

Chiropractic Use of Evaluation & Management CPT Codes

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Current Procedural Terminology (CPT) Codes list five levels of new patient (99201-99205) and five levels of established patient (99211-99215) evaluation and management codes. The codes, which have been in effect since January 1992, are a substantial improvement over their predecessors. However, they are still wrought with inconsistencies when applied in clinical settings on a day-to-day basis, particularly for the chiropractic practitioner.

Table 1	
Categories of Examination Procedures for Current E/M Codes: 99201-99205 New Patients 99211-99215 Established Patients	
General multi-system examination	Hematological/lymphatic/immunologic examination
Cardiovascular examination	
Ear, nose and throat examination	Musculoskeletal examination
Eye examination	Neurological examination
Genitourinary examination	Psychiatric examination

The examination procedures required to meet the specifications for current E & M codes were formulated for allopathic practitioners; physical diagnostic procedures unique to chiropractic practice were excluded. While many procedures (history, range of motion, DTRs) are used by both allopathic and chiropractic practitioners, chiropractors are forced to perform allopathic procedures and chiropractic procedures in order to meet coding requirements and treat patients. If the doctor of chiropractic chooses to limit examination procedures to chiropractic evaluation methods, he or she is placed at risk for sanctions by insurance carriers and their reviewers. It is easy for a chiropractic exam to be reduced to a lower code and/or accuse the practitioner of "up coding" (billing for a higher level of service than was performed) due to a lack of required exam content. Consequently, chiropractic practitioners must work harder than allopathic practitioners to meet coding requirements. Adding insult to injury, doctors of chiropractic typically receive lower reimbursement for evaluation and management procedures, despite their extra effort.

Examination codes prior to 1992 (90000-90020 new patient and 90030-90080 established patient) were also difficult for doctors of chiropractic to utilize. Descriptions for lower level codes were vague. Higher code levels mandated complete physical examination (heart, lung, breast, prostate, etc.) of the patient. Many of the procedures required for the higher codes were not part of the typical chiropractic examination, and in many states they were restricted by scope of practice laws. The codes prior to 1992 were also devoid of chiropractic examination methods. The previous codes were also difficult for medical practitioners to utilize. The multi-system examination approach did

not fit the modern structure of allopathic medicine that emphasizes specialization. For example, medical orthopedists do not perform ENT or vaginal exams and psychiatrists do not perform prostate or range of motion exams. Most medical personnel, therefore, did not meet their own coding requirements under the old system. However, it is doubtful that the issue was ever pressed.

Current codes, with the exception of those for general and internal medical practice, utilize a single system or specialty approach (Table 1). Examinations are now based on procedures emphasized in a practitioner's field of expertise. Evaluation of other systems/regions is limited to a review of systems and the past history.

Examination procedures for each specialty category from table 1 are described in separate tables with each procedure identified by a bullet (• = bullet). Musculoskeletal and neurological bullets are provided as examples (See Table 2 below and Table 3). Exam content requires the inclusion of a specific number of bullets for each code level from the list related to the examiners field of practice (See Table 4). The new system improved coding for allopathic practitioners. The system did little to improve coding for chiropractors. As stated previously, evaluation procedures unique to chiropractic practice are excluded, forcing chiropractors to use both allopathic and chiropractic procedures in order to meet coding requirements and treat the patient.

Table 2: Musculoskeletal Examinations	
System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • 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 habits, deformities, attention to grooming)
Head and Face, Eyes, Ears, Nose, Mouth and Throat, Neck, Respiratory	NO BULLETS
Cardiovascular	<ul style="list-style-type: none"> • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary	NO BULLETS
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axilla, groin and/or other location
Musculoskeletal	<ul style="list-style-type: none"> • Examination of gait and station • 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: <ul style="list-style-type: none"> • 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, cogwheel, spastic) with notation of any atrophy or abnormal movements <p>Note: For the comprehensive level of examination, all four of the 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.</p>
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, Café-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 <p>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 constitute two elements.</p>
Neurological/Psychiatric	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)
*Adapted from E/M Coding Made Easy, 3rd Edition.	

While the procedures identified by bullets in the musculoskeletal and neurological lists are already utilized by most chiropractors, these procedures are of modest help in identifying subluxations.

Problems also exist in the current system with the history requirements, required number of bullets, decision-making complexities and time requirements (See Table 5). For example, a 54-year-old female entered a chiropractic office with a chief complaint of dizziness. She had been evaluated by her medical doctor who, according to the patient, diagnosed inner ear "irregularities." An eight-week course of medication and physical therapy had been unsuccessful. Her history was positive for hypertension, her dizziness was worse with head rotation, and she had recently collapsed twice without losing consciousness (drop attacks).

Table 3 Neurological Examination	
System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • 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)
Head and Face	NO BULLETS
Eyes	<ul style="list-style-type: none"> • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth, and Throat, Neck, Respiratory	NO BULLETS
Cardiovascular	<ul style="list-style-type: none"> • Examination of carotid arteries (e.g., pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary	NO BULLETS
Musculoskeletal	<ul style="list-style-type: none"> • Examination of gait and station Assessment of motor function including: <ul style="list-style-type: none"> • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive (dyskinesia))
Extremities Skin	(See Musculoskeletal)
Neurological	<p>Evaluation of higher integrative function including:</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) <p>Test the following cranial nerves:</p> <ul style="list-style-type: none"> • 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements) • 5th cranial nerve (e.g., facial sensation, corneal reflexes) • 7th cranial nerve (e.g., facial symmetry, strength) • 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (e.g., spontaneous or reflex palate movement) • 11th cranial nerve (e.g., shoulder shrug strength) • 12th cranial nerve (e.g., tongue protrusion) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities • 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)

*Adapted from E/M Coding Made Easy, 3rd Edition

Table 4	
Exam Requirements for Evaluation and Management CPT codes 99201-99205	
Code	Number of Elements
99201	1 to 5 elements identified by bullets
99202	At least 6 elements identified by a bullet
99203	At least 12 elements identified by a bullet
99204/99205	All elements identified by a bullet
*Adapted from <i>E/M Coding Made Easy, 3rd Edition</i>	

Following history, auscultation of the carotid arteries revealed bilateral Bruits. Hautant's and dizziness tests were positive, indicating possible vertebral artery compromise. The examination was discontinued and the patient was referred to a cardiovascular specialist. The specialist ordered vascular imaging studies, which revealed significant occlusion of the vertebral and carotid arteries. Treatment consisted of bilateral endarterectomies.

A second patient entered the same day with chief complaints of generalized neck and back pain. A complete orthopedic, neurological and spinal examination was performed, with the resulting diagnosis of cervical and lumbar facet joint subluxation.

Table 5			
Evaluation & Management (E/M) Service			
New Patient		Requires 3 of 3* Key Components	
Code	*History	*Exam	*Decision M
99201	Chief Complaint Brief HPI (1-3 Elements)	1-5 Bullets in 1 or more Regions/System	Straight For
99202	Chief Complaint Brief HPI (1-3 Elements) ROS (1 or more)	6 Bullets in 1 or more Regions/Systems	Straight For
99203	Chief Complaint Extended HPI (4-8 Elements) ROS (2-9) PFSH (1 or more)	12 Bullets in 2 or more Regions/Systems	Low Comple
99204	Chief Complaint Extended HPI (4-8 Elements) ROS (10 or more) PFSH (2 or 3)	All Bullets Shaded Boxes 1 Bullet Unshaded Boxes	Moderate Co
99205	Chief Complaint Extended HPI (4-8 Elements) ROS (10 or more) PFSH (2 or 3)	All Bullets Shaded Boxes 1 Bullet Unshaded Boxes	High Comple
*Adapted from <i>E/M Coding Made Easy, 3rd Edition</i>			

The examination performed for the first patient only qualified for the lowest level new patient examination code, 99201. This is despite the fact that the brief examination and referral delayed or avoided a stroke and possibly death for the patient.

The examination performed for the second patient, who had a lesser diagnosis, qualified for the midlevel code, 99203. Obviously, the case complexities, time requirements and the number of bullets performed are inverted in these examples.

Similar problems arise in emergency situations and for well-patient examinations. The patient experiencing severe back spasm is difficult to examine, as every procedure/movement hurts. This typically limits the number of procedures that can be performed and causes discrepancies between

the number of bullets and the complexity and severity of the situation. In basic life support (CPR), the patient's problem is highly complex and severe, with the success of care dependent upon speed, not longevity. The complexity and severity are disproportional to the corresponding time requirements. An asymptomatic patient who enters for an annual physical can maneuver endlessly through multiple exam procedures without positive findings. In this case, the time involved and the number of procedures performed are inverted with the complexity and severity of the patient's presenting problem.

Improvements in the current system should include less reliance on the number of procedures and time involved and more on the complexity of the individual situation. The eventual diagnoses rendered should also be considered. The doctor's field of practice would have to be taken into account where diagnosis is concerned, since many practitioners rarely deal with life-and-death situations. A list of diagnoses ranging from minimal to severe in nature would have to be developed for each field of practice.

Table 6 below depicts a proposed list of examination procedures identified by bullets for chiropractic examinations. The list includes the majority of items from the current musculoskeletal and neurological lists and incorporates diagnostic methods unique to chiropractic. No changes in code numbers, history requirements, required numbers of bullets, decision-making complexities or time requirements are recommended in addition to those already mentioned. While problems also exist in these areas, the list of bullets is the first and largest area of concern.

Table 6 Proposed Chiropractic Neuromusculoskeletal Examination	
System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • 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)
Head and Face	<ul style="list-style-type: none"> • Temporomandibular Joint (TMJ) (e.g., facial symmetry, joint crepitus, aberrant motion, Trismus) {See Neurological and Cranial Nerve Assessment}
Eyes	<ul style="list-style-type: none"> • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	{See Neurological and Cranial Nerve Assessment}
Neck	{See Musculoskeletal and Lymphatic}
Respiratory	
Cardiovascular	<ul style="list-style-type: none"> • Examination of carotid arteries (e.g., pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	<p>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:</p> <ul style="list-style-type: none"> • Inspection, percussion and/or palpation (static) with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of active range of motion observed or measured with notation of any limitation, pain, crepitation, aberrant movement or contracture • Assessment of passive range of motion (e.g., motion palpation, joint play, end feel) • Chiropractic analysis of functional leg length (e.g., Derefield-Thompson, Activator, etc.) • Assessment of posture (e.g., observation of antalgic posture, plumb line analysis, the use of a posture analysis device, hypolordosis, hyperlordosis, kyphosis, forward head syndrome) • Examination of gait and station • Scoliosis screening (e.g., plumb line, bilateral weight, Adam's test, slump test, actual leg length, apparent leg length, use of a posture analysis device) • Orthopedic tests (any five tests in a region) {See musculoskeletal, neurological and skin}
Extremities	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-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 • Skin temperature differences using heat sensitive instrument (e.g., Chirotherm, Dermatherm-O-Graph, Nervo-scope)
Skin	NOTE: For the comprehensive level, all four anatomic areas must be examined and documented. For the three lower levels, each body areas counted separately.
Neurological/Psychiatric	<p>MOTOR STRENGTH</p> <ul style="list-style-type: none"> • General assessment through gross and multiple joint movements (e.g., handshake, hand grasp, knee bends) or • Manual muscle testing of individual myotomes or • Use of a dynamometer or similar instrument <p>DEEP TENDON, PATHOLOGICAL and other REFLEXES</p> <ul style="list-style-type: none"> • Biceps, brachioradialis, triceps and Hoffman's • Patella, Achilles and Babinski's • Reflex Testing (e.g., Kinesiology, muscle challenge, reflex, isolation) <p>NERVE ROOT COMPRESSION/TENSION TESTS</p> <ul style="list-style-type: none"> • Upper extremity (e.g., compression, distraction, brachioplexus tension, Bakody) • Lower extremity (e.g., SLR, slump, CSLR, Kemps) <p>VERTEBRAL ARTERY SCREENING</p> <ul style="list-style-type: none"> • Any two tests (e.g., Hautants, Georges, dizziness test) <p>COORDINATION</p> <ul style="list-style-type: none"> • Test coordination (e.g., finger/nose, heel/knee/shin, tandem stance, apid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) <p>CRANIAL NERVES</p> <ul style="list-style-type: none"> • 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements) • 5th cranial nerve (e.g., facial sensation, corneal reflexes) • 7th cranial nerve (e.g., facial symmetry, strength) • 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (e.g., spontaneous or reflex palate movement) • 11th cranial nerve (e.g., shoulder shrug strength) • 12th cranial nerve (e.g., tongue protrusion) <p>CORD PATHOLOGY</p> <ul style="list-style-type: none"> • Assessment for signs of upper motor neuron lesions (e.g., spastic weakness, no muscle atrophy, no fasciculation's or fibrillations, hyper reflexia, presence of pathological reflexes) • Specific tests (e.g., Lhermette's, slump test, Brudzinski, Kernig) • Language (e.g., naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) <p>SENSATION</p> <ul style="list-style-type: none"> • Examination of sensation (e.g., by touch, pin, vibration, proprioception)

The list of bullets is, as stated, "proposed." This is the first publication of the list. The content has not been studied or endorsed by any organization or entity in chiropractic. Publication will hopefully stimulate discussion of this subject within our profession and lead to the development of a more accurate and extensive list. If inclusion of chiropractic evaluation procedures in CPT coding manuals is to become a reality, we must be prepared to contribute the appropriate information.

References

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Author's note: The CPT coding system is scheduled to be revised, effective sometime in 2005. The changes, proposed in 2000 and delayed repeatedly, are easier to follow and simplify the entire process. The current coding system outlined in this article will remain in effect through 2004 and for a changeover period in 2005; look for a follow-up article detailing the revisions in a future issue of DC.

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