Documentation for Chiropractic Evaluations
(DeskBook Chapter 4.2)

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  • Bachelor’s of Science, Accounting - Brigham Young University
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  • Certified Professional Coder (CPC) - AAPC
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Take-away

• Understand the requirements to document an initial evaluation

• Physical Examination
  o Satisfy E/M requirements
  o Add in ortho/neuros as desired
  o Use PART for subluxations

• Understand the what to include in a re-evaluation or discharge evaluation

Episode of Care

We reviewed information received about the member’s condition and circumstances. We used the Clinical Policy Bulletin (CPB): Chiropractic Services. Based on CPB criteria and the information we have, we are denying coverage for ongoing chiropractic treatment. Chiropractic services are considered medically necessary when the member has a neuromusculoskeletal disorder, the medical necessity for treatment is clearly documented, and improvement in the condition is documented within the initial two weeks of chiropractic care. When no improvement is documented within the initial two weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment has been modified. If the chiropractic treatment has been modified, improvement in the member’s condition should be documented within thirty days. The clinical documentation does not support that the patient is making continuous progress towards measurable goals in a reasonable timeframe for chiropractic treatment of the neck and back.
Episode of Care

**Documentation Requirements: Subsequent Visits**

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. **History (an interval history sufficient to support continuing need; document substantive changes)**
   - Review of chief complaint;
   - Changes since last visit;
   - System review if relevant.

2. **Physical exam (interval; document subsequent changes; a full repeat P.A.R.T. is not expected)**
   - 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. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2B)**

4. **Documentation of how the day's treatment fits within the plan of care (e.g. "visit 4 of planned 7 treatments") and any way the treatment plan is being changed.**

*From the new and improved documentation chapter in the 2018 DeskBook*
Evaluations vs. Treatments

**Evaluation visit** (similar to a standard visit to a medical doctor):

- Record history
- Note objective test results and observations
- Establish patient’s condition/diagnosis
- Formulate a plan with quantifiable, patient-centered goals

**Treatment visit** (the plan is carried out)

- Update patient-centered measurable **Subjective and Objective** information
- Assess patient specific functional progress
- Describe procedures and where the patient is in the plan

To get the whole story a reviewer would need the evaluations on either side of the treatments. This describes the entire *episode of care* rather than an isolated treatment.
Initial Evaluation

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Initial Evaluation Template

1. History:
2. Description of Present Illness:
3. Physical Exam:
4. Diagnosis:
5. Treatment Plan:
6. Date of Initial Treatment:
Initial Evaluation: History

- Symptoms causing patient to seek treatment [Chief Complaint]
- Family history if relevant [Family History]
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history) [Past History]
- Plus…

Initial Evaluation

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Initial Eval: Description of Present Illness

- Mechanism of trauma \([\text{History of Present Illness}]\)
- Quality and character of symptoms/problem \([\text{HPI}]\)
- Onset, duration, intensity, frequency, location, and radiation of symptoms \([\text{HPI}]\)
- Aggravating or relieving factors \([\text{HPI}]\)
- Prior interventions, treatments, medications, secondary complaints \([\text{Past History}]\)
- Symptoms causing patient to seek treatment \([\text{Chief Complaint}]\)

Initial Evaluation

1. History
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Physical Exam

Three distinct things should be documented in the physical exam:

1. E/M code criteria
2. Ortho/neuro testing
3. P.A.R.T. for segmental dysfunction (subluxation)
   In a way, these each stand alone

Physical Exam:  
E/M code

- Evaluation and Management (E/M) codes are how we get paid for an evaluation.
- 1997 Documentation Guidelines for Evaluation and Management codes provides a standardized outline for a nicely documented evaluation of the musculoskeletal and nervous systems.
<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td>• Examination of gait and station</td>
</tr>
<tr>
<td></td>
<td>• Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)</td>
</tr>
<tr>
<td></td>
<td>Examination of joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:</td>
</tr>
<tr>
<td></td>
<td>• Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions</td>
</tr>
<tr>
<td></td>
<td>• Assessment of range of motion with notation of any pain, crepitation or contracture</td>
</tr>
<tr>
<td></td>
<td>• Assessment of stability with notation of any dislocation (luxation), subluxation or laxity</td>
</tr>
<tr>
<td></td>
<td>• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</td>
</tr>
<tr>
<td>Neurologic</td>
<td>• Test cranial nerves with notation of any deficits</td>
</tr>
<tr>
<td></td>
<td>• Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)</td>
</tr>
<tr>
<td></td>
<td>• Examination of sensation (e.g., by touch, pin, vibration, proprioception)</td>
</tr>
</tbody>
</table>

**Physical Exam:**

**E/M code**

**Musculoskeletal System**

- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)
- Examination of joints, bones and muscles of one or more of the following six areas:
  1) head and neck;
  2) spine, ribs and pelvis
  3) right upper extremity
  4) left upper extremity
  5) right lower extremity
  6) left lower extremity
The examination of a given area includes:

- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
- Assessment of range of motion with notation of any pain, crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

Physical Exam Template

Musculoskeletal

Gait/station:
Neck
  Palpation:
  ROM:
  Stability:
  Muscle:
Spine
  Palpation:
  ROM:
  Stability:
  Muscle:
Physical Exam: E/M code
Neurologic System

- Test cranial nerves with notation of any deficits
- Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Where are other ortho/neuro tests?

Physical Exam Template

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Neurologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait/station:</td>
<td>Cranial nerves:</td>
</tr>
<tr>
<td>Neck</td>
<td>DTRs:</td>
</tr>
<tr>
<td>Palpation:</td>
<td>Sensation:</td>
</tr>
<tr>
<td>ROM:</td>
<td></td>
</tr>
<tr>
<td>Stability:</td>
<td></td>
</tr>
<tr>
<td>Muscle:</td>
<td></td>
</tr>
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<td>Spine</td>
<td></td>
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<td>Palpation:</td>
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<td>ROM:</td>
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<tr>
<td>Stability:</td>
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</tr>
<tr>
<td>Muscle:</td>
<td></td>
</tr>
</tbody>
</table>
Physical Exam: Ortho/neuro

• Screens for bad things and helps the provider decide if additional diagnostic testing/referral may be warranted

• Official Disability Guidelines suggest there are two types of neck and back pain patients:
  o Radicular
    • 5% of all neck pain patients
    • 10% of all lower back pain patients
  o Non-radicular
    • 95% of all neck pain patients
    • 90% of all lower back pain patients

• Most ortho/neuro tests are not “positive” on non-radicular patients.

Physical Exam: Ortho/neuro

• Beware of saying that a test is positive. Just describe the findings.
  o “Foraminal compression test is positive for radiating pain to the posterior left upper arm, indicative of radiculopathy.”
  o “Foraminal compression test leads to right sided neck pain of moderate intensity” is a better way to document non-radicular problems.

• Ortho / neuro does not prove the existence of a segmental dysfunction (subluxation).

• Ortho/neuro does not establish medical necessity for treatment.

• Ortho/neuro does not contribute (much) to E/M code selection.
Physical Exam: Ortho/neuro

"Positive" Kemp's test:

- **Leg pain**: nerve root compression, radiculopathy
- **Ipsilateral lower back pain**: sprain/strain, facet syndrome, meniscoid entrapment
- **Pain on contralateral side**: strain/sprain

Which one is it?

As with all orthopedic tests, state what the positive finding reveal in the clinical notes. Example, "Kemp's test was positive for radiating right L5 dermatomal pain, indicating L5 nerve root compression"
Medical record must contain documentation that fully supports the medical necessity for services.

Level of subluxation must bear a direct relationship to the patient’s symptoms, and the symptoms must be directly related to the level of the subluxation that has been diagnosed.

**Medical necessity requirements apply:**
- whether subluxation is demonstrated by x-ray or physical exam
- Applies to both initial and subsequent visits
- Both participating and non-participating providers

**Document precise level of subluxation:**
- List exact bones involved
  - C2, L4, etc.
- Area/region, if it implies certain bones
  - Lumbo-sacral
  - Sacro-iliac
According to CMS, the physical examination for a subluxation is an evaluation of the musculoskeletal/nervous system to identify:

**P.A.R.T.**

- **P** Pain/tenderness
Physical Exam: Segmental dysfunction (Subluxation)

**Pain/tenderness** evaluated in terms of location, quality, and intensity

Pain and tenderness findings may be identified through observation, percussion, or palpation.

Physical Exam: Segmental dysfunction (Subluxation)

A

Asymmetry/misalignment
Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following:

- Observation (posture and gait analysis),
- Static palpation for misalignment of vertebral segments,
- Diagnostic imaging

Physical Exam: Segmental dysfunction (Subluxation)

Physical Exam: Segmental dysfunction (Subluxation)

Range of Motion
Range of motion abnormalities may be identified through one or more of the following:

• Motion palpation
• Observation
• Range of motion measurements (i.e. inclinometers)

Physical Exam: Segmental dysfunction (Subluxation)

T

Tissue/tone changes
Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures:

- Observation
- Palpation
- Use of instruments

To demonstrate a subluxation based on examination **two of the four criteria** must be:

- Asymmetry
- Range Of Motion

**P.A.R.T.**
Physical Exam Template

**Musculoskeletal**
- Gait/station:
- Neck
  - Palpation:
  - ROM:
  - Stability:
  - Muscle:
- Spine
  - Palpation:
  - ROM:
  - Stability:
  - Muscle:

**Neurologic**
- Cranial nerves:
- DTRs:
- Sensation:

**Ortho/neuro**

**Segmental Dysfunction**
- Each Segment:
  - Pain:
  - Asymmetry:
  - ROM:
  - Tissue/tone:

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**Physical Exam**

Three distinct things should be documented in the physical exam:

1. E/M code
2. Ortho/neuro
3. P.A.R.T.
Physical Exam Template

Musculoskeletal
- Gait/station:
  - Neck
    - Palpation:
    - ROM:
    - Stability:
    - Muscle:
- Spine
  - Palpation:
  - ROM:
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Neurologic
- Cranial nerves:
- DTRs:
- Sensation:

Ortho/neuro

Segmental Dysfunction
- Each Segment:
  - Pain:
  - Asymmetry:
  - ROM:
  - Tissue/tone:

Documents
- E/M criteria
- Screens for bad stuff

Documents
- subluxation

Initial Evaluation

1. History
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6. Date of Initial Treatment
Primary diagnosis must be
- M99.00 Segmental and somatic dysfunction of head region
- M99.01 Segmental and somatic dysfunction of cervical region
- M99.02 Segmental and somatic dysfunction of thoracic region
- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- M99.05 Segmental and somatic dysfunction of pelvic region

Secondary diagnosis must be a neuromusculoskeletal condition based on the presenting problem.
- List primary/secondary for each region treated/billed

Sample from “Anatomic Diagnosis Code List” of 2017 ICD-10-CM Coding for Chiropractic
## Initial Evaluation: Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Nerve related disorders</th>
<th>(e.g. radiculopathy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Acute injuries</td>
<td>(e.g. sprains and strains)</td>
</tr>
<tr>
<td>3</td>
<td>Structural diagnoses</td>
<td>(e.g. degenerative disc disease)</td>
</tr>
<tr>
<td>4</td>
<td>Functional diagnoses</td>
<td>(e.g. difficulty with walking)</td>
</tr>
<tr>
<td>5</td>
<td>Soft tissue problems</td>
<td>(e.g. myalgia)</td>
</tr>
<tr>
<td>6</td>
<td>Symptoms</td>
<td>(e.g. neck pain)</td>
</tr>
<tr>
<td>7</td>
<td>Complicating factors/comorbidities (e.g. diabetes)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>External causes</td>
<td>(e.g. place and activity)</td>
</tr>
</tbody>
</table>

- When coding for symptoms, add the phrase “due to” for better specificity.
- Complicating factors should also be diagnosed, if relevant.
- Create “Provider Documentation Guides” for your most commonly used diagnoses.
- Learn to document a “Diagnostic Statement” that matches the code requirements.
Initial Evaluation

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Initial Evaluation: Treatment Plan

1. Recommended level of care (duration and frequency of visits)
   - Acute treatment is shorter duration, higher frequency
   - Chronic treatment is longer duration, but lower frequency
   - Initial exam is not expected to provide all the answers. A treatment trial should be instituted and assessed to determine if the plan should change.

2. Specific treatment **goals**
   - With documentation of progress or lack thereof at subsequent visits

3. Objective measures to evaluate treatment effectiveness
   - Qualitative and/or quantitative
Initial Evaluation: Treatment Plan

- Outcomes measures should be used at the beginning, during, and after treatment is recommended to quantify progress.
- Plan of care should include recommendations for ongoing amelioration of musculoskeletal complaints, such as:
  - Home program, lifestyle modifications, etc
- Introduce as soon as possible, reinforce, and document in the medical record.

Initial Evaluation

1. History
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1. **History:**

2. **Description of Present Illness:**

3. **Physical Exam:**

4. **Diagnosis:**

5. **Treatment Plan:**

6. **Date of Initial Treatment:**
Re-evaluation

• Perform every 30 days, at a minimum, to keep progress updated.
• Consider also evaluating at the midpoint of the initial trial (2 weeks?).
• Only bill for an E/M if the re-evaluation is significant and separately identifiable (25 modifier)

Re-evaluation

• Reassess abnormal test results from last evaluation
• Re-administer OATs
• Note functional progress or lack thereof and explain (i.e. complicating factors)
• Update ICD-10 codes based on exam
• Update goals, procedures, and frequency/duration of care plan
• If discharged, indicate rationale (MTB)
Re-evaluation

1. Were the goals met?
2. Are there new goals?
   o Improve NDI from 30% to 10% by 7/1/18
3. How will care change now?
   o More intense home exercises?
   o Fewer office visits?
   o Eliminate passive modalities?

The key: show progress!

The ChiroCode DeskBook is available at ChiroCode.com

Most of this presentation is covered in Chapter 4.3
Take-away

• Understand the requirements to document an initial evaluation

• Physical Examination
  o Satisfy E/M requirements
  o Add in ortho/neuros as desired
  o Use PART for subluxations

• Understand the what to include in a re-evaluation or discharge evaluation