

Evaluation and Management (E/M) Codes

One of the most aggravating and costly means of insurance company reduction of your bills is in down coding your services to a lower payment. This is very common. Unfortunately, most doctors do not know how to fight this reduction in their income.

The proper way is to know and use proper documentation to provide the proof that what you are billing is proper. The first step is knowing the guidelines for levels of Evaluation and Management (E/M) codes. The second is the proper use of the code modifier -25.

An illustration is in order for the use of the -25 modifier. In California Workers' Compensation system there is a requirement that no more than 4 therapies can be billed on any specific office visit (two attended procedure and two unattended modality therapies). Amazingly the majority of doctors I've taught over the years know they have to do periodic examinations and reports but either don't bill for these (do them for free) or try to do them on a different day than therapies which inconveniences the patient, staff and themselves or is fraudulent if the patient isn't actually in the office on that date.

Lets take an example. You have a WC patient who came in 30 days ago and was placed on temporary total work restriction. Today you expect the patient to come in, be examined and be able to return to work with a modified work restriction. You call the adjuster to have him or her call the employer to make sure the employer will be able to accommodate the modified work restrictions (it's not your job to call and you need to keep the adjuster in the loop). You explain that with the modification the patient will require a back support and you get the adjusters pre-authorization for it. These are the billing items you should include for the days service:

1. Modality #1
2. Modality #2
3. Procedure #1
4. Procedure #2
5. Back support (pre-authorized)
6. Examination (-25, this meets the definition as evaluation and is billable)
7. Activities in Daily Living training (-25, this meets the definition as management and is billable - you must take the time even *if it's only a few minutes* to teach the patient how to do their work, what the restrictions are and how to care for themselves at work)
8. Phone consultation (-25, this meets the definition of management since you were required to call the adjuster in this situation and you don't have to have prior authorization to bill this. Just document the phone conversation in the patient records.)
9. The writing and submission of the required report (-25, this meets the definition as evaluation and is billable. You can't do the report without an examination.)
10. Possible extra billing. If the ADL takes more than 30 minutes defined in the code you can bill it a second time as a duplicate billable line item so long as you document the topics covered, the person doing the training - it can be a staff person - and the total time it took. (-25, this meets the definition as management and is billable. This second line item will automatically be reduced to a smaller amount based on time allocations exceeding 30 minutes. That's acceptable and proper.)

Do you believe now that you can ONLY bill 4 lime items on any given day? You are in business which means you should be paid for your services - all of them. Just don't try to do this every visit. Once every 2 to 4 weeks is reasonable depending on the patient's current status and condition.

Evaluation and Management (E/M) Codes

HISTORY

Level 1: Problem Focused

Brief description of recent event. No prior history needed. Does NOT deal with chronic problems

Level 2: Expanded Focus

Pertinent system review of a recent event. Expanded questions on a specific organ system NOT on the complete body.

Level 3: Detailed

Extended history and/or system's review. Past medical, family, social and chain of events history. Does deal with chronic conditions. Deals with conditions that either are severe in one system or associated with other systems.

Level 4: Comprehensive

Complete picture of the patient's medical condition. Involves a serious single condition and/or complicating problems. An in depth history with a complete systems review of all organ systems, social, family and medical history.

EXAMINATION

Level 1: Problem Focused

Confined to a specific symptomatic area usually less than a full organ system. A cursory exam.

Level 2: Expanded Focus

Includes a second or related area of complaint (i.e. headache AND sore neck and shoulder area). A superficial and cursory exam.

Level 3: Detailed

A specific examination of one or more affected areas using specific examination tests to arrive at a specific diagnosis when a cursory examination might only give differentials. (i.e. to determine the difference between a cervical strain and a sprain versus generalized neck pain.)

Level 4: Comprehensive

A complete speciality examination of one system including more than just the symptomatic area or a more specific examination of multiple organ systems which may or may not be specifically related.

DECISION MAKING

Level 1: Straight Forward

Direct obvious result and treatment based on a single area of complaint and needing only a cursory examination. This is generally applied when no following test results are to be considered or when no further examination will be necessary for further care or prognosis. (i.e. a sprained finger which requires splinting,)

Level 2: Low

Direct obvious result and treatment based on a Level 1 or Level 2 examination which may need further tests results or further examinations to determine the change in care or prognosis. (i.e. a cervicothoracic sprain/strain without complicating loss of the cervical curve.)

Level 3: Moderate

A decision relating to more than one area or system and/or needing additional tests to determine the treatment plan and prognosis. Each area must be addressed specifically as to assessment and treatment plan. (i.e. a lumbar sprain/strain and paresthesia in the lower extremity or a cervical sprain/strain necessitating x-rays to determine any loss of cervical lordosis.)

Level 4: High

A decision at a moderate level which necessitates the additional considerations of multiple disciplinary action, modification of living conditions, patient or care giver training in self care as an adjunct to continuing and modifying treatment. (I.e. Work restrictions, home care modification of activities which necessitate Activities in Daily Living - ADL- training, teaching another person how to render care outside of the office, any condition in which another doctor is consulted in order to establish a diagnosis or treatment protocol.)

OFFICE EXAM CODES

NEW PATIENT - A new patient is one who has never been in our office before or a previous patient who has a new injury necessitating a totally new record. (An Affordable Chiropractic patient who later comes in with a new injury under WC or new insurance or as a PI would be considered a new patient.)

ESTABLISHED PATIENT - An established patient is one who has been in our office sometime in the last 3 years, is returning for the same or a similar condition, and will be using the same record and billing information as before. (An insurance patient coming in for a new different condition but with most of the personal information and the insurance information the same is an established patient.)

According to AMA guidelines for the CPT codes they do not establish different codes for new versus established patients in an emergency room situation even though the same patient may come to the ER more than one time during the 3 year

definition. This is because each visit must be treated as a new condition requiring new evaluation and management requirements not necessarily consistent with a general returning patient with the same condition as before.

The following table helps establish the proper coding for billing the initial and subsequent examinations.

HISTORY	EXAMINATION	CLINICAL DECISION MAKING	CODE
New Patient - Must meet or exceed 3 of the 3 components			
Focused	Focused	Straight Forward	99201
Expanded	Expanded	Straight Forward	99202
Detailed	Detailed	Low	99203
Comprehensive	Comprehensive	Moderate	99204
Comprehensive	Comprehensive	High	99205
Established Patient - Must meet or exceed 2 of the 3 components			
Minimal level - No requirement are met			99211
Focused	Focused	Straight Forward	99212
Expanded	Expanded	Low	99213
Detailed	Detailed	Moderate	99214
Comprehensive	Comprehensive	High	99215

Modifiers for E/M Codes

A modifier is an extra set of numbers added to a particular CPT code to better describe how the actual service differed from the normal use of the coded service. It is done by adding a dash and then the modifier number (I.e. 99203-21). The following modifiers are used in our office.

-25 = Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of the Procedure. The code for manipulation of any joint in the body includes an E/M part to it. This is defined as the normal review of the SOAP notes, palpating (evaluating) the spine or joint, and adjusting (managing) the joint. When a specific exam process is done to evaluate change above this normal service the -25 code is used to tell the insurance companies that they must pay for the exam and not try to downcode the CPT code and reduce the bill because the manipulation code already include the E/M component. Any time an

exam is done for reporting purposes, changing therapies, assessing periodic response to treatment or evaluating new complaints this modifier is used. This generally will end up reducing the value of the CPT code it modifies but it will raise the total bill by adding an additional code for something which would have been excluded.

-32 = Mandated Services. If a third party payor requests specific service than the proper code is used with this modifier. If an insurance company requests the completion of any form needing an evaluation of the patient (exam, expanded history, detailed prognosis, current update, etc.) They are billed for the proper Office Visit E/M code using this modifier. Generally this does not change the value of the CPT code. It is used to charge for something not normally charged for when an insurance company requires it.

-52 = Reduced Service. The coding for all CPT codes includes a major portion of it's value as NON-PHYSICIAN time and work. This is the overhead expenses, office staff work, billing, collection, reports, doctor and staff time to review the records when the patient is not there - anything except actual face to face contact between the doctor and the patient. It is used for ALL Affordable Chiropractic codes. Generally it causes a reduction in value for the CPT code it modifies.