



# Chiropractic Associates

## E/M CODE INFORMATION

E/M codes! How do I use them properly? What level of E/M code should I bill? These are common questions we get at CASD concerning E/M codes. In our ongoing effort to educate our member doctors on how to provide quality care for their patients, as well as educating them on how to properly bill, code and document the care they are providing, we have developed this document to assist you in choosing the correct E/M code.

Doctors schedule their patients to allow a certain amount of time for the process of evaluation and treatment. Because of this some doctors put every patient through the same process. The doctor must properly evaluate their patients to establish the correct diagnosis and treatment plan. Not all patients have the same presentation. Therefore, you cannot have every patient fill out the same forms and do the same examination to establish the proper diagnosis.

An examination is an investigation of the presenting patient. The appropriate level of E/M code is determined by the patient presentation, examination and complicating factors. The exam should be individualized and driven by the history and objective findings. Patients who present with minimal complaints, no significant past/present history or family history, would normally require a brief exam. Patients whose condition is of high severity would normally require a more complicated and time consuming examination.

Is the entire encounter with the patient during an exam required to be done face to face? No, the patient can complete the intake forms prior to being seen.

Once the forms are completed the doctor begins the examination process by evaluating the pertinent information gathered by the intake forms. Specific questioning, face to face, is then conducted and documented pertaining to the positive findings on the intake forms.

The history is one component of the E/M code.

With the aide of the intake forms and history the doctor determines the necessary examination procedures. The need for additional procedures may occur, depending upon the results of the examination.

Regardless of the level of exam required it is important to perform and document vitals to rule out red or yellow flags. Following the taking of the patient's vitals the following exam procedures should be performed, depending upon the patient's complaint(s). They are the components of a regional orthopedic and neurologic evaluation and include; inspection/palpation, postural findings, range of motion, orthopedic/neurological tests, muscle strength, sensory and reflexes, etc. Each patient may not require all of these examination procedures. It is dependent upon the patient presentation. Depending upon the patient's complaints and exam findings a visceral examination, diagnostic laboratory and or radiology may be necessary.

The examination is the second component of the E/M code.

The final component of the E/M code is the medical decision making component. The medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the number of possible diagnoses, the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed. The risks of complications, morbidity and/or mortality, as well as co-morbidities associated with the patient's presenting problems also add to the complexity of the medical decision making.

Besides the three key components for determining the level of E/M code, time may be an overriding factor when counseling and/or coordination of care is more than 50% of total face to face time. Reading X-rays taken at another facility, report of findings, and manual muscle testing, range of motion testing and physical performance testing are considered part of the E/M code and should be included when determining the appropriate E/M code. The time the patient spends filling out forms is not considered part of the examination. The time that the doctor spends reviewing the information, in addition to the time spent face to face with the patient performing the examination, is used to determine the level of E/M code billed.

The documentation must include all procedures performed and interpretations made. When using time as a factor the time for the entire encounter and the time spent counseling and or coordinating care must also be documented.

The following codes are used to signify the level of the exam performed in office:

**NEW PATIENT:** (a new patient is a patient who the clinic has not seen before or who has not been in the clinic in over 3 years)

In order to fulfill the requirement for a new patient exam you must have all three of these key components; history, exam, and medical decision making.

**99201:** Is a problem focused history and exam with a straight forward medical decision making typically taking 10 minutes face to face with the patient and/or family.

**99202:** Is an expanded problem focused history and exam with a straightforward medical decision making typically taking 20 minutes face to face.

**99203:** Is a detailed history and exam with low complexity medical decision making typically taking 30 minutes face to face.

**99204:** Is a comprehensive history and exam with moderate complexity medical decision making typically taking 45 minutes face to face.

**99205:** Is a comprehensive history and exam with high complexity medical decision making typically taking 60 minutes face to face.

**ESTABLISHED PATIENT:**

To fulfill the requirement for an established patient exam two of the three key components as listed above must be met.

**99211:** Usually the presenting problems are minimal typically taking 5 minutes face to face with provider.

**99212:** Requires 2 of the following 3 components: problem focused history and exam with straightforward decision making typically taking 10 minutes face to face.

**99213:** Requires 2 out of the following 3 components: expanded problem focused history and exam with low complexity medical decision making typically taking 15 minutes face to face.

**99214:** Requires 2 out of the following 3 components: detailed history and exam with moderate complexity medical decision making typically taking 25 minutes face to face.

**99215:** Requires 2 out of the following 3 components: comprehensive history and exam with high complexity medical decision making typically taking 40 minutes face to face.

## **EXAMPLE:**

**E/M Code Billed: 99203**

5/21/08 Jane Doe

Chief Complaint: Lt. C/D pain with Lt. Arm pain

Date of injury/onset: 5/20/08

History of Injury/onset: She was working at ABC Grocery. She was stocking shelves and a box weighing approx. 15 pounds fell off the shelf and hit her on the top of the head forcing her head sharply to the left shoulder.

**Review of symptoms:** Constant sharp shooting pain Lt C/D with radiation to shoulder blade on the left. If she turns her head to the left she will get tingling into the posterior arm to the elbow. Symptoms seem to be getting worse. It has caused her limitations, cannot sleep through the night in her bed, and cannot be upright very long w/o pain.

**VAS: 9**

**Neck Disability index: 80**

**Previous care of current condition:** Patient has used ice and taken Advil w/o improvement of condition. She has not seen any other provider for this condition.

**Past Medical History:** In 1989 she was rear ended in an auto accident and received care by chiropractor in Madison, Wisconsin. This was resolved after several months of care and has had no problems since. No impairment rating was given. She has never had any radiating pain down her arm in the past.

**Present Medical problems:** Patient has a history of fibrocystic breast disease. She recently had a mammography and breast exam, on 5/18/08 by Dr. John Doe, OB/GYN in Anytown, USA. She is waiting for the results and possible biopsy. She also has a history of elevated cholesterol of 280 and triglyceride of 420.

**Allergies:** Penicillin

**Medications:** Lipitor and Centrum multi-vitamin

**Previous surgeries:** 2-C-sections in 1993 and 1996, all w/o complications.

**Social history:** smokes 1 pack of cigarettes/day, 12 cups of coffee/day. No exercise.

**Family History:** Mother living at 62 w/ high cholesterol and triglyceride accompanied by insulin dependent diabetic since age 52.

**Examination:**

**Age:** 40

**Height:** 5'6"

**Weight:** 165

**Blood Pressure:** 138/84 Lt/136/80 Rt seated

**Temp:** 98.4

**Pulse:** 72bpm Lt Radial pulse and 68bpm Rt

**Respiration:** 16 per minute

**CV System:** S1/S2 sounds are EN. Carotid auscultation, no bruitis noted.

**Resp. System:** Lungs were clear with good expansion.

**Abdominal Evaluation:** Due to the patient taking Lipitor an examination of abdominal region was performed. Liver and spleen edges were not palpated. Murphy's punch was negative. Auscultation of the abdominal region was unremarkable with normal bowel sounds present.

**Body type:** Endomorph

**Observation:** Patient appears to be in acute discomfort. She is holding her head in an anterior translated position and slightly tipped towards the right.

**Palpation/percussion:** There is +3 tenderness and hypertonicity at C4-T4 all on the Lt. Active trigger points in the levator scapulae, trapezius, supraspinatous and rhomboid musculature on the Lt.

**ROM Cervical Spine: Visual**

**Flexion** 45/60

**Extension** 20/50 causing severe Lt Shoulder blade pain w/ radiation to the tricep region

**Lt Lat Flexion** 10/40 causing severe Lt Shoulder blade pain, neck pain accompanied by radiating pain to the tricep region

**Rt Lat Flexion** 30/40 reduced pain

**Lt Rotation** 30/80 causing Lt C/D pain with radiation to the posterior tricep region and shoulder blade

**Rt Rotation** 60/80 causing some pulling in the Lt C/D w/o radiation

**Extremity ROM:** ROM of the Lt shoulder was full w/o pain

**Orthopedic Examination:**

C compression was positive causing Lt C5-7 and T1-2 pain w/ shooting pain into the Lt. shoulder blade and into the posterior tricep area.

Spurling's test positive Lt C/D and shoulder blade

C Distraction was positive reducing C/D and radiating pain  
Soto Hall was positive causing pulling sensation Lt C/D  
Lt Shoulder distraction reduced pain while Rt shoulder distraction increased pain Lt C/D and radiating pain to Lt shoulder blade and post tricep  
Valsalva's was negative  
Brachial Plexus Stretch Test was negative  
Hyperabduction's test was negative

Neurological Evaluation: Biceps, triceps, brachioradialis reflexes were +2 and brisk bilaterally. Sensation upper extremity via pin wheel was EN. Romberg's test with eyes opened and closed was EN. Heel Toe walk EN. One legged stance was EN. Patient was alert and responsive to all questions. She did not lose consciousness at time of trauma.

**Muscle Testing (Manual):**

Upper extremity muscle test including biceps, triceps, deltoid, wrist flexor and extensors, interossei and finger flexors and extensors were all 5/5. No atrophy noted.

Radiographic Evaluation: Cervical Series was performed due to clinical findings and trauma including APOM, APLC, Lat C, Rt and Lt obliques. These revealed straightening of the C lordosis. C5-7 IVD degeneration to a moderate degree with anterior lipping. Posterior lipping is noted C6-7 causing IVF narrowing to a mild to moderate degree. No obvious fractures, dislocations or pathologies noted.

Assessment: C/D strain/sprain/segmental dysfunction complex with radiculitis complicated by spondylosis. 847.0. 723.4, 721.0, 739.1

Plan: Gentle C-traction w/ soft tissue mobilization, electrical stimulation, cryotherapy. Home Care; due to the patient's acute condition a c-collar was applied, she was instructed to ice every other hour for 15 minutes, no work for the next 3-4 days. We will treat her daily for 2-3 days and then 3 times per week for 2 weeks then re-evaluate. Will send our office notes, with patient's permission, to Dr. John Doe for coordination of care. Possibly see the need to rule out diabetes due to high lipoproteins and family history.

Goal: Improve condition by 50% w/in 2-4 weeks. Improve sleep pattern, decrease pain and improve function w/in 3 day. Part time duties at work within 3-5 days. If worse rule out disc involvement. Start active care as soon as possible.

Long term goals: Quit smoking and decrease high use of coffee. Increase activity level such as walking.

(Note this examination not including treatment lasted 35 minutes)

## **EXAMPLE:**

The following is a re-exam on the above named patient. Jane has now been treated 10 times since her initial worker compensation injury of 5/20/08. Jane was improving with care until she tripped and fell walking into XYZ Department Store in Next Town, USA.

## **E/M Code Billed: 99213**

6/6/08 Jane Doe

Chief complaint: Lt C/D pain with tingling down Lt arm

Re-injury: 6/5/08

History: Tripped and fell walking into XYZ Department Store in Next Town, USA. She caught herself but really jerked her neck causing immediate sharp pain in the neck with radiating down the Lt arm to the wrist.

VAS: 8

**Neck Disability Index: 72%**

**Previous care:** See previous notes. As you can see this patient was back to light duties with minimal complaints until this re-injury.

**Examination:**

**Blood Pressure 156/94**

**Temp 98.0**

**Pulse 74bpm**

**Respirations 15/min**

**Cardiovascular System: S1/S2 sounds are EN.**

**Resp:** Lungs were clear with good expansion but deep inspiration reproduced neck/arm pain.

**Observation:** Patient in acute distress, head is held in a Rt lat position with her Lt arm held above her head,

**Palpation:** +4 tenderness Lt C5-T2 and very acutely tender on even very light palpation. Muscles are very spastic at a +4, any motion causes pain and discomfort Lt C/D.

**ROM Cervical:**

Her neck was spastic and unable to move past 5 degrees in any direction w/o severe pain and radiation down the left arm.

**Extremity ROM:**

If we drop the Lt Arm from the top of her head she has acute/unbearable Lt C/D and arm pain. But no pain in the shoulder joint was noted.

**Orthopedic Examination:** C-compression was positive causing Lt C/D pain with reproduction of pain radiating Lt posterior arm to forearm. Distraction relieves neck and arm pain in fact the patient is very comfortable with this procedure, when we let her head go just the weight of her head causes Lt C/d and arm pain. Valsalva's is positive. We were unable to perform any other orthopedic tests as any movement of this patient's head reproduced neck/arm pain.

**Neurological Evaluation:** Loss of Bicep and Brachioradialis reflex on the Lt, rest of the upper extremity reflexes are 2+ and brisk. Sensation was hypersensitive in tricep region and dorsum of forearm.

**Muscle testing:** All muscles demonstrated 4/5 weakness of the left, 5/5 on the right for the upper extremity. Patient demonstrated breakaway weakness due to pain in the Lt arm therefore testing of muscle strength was not accurate.

**Radiographic Evaluation:** Due to the patient's acute pain and distress I felt APLC and Lat. C were indicated. Note we were unable to perform obliques or open mouth views as patient was too much pain for proper positioning. X-rays reveal C5-7 IVD degeneration with IVF narrowing to a moderate degree. Also noted was canal narrowing at C5-7 possible spinal stenosis.

**Assessment:** Suspected herniated disc vs spinal stenosis of C5-7 722.0, 723.0

**Plan:** This patient is in a severe acute condition therefore we applied a hard c-collar which relieved some of her pain. We then applied electrical stim and cryotherapy while she was in our clinic. After stabilizing this patient we called Best Surgery Center in Hometown, USA ordered an MRI to be performed and discussed with Dr. John Anderson of this patient's condition and the need for their evaluation and treatment. Our records and X-rays were handed this patient and her spouse to be hand delivered to Dr. Anderson. Patient left our clinic in a stable but fragile condition and will be seen in 2 hours by Dr. Anderson.

(Note this re-exam lasted 20 minutes due to the time spent referring and coordinating care)