Dynamic Chiropractic

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Hot Topics in E/M Coding

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How Do Chiropractors Code for Fill-in Doctors?

It is a common practice for a solo doctor to find someone to cover for them while they are away from the office for a temporary or extended period of time, such as medical leave or vacation. Some offices fail to code properly for the services rendered by the "fill-in" doctor. When completing the CMS 1500 claim form, do they use their doctor's name and NPI, or do they use the name and NPI of the covering doctor who actually saw and treated the patient? And which modifier is correct: Q6 *Services furnished by a locum tenens physician;* or Q5 *Services furnished by a substitute physician under a reciprocal billing arrangement*?

A substituting doctor is really just a proxy and functions as if the regular doctor were present. For most payers, the substitute physician does not need to be credentialed with the plan, but they must possess an unencumbered license in the same specialty. If the temporary doctor is hired on, then Medicare (and presumably most private plans) would require the new doctor to become enrolled before submitting claims. Temporary doctors may not be used indefinitely; CMS limits *locum tenens* to 60 days, and most other payers probably have similar guidelines.

If the fill-in doctor were hired from the outside, they should be paid a per diem or on a fee-for-time basis as an independent contractor and the -Q6 modifier would apply. *Locum tenens* is Latin for "to hold the place of" or more plainly, a "fill-in." When the covering physician is a permanent part of the office (under the same tax ID), this may constitute a reciprocal billing arrangement; thus the -Q5 modifier would apply.

To summarize:

- Use modifier -Q5 or -Q6 in box 23d of the CMS 1500 form for each line item in the claim. Append the modifier for each line-item service. Enter the regular physician's national provider identifier (NPI) in box 24J of the CMS 1500 form.
- Add the NPI and name of the locum or reciprocal physician in the notes line of the CMS 1500 form. This is not mandatory, but it may be helpful.
- Track the locum's NPI, their services and the calendar dates the locum provided services in case a carrier requests this information. Note that in either case, the payment goes to the regular physician.

Reference

1. *Medicare Claims Processing Manual*, sections 30.2.10 and 30.2.11.

Can Chiropractors Bill 99211?

This code would be used rarely in a chiropractic office, as 99211 is a low complexity examination for an established patient. It can be used by chiropractors, but in most instances, it is discouraged.

The 99211 code, also known as the nurse code, is not really made for the physician to use. In fact, the AMA CPT book states that it "may not require the presence of a physician." In the medical setting, it might be used for a visit in which the nurse just takes blood pressure or records the patient's response to a new medication.

This code is bundled into the manipulation code and therefore should not be used on the same day as a chiropractic manipulative treatment ... except when it is significant and separately identifiable. Some practices have erroneously tried to increase reimbursement by submitting 99211 along with therapies supervised by non-physician personnel every time the service is performed. The rationale is that this code pays for the presence of someone other than the doctor.

However, the "practice expense" portion of the "Relative Value Unit" includes reimbursement for office overhead required to perform the therapy code, therefore, reporting the 99211 may be considered a sort of "double dipping." If a re-evaluation or assessment is performed in addition to the therapy, then an E/M code may be appropriate.

Note that the criteria for a 99212 are very easy to meet, and a typical periodic re-evaluation in a chiropractic office is almost always a higher complexity than that seen in the 99211 code. 99211 only calls for a presenting problem that is minimal and does not require any of the three key components needed for other E/M codes. Therefore, chiropractors would very rarely use it as a re-evaluation code, since a re-exam typically meets the criteria for at least a 99212.

So, when can it be used? If the patient comes in for a follow-up visit and no adjustment is performed, then *possibly* a 99211 may be used. An example might be when a staff member pulls a chart, and an assistant gathers some sort of information from the patient and records it. Palmetto Medicare suggests that the following criteria should be met:

- A minimal presenting problem / symptom
- A relevant and necessary exchange of information between licensed personnel and the patient

As you can see, there are possibilities in which 99211 can be billed, but it should be used on an occasional basis at most. If there is no presenting problem and no treatment is given, consider a preventive medicine code instead, such as 99401. (This service must be performed by the provider.)

Reference

1. Palmetto Medicare 5/8/2011 Guidelines for Anticoagulation Services: 99211.

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