EVALUATION AND MANAGEMENT QUICK START GUIDE

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For many chiropractors the process of evaluation and management is not only confusing, but elusive. Most of us were never taught the brass tacks of coding for our examinations (which includes the information obtained during intake). This quick start guide is designed to give you a complete understanding of how your Chiropractic Forms provide the essential documentation standards for your E/M coding. Less denials and less staff time negotiating with insurance companies can contribute to a significant boost in overall office efficiency and revenue.

General Information

Your forms are in PDF format. They can easily be printed in your office or at a local print shop in bulk. Additionally, if you transition to a EMR/EHR they will act as templates for the production of your digital forms. If you would like your forms updated with a new logo/address in the future please contact me here. All coding should be based on the clinical presentation of the patient.

Your E/M coding can be broken up into 3 distinct groups: the history, the physical examination, and the chiropractic decision making.

I strongly recommended downloading the AAOS cross-reference check sheet to gain a full understanding of how to code with the best accuracy. I cannot supply this form directly because I did not produce it, however, it is an essential tool which can be downloaded for free here. Please download it before moving forward.

Chiropractic History

The short version- The Chiropractic Intake form is designed to gain all of the necessary information to have a complete and thorough history. No section of the Chiropractic Intake form should be left blank. By accurately completing the form in its entirely you can be assured that the information necessary to easily determine your E/M coding will already be taken care of.

The first form your patients will receive is the Chiropractic Intake Form. The intake form begins with the standard demographic information which most offices already collect. You will notice that there is a section for the patient to input their primary care physician and also a space for them to give permission to contact this physician. In my experience over 95% of patients will say yes to this question. If it is left blank I would encourage you, or a staff member, to ask the patient. Again, over 95% of the time they will say yes when asked. This is imperative because once you have permission you may coordinate care. This includes the sending of case notes and pertinent health information which is not only a way to reach out to the medical community, but more importantly, it keeps an accurate and complete health record.

Please follow all local/state/federal laws regarding the communication of protected health information.

We have ordered the chief complaint section according to the most common reasons people visit a chiropractic office. When any single chief complaint section is filled out entirely, it will cover the necessary requirements for a complete History of Present Illness.

Next you will see the Review of Systems, Past Medical/Social History, and Family History. Again, these should be filled out entirely to ensure you have the documentation necessary to code at the highest level possible. The review of systems section covers the 14 body systems by describing a sample of symptoms rather than diseases. It must be a positive or negative response.

When your Chiropractic Intake is filled out in its entirety you will see that you have enough bullet points (using the AAOS cross-reference sheet) to code at the highest level. This does not mean that you get to automatically code at a 99205; but it gives you the ability to move to the next section (physical examination) without any hinderances.

Physical Examination

Our physical examination forms consist of a Cervical and a Lumbar examination. You will notice the first page of each examination package is quite similar. If you are going to be performing a Cervical and Lumbar examination on the same patient then you only need to complete 1 of the first pages, as it will capture the relevant information for both regions.

All information on the examination forms should be completed in full. When you cross reference the Cervical and Lumbar exam forms with the

AAOS cross-reference sheet you will see that all of the bullet points are represented. The total amount of bullet points will simply be decided by the number of body regions examined. Six total body regions are included - neck, back, right lower extremity, left lower extremity, right upper extremity, left lower extremity. To move forward with the potential ability to code a 99204 or 99205 you will need to complete all bullet points for at least 4 body regions (for a total of 30 bullet points). Anything less than 30 bullet points, which would include the complete examination of one, two, or three body regions would not accumulate 30 bullet points and leave your highest coded possibility now at a 99203.

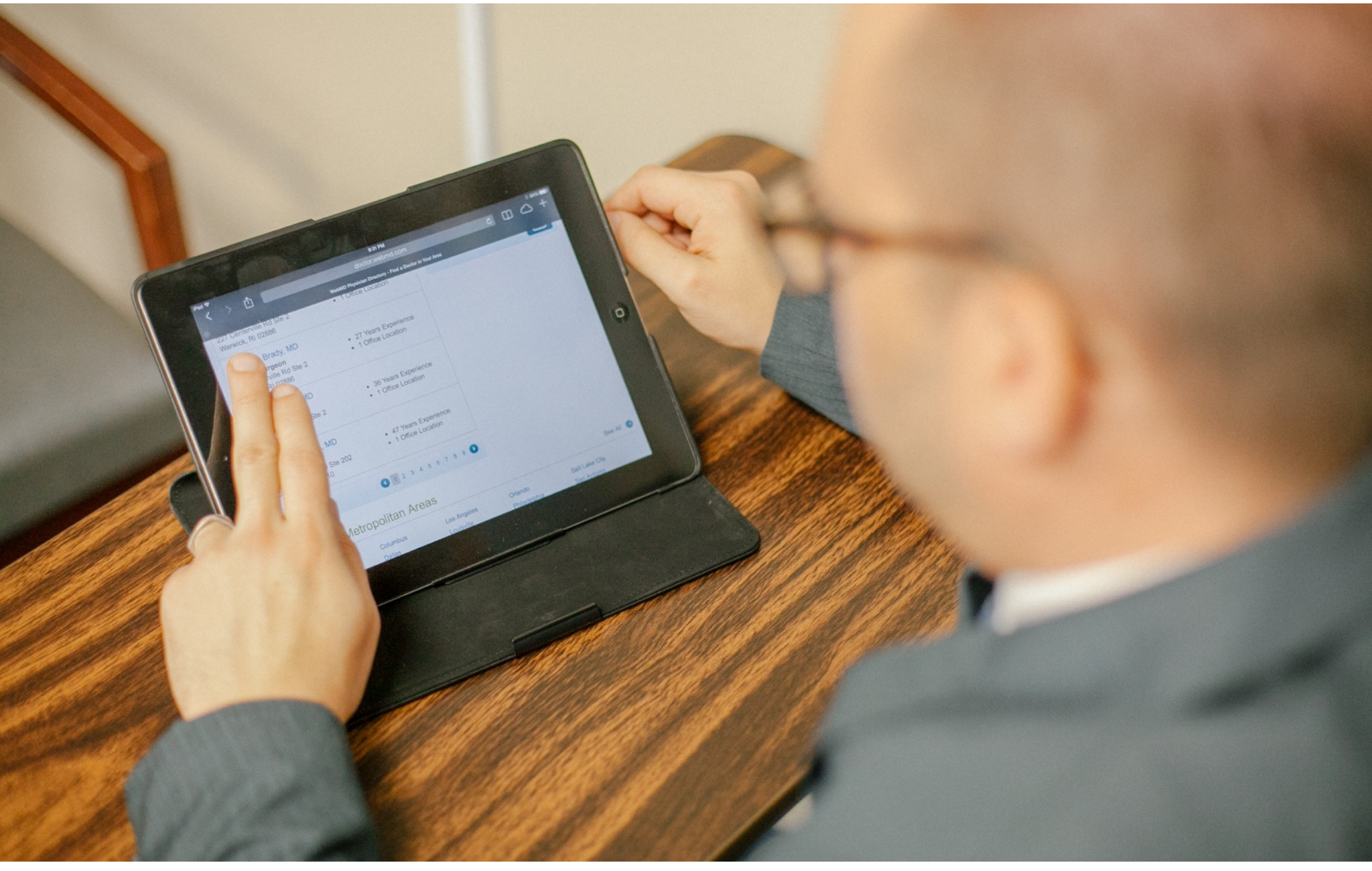
Chiropractic Decision Making

Moving into the decision making process you should have a very complete idea of the documentation you have accumulated to substantiate the proper coding of your examination. The final component to determine the exact code is the chiropractic decision making process. As you review your AAOS cross-reference sheet you will notice that it would be highly unlikely that a chiropractor would encounter a decision making process which would qualify for a 99205 code; even if your examination and history has given you enough bullet points up to that point. You will also notice that Time is not a primary component of the E/M coding system. The final determination of your E/M coding is based on the bullet points which are accumulated during your decision making process.

Please also keep in mind that your code should be the lowest of each of the 3 sections. For example- if you have completed the maximum number of bullet points for the History and Examination, yet your Decision Making has accrued only the minimum number of bullet points; then your code would be based upon those minimum number of bullet points.

The only exception to this rule is for Established Patients. With Established Patients you may use the same forms and cross reference sheet, however only 2 or the 3 sections (History, Examination, Chiropractic Decision Making) must be met or exceeded for coding purposes.

While first working with these forms it may appear to be a bit arduous to properly determine the E/M code which is appropriate based on your care. However, you will notice that the process becomes second nature very quickly as it becomes part of your standard process and procedure. Additionally, by coding in a systematic fashion you will have the documentation necessary to support your coding if you encounter a denial.



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