

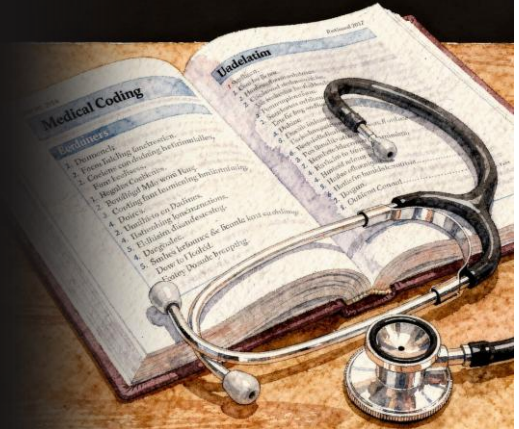


Evaluation, Management, and Diagnosis: Documenting Like an Auditor Thinks

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Course Disclaimer

Educational content only

This course is provided for educational purposes and does not constitute legal, billing, or clinical advice.

Payer policies vary and change

Rules differ across payers and are subject to change. Always verify current policies before implementation.

Verify before implementing

Confirm all coding and documentation rules with your specific payers and compliance advisors.

2

Part 1: Evaluation and Management

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2026 MPFS for Alaska							
HCPCS Code ▲	Modifier ▲	Short Description ◆	Mac Locality ▲	Non-Facility Price ◆	Facility Price ◆	Non-Facility Limiting Charge ◆	Facility Limiting Charge ◆
99202		Office o/p new sf 15 min	0210201	\$92.35	\$		
99203		Office o/p new low 30 min	0210201	\$145.71	\$		
99204		Office o/p new mod 45 min	0210201	\$222.54	\$		
99205		Office o/p new hi 60 min	0210201	\$296.88	\$		
99211		Off/op est may x req phy/qhp	0210201	\$28.41	\$		
99212		Office o/p est sf 10 min	0210201	\$72.46	\$		
99213		Office o/p est low 20 min	0210201	\$118.72	\$		
99214		Office o/p est mod 30 min	0210201	\$169.92	\$		
99215		Office o/p est hi 40 min	0210201	\$241.97	\$		



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Evaluation and Management Today

History and Exam Must Be Appropriate

History and physical exam are still required — but they do not determine the E/M level.

Code by MDM or Total Time

The E/M level is driven by medical decision-making complexity or total provider time.

Medical Necessity Still Controls

No matter how pretty your notes are, medical necessity remains the overarching standard for all E/M services.

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New Patient E/M

History & Exam

MDM

OR

Time*

99202	Medically Appropriate	Straightforward	15 minutes
99203		Low	30 minutes
99204		Moderate	45 minutes
99205		High	60 minutes

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Established Patient E/M

	History & Exam	MDM OR	Time*
99211	Medically Appropriate	Services performed by clinical staff	
99212		Straightforward	10 minutes
99213		Low	20 minutes
99214		Moderate	30 minutes
99215		High	40 minutes

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Suggested **initial** history and exam*

Chief Complaint:

History of present illness (at least 4):

Location:

Quality:

Severity:

Timing:

Duration:

Context:

Modifying factors:

Associated signs and symptoms:

Past history:

Family history:

Social history:

(1 or 2)

Exam (at least 2):

Musculoskeletal:

Neurologic:

Others (vitals, skin):

Review of systems (at least 2):

Neurological:

Musculoskeletal:

Condition specific relevant systems:

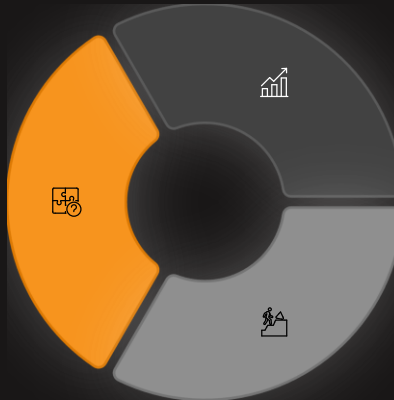
*Based on the old rules from the '97 DGs for 99203.

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Medical Decision Making: Three Elements

Problems Addressed

Conditions evaluated or treated today



Data Reviewed or Analyzed

Tests, records, and independent interpretation

Risk of Management

Risk from treatment decisions and diagnostic tests

- Two of three MDM elements determine the E/M level.

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Problems Addressed

Evaluated or Treated Today

Only problems actively addressed during the encounter count toward MDM complexity.

Not Every Symptom Is Separate

Related symptoms that are part of the same condition are counted as one problem, not multiple.

Stable vs Worsening Matters

A worsening or new problem carries more MDM weight than a stable, chronic condition.

Comorbidities Count When Relevant

Comorbidities contribute to MDM only when they directly affect the management of today's problem.

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Data Reviewed



What Counts as Data

- Tests ordered or reviewed
- External notes reviewed
- Independent interpretation when appropriate
- Do not double count billed services

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Risk of Management

Risk from Treatment Decisions

The complexity of the management plan itself contributes to risk level in MDM.

Risk related to Complications

A patient's overall health status and comorbidities can elevate the risk category.

Referral or Escalation Decisions

Decisions to refer, escalate, or hospitalize a patient reflect higher management risk.

Do Not Inflate Routine Care

Routine chiropractic most likely qualifies as low risk (i.e. level 3).

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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 <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	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

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99202 / 99212

Level of MDM	Problems	Data	Risk
Straight-forward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

"The Medical Decision Making at this encounter is straightforward. The problem appears to be self-limited or minor because it is transient and not likely to permanently alter the patient's health status. There appears to be a minimal risk of morbidity or functional impairment of substantial duration."

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99203 / 99213

Level of MDM	Problems	Data	Risk
Low	<u>Low</u> • 2 or more self-limited or minor problems • 1 stable, chronic illness • 1 acute, uncomplicated illness or injury • 1 stable, acute illness • 1 acute, uncomplicated illness or injury requiring hospital	<u>Limited</u> • Order or review two tests or notes OR • Independent historian	<u>Low</u> risk of morbidity from additional diagnostic testing or treatment

"The Medical Decision Making at this encounter is low. The problem appears to be acute and uncomplicated because it is recent, likely short-term, and full recovery without functional impairment is expected. There appears to be a low risk of morbidity or functional impairment of substantial duration."

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Coding by Time

Total Provider Time That Day

Time-based coding uses the total time the provider spends on the patient's care on the date of service.

Face-to-Face and Non-Face-to-Face

Both direct patient contact time and time spent on documentation and coordination may be counted.

No Separately Billed Services

Time spent performing procedures billed separately (e.g., CMT or x-ray) cannot be counted toward E/M time.

Do Not Include Staff Time

Only the billing provider's time counts. Staff time is excluded from E/M time calculations.

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The following activities count towards time:

Preparing to see the patient
(e.g. review tests)

Reviewing separately obtained history

Performing an exam

Counseling and educating the patient/family

Ordering test or procedures

Communicating with other healthcare professionals

Documenting clinical information

Interpreting test results and communicating them to the patient and family

Care coordination

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Time Documentation

What to Document

- Document total time, with start and stop time
- Describe qualifying activities
- Exclude separately billed procedures
- Avoid vague time ranges

"Physician spent 24 minutes of total time (from 12:26PM to 12:50PM), not including separately billed procedures, performing a medically appropriate examination, educating the patient, and documenting clinical information in the electronic record."

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Re-exams and CMT

Why This Matters

Re-exam denials cost your practice thousands annually. Learn to bill correctly and get paid fairly.

What You'll Learn

Understanding same-day E/M billing, applying modifier-25 correctly, and defending your claims with confidence.

Practical Application

Simple, defensible strategies anyone in your office can implement immediately.

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Common Pain Points

1

Frequent Denials

Re-exam claims rejected despite proper documentation, leaving revenue on the table.

2

Modifier-25 Confusion

Uncertainty about when and how to apply modifier-25 correctly leads to inconsistent billing.

3

Inconsistent Payer Rules

Different insurance companies apply different standards, creating frustration and unpredictability.



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CMT Includes More Than You Think



Pre-Service Work

- A brief evaluation of the member's medical record documentation and chart review
- Imaging review
- Test interpretation and care planning



Intra-Service Work

- Treatment applied
- Pre-manipulation (e.g., palpation, etc.)
- Manipulation
- Post-manipulation (e.g., assessment, etc.)



Post-Service Work

- Chart entry and documentation, including:
 - Subjective
 - Objective
 - Assessment
 - Plan consultation reporting

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CMT Includes More Than You Think

P.A.R.T. Components

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

Asymmetry/misalignment identified on a sectional or segmental level;

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

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



Understanding what's bundled helps identify when E/M is truly separate

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When E/M and CMT Can Coexist

- New Problem or Injury**
A new complaint requiring separate evaluation supports billing both E/M and CMT.
- Significant Change in Condition**
A meaningful change in the patient's status that requires clinical judgment beyond routine CMT.
- Re-Exam Requiring Clinical Judgment**
Evidence-based "trial of care" periods necessitate formal reassessment of treatment effectiveness.
- Service Beyond Routine CMT Work**
Any significant and separately identifiable evaluation service performed on the same date.

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The 25 Modifier

"Significant and separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service."

Significant

Goes beyond the typical pre- and post-service work of CMT.

Separately Identifiable

Clearly distinct from the examination required for manipulation.

Why Payers Still Deny: Documentation often fails to demonstrate the separation clearly, even when services are legitimately distinct.

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E/M and CMT



According to the CPT manual:

- "Additional E/M services....may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure."
- Modifier 25 tells the payer that the E/M service is not part of the CMT service and should be paid separately.
- *Note: Do not add the 25 to the E/M if CMT is not also billed that day.*

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E/M and CMT



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Medical Necessity Rules All

The Ultimate Deciding Factor

No amount of clever coding can overcome a lack of medical necessity. The service must be reasonable and necessary for the diagnosis or treatment.

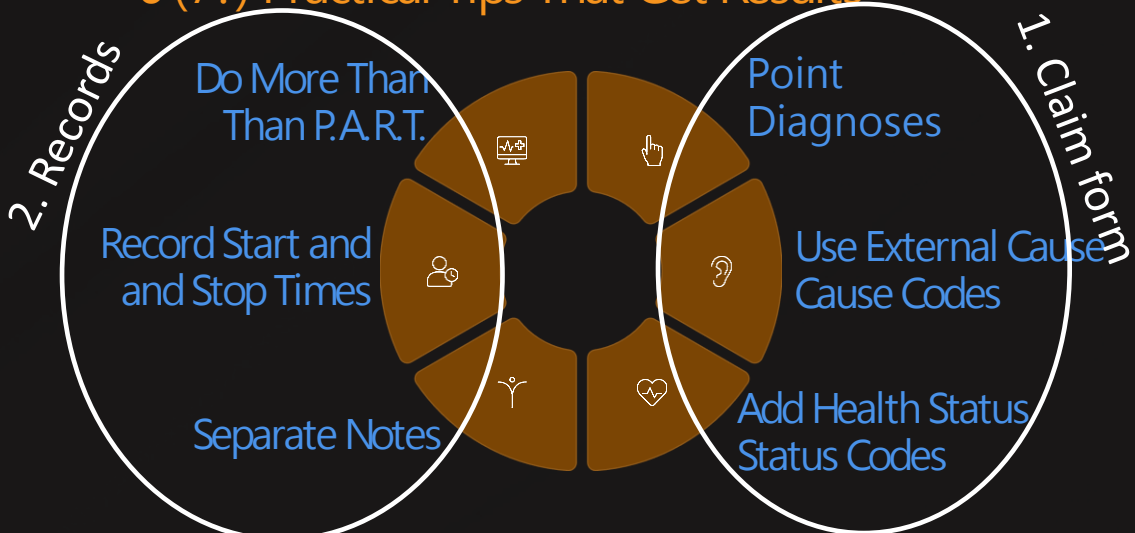
What Doesn't Count

"Because I want to get paid" is never a valid reason for billing an E/M code.

Document the clinical rationale first, code second.

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6 (7?) Practical Tips That Get Results



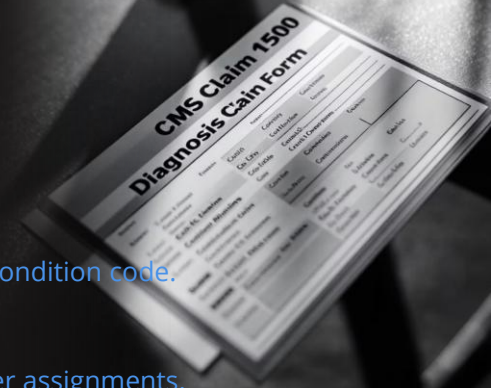
Each tip builds a stronger case for reimbursement while maintaining compliance.

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Tip 1: Tell the Story on the Claim Form

Use Box 24E Strategically

- 1 **Identify Conditions**
List segmental dysfunction for CMT and secondary/unrelated condition for E/M.
- 2 **Assign Pointers**
Point CMT to M99.0- codes, E/M to the separate condition code.
- 3 **Document Link**
Ensure clinical notes support the diagnosis pointer assignments.



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D

g

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES (RELATED TO CURRENT SERVICES) FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAST? ☐ YES ☐ NO \$ CHANGES										21. PRIOR AUTHORIZATION NUMBER																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide A-L to service line below (240))										22. DISPOSITION CODE										23. ORIGINAL REF. NO.																																							
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE CPT/ICD-10 C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHANGES G. DAYS ON SUPPLY H. PROX. PAY. Pct. I. DUAL J. RENDERING PROVIDER ID. #										PHYSICIAN OR SUPPLIER INFORMATION																																							
1																																																											
2																																																											
3																																																											
4																																																											
5																																																											
6																																																											
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For Phil. med. aid only) ☐ YES ☐ NO										28. TOTAL CHARGE										29. AMOUNT PAID										30. Paid for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI b. _____										c. NPI d. _____																																							

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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Tip 1 in Action

Pairing ICD-10 Codes

Simple Workflow Example

1. Patient presents with new headaches (separate from ongoing neck care)
2. Perform comprehensive E/M including history, neuro exam, differential diagnosis
3. Document E/M separately from CMT note (more on this later)
4. Bill 99212-25 with pointer to R51.9, and 98940 with pointer to M99.03

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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or services described below.

SIGNED _____ DATE _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL. _____

15. OTHER DATE (MM/DD/YY) QUAL. _____

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM (MM/DD/YY) TO (MM/DD/YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES _____

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Reads A-L to service line below (24E)) ICD Int. _____

A. M9901 B. R519 C. _____ D. _____

E. _____ F. _____ G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

22. DISPOSITION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

	24. A. DATES OF SERVICE						B. PLACE OF SERVICE (EMO)	C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances)	D. CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATE OF LAST VISIT	H. REFERRAL FROM (NPI)	I. QUAL. (NPI)	J. REFERRAL PROVIDER (NPI)
	From (MM/DD/YY)	To (MM/DD/YY)	MM	DD	YY										
1							99212	25		B					
2							98940			A					
3															
4															
5															

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Tip 2: Add External Cause Codes When Relevant

When to Use Y or V Codes
External cause codes (V, W, X, Y) strengthen your narrative by explaining *how* the condition occurred.

Why They Help

They demonstrate a distinct event requiring comprehensive evaluation beyond routine care, supporting medical necessity for E/M.



Note: Some payers may require additional questionnaires for accident-related codes, which can delay payment.

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Tip 2 in Action

Case Example: Injury While Pruning Trees

01

Patient Scenario

Established patient falls from a low ladder while pruning trees, presents with new acute low back pain.

02

Code Assignment

Primary: S39.012A (Strain of muscle, fascia and tendon of lower back, initial encounter)

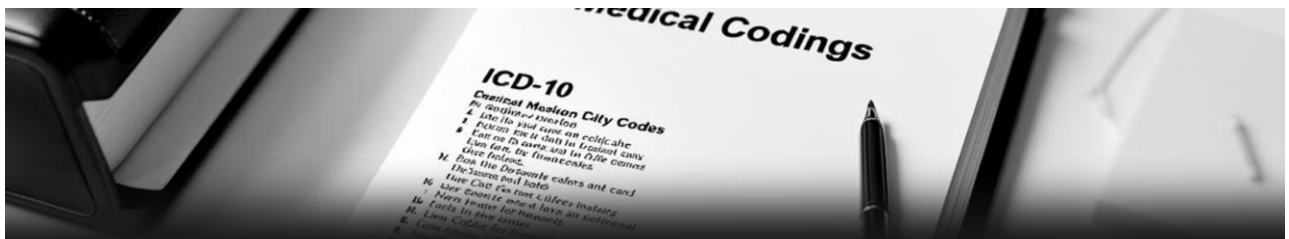
External: W11.XXXA (Fall from ladder, initial encounter)

03

Documentation

E/M note details mechanism of injury, comprehensive exam to rule out fracture, and treatment plan distinct from ongoing care.

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Tip 3: Use Z Codes for Health Status

The "Reason for Encounter" Shortcut

Z codes describe factors influencing health status and contact with health services. They're perfect for periodic re-evaluations.

Z09 - Follow-up Examination

After completed treatment for conditions other than malignant neoplasm.

Z76.89 - Other Specified Health Status

Persons encountering health services in other specified circumstances.

Z13 - Screening Examinations

When performing preventive screening as part of re-evaluation.

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Tip 3 in Action

Showing Periodic Re-Exam Necessity

Trial of Care Approach

Evidence-based practice suggests re-evaluating after 2-4 weeks of care to assess treatment effectiveness.

Use Z codes to document this clinical decision-making process.

Example Documentation

Chief Complaint: "Re-evaluation after 4 weeks of care for chronic low back pain"

Codes: Z09 (follow-up exam) + M54.50 (low back pain)

Comprehensive E/M documents outcomes, functional improvements, and continuation or modification of care plan.

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Tip 4: Evaluate Beyond Segmental Dysfunction

Why P.A.R.T. Alone Doesn't Cut It

The P.A.R.T. examination is how segmental dysfunction is identified. To justify a separate E/M, you must perform and document additional evaluation components.

What isn't P.A.R.T.?

- Blood pressure checks
- Orthopedic testing
- Neurological examination
- Differential diagnosis identification
- Review of systems



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Tip 4 in Action

1



Vital Signs

Document BP, pulse, respiration when clinically relevant to the presenting condition.

2



Neuro Testing

Perform and record deep tendon reflexes, sensory testing, or motor strength assessments.

3



Ortho Tests

Use specific orthopedic tests to rule in or rule out differential diagnoses.

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Tip 5: Separate the Notes

When E/M and CMT documentation blend together, reviewers can't distinguish which work supports which service. This invites denials.

The Problem

Combined notes make it appear that all documented work is bundled into the CMT code, undermining your modifier-25 claim.

The Solution

Use clear subheadings or separate pages to show distinct E/M and CMT services performed.

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Tip 5 in Action

What Reviewers Need to See

1

E/M Documentation Section

Clearly labeled: "Evaluation and Management Service"

Includes: Chief complaint, HPI, ROS, exam findings beyond P.A.R.T., assessment, and plan specific to E/M condition.

2

CMT Documentation Section

Clearly labeled: "Chiropractic Manipulative Treatment"

Includes: Segmental dysfunction findings, regions adjusted, techniques used, patient response.

Sample Structure

Use SOAP format for CMT + separate E/M template, or create distinct sections within your EHR.

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Tip 6: Record Start & Stop Times

Make the Separation Obvious

Documenting when each service began and ended provides irrefutable evidence of separate, distinct services.

Additional Benefits

- Supports time-based E/M coding when appropriate
- Demonstrates compliance during audits
- Shows services weren't concurrent



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Tip 6 in Action

Example Time Documentation

12:27 PM - 12:42 PM

E/M Service: Comprehensive evaluation of new shoulder pain including history, orthopedic testing, differential diagnosis, and treatment planning. (15 minutes)

1

2

12:43 PM - 12:48 PM

CMT Service: Chiropractic manipulative treatment of cervical, thoracic, and lumbar regions addressing segmental dysfunction. (5 minutes)

□ This documentation clearly shows two distinct services performed sequentially, not concurrently.

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Tip 7: Perform E/M on a Different Day

The Nuclear Option

When?

Repeated denials despite perfect documentation, or payer policies explicitly prohibiting same-day E/M and CMT.

Ethical Considerations

Never split services solely for billing purposes. Clinical necessity must drive the decision.

Patient Convenience

Balance reimbursement needs with patient preference and convenience. Explain the rationale clearly in signed intake paperwork.

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Tip 7 in Action

Financial Intake Form Strategy

Add clear language to your financial policy explaining why periodic re-evaluations may be scheduled separately from treatment visits.

"To ensure proper insurance reimbursement and comprehensive evaluation of your progress, we may schedule re-examination appointments on different days from your regular treatment visits. This allows us to dedicate appropriate time to assess your condition and document findings thoroughly."

This proactive communication prevents patient confusion and demonstrates transparency.

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Tips Summary

1. Link the E/M through proper diagnosis pointing to an ICD-10 code (not M99.0-)
 2. Document any new condition or exacerbation if present; OR in the care plan, describe phases of care as "trial of care" periods to emphasize the need for re-exams to measure progress.
 3. Link the E/M to an external cause or encounter code, if relevant;
 4. Document non-CMT elements such as blood pressure, ortho/neuros, differential diagnoses, and plans for non-CMT services in the E/M record;
 5. Create distinctly separate notes for the E/M service and CMT service;
 6. Perform and document the E/M in a different time block than the CMT;
- **Bonus:** State that the exam is "significant and separately identifiable" in the CMT record;

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Medical Necessity Rules All Be the Doctor First, Coder Second

The Foundation

You cannot code your way around a lack of clinical need. Every E/M service must be medically necessary and appropriately documented.

The Mindset

Focus on providing excellent patient care. When services are truly necessary and properly documented, reimbursement follows.

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Part 1 Key Takeaways

Code by MDM or Time

Don't let it all run together

Modifier 25 Needs Some Effort to be Supported

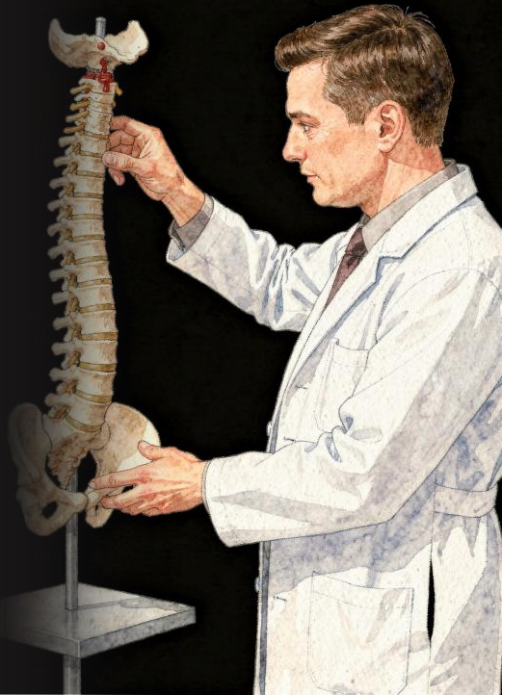


E/M and CMT can coexist — but only when the documentation clearly separates the clinical work performed for each service.

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Part 2: Diagnosis Selection and Medical Necessity

Understanding how to select, support, support, and document diagnoses that hold up under review.



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Diagnosis Is Not Just a Code

What a Diagnosis Really Does

- It explains the clinical problem
- It points to medical necessity
- It supports the services billed
- It tells the payer why today mattered

The Payer's Question

Every claim is evaluated against one core question: does the diagnosis justify justify the services billed on this date of of service?

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The Diagnosis Must Connect to the Story

Symptoms Reported

....by the patient

Objective Findings

....from the exam

Clinical Assessment

....by the provider

Services Performed

....that day

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ICD-10-CM Updates

The screenshot displays the CMS.gov website, specifically the ICD-10 codes section. The header includes the CMS.gov logo and navigation links for Medicare, Medicaid/CHIP, Marketplace & Private Insurance, Priorities, and Training & Education. The main content area is titled "ICD-10" and features a "What's New?" section with a link to "CMS announces 50 new ICD-10-PCS codes (PDF), effective April 1, 2025". Below this, there is a section for "ICD-10 Files" with a link to "2025 ICD-10 CM & PCS files". The left sidebar contains links to "ICD-10 Files & News Archive", "ICD-10 Coordination and Maintenance Committee Meetings", "Process for Requesting New/Revised ICD-10-PCS Procedure Codes", "ICD-10 Coordination and Maintenance Committee Meeting Materials", "ICD-9-CM Diagnosis and Procedure Codes: Abbreviated and Full Code Titles", and "Updates and Revisions to ICD-9-CM Procedure Codes".

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ICD-10-CM Updates 2027



ZA1 Certain infectious diseases caused by zombies

ZA1.0 Allergic reaction to zombies

ZA1.00 Allergic reaction to zombie saliva

ZA1.01 Allergic reaction to zombie dogs

ZA1.02 Allergic reaction to zombie hair

ZA1.1 Infection caused by zombies

ZA1.10 Certain zombification of body parts

ZA1.100 Zombification of arm

ZA1.101 Zombification of leg

ZA1.102 Zombification of foot

ZA1.103 Zombification of hand

ZA1.104 Zombification of eye

ZA1.105 Zombification of tongue

ZA1.11 Total zombification

ZA1.2 Nausea caused by zombies

ZA1.20 Nausea caused by zombie stench

ZA1.21 Nausea caused by zombie appearance

ZA1.22 Nausea caused by neighbors massacred by zombies

ZA1.23 Nausea caused by own injury from a zombie

ICD-10-CM TABULAR LIST of DISEASES and INJURIES
© April 1st, 2012 - Find A Code - April Fools'

2013

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Diagnosis Hierarchy

1. Nerve-related disorders (e.g. radiculopathy)
2. Acute injuries (e.g. sprains and strains)
3. Structural diagnoses (e.g. degenerative disc disease)
4. Functional diagnoses (e.g. difficulty with walking)
5. Symptoms (e.g. neck pain)
6. Comorbidities (e.g. diabetes)
7. External causes (e.g. place and activity)

****Follow payer rules first, and *then* apply this hierarchy****

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Diagnosis Pointing

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)										ICD Ind. 0		22. RESUBMISSION CODE			
A. M9903			B. M9904			C. M9902			D. M25552			23. PRIOR AUTHORIZATION NUMBER			
E.			F.			G.			H.						
I.			J.			K.			L.						
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PT. FEE
MM	DD	YY	MM	DD	YY			CPT/HCPCS		MODIFIER					
10	25	2024	10	25	2024	11		98941				ABCD	6000	1	
10	25	2024	10	25	2024	11		98943				ABCD	3500	1	
10	25	2024	10	25	2024	11		97140	59			ABCD	5000	1	

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Specificity Beats Habit



Region

Identify the anatomical region clearly in every diagnosis.



Laterality

Document left or right side when available and clinically relevant.



Acute vs Chronic

Distinguish acute from chronic presentation when it affects care decisions.

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ICD-10 conventions and guidelines



- Seventh characters
- Excludes1, Excludes2
- Symptoms
- Certainty
- Comorbidity

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Seventh Character



S16 Injury of muscle, fascia and tendon at neck level
Excludes2:

sprain of joint or ligament at neck level (S13.9)
Code also any associated open wound (S11.-)

The appropriate 7th character is to be added to each code from category S16

A - initial encounter
D - subsequent encounter
S - sequela

Example: S16.1xxA

S16.1xx_ Strain of muscle, fascia and tendon at neck level

S16.2xx_ Laceration of muscle, fascia and tendon at neck level

S16.8xx_ Other specified injury of muscle, fascia and tendon at neck level

S16.9xx_ Unspecified injury of muscle, fascia and tendon at neck level

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Seventh Character

A – initial encounter

D – subsequent encounter

S – sequela



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Seventh Character

A – initial encounter, while patient is receiving active treatment including continuing treatment by the same or a different physician

D – subsequent encounter, routine care during the healing or recovery phase, such as aftercare and follow up

a. Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

60

Excludes1

Mutually Exclusive Conditions

Excludes1 means the two conditions cannot occur together and cannot be coded on the same claim.

Do Not Code Together

If an Excludes1 note exists between two codes, selecting both is a coding error.

Check Before Combining

Always review Excludes1 notes before pairing spine or musculoskeletal diagnoses on a claim.

Especially Important with Spine Codes

Spine diagnosis codes frequently carry Excludes1 relationships that affect chiropractic claims.



61

M54.50 Low back pain, unspecified

Excludes1

- Low back strain (S39.012_)
- Lumbago due to intervertebral disc displacement (M51.2-)
- Lumbago with sciatica (M54.4-)

M54.6 Pain in thoracic spine

Excludes1

- Pain in thoracic spine due to intervertebral disc disorder (M51.2-)

M54.1- Radiculopathy

Excludes1

- neuralgia and neuritis NOS (M79.2)
- radiculopathy with cervical disc disorder (M50.1-)
- radiculopathy with lumbar and other intervertebral disc disorder (M51.1-)
- radiculopathy with spondylosis (M47.2-)



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Understanding Excludes2

- Not included here — but may exist separately
- May code together if both conditions exist
- Still requires documentation for each condition
- Do not use as a shopping list for extra codes

Key Distinction

Unlike Excludes1, an Excludes2 note means the excluded condition is not part of the indexed code — but both may be reported if clinically supported and documented.

63

M50.1- *Cervical disc disorder with radiculopathy*

Excludes2

- Brachial radiculitis nos (M54.13)

S13.4XX- *Sprain of ligaments of cervical spine*

Excludes2

- Strain of muscle or tendon at neck level (S16.1-)

64

Symptoms and Definitive Diagnoses

- ☒ Code symptoms when diagnosis is not established
- ☐ Do not duplicate routine symptoms
- ☐ Code additional meaningful symptoms
- ☒ Keep the record consistent

65

R68.84 *Jaw pain*

Would not be coded with....

M26.62 *Temporomandibular joint arthralgia*

But....

R11.0 *Nausea*

Might be coded with....

S13.4xxA *Sprain of ligaments of the cervical spine*

66

Uncertain Diagnoses

Outpatient Coding Is Conservative

In outpatient settings, code only what is confirmed — not what is suspected or being ruled out.

Do Not Code "Rule Out" Conditions

Conditions described as "rule out," "possible," or "probable" are not coded in outpatient settings.

Document Differential Reasoning

Record your clinical reasoning even when a definitive diagnosis has not yet been established.

Code What Is Known Today

Report the highest level of certainty supported by today's clinical findings and documentation.

67

Comorbidities

The image shows a sample medical history form. It has three main sections: 'Medications' with a pill bottle icon, 'Allergies' with a flask icon, and 'Chronic Conditions' with a heart icon. Each section has a header and several lines for text entry. There is also a small illustration of a person in the bottom right corner of the form.

- Code when they affect care
- Explain how they affect risk
- Avoid irrelevant problem dumping
- Update when they no longer matter

Example: Z33.1 *Pregnancy, incidental*

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Top Diagnosis Codes for Chiropractic

Pain

Segmental dysfunction

Radiculopathy

Discs

Sprains/strains

Muscles

Headaches

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Pain and Stiffness

M25.5- *Pain in joint*

M25.6- *Stiffness of joint, not elsewhere classified*

M54.2 *Cervicalgia*

M54.50 *Low back pain, unspecified*

M54.6 *Pain in thoracic spine*

M79.6- *Pain in limb, hand, foot, fingers and toes*

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Pain Codes: Useful but Thin

Pain describes the complaint

Pain codes often capture what the patient reports, but may not explain the underlying condition.

Add "due to" when supported

When the cause is established, replace the pain code with the underlying diagnosis for greater specificity.

Do not invent certainty

Only code what the clinical record supports. Avoid assigning definitive diagnoses without objective evidence.

71

Subluxation

M99.0- Segmental and somatic dysfunction

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

M99.06 Segmental and somatic dysfunction of lower extremity

M99.07 Segmental and somatic dysfunction of upper extremity

M99.08 Segmental and somatic dysfunction of rib cage

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Segmental Dysfunction

Common CMT-Linked Diagnosis

Segmental dysfunction is the most frequently used diagnosis paired with chiropractic manipulative treatment.

Document the Region

Specify the spinal region involved. Vague regional references are insufficient.

Support with PART Findings

Pain/tenderness, asymmetry, range of motion, and tissue changes must be documented.

Avoid Unsupported Language

Avoid unsupported "subluxation" language that is not backed by backed by objective clinical findings.

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Radiculopathy

M54.1- *Radiculopathy*

M54.3- *Sciatica*

M54.4- *Lumbago with sciatica*

M50.1- *Cervical disc disorder with radiculopathy*

M51.1- *Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy*

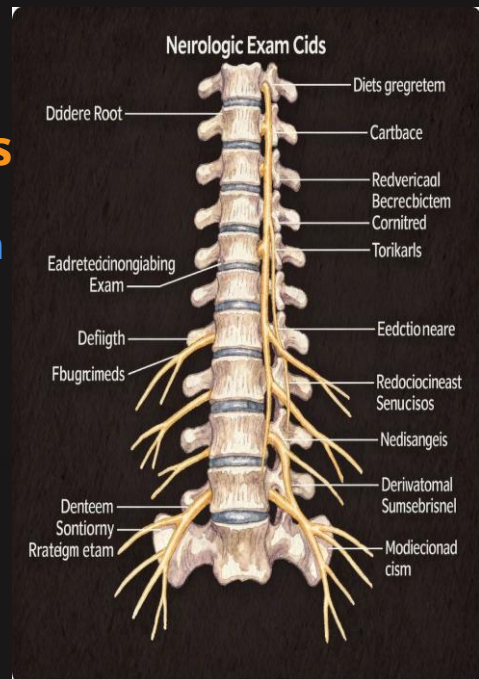
M47.2- *Other spondylosis with radiculopathy*

M51.361 *Other intervertebral disc degeneration, lumbar region, with lower extremity pain only*

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What Radiculopathy Requires

- Requires more than radiating pain
- Look for neurologic support
- Watch excludes notes
- Consider more definitive disc or spondylosis codes



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Muscle conditions

M60.8- *Other myositis*

M62.4- *Contracture of muscle*

M62.81 *Muscle weakness (generalized)*

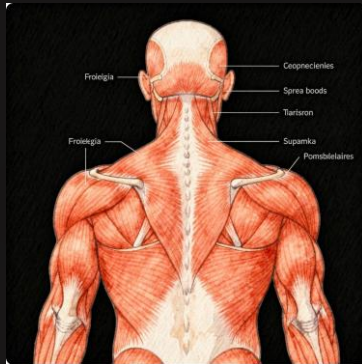
M62.83- *Muscle spasm*

M79.1- *Myalgia*

M79.7 *Fibromyalgia*

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Muscle Diagnoses



- Spasm, myalgia, weakness, contracture
- Use objective support
- Match to therapy rationale
- Do not code every sore muscle

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Discs

M50.- Cervical disc disorders

- M50.0- Cervical disc disorder with myelopathy
- M50.1- Cervical disc disorder with radiculopathy
- M50.2- Other cervical disc displacement
- M50.3- Other cervical disc degeneration
- M50.8- Other cervical disc disorders
- M50.9- Cervical disc disorder, unspecified

M51.- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders

- M51.0- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with myelopathy
- M51.1- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy
- M51.2- Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
- M51.3- Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
- M51.4- Schmorl's nodes
- M51.8- Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders
- M51.9- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorder, unspecified

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Disc Diagnoses

Document Level When Known

Specify the disc level (e.g., L4-L5) when imaging or clinical findings support it.

Be Careful About Coding Included Symptoms

Do not separately code symptoms already included in the disc diagnosis code.

Use Imaging Carefully

Imaging findings must correlate with clinical presentation before driving the diagnosis.

Connect Findings to Treatment

The disc diagnosis must logically support the treatment services billed.

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Sprain/Strain*

S13.4XX_ Sprain of ligaments of cervical spine

S16.1XX_ Strain of muscle, fascia and tendon at neck level

S23.3XX_ Sprain of ligaments of thoracic spine

S29.012_ Strain of muscle and tendon of back wall of thorax

S33.5XX_ Sprain of ligaments of lumbar spine

S39.012_ Strain of muscle, fascia and tendon of lower back

S33.6XX_ Sprain of sacroiliac joint

S39.013_ Strain of muscle, fascia and tendon of pelvis

***Spine only**

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Sprain and Strain

Document Mechanism of Injury

Record how the injury occurred to support the sprain or strain diagnosis.

Sprain and Strain Are Different

Sprains involve ligaments; strains involve muscles or tendons. Code the correct structure.

Use Encounter Characters Correct

Apply initial, subsequent, or sequela encounter characters as required by ICD-10.

Update as Active Care Changes

Transition encounter characters appropriately as the case progresses through phases of care.

81

Headaches

G43.- Migraine

G43.0- Migraine without aura

G43.1- Migraine with aura

G43.7- Chronic migraine without aura

G43.8- Other migraine

G43.9- Migraine, unspecified

G44.- Other headache syndromes

G44.0- Cluster headache syndrome

G44.1 Vascular headache, not elsewhere classified

G44.2- Tension-type headache

G44.3- Post-traumatic headache

G44.4- Drug-induced headache, not elsewhere classified

G44.86 Cervicogenic headache

R51.- Headache

R51.0 Headache with orthostatic component, not elsewhere classified

R51.9 Headache, unspecified

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Headache Diagnoses

Identify the Headache Type

Tension-type, cervicogenic, migraine, and cluster headaches each have distinct codes. Specify the type.

Avoid Defaulting to Unspecified

Unspecified headache codes are weak. Document enough to support a more specific classification.

Document Related Neck Findings

Cervicogenic headache requires documented cervical spine involvement to support the diagnosis.

Watch Red Flags and Referrals

Document red flag screening and any referral decisions made during the encounter.

intractable: pharmacoresistant (pharmacologically resistant), treatment resistant, refractory (medically) and poorly controlled

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Diagnosis Code Check

- 1** Does the diagnosis match the complaint?
- 2** Does the exam support the diagnosis?
- 3** Does the treatment fit the diagnosis?
- 4** Does the claim match the record?

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Part 2 Key Takeaways

Be Specific

Use precise findings rather than habitual or vague codes.

Match the Story

Diagnosis must align with patient narrative and visit details.

Prove in Record

Document objective evidence that supports billed services.

A strong diagnosis is specific, supported by objective findings, and directly tied to the services billed on that date of service.

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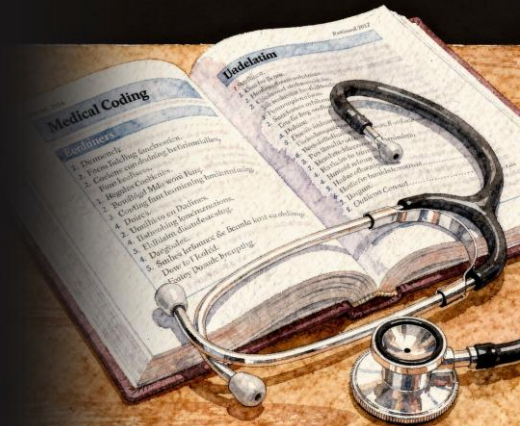
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