VELOCE
WEBINAR

INNATE XTREME WEBINAR SERIES

NOTES! NOTES! NOTES!

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OUTLINE

- Keys to compliant notes
- What's the problem with my notes the way they are?
- Initial Visit
- Subsequent Visit
- Re-evaluation/Update Visit

KEYS

1. Initial paperwork: Collect it all from the patient and input it correctly. (*See 6/28/2022 webinar)
2. KEEP IT SIMPLE!
    - Don't complicate diagnosis codes
    - Don't creative bill
    - Document every patient the same despite Financial Profile
    - Keep MACROS simple. You're contradicting yourself
    - DO NOT use eXpress S & O on Diagnosis codes
    - Be organized. Complaints must be in same order as your diagnosis.
3. Subsequent visits: Document changes.
    - When to use an S-ESN
4. Update/Re-evaluation Visits:
    - Check/Change - recurring notes, Examination, Treatment Plan, Diagnosis and Subluxations, Charges, Orders

KEYS

5. Remember…THERE'S NO SUCH THING AS PERFECT NOTES!
6. Use your express note to help you.
    - Functional Goal reminder for example. Ie. Walking 10 feet

DOCUMENTATION ERRORS

#1 Insufficient treatment plan - 83%
#2 Medical necessity not shown or miscoded - 67%
#3 Contraindications not checked - 66%
#4 Evaluation: Improper or missing - 34%
#5 Diagnosis: Improper or missing - 33%

*Chirocode DeskBook 2017 *(page 221)*

<u>CMS Probe Review Error Rates</u>

- Chiropractic – 100% error rate

* https://www.cgsmedicare.com/partb/pubs/news/2017/02/cope2067.html

DOCUMENT EVERYONE THE SAME

Not only is it easier for your office, its a State Law!

- Did you know that your State Board has rules/requirements for Record Keeping and Documentation?

  - This means that even your cash/no charge patients must have the minimum documentation on each visit.
    - Example: Colorado Rule 22

  - Each insurance company can require different levels of documentation for IN or OUT of network. If you bill them, you must follow their documentation rules.

In 2021, the requirements to BILL a certain E/M was updated, but the note requirements were not. For that reason, we will still want to adhere by the 1997 Guidelines as this is what is still required in notes.

INITIAL VISIT

Subjective:
- History
  - Chief Complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family, and Social History (PFSH)

Objective:
- Exam
  - Musculoskeletal exam
    - include PART for each specific Subluxation
  - X-ray Findings (If x-ray taken)

Assessment:
- Diagnosis
- Subluxation Listings

Plan:
- Plan of Care (Treatment Plan)
  - Use Functional Rating Index (FRI)
- Orders
- Charges
  - 9894# - include specific spinal level adjusted
  - Choose correct E/M level CPT code

All New Patients:
An individual who did not receive any professional services from the physician within the previous 3 years.
- * 99202 or 99203

Medicare:
New patient, New condition, & Exacerbations.
- ** This means a New Case!
  - * 99202 or 99203
  - 99212 or 99213

SUBJECTIVE

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and Social History (PFSH)

CHIEF COMPLAINT (CC)

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. * The CC is usually stated in the patient's own words.

Keys:
Location, Laterality, Radiation (if radiates, location) for EACH complaint.

CHIEF COMPLAINT (CC)

Examples:

- The patient complains of right low back pain that does not radiate.
- The patient complains of left low back pain that radiates down the back of the left leg to the bottom of his foot.
- The patient complains of right low back pain that does not radiate, mid back pain between his shoulder blade without radiation, and right upper neck pain that radiates into the back and side of his head to his ear and scalp.

SECONDARY COMPLAINTS

What is the difference between a Chief and Secondary Complaint?

Chief complaint – Symptom causing patient to seek treatment

Secondary Complaints – Other complaints not related to the CC that may have existed before, but were not severe enough to prompt the patient to come in for a visit.

NOTE: EXAMPLE 1

Example 1 - Patient presents with acute low back pain from working in the yard. They also report they have had chronic upper back and neck pain over the years too.

* How many regions could you bill vs diagnosis? 1/3

Note:
Chief complaint: The patient presents with right low back pain that does not radiate. Secondary complaints: They also report they have had chronic upper back and neck pain on both sides without radiation.

* Repeat Subjective Note

NOTE: EXAMPLE 2

Example 2 - Patient tripped and fell while working in the yard and they now have a acute low back, mid back, and neck pain.

* How many regions could you bill vs diagnosis? 3/3

Note:
Chief complaint: The patient presents with right low back pain, pain between his shoulder blades on both sides, and left lower neck pain without any radiation.

* Repeat Subjective Note

HISTORY OF PRESENT ILLNESS (HPI)

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. Include history of onset/mechanism of trauma.

HPI elements are: LOPPQRST
Location (example: left leg)
Quality (example: aching, burning, radiating pain)
Severity (example: 10 on a scale of 1 to 10)
Duration (example: started 3 days ago)
Timing (example: constant or comes and goes)
Context (example: lifted large object at work)
Modifying factors (example: better when heat is applied)
Associated signs and symptoms (example: numbness in toes)

*The two types of HPIs are brief and extended.
- Brief – 1 to 3 elements
- Extended – 4+

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

PFSH consists of a review of three areas:

1) Past history includes experiences with illnesses, operations, injuries, and treatments. (Meds, allergies, operations, hospitalizations)

2) Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk (health status of 1st degree relatives – parents, children, siblings)
*Note: Unknown means the patient does not know. (ie. Adopted) vs. Unremarkable

3) Social history includes an age appropriate review of past and current activities (marital status, employment, drugs, alcohol, tobacco, education, sexual history)

*The two types of PFSH are pertinent (1) and complete (all).

REVIEW OF SYSTEMS (ROS)

ROS is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms the patient is currently experiencing.

These systems are recognized for ROS purposes:

1) *Constitutional Symptoms (for example, fever, weight loss)*
2) *Eyes*
3) *Ears, nose, mouth, throat*
4) *Cardiovascular*
5) *Respiratory*
6) *Gastrointestinal*
7) *Genitourinary*
8) *Musculoskeletal*
9) *Integumentary (skin and/or breast)*
10) *Neurological*
11) *Psychiatric*
12) *Endocrine*
13) *Hematologic/lymphatic*
14) *Allergic/immunologic*

**The three types of ROS are problem pertinent (1), extended (2-9), and complete (10+)*

HISTORY REQUIREMENTS PER E/M LEVEL

	History (3 of 3)			
	CC	HPI	ROS	PFSH
99202	Y	1-3	1	n/a
99203	Y	4+	2-9	1

HISTORY REQUIREMENTS per E/M LEVEL

99202 = Expanded Problem Focused

1) CC = Required
2) HPI-Brief = at least 1-3 out of 8 elements of the present HPI (**Location, Quality, Duration)**
3) ROS-Problem Pertinent = list the system directly related to the problem **(musculoskeletal)**
4) PFSH = N/A

99203 = DETAILED

1) CC = Required
2) HPI-Extended = at least 4 out of 8 elements of the present HPI (**Location, Quality, Severity, Duration)**
3) ROS-Extended = list the system directly related to the problem and 2-9 additional systems. **(musculoskeletal, neurological and constitutional = the problem plus 2 additional systems)**
4) PFSH-Pertinent = must document at least **one** item from any of the three history areas directly related to the problem. **(Past history, Family History, Social History)**

INNATE

Initial Visit - Subjective section

OBJECTIVE

- Exam
  - Musculoskeletal exam
    *Include PART for each specific Subluxation
- Results
  - X-ray Findings (If x-ray taken)
- Outcome Assessment Tools (OAT)

EXAMINATION

Reference: 1997 Documentation Guidelines for Evaluation and Management Services

11 systems:

- **Cardiovascular**
- **Ears, Nose, Mouth, and Throat**
- **Eyes**
- **Gastrointestinal**
- **Genitourinary**
- **Hematologic/Lymphatic/Immunologic**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Respiratory**
- **Skin**

The 2 types of exam:

1. **General Multi-system Examination**
2. **Single Organ Examination**
   - **We will focus on the Musculoskeletal exam**

The 4 levels of exam:

1. ~~Problem Focused 99201~~
2. Expanded Problem Focused 99202
3. Detailed 99203
4. Comprehensive – Will Never Use! 99204-99205

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Single Organ Examination - Musculoskeletal

SPECIALTY EXAM: MUSCULOSKELETAL

HIC#	DATE OF SERVICE

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

Performed and Documented		Level of Exam
One to five bullets	99201	Problem Focused
Six to eleven bullets	99202	Expanded Problem Focused
Twelve or more bullets	99203	Detailed
All bullets	99204 & 99205	Comprehensive

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

System/Body Area	Elements of Examination
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	(See Musculoskeletal and Skin)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity Note: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

System/Body Area	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)
Musculoskeletal **NOTE:** Determine the number of body areas addressed within each bullet. Enter that number on the line beside each bullet. Total at the bottom of this box. Inspection, percussion and/or palpation: _____ Assessment of range of motion: _____ Assessment of stability: _____ Assessment of muscle strength and tone: _____ * Total Bullets: _____ (including gait and station)	• Examination of gait and station *(if circled, add to total at bottom of column to the left) Examination of joint(s), bone(s), and muscle(s)/tendon(s) of **four 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: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (e.g., straight leg raising), 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 Note: For the comprehensive level of examination, all four elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

EXAM	One to Five Bullets	Six to Eleven Bullets	Twelve or more Bullets	All Bullets
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Note: The Chest (Breasts); Gastrointestinal (Abdomen); Genitourinary; Head/Face; Eyes; Ears, Nose, Mouth and Throat; Neck and Respiratory systems/body areas are not considered to be part of this Musculoskeletal exam.

SUBLUXATON

2 Ways to document a subluxation:

1. PART thru examination

2. X-ray

** X-ray report MUST document the subluxation (RESULTS)*

Location of subluxation - Level and listing specific

Subluxation must correlate and be causal to the symptoms reported

The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 states: "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine, as demonstrated by x-ray or physical exam."

SUBLUXATON – PART THRU EXAMINATION

Evaluation of Musculoskeletal/nervous system through Physical Exam.
Documenting Subluxation:

P: Pain/tenderness, evaluated in terms of location, quality, & intensity

A: Asymmetry/misalignment identified on sectional or segmental level

R: Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in increase or decrease of sectional or segmental mobility)

T: Tissue, tone changes in characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament

*Must meet at least 2 of the PART AND use A or R as 1 of the 2.

Document secondary supporting diagnosis here as well.

SUBLUXATON – X-RAY

X-ray was taken no more than 12 months prior or three months following initiation of treatment;

or

History supports chronic subluxation (e.g. scoliosis) has existed longer than 12 months and it can be reasonably concluded that condition is permanent;

or

Subluxation is demonstrated by previous CT and/or MRI

- Document the results for EACH date and area/region separately.

** HINT: If you took the x-rays that day, you should have an order, a result, and a plan note for EACH x-ray.

*** HINT: If you took an x-ray of a region, you should have a diagnosis in the region too!

OUTCOME ASSESSMENT TOOLS (OAT)

This tools are objective measures that help document the patient's progress. They are usually required by most insurance companies to justify treatment progress.

Examples:
- Functional Rating Index (FRI)
- Oswestry
- Vernon Minor

INNATE

Initial Visit - Objective section

ASSESSMENT

- Diagnosis
- Subluxation Listings

DIAGNOSIS

- For Insurance, it varies by state and carrier
- For Medicare, this is LCD Specific

- In some LCDs: Claims must include a primary diagnosis of subluxation and a secondary diagnosis reflecting the patient's neuromusculoskeletal condition. The patient's medical record must support the services submitted.

- In other LCDs: Subluxation is the only allowed Diagnosis

- M99.01, M99.02, M99.03, M99.04, M99.05

DIAGNOSIS

Hints:

- Order these to match order of CC
- M99 codes: include P – pain
  - Only add secondary diagnosis of pain/'-algias' when required to have the secondary present.
- If billing for therapies, make sure to have a diagnosis to point the Charge at. * See Plan section
- If billing for x-rays, be sure to have a diagnosis to point at for that series. * See Plan section

SUBLUXATIONS

Hints:

- Order these to match Diagnosis and CC
- Make sure to have # of subluxations that matches your billing codes here * See Plan section
- Make sure to include extremities subluxations. * See Plan section
- Subluxations should correlate with diagnosis and area of complaint.
  - Ie. CC: Left Lower Neck pain > M99.01 > C5L

INNATE

Initial Visit - Assessment section

PLAN

- Plan of Care (Treatment Plan)
  - Use Objective Measures
    - Ie. Functional Rating Index (FRI)

- Orders

- Charges
  * Choose correct E/M level CPT code
  ** 9894# - include specific spinal level adjusted

- Pointers

PLAN OF CARE (TREATMENT PLAN)

MOST IMPORTANT NOTE!!!

Recommended level of care (duration and frequency of visits)

Initial date of treatment: xx/yy/zzz
Resolution of C/C: approximately 90 days from initial date of treatment (# of treatments)
Progress evaluation: Re-evaluate in 30 days (MAXIMUM)
Frequency: 3 times a week until progress evaluation

Treatment will include: Spinal Manipulation, IST, ET…..**THIS IS WHERE YOU PUT YOUR WHY!**
Based on your S & O

Statement of medical necessity WITH Consent to treat.

Patient Instructions: Home exercises, RICE, Off work

Future tests: MRI, CT, X-ray that could be ordered in this POC f no response

Referrals: No Referrals needed at this time

Contraindications/Complicating factors that are/could delay recovery.

PLAN OF CARE (TREATMENT PLAN)

Specific treatment goals & Objective measures to evaluate treatment effectiveness (OAT) – ie. Functional Rating Index

"Pain in and itself is not sufficient to support medical necessity. There must be functional limitations on ADLs to support treatment, with a reasonable expectation of measurable improvement through treatment."

1. Pain (Short Term and Long Term goals)
2. Function (ADL affected by current health condition - Short and Long Term Goals)

Short term goals: To decrease pain to ?/10 and improve function by 1 level in the _____section of the Functional Rating Index OAT.

Long Term Goals: MMI or Pre/episode status or Sleep to level 1….

PLAN OF CARE (TREATMENT PLAN)

HINT: You do NOT need to use an OAT unless the insurance company requires it.

"Pain in and itself is not sufficient to support medical necessity. There must be functional limitations on ADLs to support treatment, with a reasonable expectation of measurable improvement through treatment."

So.. In examination you can add other objective functional measures:

- Range of motion with degrees
- Leg length with measurement
- Dual weight for balance
- Functional Movement Screening Test with results

* On re-examination days, you will need to reperform these measures to show improvement or not. Just like you would an OAT.

** HINT: If you cannot find a functional limitation to measure, it's probably maintenance care.

PLAN NOTES

Keep them simple!!
Don't put verbiage in here that is not in your S or O notes above!!

9894# - Manual manipulation of the spine to correct subluxation. Specific level adjusted.
97012 – Intersegmental traction was performed to mobilize the spinal segments above and below the level of subluxation
992## - Examination performed today
77### - X-ray of _____ was performed today. (insert views)

Where does the extra verbiage go on why? > Treatment plan!

Remember: Treatment plans only last 30 days

CHOOSING THE RIGHT CODE

2021 Evaluation and Management Guideline - Updates

Select the appropriate level of E/M services based on the following:

1. The level of the **medical decision making** as defined for each service;

Or

2. The **total time** for E/M services performed on the date of the encounter.

2021 MEDICAL DECISION MAKING

Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. Medical decision making in the office and other outpatient services code set is defined by **three elements**:

▪ The **number** and complexity of problem(s) that are addressed during the encounter.

▪ The amount and/or **complexity** of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.

Data is divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
- Independent interpretation of tests.
- Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

2021 MEDICAL DECISION MAKING

▪ The **risk** of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.

- For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

***Complete 2 out of 3 to choose the correct code.**

2021 MEDICAL DECISION MAKING

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

2021 TIME

Total time on the date of the encounter (office or other outpatient services [99202-99205, 99212-99215]): For coding purposes, time for these services is the **total time on the date of the encounter**. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and **does not** include time in activities normally performed by clinical staff).

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (ie. review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

2021 TIME

New Patient

- (99201 has been deleted. To report, use 99202)

- 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

  When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

- 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

  When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

NEW PATIENT E/M MATRIX - 1997

	History (3 of 3)				Exam	MDM (2 of 3)		
	CC	HPI	ROS	PFSH	97 DGs	Dx	Data	Risk
99202	Y	1-3	1	n/a	6-11	1	0-1	min
99203	Y	4+	2-9	1	12 in 2	2	2	low

INNATE

Initial Visit - Plan section

INNATE

Initial Visit – Introduction & Closing sections

SUBSEQUENT VISIT

Subjective:

Review of chief complaint
Changes since last visit
ESN note – LEVEL SCENARIO IS A B or W. If they tell you something you need to Document. (remember the GOAL)
System review (if relevant)

Objective:

Changes since last visit
Physical exam
Exam of area of spine involved in diagnosis
PART for each subluxation
ESN note – Objective finding you need to Document.

Assessment:

Assessment of change in the patient's condition since last visit
Evaluation of treatment effectiveness: + or –
Any changes needed to treatment plan (Can place in Level Scenario Codes)
Diagnosis
Subluxation listings

Plan:

Documentation of treatment given on day of visit
Manual manipulation of the spine to correct subluxation. Specific level adjusted.
Short term and long term goals remain unchanged as stated in the current POC.
ESN note – 1x plan you need to Document.

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Subsequent Visit

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RE-EXAMINATION VISIT

Subjective:

- History
  - Chief Complaint (CC) - review
  - Review of Systems (ROS)
  - Encounter Specific Note

Objective:

- Exam
  - Musculoskeletal exam
    - *include PART for each specific Subluxation
  - Results ie. X-ray Findings (If x-ray taken)

Assessment:

- Diagnosis
- Subluxation Listings
- ***NO SAME LEVEL SCENARIOS TODAY!** Ie. 3S1

Plan:

- Plan of Care (Treatment Plan)
  - Use Functional Rating Index (FRI) or other measurement tool
- Orders
- Charges
  - 9894# - include specific spinal level adjusted
  - Choose correct E/M level CPT code

*E/M Code:
99212 or 99213

CHOOSING THE RIGHT CODE - *REFRESHER*

2021 Evaluation and Management Guideline - Updates

Select the appropriate level of E/M services based on the following:

1. The level of the **medical decision making** as defined for each service;

Or

2. The **total time** for E/M services performed on the date of the encounter.

2021 TIME

Established Patient

- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

- 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

  When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

- 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

  When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

ESTABLISHED PATIENT E/M MATRIX - 1997

	History (3 of 3)				Exam	MDM (2 of 3)		
	CC	HPI	ROS	PFSH	97 DGs	Dx	Data	Risk
99212	Y	1-3	n/a	n/a	1-5	1	0-1	min
99213	Y	1-3	1	n/a	6-11	2	2	low

INNATE

Re-examination Visit

HOW TO DOCUMENT A FLARE-UP

Subjective:

- Review of chief complaint
- Changes since last visit
- History of Present Illness – Document the flare-up.
- System review (if relevant)

Objective:

- Changes since last visit
- Physical exam
  - Exam of area of spine involved in diagnosis
    - PART for each subluxation
- New OAT or Functional Measurement

Assessment:

- Assessment of change in the patient's condition since last visit
- Evaluation of treatment effectiveness: + or -
  - Any changes to treatment plan?
- Review Diagnosis
- Review Subluxation listings
- Update Level Scenario – *Should be a W code

Plan:

- Documentation of treatment given on day of visit
- New Treatment Plan – Document Flare-up

INNATE

Document a Flare-up

- Flare-up is same condition, same case
- Extends current Plan of Care
  - Even if you did a normal re-examination update yesterday that showed improvement, you can use today to document a flare-up.
  - Get another OAT, Examination, Treatment plan!

AMENDED RECORDS

Reference: Noridian – Documentation Guidelines for Amended Medical Records – 8/14/2018

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services.

- Must show current date the entry was made and be signed by person change.

- **LATE ENTRY:** A late entry is something that was omitted from the original. Add as soon as possible and only if the person documenting has total recall of the information. Sign and date.
  - Ie. The neck pain is on the right lower neck without radiation. John Doe 07/19/2022

- **ADDENDUM:** An addendum is used to provide information that was not available at the time of the original entry. Add as soon as possible and sign and date with the reason for.
  - Ie. The lumbar x-ray report was reviewed and showed DDD at L5. John Doe 07/19/2022

AMENDED RECORDS

Reference: Noridian – Documentation Guidelines for Amended Medical Records – 8/14/2018

- **CORRECTIONS:** When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to the medical record was made in error. ~~Handwritten notes~~ Electronic notes: Leave the error alone and add a correction note referencing the error note. Both notes must make clear the change made. Sign and date.

- **FALSIFIED DOCUMENTATION: - *Felony Offense***
  - Creation of new records when records are requested
  - Back-dating entries
  - Post-dating entries
  - Pre-dating entries
  - Writing over
  - Adding the existing documentation **UNLESS** as described in late entries, addendums, and corrections.

• Corrections made PRIOR to claim submission and/or medical review request will be considered.
  - So if the entries are signed and dated AFTER the review request, they will not be considered.

AMENDED RECORDS

Reference: Noridian – Documentation Guidelines for Amended Medical Records – 8/14/2018

- **DISCHARGE SUMMARY:** Release from care
- **PROGRESS REPORT:** Follow up with a patient regarding their care. Use when you haven't heard from them in while.
- **ENCOUNTER:** Use this if you have a **second visit that same day** or a phone consult etc… Document the encounter here.

INNATE

Amended Records

And Final Note Sample