Dynamic Chiropractic

BILLING & CODING

Updated E&M Codes a Big Benefit to Chiropractors

Samuel A. Collins

Question:*I billed a 99201 and it was denied. What happened? Are E&M codes no longer valid, or have they changed?*

Yes, for 2021 there has been an update to the evaluation and management (E&M) codes including the elimination of code 99201. E&M codes were not deleted, but were revised in ways I believe are going to be helpful to chiropractors.

What's Changed With the Codes (and What Hasn't)

The E&M codes range from 99202 through 99205 for a new patient and 99211 through 99215 for an established patient. The only code eliminated was 99201, but all codes have an update to their description and the manner in which you choose the appropriate level of E&M service.

What has *not* changed is how you choose a new-patient or established-patient code. The codes for new patients (99202-99205) still maintain that a new patient is someone who is new to the office or has not been seen in three years or longer. An established-patient code (99211-99215) is for the evaluation of any patient seen by the provider within three years. A new injury or new complaint of an existing patient (less than three years) does not constitute a new patient for coding of E&M services.

What the Codes Now Mean

The codes are now described in the following manner:

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *straightforward* medical decision-making. When using time for code selection, *15-29 minutes of total time* is spent on the date of the encounter, (99201 has been deleted; to report use 99202.)

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *low level* of medical decision-making. When using time for code selection, *30-44 minutes of total time* is spent on the date of the encounter.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *moderate level* of medical decision-making. When using time for code selection, *45-59 minutes of total time* is spent on the date of the encounter.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *high level* of medical decision-making. When using time for code selection, *60-74 minutes of total time* is spent on the date of the encounter.

99211 Office or other outpatient visit for the evaluation and management of an established patient, and may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *straightforward* medical decision-making. When using time for code selection, *10-19 minutes of total time* is spent on the

date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *low level* of medical decision-making. When using time for code selection, *20-29 minutes of total time* is spent on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *moderate level* of medical decision-making. When using time for code selection, *30-39 minutes of total time* is spent on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *high level* of medical decision-making. When using time for code selection, *40-54 minutes of total time* is spent on the date of the encounter.

Why the Changes Benefit You: Accounting for the Time Factor

The new code descriptions indicate specifically that the time spent is per the *date of the encounter,* not just time as typical or face to face. Based on this new description, time may be used as a controlling factor for choosing the proper code.

The prior description indicated providers would spend a typical amount of time face to face with the patient. This statement did not allow providers to use time as a controlling factor for the level of exam, and would instead be based on three main factors including history, examination and medical decision-making (severity) of the patient's condition.

This protocol often meant doctors of chiropractic who might require an hour of history and evaluation for a chronic patient would not qualify for a code higher than 99203, as the severity and medical decision-making did not meet the requirements of morbidity or mortality.

Even with this lengthy history and other details necessary, the severity and medical decision-making would only allow for use of a lower-level code. The prior guidelines used for evaluation and management codes also were complex and more than 50 pages in length. (You may recall all the requirements for bullets and organ systems, and the minimum you needed to include.)

Moving forward, you can document the time that was spent on the evaluation (not just face to face, but also time before, during and after the face-to-face time that is part of your evaluation) to qualify for the appropriate level of service and coding.

For example, many offices now use specific intake forms, whether an electronic record-keeping system or another style, whereby the patient will fill out detailed history and complaint forms before the examination. This could include the information detailed by a historian or staff member before direct interaction by the chiropractor. This information is not static, but reviewed before the chiropractor sees the patient. The time to review this data now counts toward the total time of evaluation as long as it is done on the same date as the visit. Furthermore, the information no longer is required to be rewritten by the provider, but simply noted as reviewed.

Time as used for determining the appropriate code (along with level of medical decision-making) represents the total provider time spent on date of service, including:

- Preparing to see the patient (e.g., review of tests)

- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating patient / family / caregiver
- Ordering tests or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in electronic or other health records
- Independently interpreting results (not separately reported) and communicating results to the patient / family / caregiver
- Care coordination (not separately reported)
- Discussing ongoing treatment, lifestyle modifications and preventive health care needs

The protocols for choosing the proper E&M service maintain medical decision-making as a method to choose the code. For example, a patient with a life-threatening condition may still have an evaluation (even if it takes less than one hour) that would qualify for 99205. As a consequence, there will be times that you will see a patient for a serious condition and a 15-minute face-to-face visit may still qualify for a high-value code.

The difference now is doctors of chiropractic are no longer limited to lower-level E&M codes even when they have to spend considerable time with the patient on evaluation. However, I caution that if you spend one hour with every new patient, that may be a style issue. I would not use 99204 and 99205 when there is a minor or self-limited problem that would require an explanation of the need for such time. Not impossible, but improbable.

You may be wondering, *what if I spend less than 10 minutes on an evaluation on a new patient; what code can I use?* It would still be a 99202. Although you may not have spent 10 minutes, the medical decision-making for a 99202 starts with one self-limited or minor problem; and just as the other codes can use medical decision-making without the time element, this would, too. So, if you were using a 99201 and the time was 10-19 minutes or it was one self-limited problem, you would now use 99202.

Editor's Note: Have a billing question? Submit it via email to Sam at sam@hjrossnetwork.com. Your question may be the subject of a future column. Alink to a short video presentation by Sam explaining these codes is available in the digital version of this article.

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