CODING CHANGE FOR 2023 WITH DR. EVAN GWILLIAM

Mike Whitmer:

Hello and welcome. Thank you for joining us today. My name is Mike Whitmer. I'm Vice President of Corporate Relations at NCMIC, and I'm going to be moderating today's discussion. So before we get started, there are just a few housekeeping items I'd like to review with you. Today's webinar is prerecorded to accommodate schedules during this busy time of year. That means that you won't have the opportunity to ask questions live. But if you do have questions, you can go to the contact us section on NCMIC.com, type your question in there and we'll we'll be happy to connect you to resources to help. You can also just pick up the phone and give us a call in our client service center here at NCMIC as well. I also want to tell you about our next webinar that's coming up on January 19th at 2:00 PM I hope that you'll be able to join us for that.

That one will be live, but it will also be recorded if you can't watch live. And we will post that on the resources section of NCMIC.com as soon as it's available. So now for today's program, I'd like to introduce our guest, Dr. Evan Gwilliam. Evan is a frequent guest on our webinars and he's Clinical Director for PayDC Chiropractic Software. He's a graduate of Palmer College and is a certified professional coding and ICD10 lecture instructor, Medicare compliance specialist and certified professional medical auditor,

Dr. Gwilliam provides expert witness testimony, medical record audits and online courses for healthcare providers. I'm really excited to have Dr. William back with us today to address some coding changes that are coming down the pipe for 2023. So with that, Dr. Gwilliam, thank you for being here as always and talking with us today. Welcome, and I'll go ahead and turn the platform over to you.

Dr. Evan Gwilliam:

Thank you so much Mike. It is great to be with you guys today. I am the Clinical Director for PayDC, which is an EHR software, but I'm also on the Speakers Bureau for NCMIC. So I am honored to be able to come and speak to everyone about these things. As I was asked to put this presentation together, I struggled to come up with the most potent, most useful information I might be able to share with you that I would wish I knew going into 2023. So that's what we're going to try to action pack into this presentation for you today.

And so follow along, reach out with follow up questions cause I bet there will be some and we'll do our best to get you the right answers. So without further ado, I'm going to jump right in here. And one quick disclaimer, this is my best effort to give you the most recent information, but things do change. So please stay tuned and keep in touch so that you can get what you need. I hope that none of what I share with you is wrong, but it all might be you never know.

So I'm going to give you again what I wish I knew going into 2023 and share with you some important coding issues. Some of these things I'm going to share with you are new. They're changes such as some ICD-10 code changes, but some are old that are just kind of becoming more prevalent. And that's this thing about Excludes1, we'll talk about. Also this issue with the GP modifier. It's been around for a few years, but there's still issues with it. I was chatting with a billing friend of mine and she was like,

if she was doing this webinar, she'd make sure everybody knew about the GP modifier issue cause it seems like a lot of doctors still don't, even though it's been around for a couple years.

So I'm going to explain it to you. There's a newish issue about roller tables we'll discuss and the code 97012. Also, they updated the E/M code guidelines for 2023. While it's beyond the scope of this presentation to get, we'll really deep dive into it. I'm going to give you the highlights and let you know where you can go for more. And then E/M bundling is not a new issue either, but it's just an issue that seems to keep coming up and it's something I want to mention to you and help you understand how you can manage it as effectively as possible.

I'm also going to mention something from a comparative billing report from Medicare that I want to share with you that I think you may just find interesting and it may help guide your decision making as you try to figure out how to best move your practices through the next year and avoid these payment issues or possible liability from billing mistakes or heaven forbid, being accused of fraud or abuse, which is the last thing we want. So I'm here to give you some guidelines to help you know how to stay out of trouble, get paid right and just live happily ever after.

All right, so it's a lot that I'm trying to cram in here. So we'll jump in. ICD-10 are the codes that we use to disclose what our patient's problem is, what their diagnosis is, what we're treating them for. And they are updated every year on October 1st. So at the time of this recording, the changes for 2023 have already been put in place back on October 1st, 2022. I just drew in this quick table to show you the last few years of what's kind of been the trend with changes. ICD-10 has been updated ever since it was implemented in 2015, but just the last few years you can see how many new codes there were, how many were revised, how many were deleted.

They did a bunch of changes for 2022. Some of those actually are kind of due to the issues we dealt with COVID and other things. So they don't affect chiropractic specifically quite as much. In fact, there are very few code changes that were put into place 2022 that affect 2023 that apply to chiropractic, but let's get into them. If you want to go right to the source, simply go to your browser, an internet browser and type in ICD-10-CM CMS or Medicare and it will take you to this page, which is where Medicare stores and releases the most current information about ICD-10. If you want to go right to the stores, you can get the full ICD-10 code set, different summaries. There's an addendum that summarizes and captures all the changes I'm going to show you in a minute, and you can get all those resources yourself right there.

But let me give you the chiropractic NCMIC narrowed down version so you don't have to wade through all this stuff from the whole full code set and all those changes. I believe there are three different codes that you might want to be aware of, and honestly I don't know that they affect that many chiros. Here's the first one. If you look at this, this is just a screenshot right out of the addendum, which is released every year to show what the-ICD-10 changes are for the next year. So I took a screenshot of this so you could see these codes. So they still have the category of M51. Well if you look at M50, they changed the rule. They said you don't have to code to the most superior level of the disorder. That used to be a rule, they got rid of it.

That's the codes for cervical discs. For M51 are the codes for all the other disc disorders, thoracic and lumbar. And they added these M51A codes. And basically what they are, are codes that include the type of disc problem that says the problems with the annulus fibrosis. The disc defect is with the annulus, which is a specific part of the disc. So all these new codes you see on your screen, all they did was create codes that also say specifically that the disc problem was the annulus fibrosis where the issue is. And then it lists all the regions. So if you look at all these codes, the one at the top is for lumbar region. As you work your way down, it goes down to lumbosacral, and it talks about the size of the lesion and whether it's small or large. So those are the details, all these new codes.

And if you provide a diagnosis code on your claim forms for disc disorders, you could become very specific if you wish to use these codes. I don't know that chiropractor's going to use these that much. I think this is more for radiologists reading an MRI report. But you should know about these in case you see them or you end up needing to use them because you want to be very specific. Okay? That's the first change that I think a chiropractor should be aware of. The next one is codes about muscle wasting and atrophy. There are new codes that were added. M62.5 was the subcategory that's still there. It's muscle wasting and atrophy. But what they did was they added specifics about the location. So you can see there's four new codes at the bottom of your screen there.

Those are all new. And those explain specific areas in the back or the spine or, well, the cervical, thoracic or lumbosacral area of where muscle wasting atrophy could occur. Again, I don't know that a lot of chiropractors are commonly diagnosing muscle wasting an atrophy, but it's possible and it pertains to the spine and areas we treat. So be aware of these new codes if you weren't already. The last ICD-10 change, actually, the second to last one I want to show you is with concussion codes. So if you do a lot of personal injury, you're doing a lot of auto accidents, you use the concussion diagnosis codes for traumatic brain injury and so on, they made some changes to the codes about the duration of the loss of consciousness were related to concussions. So if you look at the bottom half of this box that I've snipped and thrown up on the screen for you, the big change here is there used to just be two codes. One that said concussion with loss of consciousness of 30 minutes or less. And another one that said unspecified.

Well they added one in between that says status unknown, and they added some additional inclusion terms as well. So the word brief, when you say brief loss of consciousness, it's the same as 30 minutes or less. That's S06.0X1 is the code I'm talking about there. The new code is S06.0XA, which is concussion with loss of consciousness, status unknown. So either you document, you didn't know how long they were unconscious or you neglect to document it. Actually if you neglect to document it, you choose S06.0X9. The last code there, that is the patient had loss of consciousness and you don't even document whether it was or how long it was, you don't know. And that's when you use the unspecified duration.

Okay? So that is some new codes you need to be aware of that kind of clarifies a little bit more about the duration of unconsciousness with concussions if you do this kind of work in your office and you have the proper evaluation in place to determine

concussion and all that. So that's the other change, the other new code. There's one other big change I wanted to mention to you and it is this proposed new chapter. There are currently 21 chapters in ICD-10 and there is a movement out there to add this extra chapter about infectious diseases caused by zombies. And if you look at the subcategories, we have allergic reactions to zombies. We have infections caused by zombies and you see it breaks it down by body region. Then we have total zombiefication. And my favorite is nausea caused by zombies. It can be caused by zombie stench, zombie appearance, or the best code in here is ZA1.22, nausea caused by neighbors massacred by zombies.

Of course, if you're paying attention right now, you're like rolling your eyes, you're wondering what's going on. I'm just kidding. Okay? If you look at the bottom of this, this was an April fool's joke from many years ago, and I think it's great and I just want to see if you guys are paying attention to me. I use this joke every year. If some of you heard me last year when we did this presentation, I think I used this then to. I'm sorry, there are no zombie codes for those of you are getting excited. So anyway, just making sure you were paying attention. There was another ICD-10 issue I want to talk to you about though, and that is the Excludes. Now, when ICD-10 kicked in, in 2015, the Excludes rules were laid down and they were clear and a bunch of codes said, "Here's a code, but it excludes that code. And this one excludes that." And they put in all these rules for us.

But in the last year or two, we are seeing denials like crazy from payers who've suddenly applying these rules. So this is not a new rule, it was always there, but it's being applied by payers when it wasn't before. Here's what you need to understand. When you look at the code in ICD-10, there's guidelines around that code and many codes have excludes around them. And there's Excludes1 and Excludes2. What I want to talk to you about right now is just Excludes1 because that's the one that is causing doctors to not get paid for the work they're doing. Excludes1 is used when two conditions cannot occur together. They're not coded here. They're mutually exclusive, two conditions that cannot be reported together. For example, a congenital condition and an acquired condition, either it was congenital or it was acquired.

And you'll see an Excludes1 around those kinds of codes, and that means you cannot code for both. You can't code that someone acquired something later and was born with it. It's one or the other. Okay? That's what Excludes1 means. Excludes2 is a little different. And for the sake of time, I'm not going to get into that one here, but let me give you some examples to clarify Excludes1. When you see a code in it says Excludes1. It means you should consider these other codes instead. You can only use one of the codes, either the one you're looking at or one of the ones under the list that Excludes1. They're mutually exclusive of each other. So here's a classic example. M5450 was a new code in 2021, but it Excludes1 was the same as the old code. It says basically if you code for a low back strain, if you code for lumbago due to intervertebral disc displacement, if you code for lumbago with sciatica, any of those, you may not also code for low back pain.

It's mutually exclusive. Those codes cannot be coded together because those conditions overlap. If you think about it, someone who strained their low back, of

course they have low back pain. They're saying don't report low back pain, we already know. It's a waste of time and space. And you might say, "Well, yeah, but it gives more detail," whatever. I'm telling you, the coding rule is you can't do it. And if you do it, I'm seeing, and I'm hearing stories of payers more and more simply denying because you're not allowed to use those codes together. So there's many other examples of Excludes1, and if you are finding that you're getting denial and they're saying you're not coding properly with ICD-10 or something, odds are pretty good there's an Excludes1. You can always look it up online and find out if you have an Excludes1 with the codes you're using.

There are all kinds of code search tools and you just have to understand that if you look up your code and it says Excludes1, it lists the other code you might have listed, that's why you're getting a denial. If you're really having a hard time with this and you can't figure it out and you don't understand why they're denying your codes, shoot me an email. I'll look it up for you, okay? I'll help you out. I have this tool that I can use online to determine this very easily. Otherwise, you got to look it up in the coding book or online and look at the Excludes yourself and see if they're mutually exclusive. This is going to potentially affect your payment. So watch out for this one. All right. Not a new rule, just a rule that I wish I knew about or I want you to know about because doctors are seeing it and don't know what to do with it.

And if they're saying it should probably be a diagnosis code, that's probably why. Okay? Other issues: I'm going to move from my slides for a second and show you a couple of other things right here, the GP modifier. All right, so this is a policy that was released by United Healthcare. Let me make this bigger for you. So look, United Healthcare, you can find this online, just Google it if you want. It's policy number this. It looks like it might have been updated in 2022, but they released this a long time ago, several years ago, and I just highlighted what I want you to know. United Healthcare says anything that happens after July 1st, 2020 for always therapy services according to Medicare needs, the GP modifier, if there's a physical therapy plan. These other modifiers are for occupational and speech therapy, GN and GO.

So they probably don't apply to chiros, but the GP does. What I'm trying to let you know is United Healthcare, along with quite a few Blue Cross carriers that are state specific, this is not universal to Blue Cross, but several state specific Blue Cross carriers have chosen to do this too. If you use an always therapy code, which is basically any code that starts with 97. So you're billing a procedure code with 97, such as ESTIM or exercises, neuromuscular education, massage therapy, the codes that begin with 97, 970, 971 or 975 are the ones that we use as chiros. You must attach the GP modifier on it in order for it to be processed correctly, okay? That's what this policy says, and I wanted you to see it. It's not new. These aren't new coding rules, but doctors still miss this a lot or didn't hear about it, and they don't know why they're getting these denials.

What that modifier means is that you have a therapy plan in place and if someone wanted to audit your records, they could find it. So if you say, I'm doing exercises, 97110-GP, basically by seeing them on a claim form, I would know that in your records, I could see you did exercises with the patient and you have a therapy plan in place for those patients, for the person who got that code. That's what that means.

So don't attach a GP modifier if you don't have a plan, but then you won't get paid either. So in other words, to do these therapy services, you must have a plan and say, "Well, I'm doing ESTIM because I hope to accomplish this. That's why the ESTIM is being done." Explain that in your notes. Add the GP modifier and you should be totally fine. If you're getting denials for some of your therapy codes, all your nine sevens, it may be because you're forgetting the GP modifier or a payer has begun to adopt the need of the GP modifier.

This whole thing came from an idea that Medicare came up with for physical therapist and the United Healthcare adopted it and some Blue Crosses, and it applies to anyone who uses these codes regardless of whether or not you're a physical therapist. So as chiros, we got to have the GP. Okay? So that's one I wanted you to be aware of. Again, this is not new, you can find it yourself. Or if you really want to, you can email me and I'll send you this if you wanted to look at it and read the official. But I highlighted the important part here. Let's see, 97012 and roller tables, this is a new issue kind of as well. It's right here.

The American Chiropractic Association provides opinions on coding rules. Their committees meet, they have all these experts. I'm buddies with some of them. I've never been on this committee, but I'm friends with several people on these committees. And oftentimes I've seen it used in cases of denials or even legal cases where the ACA is cited as an authority on this. This was a policy that they updated finally this year, about 97012 mechanical traction. I've highlighted the important part of this one. Basically a lot of chiropractors use roller tables or the spinalator, and the deal is we've always built it as 97012. But back in 2020, the American Medical Association clarified their coding guidance and said, "Hey, roller tables don't qualify for 97012, which is the code for mechanical traction." And the ACA finally released their response to that for chiropractic specifically and said, "Yeah, you know what? It's been determined that roller tables are not going to qualify as 97012, it shouldn't be billed that way and it should be billed as 97039."

97039 is unlisted modality. And we could also put in the description here, ain't nobody paying for this, right? That's what that code means. I'm going to bill 97039 for something that's not listed. And in this case, roller tables are considered unlisted cause there's no code for them. And 97039 is a code. You might get excited and say, "Ah, I got a code, I'll bill it," but it ain't nobody paying for that. That's how I summarize 97039. You'll see exceptions maybe under personal injury carriers and stuff. But most are going to say, "Thanks for assigning a code and telling us you do roller tables, but we don't pay for it." So I wanted you to be aware of this update. Again, this sort of really happened back in 2020 back here from the American Medical Association, but it wasn't until this year that the American Chiropractic Association kind of got on and updated their policy too.

And here it is, it's brand new. I don't know if this is accessible to the public online or not. You might have to be a member to see this document. Or they might not put it on their site yet. I have inside connections. So I just wanted you to see that roller tables should not be built as 97012 and they should be billed as 97039, and then you shouldn't get paid for them and they end up being a cash thing. Okay? So that's one of the only CPT code issues that I want to mention to you.

There are some new E/M guidelines. Before I do that, I want to mention some general information to you. Some of you may or may not have received something like this. This is a comparative billing report or a CBR from Medicare. And this is one that a client of mine received just in January of 2022. And if you received one of these from Medicare, in order to qualify for one of these, you have to meet certain criteria, and it's right here. You have to do more than most other people do. You have to have at least 60 beneficiaries with Medicare and you have to have at least $20,000 in total charges.

So if you haven't seen one of these reports, you may be because you're below the threshold or you fall right in line with everybody else in terms of the averages. But many of you are not going to be average because by definition the average is only a certain number and lots of people are on either side of that. So I just want to show you one thing from this report that I thought you might be interested in. It's not really coding issues per se, it's right here.

There are 42,813 providers nationwide that bill Medicare for Chiropractic and they billed Medicare this past year, 768 million.The reason I want to point that out to you is because the average chiropractor therefore sends charges to Medicare for about $18,000. I'm letting you know that because now you can look at your own numbers and go, "If I'm well below $18,000, Medicare isn't going to care that much about me. If I'm well above $18,000, then they're more likely to look at me." Also, Medicare says that the average beneficiary is seen nine times, that chiropractors bill Medicare an average of 9.05 times for chiropractic manipulative treatment in a year, each beneficiary in a year. This particular doctor, his average was 10. And so they said, "You're kind of high because you do 10 and the average is nine," which isn't that big a deal.

And his state average is even lower. It's closer to seven in the state for this doctor. There are other issues they looked at, but I wanted you guys to just know that the average chiropractor sees, does about... What did I say? $18,000 and sees patients an average of nine times. Okay, so that's interesting numbers. I just thought that might be helpful to you.

The last issue I have that I wanted to talk to you about that's a little bit deeper is these changes have happened with E/M codes. If you've been paying attention to the coding rules, or if you've heard any topics about this, in 2021, they modified E/M codes dramatically. They got rid of 99201. They changed the rules so that instead of three key components, you could choose the code based on time or medical decision making. And that is another presentation we can do another time. I can sit there and go through a nice 60 minutes and just talk about E/M codes and how you can understand them and how they apply to chiropractic. But what I want to emphasize right now are the changes that happen, most recently or they're happening for 2023.

So January 1st, 2023, they release these new guidelines and I highlighted the important parts for chiropractors. They got rid of consultation codes. I don't know if you've ever been billing these before. Most chiropractors don't. They deleted some consultation codes. And consultation codes are ones where you've charged more because you're getting asked to a consult by someone else. Some doctors have

overused it in the past because they're all excited to charge more when a MD sends one over. But consultation codes are for when someone doesn't send someone over, but rather they ask for your consult and then they keep the patient.

It's a tricky issue. So just don't worry about it and email me if you want to know more about consultation codes, but they're getting rid of them essentially. They also made some changes to prolonged services. If you end up billing more than the threshold for E/M codes, then there's some rules you need to understand about how to apply those. So this whole document is 42 pages. I'm not going to take you through the whole thing. I went through these guidelines and I looked at what was changed and what was different. And there's not much for 2023 that's really critical. But there are some changes you should be aware of and you might want to review the change that happened in 2021 in case you don't really understand E/M codes or you're billing all the same codes because you just don't even know the rules.

Maybe we can spend some time later and we can do a webinar on just E/M coding so that you guys get the basics and fundamentals if you don't have access to that already. But you can also just find these guidelines yourself and look them over. It's just 42 fun pages you can read with your children in the evenings. That's what I do. So they made some changes here. I just want to zip down to another page here. There's all these tables that kind of help us understand how the codes apply and how to figure them out for medical decision making. I'm going to show you something on this in a minute, so don't get too worried about it. But see, there's all these tables in here. What I highlighted here is brand new, the tables added some other options here, this is basically for a level three, like a 99203 or 99213.

They added two more things on that list. That's one of the biggest changes. But they define those for us. And I go way down here and this page is just a bunch of definitions. So here's my advice to you, if you want to, find these guidelines and look at these definitions and ask yourself, "When I bill for these codes, am I meeting these definitions?" And again, I have a presentation that does a deeper dive into this, but a lot of chiropractors see patients with acute uncomplicated illness or injuries. It would be nice if you looked at these guidelines and tried to employ some of these words right in your records to make it really clear that this is what you mean and this is what the guidelines say too so they all line up really nice. Okay? One of the hardest things for auditors to do is try to figure out what you're saying versus what the guidelines say and having to compare.

So one of the things I always advise my clients to do is put in the verbiage that comes from the guidelines, as long as it's accurate and true, and it makes it a lot harder for a third party auditor to be confused or to have to try to research it or take time and dig in. They see it right away, they get the answers they need and they just move on. So these are the E/M guidelines. All these PDFs I've got right here, if you can't find them online, shoot me an email, I'll send them over to you so you have them if you really want to get that deep. I want to take a few minutes and talk about these E/M changes just a little bit and some E/M fundamentals for you so that you can make sure you're not making mistakes that can cost you money and/or possible liability. Okay?

So this is a couple slides from my bigger presentation, but this is what the table looked like when they released it in 2021 to say, "Here's the easy way to figure out ENM codes." And you might look at this and go, "That's not easy. There's like hundreds of words and they're tiny and there's all kinds of stuff." But the gist of it is this. They said, "Look, there's three categories of medical decision making when it comes to E/M codes." And I'm going to summarize their names as how many problems does a patient have? What's the data you have to consider and how much risk is associated with treating this condition? Then based upon how you line it up in the table, you figure out which code you want, which is down the left hand side of this table. Now, they also told us, you can do this instead of looking at it this way, you can just base your code selection on time and that is an option you have and that's fine.

The issue with time is I think some doctors oversimplify it or they cut themselves short. Let me just show you time real quick, right? They told us we can pick 99202 if we hit at least 15 minutes based on time. Well, what if you do a 12 minute exam? If you do a 12 minute exam, you can't bill a 99202, okay? If it's a re-exam and you spend 15 minutes and you want to bill to level three, you can't. You have to hit 20 minutes. So time has limitations too, but the advantage of using time for your E/M code selection is that you don't have to look at this great big table and figure out how it lines up on here.

Nonetheless, I think that this is not that difficult to follow. What I want to do is just show you one section of it that I've simplified to make it as clear as I can without the deeper dive. If you bill a 99203 or a 99213, and you look at that table, that means that you believe you have a low level of medical decision making. So this is not time. This is medical decision making, the other way you can pick your E/M code. And basically you see the three categories there and the different colors that I've got, the red, blue, and green. You need to pick one of the things from the problems list there. There's five options. There used to be only three, and that was the change for 2023. They gave us two more new ones to list in this part of the table specific to 99203 or 99213. And you look at those and go, Which one of those is my patient? And the example text I put below is what I suggest you might want to document in your record if you did the third bullet, which is acute and uncomplicated illness or injury.

That's a pretty common thing for chiropractic, like a sprain or strain for example. And then I put in the definition in that phrase you see on your screen straight from the guidelines because the way they define it is recent, short term, full recovery without functional impairment is expected. Then I added some verbiage about the risk being low and the exact verbiage for the official guidelines and how they define morbidity and what it means to have low risk. Because I feel that most chiropractors do things that are considered low risk, which is physical therapy manipulation. Those are considered low risk. So again, there's a whole lot more much deeper dive we could do here. What I'm trying to share with you is that the guidelines changed a little bit. They added a few options. I don't know that they're that big or that impactful for chiropractic, but my bigger concern is that you never learn the guidelines when they changed in 2021.

And it's not a bad idea to take some time, sit through a presentation, look up the guidelines if you want, and get them figured out to make sure that you're billing properly and you're not undercoding or overcoding, or heaven forbid, committing some sort of fraud by billing for things you shouldn't get paid for. Know what you should get paid for. Follow the rules, drop them in, make it clear and get paid properly and live happily ever after.

One last topic, I want to talk to you about it. And it's E/M a little bit further. This is not new. This is old as E/M codes are, which actually goes back to the '90s. It's the problem of bundling. It's the issue that we run into where as chiropractors, we often bill an E/M service, which is an exam, on the same days as a chiropractic manipulative treatment.

And the guidelines tell us that those are bundled. So here's what I want you to consider. Think about a chiropractic encounter as like a pie. Okay? It's Thanksgiving, right? And you don't want a pecan pie or an apple pie or a pumpkin pie, rather. You want a pie that splits them in half. So I've got a picture here of a pie that has two in it. The thing about this pie is it costs 10 bucks, okay? But I'm only getting half of each pie, right? This pie includes chiropractic manipulation and the evaluation of management. It's 10 bucks. If you do chiropractic adjustments, you get paid for a pie that has multiple flavors in it, and the pie costs 10 bucks and that's it. So chiropractic adjustment and E/M codes are bundled together. And when you see a patient, do an adjustment, you get paid to do the evaluation on that patient at that same encounter.

Even though there's multiple flavors in the pie, you would say, "Hey, I'm doing an exam and an adjustment." And they're like, "Nope, they're one pie. You get 10 bucks even though they have two flavors in it," Okay? That's the rule. However, in the guidelines, we are told that additional E/M services can be reported using the modifier 25 if the E/M is significant and simply identifiable and above and beyond the usual pre-service of post-service work that's associated with the chiropractic manipulation. So we can get paid for two pies if we give them the 25 modifier. That 25 modifier tells the payer that the E/M service is not part of the CMT, the chiropractic adjustment and should be paid separately. Another way to say that is the 25 doesn't have to be added if there's no adjustment that day.

If all you do is the exam, don't add the 25. Some people always add the 25. So look at it this way. I want this pie, but I want to get paid for two full pies. I've got a full pecan and or a pumpkin pie. I keep saying apple cause apple's my favorite. And I'm looking forward to Thanksgiving cause I'm going to be all about the apple pie. I don't care for pumpkin as much. I'm sorry for some of you love it. It just doesn't do it for me. The texture's too weird. But let's say you want to get paid for both pies, you need to clearly and distinctly document and show that you did a separate E/M, add the 25 modifier to that E/M code. And then you can get paid 10 bucks for that pie and 10 bucks for your CMT pie.

Okay? The way that I think you can best do that is in these sort of circumstances. I believe that you can justify a periodic reevaluation as a separate and significant E/M. And I bet some of you're sitting here going, "I just did that. I bill it and they deny it. And then I asked them why." And they said, "Well, we never pay for any E/M when it's

an adjustment the same day, we always bundle them." And that is wrong. They shouldn't do that. The guidelines we just saw says that you should be able to pay separately if it's significant and simply identifiable. So I believe you should fight and try to get paid for period reevaluation. But at the end of the day, I recognize you may not win that fight. Payers are just punked sometimes and they just won't pay it, but they should.

The guidelines allow it, and I think it's separately reimbursable and it should be. I believe it's ethical and correct and it's clinically best for your patients. The other more obvious reasons you might add the 25 modifier to an E/M code is when it's a new condition, an exacerbation, or they've been gone for a few months and they return after a lapse care. I believe you can also bill a separate and distinct E/M service when you're releasing the patient and do a discharge exam. So here's a pro tip for you. Document in your record a significant and separately identifiable E/M service was performed and say it was before or after the adjustment. Don't just say, I did a bunch of stuff and there's an exam in there along with my adjustment. Say I did an adjustment, I ended that and I began an exam. Or vice versa, whatever works for how your office flows.

Document that. Even if you want to get really, really picky, say I did an adjustment and I was done with that adjustment at 11:41 AM. At 11:42, I began to do an exam. Make it super crystal clear to someone reading it that that 25 modifier is justified. It is significant, self identifiable. Use those words in your records and I promise you that will increase the odds that they will have to honor the coding rules and pay you separately for that. This whole issue with the 25 modifier, old news been around for decades, been a problem for decades, but seems like payers are bundling them more and more and challenging it more and more because they feel like chiropractors are just inflating their bill trying to get paid for an exam when they're not really doing one or when it's not justified. So justify it, make it clear, get paid for the work you do.

You're clinically, if patients need this, you need this information, you figure out how to take care of them. So do the work and get paid for it. That's what I hope happens to you as a result of this. There's one Blue Cross Blue Shield carrier that says in their policy that you can get paid for a separate E/M code at the same encounter as an adjustment at the initial eval or when there's significant change. Significant change, so document significant change. Check with your Blue Cross carrier, if you're not sure what they say. Or if they keep denying yours, go and look at their guidelines and see if they give you some specificity you can use to your advantage to understand how to properly document and code so that you satisfy their rules. Okay? So those are the coding issues I have brought to share with you.

I explained to you three different ICD-10 changes plus the zombie codes. We talked about Excludes1 and how you need to check and make sure that your codes don't have mutually exclusive limits on them if you're getting denials as a result of that. I talked to you about the GP modifier with your always therapy codes or the 97 CPT codes. United Healthcare is responsible for this and some other carriers have picked it up where if you forget the GP modifier on your 97 codes, you don't get paid. I talked to you about the HCA policy about roller tables and 9702 that doesn't fit.

Roller tables don't qualify as traction according to the authoritative sources out there from the AMA and the ACA. We talked about how the E/M code rules changed a bit, where they added a few more definitions for the 99203s and 99213s, but that isn't really that impactful in chiropractic.

They also added some rules about prolong services. And if you're billing for exams that are more than an hour, you may need to look into that. But I didn't get into that in the presentation. So email me and I'll send you the guidelines if you want. We talked about E/M and bundling with the 25 modifier and how to do that properly. I hope that was helpful to you as a kind of a crash course. I also talked to you about the general statistics about Medicare without CBR that compared to billing report and what average chiropractors are doing around the country in terms of the dollars they're billing to Medicare, how many times they're seeing their patients. So I'm hoping that information was helpful to you as well.

So those are the 2023 coding issues for chiropractic I hope you find helpful. They will make your practices run a little smoother, a little cleaner. And you see on the screen here, this is my email address, reach out to me. If you want to know more about EHR software, I'd love to show you ours. But if you have questions about this presentation, please don't hesitate to reach out to me. I know that where this is going to be posted, I believe that you'll be able to contact NCMIC directly and they can point you to whatever resources, whether it's me or something else that can help you when you have further questions on these great fun topics. So without further ado, let me turn it back over to Mike.

Mike Whitmer:

All right. Thank you, Dr. Gwilliam. Appreciate it very much. Before we go, I have a few housekeeping notes. First of all, let me say that Dr. Gwilliam, I am a bit disappointed to learn that the zombie codes were a joke. I was a little excited about that, but you cleared that up right away.

Dr. Evan Gwilliam:

Sorry I led you along.

Mike Whitmer:

Okay, so just to before we go, a couple reminders about resources for NCMIC. Go out to NCMIC.com, check out the resources section. That's where this webinar is posted. There's a lot of other great information out there. You can also keep track of new resources from NCMIC by following us on social media, on Facebook, Instagram, Twitter, and LinkedIn. Our next webinar is going to be January 17th, so I hope you'll be able to join us for that. And with that, thank you again, Dr. Gwilliam. Appreciate it as always, very much.

Dr. Evan Gwilliam:

You bet, Mike. My pleasure.