

NEW PATIENT EXAMINATIONS AND CODING

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All new patients must receive an intake history including an interview with the treating doctor. The doctor must make notes to indicate the findings discovered from such an interview with a patient. Simply having patients fill out an intake form without interviewing them is considered substandard care and a violation of Board Rule 22 - Record Keeping Requirements.

Records of the initial consultation with the patient should include, but is not limited to, the following:

- History
- Past Medical History
- Social and Family Medical History

The history of the chief complaint should involve a description of onset, location, quality, severity, timing and associated signs and symptoms relating to the presenting complaint(s).

CHOOSING THE APPROPRIATE BILLING CODE:

The key components in selecting the level E/M services are:

- History
- Examination
- Medical Decision Making

For example, if the visit is billed as a 99203, this would include a Detailed History, Detailed Examination and Medical Decision Making of Low Complexity. A detailed history includes the chief complaint, extended history of present illness, problem pertinent system review extended to include a limited number of additional systems, and **pertinent** past family and/or social history directly related to the patient's problems. If a history included only chief complaint, brief history of present illness, and problem pertinent system review, this would drop the level of the exam to qualify only for a level of 99202.

COMMON MISTAKES THAT THE BOARD REVIEWS:

The mistaken notion that time relates to level of service. The time override option is when counseling or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter. The extent of counseling and/or coordination of care must be **documented** in the medical record. Too often the Board finds that doctors believe that since a great deal of time was spent with the patient, this qualifies for the time override option.

The next mistaken notion is that because the chiropractor believes only in a subluxation-based practice, the licensee is exempt from acquiring the appropriate level of intake history and examination. Whatever the chiropractor's belief system on treatment of the patient, an appropriate history and examination level based on the patient's intake complaints is required.

Standard of care concerning documentation. If it is not documented in the patient's record, it does not exist.

By avoiding these common mistakes, you can prevent a review by the Board and enjoy a successful practice.

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