

IL Advantage

ICS Member Exclusive Newsletter

Issue 82,05/10

“to advance the chiropractic profession and enhance quality health care for all”

Health Care Reform Timeline

The new Health Care Reform law has an incredible number of provisions that do not take effect immediately. In fact, portions of the legislation do not take effect until 2018, nearly 8 years after the bill was signed into law. As a result, there have been many questions raised regarding when different provisions take place.

The American Chiropractic Association has developed the following timeline of enactment. For more information from the ACA and for a glimpse at their incredible effort on your behalf, please visit www.acatoday.org.

Within the first year

- Young adults will be able stay on their parents' insurance until their 26th birthday.
- Insurers will be barred from imposing exclusions on children with pre-existing conditions. Pools will cover those with pre-existing health conditions until health care coverage exchanges are operational.
- Insurers will not be able to rescind policies to avoid paying medical bills when a person becomes ill.
- Lifetime limits on benefits and restrictive annual limits will be prohibited.
- New plans must provide coverage for preventive services without co-pays. All plans must comply by 2018.
- A temporary reinsurance program will help offset costs of coverage for companies that provide early retiree health benefits for those ages 55 to 64.
- New plans will be required to implement an appeals process for coverage determinations and claims.
- Adoption tax credit and assistance exclusion will increase by \$1,000. The bill makes the credit refundable and extends it through 2011.
- Businesses with fewer than 50 employees will get tax credits covering 35 percent of their health care premiums, increasing to 50 percent by 2014.

January 1, 2011

- Medicare will provide free annual wellness visits and personalized prevention plans. New plans will be required to

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Doctor, Are You Billing Insurance the Correct Evaluation and Management CPT Code?

Part II

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ICS Insurance Specialist

In my last article on evaluation and management (E/M) codes, I discussed the seven components of an E/M code. The three key components include: History, Examination, and Medical Decision Making. The three contributory components include: Counseling, Coordination of Care and Nature of the Problem. The last component is Time.

For a new patient E/M code level to be met (99201-99205) all three key components (history, examination and medical decision making) must meet or exceed the E/M requirements for the level billed. Two of the three components must meet or exceed the requirements to qualify for a specific E/M code level for an established patient (99211-99215). The exception to this rule is in cases where a patient's visit consists predominantly of counseling and coordination of care. I also discussed in detail the History component of the E/M service and the four elements that determine which level of history was completed. In this article I will discuss how to determine which level of physical examination has been completed by a physician.

The Current Procedure Terminology (CPT) book list four types of examinations: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. (1)

1. According to CPT and the 1995 Medicare Documentation Guidelines for Evaluation and Management Services a Problem Focused Examination is a limited examination of the affected body area or organ system. (1, 2) A Problem Focused Examination is required for a 99201 or a 99212 E/M code level.

2. An Expanded Problem Focused Examination is a limited examination of the affected body area or organ system and any other symptomatic or related organ system. (1, 2) This level of examination is needed for a 99202 or a 99213 E/M code.

...Continued on Page 2

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CPT Code... Continued

3. A Detailed Examination is an extended examination of the affected body area(s) and any other systematic or related organ system(s). (1, 2) This level of exam is needed for a 99203 or 99214 E/M service level.

4. A Comprehensive Examination is a general multisystem examination or a complete examination of a single organ system. (1, 2) This level of examination is needed to bill a 99204, 99205 or a 99215 E/M code.

The CPT code book and Medicare recognizes the following body areas: Head (including the face); Neck; Chest (including breast and axilla); Abdomen; Back; Each Extremity; and Genitalia/groin/buttocks. (1, 2) The following organ systems are recognized: Eyes, Ears/nose/mouth/ and throat; Cardiovascular; Respiratory; Gastrointestinal; Genitourinary; Musculoskeletal; Skin; Neurologic; Psychiatric; and Hematologic/lymphatic/immunologic. (1, 2) A physician can only use body areas or organ systems when conducting an exam. The two cannot be combined.

Common questions I receive at the ICS by doctors and their staff include: "What is an extended exam vs. a limited exam?" and "How do I know what I need to do for a complete exam or an extended exam?" Understanding what is meant by a limited, an extended and a complete examination is difficult since the CPT guidelines and the 1995 E/M documentation guidelines do not go into this detail. This created a large degree of confusion causing many disagreements between providers and reviewers. To solve this problem, the 1997 Documentation Guidelines for Evaluation and Management Services was developed by Medicare. The 1997 E/M Guidelines go into great detail by using specific elements of the exam and bullets under each element that must be completed to qualify for each exam level.

According to the 1997 E/M Guidelines, a physician may perform a general multisystem examination or a single organ system examination. The single organ systems include: Ears/Nose/Mouth/Throat; Eyes; Genitourinary (female or male); Hematologic / Lymphatic / Immunologic; Cardiovascular; Musculoskeletal; Neurological; Psychiatric; Respiratory and Skin. (3) The content and documentation requirements for each

exam level will be summarized in this article, however for detailed element and bullet requirements for each single organ system or general multisystem examination will not be in this article due to a lack of space. The complete 48 page 1997 Documentation Guidelines for Evaluation and Management Services document can be downloaded at: www.cms.hhs.gov/mlnedwebguide/25_emdoc.asp

The General Multisystem examination guidelines are summarized below (3):

The 1997 General Multisystem Examination Guidelines

Examination Type	Number of Elements Performed & Documented	CPT Code Level
Problem Focused	1-5 elements identified by a bullet in one or more organ system(s) or body area(s)	99201, 99212
Expanded Problem Focused	6 or more elements identified by a bullet in one or more organ(s) or body area(s)	99202, 99213
Detailed	At least two elements identified by a bullet in at least 6 organ systems or body areas. OR At least two elements identified by a bullet in 2 or more organ systems or body areas	99203, 99214



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CPT... Continued

Comprehensive	All elements identified by a bullet in at least 9 organ systems or body areas.	99204, 99505, 99215
	OR At least two elements identified by bullets for all body areas or organ systems.	

According to the 1995 and 1997 E/M Guidelines a Comprehensive examination is very extensive. This is why billing a 99205 or 99215 E/M code for all patients or a majority of patients is a red flag for most insurance companies. Most 3rd party payers accept both the 1995 and 1997 guidelines; however it is important to check with each 3rd party payer. For purposes of medical review of documentation the 1997 guidelines are usually used first. If an examination has not met the 1997 guidelines for the code level billed then the reviewer will use the 1995 guidelines which are more subjective.

The use of physical and orthopedic exam forms are acceptable however, the following documentation rules apply. All documentation should clearly describe what was examined. It is acceptable to document normal finding as “negative, normal or WNL” however any abnormal or unexpected findings of the symptomatic or asymptomatic body area(s) or organ system(s) must be described in detail in documentation. Noting a finding as positive or abnormal without further details is insufficient. A short note on the exam form or in the doctor’s notes provides the further details required.

The single organ system examination guidelines are summarized below (3):

The 1997 Single Organ System Examination Guidelines

Examination Type	Number of Elements Performed and Documented	CPT Code Level
Problem Focused	1-5 elements identified by a bullet, whether in a box with a shaded or unshaded border.	99201, 99212
Expanded Problem Focused	6 or more elements identified by a bullet whether in a box with a shaded or unshaded border.	99202, 99213
Detailed	12 or more elements identified by a bullet whether in a box with a shaded or unshaded border (exceptions include eye and psychiatric exams).	99203, 99214
Comprehensive	Performance of all elements identified by a bullet whether in a shaded or unshaded box and documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border.	99205, 99204, 99215

In my next article I will discuss the third key component of an E/M code, Medical Decision Making, and then in the 4th article of the E/M series I will put everything together.

- (1). *Current Procedural Terminology Professional Edition; American Medical Association; 2010, p.9, 10*
- (2). *1995 Documentation Guidelines for Evaluation & Management Services; Centers for Medicare & Medicaid Services; p.9*
- (3). *1997 Documentation Guidelines for Evaluation & Management Services; Centers for Medicare & Medicaid Services; p. 10-13*

ILChiro

Seminars

May 6th - Chiropractic Coding: Tools for Reimbursement Downers Grove, IL

May 20th - IME Peer Review Rosemont, IL

June 24th - 2010 Medicare Guidelines Oak Brook, IL

Webinars

April 27th - How to Customize Active Care Programs for Your Patients

May 18th - The Foot & Ankle Treatment

June 8th - Maximize Marketing: Trends to Increase Your Profits

July 13th - The Perfect 1500 Claim Form

Timeline... Continued

cover preventive services with no co-pay

- A plan to provide a vehicle for small businesses to offer tax-free benefits will be created. This would ease the small employer's administrative burden of sponsoring a cafeteria plan.
- The Medicare payroll tax will increase from 1.45 percent to 2.35 percent for individuals earning more than \$200,000 and married filing jointly above \$250,000.

January 1, 2013

- Health plans must implement uniform standards for electronic exchange of health information to reduce paperwork and administrative costs.
- Contributions to flexible savings accounts will be limited to \$2,500 per year, indexed by the Consumer Price Index in subsequent years.
- There will be increases to the income threshold from 7.5 percent to 10 percent of adjusted gross income. Those older than 65 can claim the 7.5 percent deduction through 2016.
- A 2.9 percent excise tax on the first sale of medical devices will be established. Excepted are eyeglasses, contact lenses, hearing aids or other items for individual use.

January 1, 2014

- Non-discrimination in health care: No health plan or insurer may discriminate against any health provider acting within the scope of that provider's license or certification under applicable State law. This will ensure that insurance companies cannot unfairly exclude doctors of chiropractic from practicing under the capacity of their training and licensure on a federal level. Provision is a federal protection applicable to ERISA and other plans established or regulated under the bill. Just as the HIPAA protections now apply across the board, the non-discrimination provision will be applicable to all health benefit plans both insured and self-insured.
- Community Health Teams: National Health Care Workforce Commission: DCs named as potential members of Community Health Teams to support the development of "medical homes." These teams support the development of medical homes by increasing access to comprehensive, community based, coordinated care. Community health teams are integrated teams of providers including primary care providers, specialists, other clinicians and licensed integrative health professionals as well as community resources to enhance patient care, wellness and lifestyle improvements. The language in the bill ensures that doctors of chiropractic can be included in these patient-centered and holistic teams.
- National Health Care Workforce Commission: DCs are specifically included as part of the National Health Care Workforce Commission defined as "Health Care Professionals," and schools of chiropractic are also included in the health professional training schools definition. The Commission is tasked providing comprehensive information to Congress and the Administration about how to align federal health care workforce resources with national needs. Congress will use this

information when providing appropriations to discretionary programs or in restructuring other federal funding. The language in the bill guarantees that the need for doctors of chiropractic will be addressed when considering federal health care workforce programs.

- Citizens will be required to have acceptable coverage or pay a penalty of \$95 in 2014, \$325 in 2015, \$695 (or up to 2.5 percent of income) in 2016. Families will pay half the amount for children, up to a cap of \$2,250 per family. After 2016, penalties are indexed to Consumer Price Index.
- Workers who are exempt from individual responsibility for coverage but don't qualify for tax credits can take their employer contribution and join an exchange plan.
- Companies with 50 or more employees must offer coverage to employees or pay a \$2,000 penalty per employee after their first 30 if at least one of their employees receives a tax credit. Waiting periods before insurance takes effect is limited to 90 days. Employers who offer coverage but whose employees receive tax credits will pay \$3,000 for each worker receiving a tax credit.
- Insurers can no longer refuse to sell or renew policies because of an individual's health status. Health plans can no longer exclude coverage for pre-existing conditions. Insurers can't charge higher rates because of health status, gender or other factors.
- Health plans will be prohibited from imposing annual limits on coverage.
- Health insurance exchanges will open in each state to individuals and small employers to comparison shop for standardized health packages.
- Credits will be available through exchanges for those whose income is above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage.
- Medicaid eligibility will increase to 133 percent of poverty for all nonelderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive increased federal funding to cover these new populations.

January 1, 2018

- Taxing "Cadillac" plans: An excise tax will be imposed on high-cost, employer-provided health plans beyond \$27,500 for family coverage and \$10,200 for single coverage; it will increase to \$30,950 for families and \$11,850 for individuals, retirees and employees in high-risk professions. **ILChiro**

Editors Note: This article has been reprinted with permission from the American Chiropractic Association (Copyright 2010, ACA). Additional documents regarding Health Care Reform are available at www.acatoday.org and include: Frequently Asked Questions, Chiropractic Perspective, Medicare, and Small Businesses.