Codify
BY AAPC

Eli's Rehab Report

Correct E/M and E-Codes Can Increase Your Reimbursement

Nugget: In some circumstances its appropriate to bill for E/M services as well as a work-related evaluation on the same day.

Coders who bill for workers compensation claims can avoid delays in reimbursement by assigning the appropriate E-code to the patients diagnosis. It is also imperative that they send the accident report with all claims, and use caution when billing for evaluation and management (E/M) services on the same day they bill for workers compensation visits, explains **Sylvia Albert, CPC**, president of the Tidewater AAPC Chapter in Virginia., and a customer support manager at the AcSel Corporation, a healthcare reimbursement consulting firm in Virginia Beach, Va.

Documentation is Key for E-Codes

Coders should always get a first accident report from the patients employer, says Albert. This is required by most workers compensation insurers, whether its a first evaluation, a follow-up visit or surgery. When you submit the claim you would attach your office notes to the accident report. She explains that you can ensure faster payment of your claims by providing as much information as possible to the insurance carrier.

This is where the E-diagnosis codes can help, and most workers compensation carriers insist on their usage. E-codes are the diagnosis codes that HCPCS has designated to indicate the external cause of injury, Albert explains, and are used with injury and poisoning codes to provide information about how the injury occurred, the intent (whether accidental or intentional), and the place where the incident took place.

For example, if a patient suffered a fracture of the shaft of his left femur when an explosion occurred that caused him to fall from the top of a ladder, the diagnosis codes would appear as follows: 821.01 (fracture, shaft of femur); E881.0 (fall from ladder); E921.9 (explosion of unspecified pressure vessel).

Albert reminds billers that E-codes should never be used as the principal diagnosis. Reporting these codes provides additional data for the injury research, she explains. She urges billers to follow the guidelines for reporting E-codes to establish consistency in claims filing, and refers coders to the ICD-9 codebook for a description of the guidelines and a complete list of E-diagnosis codes.

Understanding E/M Services

Coders need to be aware that they cannot bill a standard evaluation and management (E/M) code on the same day they bill for a work-related visit, unless a separate condition is being evaluated. CPT 2000 explains that if other E/M services and/or procedures are performed on the same date as work-related evaluations, the appropriate E/M or procedure code(s) should be reported in addition to codes **CPT 99455** and **CPT 99456** , which are designed specifically to report work-related or medical disability evaluations:

99455 work-related or medical disability
examination by the treating physician that
includes:

completion of a medical history commensurate with the patients condition;
performance of an examination commensurate with the patients condition;
formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;
development of future medical treatment plan;

and completion of necessary documentation/certificates and report

99456 work-related or medical disability
examination by other than the treating physician

Section 2370.2 of the Medicare Carriers Manual uses the following language to outline Medicares policy on paying for separate E/M services during workers compensation services.

D. Charges Included Non-Work Related Items or Services.--If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work related (see 3330.4), Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted, under WC law, to charge an individual or the individuals insurer for services which are not work related.

Therefore, if the physiatrist saw the patient for the work-related ladder accident, but during evaluation he discovered sinusitis, the coder would bill 99455 for the work-related evaluation with the diagnosis codes 821.01, E881.0 and E921.9. Then, on a separate line item, the coder would bill the appropriate E/M code (99201-99215) with the sinusitis diagnosis (473.9).

Billers who charge for separate E/M evaluations during workers compensation visits should be careful to save all documentation, including authorization forms, chart notes, accident reports, dictation, and superbills. And, when billing for any work-related claims, it is important for coders to check all state requirements, since workers compensation insurance differs from group insurance.

State-by-state Regulations

Because the regulations for billing work-related injuries are determined on a state-by-state basis, there are no national standards for coders to follow when processing workers compensation claims. Therefore, its especially important for billers to know their states workers compensation regulations before taking on any patients with work-related injuries or illnesses.

For example, a subscriber in Florida reports that her workers compensation provider does not dictate what codes to use, so she files a 99205 (office or other outpatient visit for the evaluation and management of a new patient) and adds a $100 record-review fee to the charges, since workers compensation reviews take longer than the 99205 allows.

In Kansas, our fee schedule pays about $300 an hour for the workers compensation visit, which covers the history, exam, diagnosis and assessment, says Marie Elder, who bills for three physicians as office manager at Wichita Physical Medicine in Wichita, Kan. After the evaluation, some workers compensation insurers just want to see a rating of impairment or disability [which the doctor assigns], but sometimes they ask us to conduct a re-evaluation. For those, we would still bill the 99455 or 99456 but we would cut down the charges according to the time spent with the patient. For example, if the insurance company pays $300 an hour for the evaluation, we would charge $150 for a 30-minute re-evaluation.

Medicares Workers Compensation Guidelines

Though workers compensation guidelines vary by state, insurance providers such as Medicare, Medicaid and commercial carriers have their own procedures on how to deal with secondary payment for work-related claims. Following are the key points of the Health Care Financing Administrations (HCFAs) workers compensation (WC) guidelines, which can be found in section 2370 of the Medicare Carriers Manual:

Medicare will not pay for any items or services that have been paid or can reasonably be expected to be paid under a WC law of any state (including all American territories).

If the beneficiary fails to take the necessary actions to obtain payment from WC (such as failing to file a claim in a timely manner or furnish all necessary medical information),resulting in a loss of WC benefits, Medicare benefits are not payable.

The WC system was designed to compensate employees for injury or occupational diseases suffered in connection with their employment, whether or not the injury was the fault of the employer.

No Medicare payment will be made if WC has paid an amount equaling or exceeding Medicares reasonable charge; equaling or exceeding the providers charges for Medicares covered services; or any amount that the physician/supplier accepts or is required under the WC law as payment in full.

Medicare determines its secondary payment amount by subtracting the WC payment and all deductibles and coinsurance amounts from Medicares predetermined reasonable charge.

WC payments cannot be applied toward Medicare deductibles.

In the case of automobile or no-fault insurance cases, WC would pay first, the automobile medical or no-fault insurance would pay second, and Medicare would be the residual payer.

In some states, physicians services are covered under WC only if furnished by a physician selected by the employer or WC carrier. In such cases, if the patient chooses to use a physician not approved by the WC provider, Medicare will not pay for the services.