

Basics on Health Insurance Billing Codes & The New 2005 CPT Codes for Acupuncture

This article has basic information on insurance billing codes and the new CPT codes for acupuncture.

For more information on other insurance billing topics, see the article "Healthcare Providers and Fees" on the OAA website for information on legalities of pricing your fees, Time of Service discounts, etc. See the article "Evaluation & Management Codes and How to Use Them" in the fall issue of the OAA News, also on the OAA website. See more info on AAOM's website: www.aaom.org

The OAA worked with Peter Martin, LAc, to produce this article. A big "thanks" goes to him. For years he has worked on insurance billing matters to improve our position in the healthcare system. His "Insurance 101" article (OAA News, 1997) has served as a beneficial source of information for Oregon LAc's. Thanks as well to Teresa Bresnan, who also generously shared her knowledge on billing information with the OAA and the community. The OAA strives to obtain the most accurate information in its articles. Our articles are not legal advice, however, and an attorney should be consulted about that type of information. Any comments or corrections on this article are welcome.

ICD and CPT Codes - The Two Common Sets of Billing Codes

Practitioners use "codes" when billing insurance companies. These are specific numbers that indicate what is being billed. There are two common sets of codes, the ICD diagnostic codes and the CPT procedural codes. These are the standard codes used when reporting health care services. They are placed on the CMS 1500 (HCFA) form used to bill institutional payers. CPT is the only HIPPA compliant procedural code set. Other sets of codes are used in the industry, but are much less common. In addition, if you have a contract with a healthcare plan, they may have their own definitions of codes that must be used when you bill them.

ICD Codes

The ICD codes are published in the International Classification of Diseases, 9th Revision (ICD-9). They are diagnostic codes that identify the medical condition that you are treating. For example, the ICD code for neck pain is 723.1, and for low back pain is 724.2. Oregon's rules restrict Licensed Acupuncturists from diagnosing in biomedical terms. Still, the ICD-9 contains many codes that are not oriented to a biomedical diagnosis, and identify the patient's complaint, making them well within the Oregon limits for LAc's. If you have a referral with a diagnosis and treatment plan from the primary care physician, so much the better. For example, your patient may say they have wrist pain from carpal tunnel syndrome. When billing, most LAc's choose the code that identifies the patient's complaint of wrist pain, which is 719.43. If you have documentation of the diagnosis from the physician, then it seems reasonable to use the ICD code for carpal tunnel syndrome, 354.0.

CPT Codes

The second set of codes is the CPT (Current Procedural Terminology) codes, which define the specific therapeutic procedures (or services) that the provider has done for the patient. They are 5-number codes and are published annually in the CPT manual by the AMA (American Medical Association). These codes are proprietary information of the AMA. When they change the codes or create new ones, the AMA does a random survey of appropriate practitioners and receives input from representatives from the community. But, these individuals do not have a vote in the decision. Also, since the information on codes is copyrighted, individuals actually working on the codes have to keep work in progress confidential until the new CPT manual is published.

New Acupuncture CPT Codes Begin Jan. 1, 2005

We used to have two CPT codes for acupuncture treatments, 97780 for acupuncture, and 97781 for electro-acupuncture. They were retired on December 31, 2004. Beginning January 1, 2005, the new CPT codes for acupuncture replaced the old ones for services given on or after Jan. 1, 2005.

Please note that if you are billing for a contracted company, like Alternare, you need to follow the codes set up by that company.

The Four New Acupuncture CPT Codes:

See the CPT 2005 book for the complete list of all the codes, although it does not offer any more information on the codes than what is listed here. OAA members may come to the office and look at our copy of the CPT book.

97810 Acupuncture, (without electrical stimulation) with the insertion of one or more needles, and for the initial 15 minutes of personal one-on-one contact with the patient.

97811 Acupuncture, (without electrical stimulation,) with the re-insertion* of one or more needles, and for each additional 15 minutes of personal one-to-one contact with the patient.

97813 ** Acupuncture, (with electrical stimulation), with the insertion of one or more needles, and for the initial 15 minutes of personal one-on-one contact with the patient.

97814 ** Acupuncture, (with electrical stimulation), with the re-insertion* of one or more needles, and for each additional 15 minutes of personal one-on-one contact with the patient.

* "Re-insertion of needles" doesn't mean inserting the used needle/s again. It means that the practitioner treats a second group of acupuncture points, i.e. practitioner repeats the process of washing hands, positioning the patient, cleaning the skin, inserting sterile needles, etc. When documenting this 2nd group of needle/s, your chart notes must clearly illustrate that this was a separate insertion.

**** "Mixing" Codes"**

The CPT book didn't allow practitioners to bill a mixture of acupuncture and electro-acupuncture on the same visit. They did this in an effort to prevent practitioners from charging for inserting the acupuncture needles and then charging a second code for attaching the electrodes to those same needles for the EAC. The AMA has since clarified this issue. If you perform electro-acupuncture (EAC) in the first stage of a treatment (97813,) and plain acupuncture on another (97811,) then you *can* bill 97813 (EAC, 1st increment) and 97811 (acupuncture 2nd increment.) See AMA's update for a complete description at:

http://www.medicalacupuncture.org/events/cpt_codes.html. Note that some insurance companies don't have this updated clarification and you may need to send this to them.

See below for more information.

Applying CPT Codes to Your Acupuncture Practice

The new CPT codes for acupuncture are based on the amount of time spent with the patient. They are not like the old ones where one code equaled one treatment given. Practitioners, even those who only produce "super-bills" or use a billing service, will still need to learn about these new codes and revamp their fee schedules. Depending on your style of practice, you may run into difficulties with formulating your fees. Additionally, LACs are still faced with the fact that CPT codes do not cover some of our procedures, like cupping and guasha for example.

OAA has in the past given several presentations around the state by BCBS to educate LACs about the new codes. Remember that although one can address what is appropriate billing, actual rates should not be discussed between practitioners because this could be considered "price-fixing".

RVU – The Relative Value Unit for Each CPT Code

Each CPT procedural code has a value assigned to it, called a Relative Value Unit (RVU). The RVU for each CPT code gives a measurement of what each procedure is worth compared to other procedures. The number of "units" defines the "value" which is "relative" to other procedures, including virtually everything from massage therapy to gallbladder surgery. The Reimbursement Update Committee (RUC) of the AMA/CPT determines the RVUs. CMS (the Federal Government's "Center for Medicare and Medicaid Services", also referred to just as "Medicare") publishes these values in the Congressional Record for services that are Medicare/Medicaid reimbursable. Insurance companies as well as CMS use the RVU to determine what is paid for each procedure. This is done through the use of a conversion factor.

The Conversion Factor

CMS and the insurance companies establish conversion factors that are adjusted to the economic level of every region of the country. The conversion factor is a dollar amount that is multiplied by the RVU of the CPT procedure code, in order to calculate how much reimbursement is given for each procedure: *Conversion factor x RVU = Amount of reimbursement*. If you charge an insurance company more than their calculated amount of reimbursement, then they will only pay you their calculated amount. If you charge an insurance company less than their calculated amount, they will reimburse you for your lower amount.

Setting Up Your Fees

The new codes are based on the time with the patient, and your charting needs to generally reflect this. Each practitioner sets up their own fees according to what he/she decides their services are worth, based on business expenses, anticipated earnings, etc. Charges are not to be based on “what can I get from the insurance company”, on what colleagues charge, conversion factors, RVUs, etc.

Time of Service Reductions for Payment

See our article on “Healthcare Providers and Pricing Fees”.

These matters are determined by each state. Unfortunately, the law may not have specific wording on these issues. Instead, one must go by “impressions” from attorneys that they have formed from looking at past cases. In Oregon (as in most states) providers must charge everyone the same fees. It appears that in Oregon providers can accept different amounts for payment as long as the different amounts are reasonable, defensible, consistent, and made public to your clients. Read our article mentioned above for details.

E & M Services and Pre-, Intra- & Post-Service

If you are not familiar with E&M codes, you’ll need to read our article on these codes in the fall 2004 issue of the OAA News, or view the article on our website, www.oregonacupuncture.org. Note: “E&M” is also known as “office visit”.

“Evaluation and Management”, or E&M, services refers to the work done by the practitioner in performing these tasks: obtaining the patient’s subjective report, formulating the practitioner’s objective observations, a brief assessment and plan (i.e. SOAP), giving instructions to the patient, and doing the documentation (chart notes).

Pre-service and post-service is the work done just before and after the procedure or service is administered. Each of the 4 codes for acupuncture includes three minutes of pre-service work and three minutes of post-service work. The work done during that time is considered “Evaluation and Management” service. Thus, billing for 97810 (insertion of one group of acupuncture needles) would account for 6 minutes of time spent on E&M tasks. If 2 groups of needles are inserted, there are 12 minutes included in the 2 codes for the E&M service. If the practitioner needs substantially more than those 6 or 12 minutes, one can charge separately for the additional E&M services, but the code used must be modified by adding the –25 modifier, i.e. 99211-25. Read the CPT manual.

Intra-service is the procedure or service itself and activities that are part of the service. For LACs this would include positioning the patient, washing your hands, locating and sterilizing the points, inserting and stimulating the needles, removing needles, etc. Infrequently, intra-service could include being with the patient for distal point treatment accompanied by movement of the affected area, or monitoring a patient for nausea or light-headedness. For the new CPT codes, 15 minutes of personal one-on-one contact time with the patient is allowed for intra-service time for each group of needles that are inserted. One is not required to spend 15 minutes with the patient. On the other hand, it appears that if the practitioner exceeds the 15 minutes with the patient for one group of needles, there is no additional reimbursement. This time does not include the time when the patient is simply on the table with the needles in place.

How Often Is It Appropriate to Charge for E & M Services?

Opinions on the frequency of billing E&M vary within the acupuncture community. Most insurance companies (including Regence Blue Cross Blue Shield of Oregon) have a policy that applies to all providers, which is to only reimburse for E&M services for three situations:

- 1) on the first visit,
- 2) periodically when a re-evaluation or a new treatment plan is done (typically done every 4-6 weeks), or
- 3) when the patient presents with a new problem that the practitioner must evaluate and plan treatment for.

In case #3 your CMS 1500 (HCFA) billing form is required to have:

- a) the new diagnosis code indicating the new problem, and
- b) an appropriate E&M code for an established patient (99211-99215) with the modifier “-25” added to it. See above.

The general idea is that the practitioner evaluates the problem and makes a plan for a certain course of treatments like acupuncture, PT, etc. The patient receives those treatments, and then returns to the practitioner for evaluation and adjustment of the treatment plan. Some LACs only charge for E&M services in situations #1-3. Whatever method you select, remember to make your policy reasonable, defensible, consistent, and public. See the article on “Healthcare Providers and Pricing Fees”.

Documentation (Chart Notes) – Very Important!

"If you didn't chart it, then you didn't do it." This is the saying used in the healthcare field to emphasize that everything the practitioner does or says must be charted in order to validate that it occurred. With the new CPT codes, be sure to clearly document each group of needle insertions. Although no one will be monitoring you with a stopwatch, you may want to include in your notes the time you inserted each group of needles.

Document the SOAP information as usual. SOAP stands for:

- Subjective - what the patient's reports,
- Objective - your observations,
- Assessment - your diagnosis
- Plan - what you do to treat the diagnosis.

Include all the information encompassed by the E&M tasks (as above.) If you charge separately for an additional E & M service (CPT codes 99201-05 or 99211-15), then be sure to do two things:

- First, substantiate that the level of E&M service charged for was medically necessary in your chart notes.
- Secondly, document in your notes that you fulfilled all the specific requirements of that level of E&M services as written in the CPT manual.

If you bill for services or procedures that were not documented, not necessary, or not substantiated, the insurance company may inquire about the case and investigate the situation.

Remember the basics of healthcare pricing: your charges must be reasonable, defensible, consistent, and made public to your patients.

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