Medicare Coding

Physician Fee Schedule for 2015

- The proposed Medicare Physician Fee Schedule for 2015 was published in the Federal Register last week.
- There was no significant mention of chiropractic.
- Our estimated allowed amount for 2015 is $803 million (this includes deductible and coinsurance).
- Last year it was $729 million.

Medicare Coding

- The CMS-1500 form (or its electronic equivalent) is how we communicate with our local Part B Medicare Administrative Contractor the services we have performed and why we performed them.
- You are talking to a computer and all that it knows is what you tell it through the numbers that you put on the 1500 Form.
- There are two code sets that are used to communicate information to the MAC.
    - ICD-9-CM codes.
    - CPT codes.
- ICD-9-CM stands for International Classification of Disease, 9th edition, Clinical Modification.
- We covered diagnosis in another webinar.
- CPT® stands for Current Procedural Terminology®
- The CPT® Code Set is owned by the American Medical Association.
- This is why there is a delay in the implementation of the ICD-10 codes.
- The ICD-10 codes are used both for diagnosis and procedures coding.
- The procedure codes that chiropractors use to bill covered procedures to Medicare are:
    - 98940
    - 98941
    - 98942
- Remember that the only Medicare covered procedure for chiropractors is the adjustment.
- The only reason to bill any other procedure would be at the request of the patient and then only if they have a secondary insurance that would require a denial from Medicare before they paid for the service.

Modifiers

- With all of the coding options available, sometimes there is no code to fit the situation.
- When that happens it is time to use a modifier.
- Some modifiers are specific to Medicare and some can be used with all insurance.
    - AT = Active Treatment
    - GA = Waiver of Liability Statement Issued as Required by Payer Policy
    - GY = Noncovered Service

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    - GZ = Used when service is expected to be denied and no ABN is on file. Use of this modifier results in an automatic audit.
- It is allowable to use up to four modifiers on the same code.
- Medicare carriers and MACs are required to accept two modifiers.
- When using multiple modifiers, the first one takes precedence.
- For example; when you have a signed ABN form on file and you are still under active treatment, you should use AT,GA as the modifier.

AT Modifier

- "For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of an AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review."
- The AT modifier must be on all active treatment services for correction of acute and chronic subluxations.
- If you have a signed ABN on file but are still in active treatment, use the AT,GA modifier combination in that order.
- **Do Not** use the AT modifier for care that is maintenance in nature.

GA Modifier

- The GA code signifies the "Waiver of Liability Statement Issued as Required by Payer Policy."
- The GA modifier **does not** signify that the care is maintenance.
- If you place the GA modifier on a code you **must** have a signed ABN form in the file.
- It is appropriate to report the GA modifier when the beneficiary refuses to sign the ABN.
- For chiropractors, the –AT modifier (which signifies that the patient is under active treatment and that improvement is expected) is only used with the procedure codes 98940, 98941 and 98942.
- With the new changes in effect, the –GA modifier can only be used with procedure codes 98940, 98941 and 98942.

GY Modifier

- The GY modifier is used to indicate that a service is not covered by Medicare
- Use the GY modifier when a patient's secondary insurance needs a rejection by Medicare before they will pay for a service

GZ Modifier

- The GZ modifier is used when you expect Medicare to deny the service and you do not have an ABN form signed.
- Use this modifier when you forgot the ABN.
- Expect an audit if you use this modifier

Q6 Modifier

- Services provided by a Locum Tenens physician
- Use this modifier when you have another doctor filling in for you.
- A Locum Tenens doctor can fill in for 60 days.

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Evaluation and Management Coding

- At this point in time, Medicare is not paying us for separate Evaluation and Management services.
- In part, this is because the CMT codes are bundled to include a brief E/M service prior to the adjustment.
- In part, it is because Medicare does not recognize that chiropractors perform a separate and distinct E/M service as part of a treatment episode.
- Medicare is now looking at the possibility of paying for this service.
- There are two elements to these codes:
    - Evaluation – which includes the history and examinations.
    - Management – which includes the assessment, treatment plan, and report of findings.
- There are E/M codes for two types of patients:
- New patients – which are those patients that are new to your office or have not been seen in your office for three years or more.
- Established patients – which are those patients that have been seen in your office within the past three years.
- Each category of patient, new or established has 5 levels of E/M codes:
    - 99201 – 99205 for new patients.
    - 99211 – 99215 for established patients.
- It is very unlikely that you will perform E/M services that will come up to the level of the 99205 and 99215 codes.
- If the doctor is involved in the E/M service at all, the service will exceed the level of the 99211 code.
- There are seven components to Evaluation and Management codes.
    - History
    - Examination
    - Medical Decision
    - Counseling
    - Coordination of Care
    - Nature of Presenting Problem
    - Time
- New patient E/M levels
- Whatever level is closest to the top of the chart determines the level of a new patient E/M code.

Code	History	Examination	MDM Medical Decision Making
99201	Problem Focused	Problem Focused	Straight Forward
99202	Expanded Problem Focused	Expanded Problem Focused	Straight Forward
99203	Detailed	Detailed	Low
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High

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- Established patient E/M levels
- Whatever level is second closest to the top determines the level of the established patient E/M code.

Code	History	Examination	MDM Medical Decision Making
99211	None	None	N/A
99212	Problem Focused	Problem Focused	Straight Forward
99213	Expanded Problem Focused	Expanded Problem Focused	Low
99214	Detailed	Detailed	Moderate
99215	Comprehensive	Comprehensive	High

- Each of these levels (problem focused, expanded problem focused, Detailed, comprehensive, straight forward, low moderate, and high) have a specific criteria that needs to be met.

E/M History

- The History section has three areas;
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past Medical, Family, and Social Histories (PFSH)
- Depending on how many elements of each area is present determines the level of the history.
- The Chief Complaint needs to be present.

HISTORY				
HPI: Status of chronic conditions: ❑ 1 condition ❑ 2 conditions ❑ 3 conditions OR		❑ Status of 1-2 chronic conditions		❑ Status of 3 chronic conditions
HPI (history of present illness) elements: ❑ Location ❑ Severity ❑ Timing ❑ Modifying factors ❑ Quality ❑ Duration ❑ Context ❑ Associated signs and symptoms		❑ Brief (1-3)		❑ Extended (4 or more)
ROS (review of systems): ❑ Constitutional (wt loss, etc) ❑ Ears,nose, mouth, throat ❑ GI ❑ GU ❑ Integumentary (skin, breast) ❑ Endo ❑ Hem/lymph ❑ Eyes ❑ Card/vasc ❑ Musculo ❑ Neuro ❑ All/immuno ❑ Resp ❑ Psych ❑ All others negative	❑ None	❑ Pertinent to problem (1 system)	❑ Extended (2-9 systems)	❑ *Complete
PFSH (past medical, family, social history) areas: ❑ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ❑ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ❑ Social history (an age appropriate review of past and current activities)		❑ None	❑ Pertinent (1 history area)	❑ **Complete (2 or 3 history areas)
	PROBLEM FOCUSED	EXP.PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

***Complete ROS:** 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative".

- History of Present Illness
  - Location
  - Quality

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    - Severity
    - Timing
    - Context
    - Modifying Factors
    - Associated signs and Symptoms
- Four or more of these elements results in the highest level.
- Review of Systems
    - Constitutional
    - Eyes
    - Ears, nose, mouth, throat
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary
    - Neurological
    - Psychological
    - Endocrine
    - Hematologic/Lymphatic
    - Allergic/Immunologic
    - "All Others Negative"
- PFSH
    - Past Medical History
    - Family History
    - Social History
- All three will qualify for Comprehensive with a new patient.
- Only two are needed to qualify for comprehensive for an established patient.

E/M Examination

- Chiropractors are better off to use the 1997 E/M Documentation standards examination.
- We would use the "Musculoskeletal" examination.
- This includes sections covering:
    - Constitutional
    - Cardiovascular
    - Lymphatic
    - Musculoskeletal
    - Skin
    - Neurological/Psychiatric
- Each section has specific actions that count toward the examination of that part of the body.
- The number of these actions that you perform contributes to determining the level of E/M code.
- In each of these sections, circle the bulleted item that applies.
- In the Musculoskeletal and skin sections, circle each bullet for each body section performed.

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- The Constitutional section

Constitutional	• 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 (eg, development, nutrition, body habitus, deformities, attention to grooming)

- The Cardiovascular section

Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

- The Lymphatic section

Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location

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- The Musculoskeletal section

Musculoskeletal	• 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: • 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 (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements 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.

- The Skin section

Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-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. 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 extremitites constitutes two elements.

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- The Neurological/Psychiatric section

Neurological/ Psychiatric	• Test coordination (eg, 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 (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception) Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

- 1 to 5 bullets identified equals a Problem Focused Examination.
- 6 to 11 bullets identified equals an Expanded Problem Focused Examination.
- 12 or more bullets identified equals a Detailed Examination.
- All bullets identified equals a Comprehensive Examination.

E/M Medical Decision Making

- Medical Decision Making has been quantified with three elements
- Number of Diagnoses or Treatment Options
- Highest Level of Risk
- Amount and Complexity of Data
- Number of Diagnoses or Treatment Options

Number of Diagnoses or Treatment Options			
A	B X C = D		
Problem(s) Status	**Number**	**Points**	**Result**
Self-limited or minor (stable, improved or worsening)	*Max = 2*	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	*Max = 1*	3	
New prob. (to examiner); add. workup planned		4	
		TOTAL	

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- Highest Level of Risk

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clincal laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with addititives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

- Amount and Complexity of Data

Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

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- All three elements are combined to develop the level

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

- Take the level that you determined from each section circle it on the this table.
- For a new patient the code would be the one with the level closest to the top of the table.

Code	History	Examination	MDM Medical Decision Making
99201	Problem Focused	Problem Focused	Straight Forward
99202	Expanded Problem Focused	Expanded Problem Focused	Straight Forward
99203	Detailed	Detailed	Low
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High

- For established patients the code would be the level that is second closest to the top of the table.

Code	History	Examination	MDM Medical Decision Making
99211	None	None	N/A
99212	Problem Focused	Problem Focused	Straight Forward
99213	Expanded Problem Focused	Expanded Problem Focused	Low
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