



Update

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Affected Programs: BadgerCare Plus, Medicaid
To: Chiropractors, HMOs and Other Managed Care Programs

Changes to Billing Policy for Chiropractic Services

This *ForwardHealth Update* announces changes to billing policy for chiropractic services.

New Billing Policy

Effective for dates of service (DOS) on and after September 1, 2016, ForwardHealth will separately reimburse evaluation and management (E&M) services rendered by chiropractic providers when appropriate and performed on the initial visit of a spell of illness (SOI). ForwardHealth will adjust rates for spinal manipulation to reflect the separate reimbursement of E&M services.

This publication updates the guidance on E&M services and spinal manipulation reimbursement that was provided in the August 2015 *ForwardHealth Update* (2015-40), titled “New Requirements and Clarified Policy for Chiropractic Services.” All other policy related to *Update* 2015-40 remains unchanged.

Procedure Codes for Evaluation and Management Services

Effective for DOS on and after September 1, 2016, E&M *Current Procedural Terminology* (CPT) procedure codes 99201–99203 and 99212–99214 will be separately reimbursable for chiropractic providers when appropriate and performed on the initial visit of an SOI. Providers are expected to submit the correct E&M procedure code based on the level of complexity. While procedure codes 99203 and 99214 are reimbursable, these codes represent higher-complexity visits and would be expected to be submitted only in rare situations.

Note: Reimbursement is not available for extended or comprehensive E&M services (procedure codes 99204–99205 and 99215), for an unlisted E&M service (procedure code 99499), or for an E&M service that does not require the presence of a physician (procedure code 99211).

Claim Submission

One E&M service is reimbursable per SOI; the E&M service must be on the same DOS as the initial visit for a new SOI where the new problem is diagnosed with a new treatment plan developed or the member is referred out to another provider.

An E&M service may be submitted on a claim with the same DOS as a manipulative treatment if it is significantly and separately identifiable, per the National Correct Coding Initiative guidelines. In these situations, the E&M code must be submitted with modifier 25.

To select the appropriate E&M code set for new or established patients, providers should refer to CPT E&M coding guidelines and to policy in the ForwardHealth Online Handbook on the ForwardHealth Portal at www.forwardhealth.wi.gov/. To determine the level of CPT code to use, providers should refer to the federal Centers for Medicare and Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines for Evaluation and Management services and to policy in the Online Handbook.

Documentation

BadgerCare Plus and Wisconsin Medicaid have adopted the federal CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services in combination with BadgerCare Plus and Wisconsin Medicaid policy for E&M services. Providers are required to present documentation upon request indicating which of the guidelines or BadgerCare Plus and Medicaid policies were used for the E&M procedure code that was billed.

The documentation in the member's medical record for each service must justify the level of the E&M code billed. Unless otherwise described in BadgerCare Plus or Wisconsin Medicaid policy, providers should follow CMS documentation guidelines. Providers may access the CMS documentation guidelines on the CMS website. BadgerCare Plus and Medicaid policy information can be found in service-specific areas of the Online Handbook.

Documentation Requirements

Providers are required to meet the following documentation requirements for E&M services:

- The documentation must accurately reflect the service rendered and support the level of service submitted on the claim.
- Providers are required to document the E&M service at the time the service is provided, or as soon as reasonably possible after the service is provided, in order to maintain an accurate medical record. All documentation must be complete prior to submission of the claim. Before a service is reimbursed, the provider is required to meet all recordkeeping requirements, according to Wis. Admin. Code § DHS 106.02(9)(f).
- Providers should only consider medically relevant documentation in determining the appropriate procedure code to bill. The E&M level of service chosen by the provider should not be solely based on the amount of documentation recorded.

As a reminder, all providers who receive reimbursement from Wisconsin Medicaid are required to maintain records that fully document the basis of charges upon which all

claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a).

ForwardHealth recognizes certain corrections or changes to a member's medical record when amended legally to accurately reflect the member's medical history. However, if these corrections or changes appear in the medical record following reimbursement determination, only the original medical record will be considered when determining if the reimbursement of services billed was appropriate.

No documentation iterations or sections of iterations may be destroyed, deleted, whited-out, or rendered illegible. When using a medical electronic health record (EHR) or medical paper record, the provider must be able to generate an unadulterated audit trail that can verify the information and indicate which actions occurred, when they occurred, and by whom. The date, time, member identification, and user identification must be recorded when information within the record is created, modified, or accessed. Paper-based records must redact previous entries by putting a line through the notation and having it initialed and dated by the user.

Pre-loaded Text for Electronic Health Records

When using EHR, it is acceptable for the provider to use pre-loaded text or other pre-generated text as long as the required personal documentation is in a secured (password-protected) system, and the documentation reflects the actual service rendered. For any pre-loaded or other pre-generated text, the documentation must support that the provider verified the information as part of the professional service rendered.

Personal changes to the pre-loaded or pre-generated text made by the provider generally supports that the information has been verified as part of the professional service billed. Phrases that cannot be verified are not acceptable. Examples of non-verifiable types of phrases include the following:

- The complete Review of Systems (ROS) was performed in detail and was negative.
- The 14-point ROS was performed in detail with the member and is negative.

- All other 14 systems are negative.

Furthermore, only medically necessary elements in the pre-loaded or other pre-generated text should be used to determine the level of service reported (i.e., pertinent to the presenting complaint).

The EHR record must be signed by the renderer of the service. Providers can refer to the Policy Requirements for Use of Electronic Signatures on Electronic Health Records topic (topic #16157) of the Documentation chapter of the Provider Enrollment and Ongoing Responsibilities section of the Online Handbook for more information on electronic signatures.

Reimbursement for Spinal Manipulation Procedures

Adjusted rates for spinal manipulation procedures were previously published in *Update* 2015-40. Since E&M services will now be separately reimbursable, effective for DOS on and after September 1, 2016, ForwardHealth will adjust reimbursement rates for spinal manipulation procedures (procedure codes 98940–98942) accordingly.

For reimbursement rates, refer to the maximum allowable fee schedule available on the Portal by clicking the Fee Schedules link in the Providers box on the Portal home page.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

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