

Common Coding Mistakes

5 Common Chiropractic Coding & Billing Mistakes to Avoid

By Tom Necela

Everyone knows denials and documentation requests reduce the value of your chiropractic claim and frustrate your billing department. To get paid on time and in full, be sure you avoid the following common errors in your chiropractic coding and billing:

1. Modifier Failures. Depending on which procedure code you use, a modifier may be appropriate. In Medicare, for example, you need to indicate whether the service represents Active Treatment (using the modifier -AT) or it will not be paid. Similarly, performing Manual Therapy (97140) on the same visit as an adjustment will also require a modifier to be present to signify that it was a separate and distinct service (Modifier -59).

2. Stagnant Adjustment Codes. Billing for a 5 region adjustment (98942) on every visit just because you are a full spine doctor will not sit well with most insurance companies. From the viewpoint of the insurance company, it is statistically improbable that every one of your patients needs an adjustment from top to bottom every visit.

3. Routine Use of Full Spine X-rays. This is another easy red flag for an insurance company to spot and it follows the same logic as the previous entry. If other practitioners all take x-rays in a wide variety of anatomical regions, but every one of your x-rays is a full spine series, then you suddenly stand out from the rest of the pack and are essentially inviting an auditor to investigate your billing and coding practices.

4. Billing for an E/M Code on a Daily Basis. Some shady chiropractic

"coaches" and practice management gurus advise their clients to increase services through the repeated, routine (or even daily). Unfortunately, anyone with a knowledge of proper coding practices will tell you that this is not warranted and will just lead to big trouble when the insurance company catches on.

5. Billing for all New Patients With a High Level E/M Code. Certainly, high level E/M codes such as 99204 or 99205 reimburse the most. But there are probably few (if any, in certain chiropractic offices) times when an exam truly meets the criteria of these codes. To simply bill these codes in hopes that it will fly under the radar is foolish and misguided at the least and possibly fraudulent as well.

Hopefully, this "red flag list" will serve as a reminder of some of the poor practices that will get you audited by a third party payer. If you are a chiropractic office that is actually utilizing one of the above billing or coding practices in your office, let this article be a warning that your current procedures have you headed for trouble. My advice would be to correct any of the actions necessary immediately and/or get experienced help quickly. There are many ways to get paid for your services through proper chiropractic billing, coding and documentation; utilizing some of the above methods will only get you in trouble over time.

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Avoiding common coding mistakes

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Following are some examples of coding and documentation errors found in real charts in real physician offices. Although the errors were not intentional, the fines and penalties that could be assessed are very real.

No one especially enjoys being proven wrong, but most physicians are pleased when a trusted adviser-not the Office of the Inspector General or an insurance company-can deliver a proactive message. By obtaining the expert advice of a certified coder, some logic and order can be interjected into what is often a confusing and frustrating activity.

Get the Easy Stuff Right

There are fundamental rules for coding and documentation that each practice should follow, and although these basic rules are brought to the attention of physicians at many different venues, the same mistakes keep showing up in patient charts. Here are some

examples that are easily correctable:

Choosing an evaluation and management (E&M) code based on time intervals or diagnosis selection. In many cases, these methods are both incorrect. E&M code assignment is based on three components: history, examination, and medical decision-making. The combination of the three documentation elements drives the code that is used. As an exception, and if accurately documented, time can be used to pick a code, but should not be used as the default.

Billing for a service that is not documented. If the service does not appear in the provider notes, it cannot be billed. If a urinalysis is included on the bill, it must be documented in the notation for the day.

Encounters that cannot stand alone. Each encounter must tell the complete story. An auditor looks only at the date of service they are auditing. Information provided in prior encounters cannot be considered unless referenced by date in the encounter being audited.

Handwriting that does not match. The handwriting that documents the exam, medical decision-making and treatment plan must match the physician's handwriting.

other areas of the chart. Ancillary staff may or may not document the history portion of an encounter. A scribe may be used, but the use of one must be appropriately documented.

Confusing verbiage about the type of patient visit. If the note states "new pt ref by Dr. Smith," should the visit be billed as a new patient visit or as a consultation? As this is a common area of confusion, it should be made crystal clear what type of service is being provided. Another area of confusion is whether it is a new patient or an established patient. Many notes do not state that the patient is new to the practice and, in this event, an insurer may change the code to an established patient code during an audit.

Coding signs and symptoms. A record declaring that the patient has cancer after presenting for a lump in the eyelid must include results of lab tests. A diagnosis cannot be assigned before it has been confirmed. "Rule out," "probably," and "suspected diagnosis" should never be coded. When not sure of the diagnosis, codes should be chosen to identify signs and symptoms from the ICD-9 manual.

Incomplete documentation for consultations. A consultation requires three components: (1) must be requested by another physician, (2) the request must

documented in the encounter and (3) there must be proof that an opinion was returned to the requesting physician. Without this complete information, a consultation cannot be billed.

Frustrating Process Errors

The best documentation and code selection can be wasted effort if the rest of the process is not implemented correctly. Here are some examples:

- The CMS 1500 form states that the patient is female while the documentation clearly states that the patient is male.
- A 99211 code was billed after the physician saw the patient. A 99211 should only be used when ancillary staff sees a patient.
- The date of service billed does not match the date of service documented in the patient's chart.
- The physician circles the code chosen for the encounter on the billing worksheet. The code billed on the CMS 1500 does not match the billing worksheet. The physician is ultimately responsible for what is billed under his or her name. If the physician is making the code selection, it should not be changed by the billing staff.
- A procedure is performed on the same day as an evaluation and management code, but no modifier appears on the claim form. The evaluation and management code should be billed with modifier 25.

management service must be modified with a 25 for both services to be paid.

- The CMS forms show a place of service code of 03 to designate services provided in the office. This code has not been used for many years. The correct code is 11. Incorrect codes may slow down payment or queue a flag.
- The physician documents two or more diagnoses, but only one is billed. If more than one diagnosis is documented, all should be billed. This is the best way to convey medical necessity and the illness burden of the patients in the practice.
- The CMS 1500 form does not reflect the same diagnosis order that is documented by the physician. Again, this can skew the correct assignment of medical necessity that should be communicated to the insurer. Illness burden can affect bonus payments from many types of insurance plans.
- Lab tests are performed and documented, but they are not billed. This is a clear loss of revenue for the practice.
- The handwriting in the chart is illegible. Many records are very difficult to read, but can be deciphered with effort. However, too many charts are just flat-out unreadable. If audited, an unreadable record may be considered "unbillable."

Attempting to Skip the Hassle By Under Coding

Billing for services at a level higher than the documentation supports is considered up coding. Being accused of up coding is mortifying, especially when it is not intended. Many times, up coding occurs and physicians are shocked because they assume the documentation in a prior encounter will provide the information needed to support their code selection.

In other instances, many physicians think they will avoid the specter of an up coding allegation by deliberately billing lower level codes regardless of what services are performed. But, there are risks and downsides to this strategy.

For starters, it costs the practice money. One example is an audit of 10 charts with a total charge amount of \$500. An audit showed that down coding accounted for a total loss of \$125—25 percent of the total billed. In today's atmosphere of low reimbursement, a 25 percent loss of revenue is unacceptable.

Solutions

The best strategy, proven effective by thousands of chart audits, is to clearly and thoroughly document the services provided and then bill in accordance with the documentation. The best way to do this is to periodically perform a documentation audit of your own. A random sampling of charts on a regular basis for each physician or mid-level provider can offer insight into problems that may be occurring in the practice. There are many audit templates available to assist a practice in the process.

Regular review and education assist a practice to stay compliance.

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