

Increased Revenue To Your Practice Through Enhanced Patient Care

The provided CPT billing codes are meant as a guideline for potential billing to insurance companies for services rendered. With constant changes being made to CPT billing codes Danard Lilly Corporation does not guarantee that the below CPT codes are valid for all or any given situation in the utilization of Danard Lilly Corporation's Computerized Pain Assessment. It is suggested that CPT billing codes be verified with insurance providers prior to use to insure that they're correct to meet your office or facilities particular requirement.

CPT Guidelines indicate your office may bill for the following procedure codes. CPT code verification is recommended prior to billing submission.

96150 Health and behavioral assessment (health focused clinical interview, behavioral observations, psycho physiological monitoring, health orientated questionnaires).

INITIAL (NEW PATIENT) EVALUATION AND MANAGEMENT (E&M)

99205 E&M of New Patient: An comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Frequency: Code 99205 is to be used once per patient to represent an initial assessment.

99212 E&M of Est. Patient: An expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

99213 E&M of Est. Patient: An detailed problem focused history, a detailed problem focused examination, and medical decision making of low complexity.

99215 E&M of Est. Patient: An comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Frequency: Codes 99215 can be used each time a new complete assessment is made. This typically takes place every 4-8 weeks.

Note: Only use these codes for Commercial Insurance Carriers. Medicare does not accept these codes from Chiropractors.

The E/M service may be separately identified using a code appropriate for the level of service provided if the service is: significant (i.e., a service that has components that warrant identification with some level of E/M) and separately identifiable (i.e., a service that contains components performed separately from, or not included as part of some other service).

If the patient goes back another day to receive the results (level-two evaluation) of the assessment, results (meeting key component requirements for a level-two visit), the code 99212, or 99213 should be used to identify the service provided.

A Pain Assessment administered every 6-8 weeks for treatment analysis may be administered for comparison and documentation of change. Up to four Pain Assessments can be used in the Pain Assessment Comparison reports.