Chiropractic Coding & Compliance Alert

E/M & Reimbursement: Safeguard Your E/M Services Payment for the New Patient

Chime in with the nuances of E/M services coding.

Are you facing denial from payers, including Medicare, regarding your E/M services for established patients? Here are some tips from the American Chiropractic Association (ACA) to help you file successful claims.

Is E/M Only Paid for New Patients?

The current picture: Most often, payers do not pay for your E/M services for established patients. Moreover, when you report a chiropractic service and an E/M service for the same beneficiary on the same date of service, there's no guarantee that Medicare and some other payers will pay for both.

Here's why: Most payers consider the E/M work part of the Doctor of Chiropractic (DC) service.They expect the Chiropractic Manipulation Therapy or CMT codes to include the requisite assessment as well.

"Some payers do consider an assessment as part of the adjustment," says **Elizabeth Earhart, CPC**, with Godshall Chiropractic in Millersville, PA. She explains further: "Most payers do not question as long as you document the exam, and I mean include everything! Vitals, range of motions, outcome assessments, Oswestry if done, etc."

The fact: The ACA states that, "The physician work component of the CMT codes includes a brief pre-manipulation patient assessment. Additional evaluation and management services may be reported separately using the modifier -25 if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure."

Can you see now where the problem lies? The payers go by the first sentence of the ACA statement, and assume the work component of CMT codes to include all E/M, especially so for the established patients.

Your focus: You should be going by the last phrase of the quote above, and positively demonstrate that your separately identifiable E/M service was, in fact, above and beyond the usual pre-service and post-service work associated with the procedure.

"Your documentation should support the exam. Medicare considers it a new condition after 30 days, so support it with an exam," explains Earhart. "In our office for non-Medicare patients, our rule is if there has been a recent accident, it has been more than six months, or the patient reports a new problem on the sixth or twelfth visit of their plan for re-evaluation, then we do an exam complete with outcome assessments, range of motions, and vitals." Earhart further advises that, "We educate our patients on this so they are not surprised and can help us fight a denial. I can't say it enough document! Document! Document!"

Learn How to Get Around the Fix

All is not lost: The AMA's Common Procedural Terminology (CPT®) book states that there are instances when it is appropriate to bill a CMT and an E/M code together on the same date of service.

Good news: You can use one of the four CMT procedure codes with new patient E/M codes, (99201-99205, Office or other outpatient visit for the evaluation and management of a new patient ...) and get paid for the E/M separately. You'll report one of the following CMT codes:

- 98940 (Chiropractic manipulative treatment [CMT]; spinal, 1-2 regions)
- 98941 (...spinal, 3-4 regions)
- 98942 (...spinal, 5 regions)
- 98943 (...extraspinal, 1 or more regions).

When you bill the CMT and E/M codes together, attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code. The -25 modifier signals the payer that your provider performed an additional service, above and beyond the usual pre- and post-service work associated with the CMT code. This allows you to seek reimbursement for both the E/M service and the CMT service.

Drive Value With Your Documentation

The E/M service may be prompted by the symptom or condition for which your DC provided the procedure and/or service.

Examples: You can bill a separate E/M code on the same day as a CMT code for a new patient visit; an established patient with a new condition, new injury, re-injury, aggravation, exacerbation; or a re-evaluation to determine if a change in treatment plan is necessary. Remember to support all this with appropriate documentation.

Learn Your Payers' Rules

Some payers agree with paying the E/M separately for both established and new patients, but first they enforce criteria that you must meet. You need to learn your payers' rules.

"I have discovered over the years that most payers will support you if you know their rules," reveals Earhart. "Sometimes they will even question the denial themselves when you present them with the facts. Know your LCDs for your state. Know what each payer will cover and know your patient's policy before you challenge a denial." She cautions that, "telling the CSR to hold on while you look something up is just as aggravating to them as it is to you when you are put on hold."

Example: The Washington State Department of Labor & Industries (L&I), which administers Washington's workers' compensation program, says there is a limit of one payable chiropractic care visit per day.

It will pay E/M codes for new patients with the chiropractic care visit codes, but only when you meet the following criteria:

- The E/M service is for the initial visit.
- The E/M goes beyond the usual pre- and post-chiropractic care work.
- Attach modifier 25 to the E/M code.
- Ensure documentation describes both the E/M and the chiropractic care.

Heads up: Washington L&I does allow payment of established patients' DC care visits if an established patient needs re-evaluating for an existing issue.

Miles to go... All set with the criteria above? Well, there can always be some more issues getting the reimbursement you deserve. Most insurance companies prefer manipulation codes. Providers therefore-typically do not use an E/M code, unless they are investigating a new event, or performing procedures that do not include an adjustment.

Remember: "Many insurance companies will not pay a therapy code without documentation," stresses Earhart. "We will sometimes bill the first visit as an exam with a therapy (exercises and stretches that we give for home use that have been demonstrated in the office) and no CMT. That's when documentation comes in handy as well as knowing the guidelines."

Stay tuned: After receiving very few comments in 2014 on the topic of allowing chiropractors to bill separately for E/M services, CMS said, "Any possible changes to our current policy on allowing chiropractors to bill E/M services will be

addressed in future notice and comment rulemaking."