

# **E/M and CMT:**

## **A Toolkit to Help Chiropractors Get Paid for Both**

By Evan M. Gwilliam, DC MBA QCC CPC CCPC CPMA CPCO AAPC Fellow  
Senior Vice President, Practisync

### **Contents**

|                                                                                    |    |
|------------------------------------------------------------------------------------|----|
| Background .....                                                                   | 2  |
| CMT Components .....                                                               | 2  |
| Pre-Service .....                                                                  | 2  |
| Intra-Service .....                                                                | 2  |
| Post-Service.....                                                                  | 2  |
| When is an E/M Appropriate? .....                                                  | 3  |
| NCCI and the 25 Modifier.....                                                      | 5  |
| Tips for Countering Inappropriate E/M Denials.....                                 | 5  |
| Tip #1: Tell the story on the claim form.....                                      | 5  |
| Tip #2: Consider Reporting External Cause ICD-10 Codes with E/M .....              | 6  |
| Tip #3: Consider Reporting Health Status ICD-10 Codes with E/M.....                | 7  |
| Tip #4: Evaluate conditions in addition to segmental dysfunction .....             | 8  |
| Tip #5: Create an E/M note separate from the CMT note .....                        | 9  |
| Tip #6: Record the Start and Stop Time of the E/M .....                            | 10 |
| Tip #7: Just Perform the E/M a Different Day (when the other tips don't help)..... | 10 |
| Medical Necessity is the Overarching Criteria.....                                 | 11 |
| Final Thoughts.....                                                                | 11 |
| References: .....                                                                  | 12 |

# Background

Reimbursement from third parties relies upon the use of CPT, or Current Procedural Terminology, codes that are published (and copyrighted) by the American Medical Association and mandated for use on health care transactions in the United States by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. Chiropractic manipulative treatment (CMT) codes are the bread and butter of most chiropractic practices, but it is often challenging to get paid for evaluation and management (E/M) services when billed on the same day as a CMT.

In this guide, you will find the information you need to understand and the methods you should follow to help improve your chances to overcome this common obstacle in chiropractic practice.

If you would like guidance on how to support different levels of E/M codes, including documenting time and/or medical decision making, see the four-part series at [practisync.com](https://practisync.com).

## CMT Components

Most major carriers follow CPT guideline requirements. For example, the following description from Blue Cross Blue Shield of Illinois<sup>1</sup> is consistent with the guidance most payers offer on what is included when a provider bills a CMT service.

### Pre-Service

- A brief evaluation of the member's medical record documentation and chart review,
- imaging review,
- test interpretation and care planning

### Intra-Service

- Treatment applied,
- Pre-manipulation (e.g., palpation, etc.),
- Manipulation,
- Post-manipulation (e.g., assessment, etc.)

### Post-Service

- Chart entry and documentation, including
  - subjective,
  - objective,
  - assessment,

- plan consultation reporting

Medicare, arguably the documentation gold standard for the insurance industry, provides an outline for the evaluation which establishes that a patient would benefit from chiropractic manipulative treatment. Per CMS, the condition that justifies the need for CMT is reported with ICD-10-CM codes in the M99.0- subcategory which indicate segmental dysfunction (a.k.a. subluxation). The physical examination, known by the acronym “P.A.R.T.”, to support these diagnoses, includes the following:

1. **Pain**/tenderness evaluated in terms of location, quality, and intensity;
2. **Asymmetry**/misalignment identified on a sectional or segmental level;
3. **Range** of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
4. **Tissue**, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

The guidelines note that two of the four criteria (one of which must be asymmetry/ misalignment or range of motion abnormality) are required.<sup>6</sup>

In other words, all this evaluation work might be included in payment for CMT and wouldn't count towards any other code billed at the same encounter, such as an evaluation and management (E/M) code for a re-exam. The documentation related to E/M services include similar information, making it challenging to determine where the separation is.

The purpose of this guide is to define what makes an E/M code distinct from CMT.

## When is an E/M Appropriate?

Regardless of payer policies, the chiropractic standard of care requires periodic re-exams beyond the routine work associated with chiropractic manipulative treatment. This is supported by several evidence-based guidelines<sup>4,5</sup> which recommend evaluations that are performed at the end of relatively brief trial periods of care (i.e., 6-12 visits), to determine if another trial period is warranted.

These evaluations are not conducted at each CMT service, but rather after carrying out prescribed care for a period of time and then making a new decision to determine if another trial, or phase of care would be beneficial, based upon the determinations made from an updated

evaluation. The guidelines suggest that patients should be evaluated periodically to monitor progress to ensure the best outcomes.

Blue Cross Blue Shield of Illinois<sup>1</sup> provides guidance for when E/M can be billed along with CMT (in agreement with CPT coding guidelines):

“Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations.”

It is the “periodic re-evaluations” as separately billable services that are often the subject of debate. Some reviewers suggest that re-exams, in the absence of new complaints or significant changes to the patient’s condition, are never payable at the same encounter as CMT. Providers may be bound by contract, so it is wise to become familiar with specific guidance from each contracted payer.

This guideline from a large payer network<sup>9</sup> also supports that it is necessary to perform evaluations after a *trial* of care, to measure progress:

“A reevaluation is considered medically necessary following a trial of care to determine whether that care resulted in significant clinical improvement documenting the need to continue a course of therapy, if modification of the approach to care is warranted, if there is need for referral to other healthcare practitioner(s)/specialist(s), or that discontinuance of treatment is warranted.”

One take-away from this might be for a provider to document the care plan with each phase of care identified as a “trial of care” and explicitly state that the decision for further care is entirely dependent on the results of a re-evaluation, consistent with evidence-based, and payer-specific clinical practice guidelines.

Blue Cross Blue Shield of Kansas City<sup>2</sup> tells us that:

“An additional evaluation and management code may only be submitted if the patient’s condition requires a significant, separately identifiable E/M service, beyond the usual pre-service, intra-service and post service work associated with the procedure.”

This begs the question, what is “significant and separately identifiable” and beyond the usual work associated with CMT?

## NCCI and the 25 Modifier

The National Correct Coding Initiative (NCCI) is a database with edits (i.e., the automatic application of payment policies to submitted claims) and guidelines developed by the Centers for Medicare & Medicaid Services (CMS) to promote proper coding and prevent improper payments for services. Most private payers rely on these NCCI edits to process claims. Among other things, they identify code pairs that are considered bundled services, meaning one code is inherently included in the other, and should not be billed separately. The NCCI database places a superscript of “1” on the E/M codes when paired with CMT, which means that, even though E/M is sometimes included in CMT, an appropriate modifier may be used to override the edit, allowing both procedures to be billed and potentially reimbursed under specific, documented circumstances.<sup>8</sup>

The appropriate modifier is 25, and, when added to the E/M service, it lets the payer know that it is “significant” and “separately identifiable” from the service into which it is normally bundled. A key to getting paid for an E/M when performing a re-exam on the same day as a CMT is to make it crystal clear that the service is both “significant” and “separately identifiable.” The provider would be wise to explicitly state in the record that the E/M is “significant and separately identifiable” just to make sure it is spelled out for any reviewer. However, records must include detailed documentation to support that statement.

Unfortunately, many payers ignore the 25 modifier or override its application and continue to bundle E/M codes with CMT codes, even when the services are legitimate and in the patient’s best interest.

## Tips for Countering Inappropriate E/M Denials

Given the background information outlined above, the remainder of this guide is a list of tips that should decrease denial rates for E/M services performed on the same day as CMT. While reimbursement cannot be guaranteed, the more tips that are followed, the less ammunition a reviewer will have to justify a denial. There are three categories for these tips.

- Tips 1-3 are for the claim form (diagnosis pointing)
- Tips 4-6 are for the documentation (which supports the claim form)
- Tip 7 is the last resort

### Tip #1: Tell the story on the claim form

To reduce the likelihood of a documentation review by the payer and tell more of the patient’s story right on the CMS-1500 claim form, utilize the diagnosis pointer in box 24E. The CPT

guidelines tell us that a different condition or symptom is not required, so the same diagnosis could be used to support both the E/M and CMT codes. However, if the M99.0- diagnosis is reserved for the CMT only, and the E/M is linked to another condition that is being managed, this sends a clear message that the two services do not overlap. Note this guidance from Moda,<sup>3</sup> a payer network in Oregon:

“E/M of a different problem/issue not addressed or treated by the procedure would be eligible for consideration of modifier 25.”

The “procedure” mentioned in this guidance is CMT. Other conditions, such as degeneration or muscle strains, could be used as the diagnosis pointers for the E/M code. These other conditions could be outlined in the separate E/M note (explained below) as rationale for non-CMT services such as therapeutic exercises or electrical stimulation, rather than as rationale for CMT. Note this additional guidance:<sup>3</sup>

“RVU for the (CMT) procedure includes reimbursement for the assessment of the problem, determining that the procedure is necessary, evaluating whether the procedure is appropriate and the patient is a good candidate, discussing the risks and benefits, and obtaining informed consent, as well as performing the procedure. To support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure.”

In other words, the diagnoses on the claim form can show that the evaluation goes beyond what is related to chiropractic manipulative treatment (CMT.) The next two tips are ways to use some lesser known, but very descriptive, ICD-10 codes to help tell a more complete story. They won’t apply in all situations, but there are times when they can strengthen the case and increase the chances of being paid for an E/M that is significant and separately identifiable from the evaluation portion of the CMT.

## Tip #2: Consider Reporting External Cause ICD-10 Codes with E/M

Some ICD-10 codes are informational, and, while they don’t identify a condition, they help convey information to assist in the adjudication of a claim. Chapter 20 of ICD-10 contains external cause codes that explain the circumstances or location of an incident. According to the guidelines, they are optional and should be reported last on the CMS-1500 claim form.<sup>11</sup> They would not be linked to the CMT service in 24E on the claim form if the purpose is to show that the E/M is unrelated.

Example 1: Suppose a patient exacerbated a condition while pruning trees, therefore prompting an exam above and beyond the usual pre- and post-service work related to a routine CMT. The E/M service (and not the CMT service) could be linked to:

**Y93.H2** - *Activity, gardening and landscaping*  
*Activity, pruning, trimming shrubs, weeding*

Example 2: There is a whole sub-group of external cause codes dedicated to providing details of accidents related to transportation. They all start with the letter V, and those in the range from V40 to V49 cover car occupants injured in a transport accident, which might be considered relevant to conditions often treated in a chiropractic setting, such as:

**V43.51XA** - *Car driver injured in collision with sport utility vehicle in traffic accident, initial encounter*

These kinds of ICD-10 codes, if linked directly to the E/M code in box 24E on the CMS-1500 form, can explain clearly why an exam was warranted, even if a CMT was offered that same day. However, these codes may not relate to a periodic re-exam, but rather a circumstance where the exam is prompted by a new injury or incident.

**Important:** note that it is possible that accident-related codes could trigger a questionnaire to be sent to the patient to determine if another party might be financially responsible, which could delay payment.

### Tip #3: Consider Reporting Health Status ICD-10 Codes with E/M

Z codes from Chapter 21 in ICD-10-CM represent reasons for encounters. They can directly convey the purpose of an exam. For example, to report a periodic re-exam at the end of a phase or trial period of care, consider:

**Z09** - *Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm*

This code might be linked to both the CMT and the E/M, and useful if trying to convey that the 2-to-4-week trial of care might have concluded, and you need more information to decide if the second phase you anticipated might be medically necessary. In other words, this might be used when performing a periodic re-exam related to CMT, but note that a payer may interpret the use of Z09 to indicate that you believe that treatment is “complete”, so the decision making should be clearly documented if further care is expected.

Another Z code possibility is:

**Z76.89 - Persons encountering health services in other specified circumstances**  
*Persons encountering health services NOS*

ICD-10 guidelines explain that “other specified” or “NOS” are included in code descriptions when a patient's condition is documented and understood, but there isn't a more specific ICD-10 code available for it.<sup>11</sup> Since the code doesn't provide any detailed explanation, the provider is essentially using the code to signal to a reviewer that the record contains sufficient information to justify the exam. Therefore, this code's use might be an invitation for a documentation review, which should reference the clinical necessity for a periodic re-evaluation after a trial period of care. Conversely, its use may be a clear demonstration that the notes contain information about the distinct and separate E/M, thereby warding off additional review.

The claim form is the first line of communication and therefore should be leveraged to get information to the payer that helps them to properly adjudicate the claim. However, the information from the claim form is only as good as the documentation that it relies upon. If a denial of legitimate services still follows the claim that includes proper diagnosis pointing, then the provider may need to appeal and provide documentation to show more clearly that the E/M is justified and supported.

#### **Tip #4: Evaluate conditions in addition to segmental dysfunction**

The P.A.R.T. exam, outlined above, supports the segmental dysfunction, M99.0-, diagnosis. Per CMS, the M99.0- diagnosis justifies the performance of CMT; therefore, it may be concluded that any evaluation procedures beyond P.A.R.T. could qualify as “significant” from the pre-service work that is included in CMT. Examples might include:

- Performing a blood pressure check at a re-exam in a patient with low back pain. Low back pain is known to contribute to high blood pressure, and this evaluation has no connection to M99.0-, and hence CMT.
- Performing the O'Donoghue test to help support a diagnosis of sprain or strain. These conditions are not associated with CMT, and in fact, might be considered contraindications to manipulation. The O'Donoghue test is not listed as an element of P.A.R.T. and therefore can be considered significant.

Any objective tests, such as orthopedic, neurologic, or vital signs that are performed to monitor the patient or evaluate conditions related to non-CMT services could be considered beyond the usual work associated with the CMT.

Differential diagnoses that are evaluated are also not included in the pre-service evaluation or P.A.R.T. exam, so be sure to clearly document work and conclusions associated with differentials, which show clinical due diligence. Note that differential diagnoses, which, by definition, are not certain, would not be listed on the claim form, per ICD-10 guidelines.<sup>11</sup> They should instead be discussed in the separate E/M note, as explained below.

## Tip #5: Create an E/M note separate from the CMT note

Medicare guidance on the 25 modifier from Novitas says:

“A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.”<sup>10</sup>

Simply put, the E/M service is supported if the documentation is there, so it behooves a provider to become familiar with E/M guidelines, and make sure it is obvious that the record aligns with them. This is similar to Blue Cross Blue Shield of Illinois guidance:

“To bill for an evaluation and management service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the member that day.”<sup>1</sup>

This could be interpreted to mean that the 25 modifier is justified if E/M documentation is complete and easy to find, but not mixed in with documentation for anything else, such as the pre- and post-service work tied to the CMT.

Moda<sup>3</sup>, a group out of Oregon, gives a perspective on how other payers might view these requirements.

“The documentation of the procedure and the documentation of the significant, separately identifiable E/M service must be clearly separate and distinct in the medical record to fulfill the requirements of “separately identifiable.” If both services are mixed in a single visit entry without any separation (e.g., under a sub-heading) to identify the separate and distinct nature of the services, then the requirement for a ‘separately identifiable’ service has not been met.”

To show that the E/M is separately identifiable, it could go under its own subheading, with no overlapping documentation for other procedures performed the same day. “P.A.R.T.” would not be included in the exam section, nor would the description of the CMT procedure. In fact, this would be even clearer if the E/M work was documented in a separate note, on a new page.

The plan section of the exam note could discuss goals and procedures other than the CMT. In the CMT note, other modalities or therapies would not be addressed; rather the plan in that separate note might just be an outline for the location and schedule for the CMT service.

## Tip #6: Record the Start and Stop Time of the E/M

Clearly indicating the start and stop time in the record is not required by the E/M guidelines but would make the service much more clearly “separately identifiable.” If the CMT service occupies a different time period than the E/M service, then a payer can’t (as easily) make the case that they overlap. Use your best clinical judgment to decide which service should happen first. The record might read as follows:

*“The CMT service began at 12:27PM and concluded at 12:32PM and the evaluation and management service began at 12:33PM and concluded at 12:48PM.”*

This also supports time-based E/M level selection as an alternative to medical decision-making. A complete discussion on how to select an E/M code based on time, and how to support it properly with defensible documentation can be found here: [practisync.com](https://practisync.com)

Following the above six tips creates a claim and documentation that are very defensible. Using only one or two tips may not bring the desired result, so providers are strongly encouraged to employ ALL of these strategies before resorting to tip #7, the last resort.

## Tip #7: Just Perform the E/M a Different Day (when the other tips don’t help)

CMT and E/M services can’t be bundled if they are performed at separate encounters on separate days. However, this can be challenged from an ethical perspective if this arrangement delays care and/or causes unnecessary inconvenience to the patient.

One might argue that financial incentives drove the decision over what might be in the best interests of the patient, so it is important to outline within the clinic’s standard operating procedures that that is not the case. This approach might be more defensible if a clinic creates a signed financial intake form that states that they perform exams on separate days due to the limitations placed on them by the patient’s health plan, and performing the exams are the standard of care.

# Medical Necessity is the Overarching Criteria

Note that, no matter how many of these tips you use, or how long the note is, or any other information you include, the overarching factor is still medical necessity. Billing for an E/M for no reason other than to seek reimbursement is unethical. Medicare<sup>7</sup> (who doesn't reimburse chiropractors for E/M service, but still has a lot to say about them) says:

“A service's medical necessity is the main criterion for payment besides the individual requirements of a CPT code.”

Checking everything off of the summary list below is meaningless if the service is not considered medically necessary.

## Final Thoughts

Use this checklist to increase the odds of getting paid for an E/M at a re-exam when CMT is also performed:

### Claim form tips

1. Link the E/M through proper diagnosis pointing to a condition other than M99.0-, save that code for CMT only;
2. Link the E/M to an external cause code, if relevant;
3. Link the E/M to a health status code, such as Z09, if relevant;

### Documentation tips

4. Document non-CMT elements such as blood pressure, ortho/neuros, differential diagnoses, and plans for non-CMT services in the E/M record;
5. Create distinctly separate notes for the E/M service and CMT service;
6. Perform and document the E/M in a different time block than the CMT;

### Bonus documentation tips:

7. Explicitly state in the record that the exam is “significant and separately identifiable”;
8. Document any new condition or exacerbation if present;
9. In the care plan, describe phases of care as “trial of care” periods to emphasize the need for periodic re-exams to measure progress.

**Disclaimer:** These factors increase the defensibility of a separately payable E/M at the same encounter as a CMT but, of course, cannot guarantee that the payer or reviewer will agree. However, employing these processes bolsters both patient outcomes as well as the profession by increasing the likelihood you will receive fair reimbursement for your adherence to the regulatory standard of care.

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*Dr. Gwilliam is the Senior Vice President of Practisync, which helps practices improve efficiency and collect more through outsourced expert billing services with very competitive rates. If you would like to see if Practisync could be a good fit, reach out to Dr. Gwilliam at [evan.gwilliam@practisync.com](mailto:evan.gwilliam@practisync.com) or visit the website for more details.*

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