the patient's pelvis. The patient experienced pain in the joint. When the right side was tested, there was no pain elicited.

Patrick's Test was negative bilaterally. With the patient supine, the examiner placed the foot of the patient's involved side on the opposite knee. This made the hip joint flexed, abducted, and externally rotated. In this position, the patient did not experience any significant pain. The same result was obtained on the other side.

ACT

121

Spinal Palpation

OBJECTIVE:

Palpation revealed a moderate degree of fixation at C5 - C7, T1 - T4, T10, T11, L4, L5 and the left/right ilium - sacrum. There is evidence elicited on palpation of a moderate degree of pain at C5 - C7, T1 - T4, T10, T11, L4, L5 and the ilium - sacrum bilaterally. **Palpation revealed moderate tension** of the cervical paraspinal muscles, upper thoracic muscles, lower thoracic muscles, lumbar paraspinal muscles and gluteal muscles bilaterally.

Additionally there was **focal pain upon palpation at C5-C7 spinous processes, and T1-T4 spinous processes**. There was also moderate to severe tenderness at the left L4 and L5 spinous processes.

ACT

124

Ortho/Neuro Testing

Ely Heel To Buttock Test was positive on the left, negative on the right. This two stage test was performed with the patient lying prone. The examiner flexed the patient's knee approximating the heel to the opposite buttock. From this position, the examiner hyperextended the patient's thigh. The test was positive if the patient was unable to do the test, unable to extend the thigh, if femoral radicular pain was produced, and/or if upper lumbar discomfort was present. The test was negative on the right as the patient was able to perform this test without any difficulty.

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Patrick's Test was negative bilaterally. With the patient supine, the examiner placed the foot of the patient's involved side on the opposite knee. This made the hip joint flexed, abducted, and externally rotated. In this position, the patient did not experience any significant pain. The same result was obtained on the other side.

ACT

122

Etiology Last Diagnosis

V47.02xS Driver of other type of car injured in collision with fixed or stationary object in nontraffic accident

ACT

127

ICD-9 Diagnosis

DIAGNOSIS:

- 739.3 Segmental Dysfunction, Lumbosacral Region
- 739.5 Nonallopathic Lesions of Pelvic Region, not elsewhere classified
- 739.4 Nonallopathic Lesions of Sacral Region, not elsewhere classified
- 720.1 Spinal Enthesopathy
- 724.2 Lumbar Spine Pain
- 739.2 Segmental Dysfunction, Thoracic Region
- 729.1 Myofascitis
- 724.1 Pain in Thoracic Spine
- 739.1 Segmental Dysfunction, Cervical Region
- 724.8 Cervical Facet Syndrome
- 723.1 Cervicalgia

ACT

125

For more information

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Lets Compare

ICD-9

DIAGNOSIS:

- 739.3 Segmental Dysfunction, Lumbosacral Region
- 739.5 Nonallopathic Lesions of Pelvic Region, not elsewhere classified
- 739.4 Nonallopathic Lesions of Sacral Region, not elsewhere classified
- 720.1 Spinal Enthesopathy
- 724.2 Lumbar Spine Pain
- 739.2 Segmental Dysfunction, Thoracic Region
- 729.1 Myofascitis
- 724.1 Pain in Thoracic Spine
- 739.1 Segmental Dysfunction, Cervical Region
- 724.8 Cervical Facet Syndrome
- 723.1 Cervicalgia

ICD-10

- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.05 Segmental and somatic dysfunction of pelvic region
- M99.04 Segmental and somatic dysfunction of sacral region
- M46.06 Spinal Enthesopathy, lumbar region
- M54.5 Low Back Pain
- M99.02 Segmental and somatic dysfunction of thoracic region
- M79.1 Myalgia
- M54.6 Pain in Thoracic Spine
- M99.01 Segmental and somatic dysfunction of cervical region
- M53.82 Other specified dorsopathies of cervical region
- M54.2 Cervicalgia

ACT

126