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.

Tom Necela, DC, CPC is the President of The Strategic Chiropractor, a consulting firm dedicated to helping chiropractors maximize reimbursements and minimize their risk of audits by teaching sound billing, coding, documentation and collections strategies. If you'd like more information, go to http://www.strategicdc.com/

Article Source: http://EzineArticles.com/?expert=Tom-Necela

Avoiding common coding mistakes

By Tracey Glenn, BBA, CPC & Sharon Ryan, MBA

Published December 2002

React to this article in the Discussion Forum. Following are some examples of coding a documentation errors found in real charts in rephysician offices. Although the errors were intentional, the fines and penalties that could be assess are very real.

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

Get the Easy Stuff Right

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

examples that are easily correctable:

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

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

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

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

other areas of the chart. Ancillary staff may of document the history portion of an encounter. A scrimay be used, but the use of one must be appropriate documented.

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

Coding signs and symptoms. A record declaring that a patient has cancer after presenting for a lump in eyelid must include results of lab tests. A diagnocannot be assigned before it has been confirmed. "Rout," "probably," and "suspected diagnosis" should need be coded. When not sure of the diagnosis, codes show be chosen to identify signs and symptoms from ICD-9 manual.

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

documented in the encounter and (3) there must be protected that an opinion was returned to the requesting physicial Without this complete information, a consultation can be billed.

Frustrating Process Errors

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

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

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

- The CMS forms show a place of service code of 03 designate services provided in the office. This code I not been used for many years. The correct code is Incorrect codes may slow down payment or queue a flat
- The physician documents two or more diagnoses, I only one is billed. If more than one diagnosis documented, all should be billed. This is the best way convey medical necessity and the illness burden of patients in the practice.
- The CMS 1500 form does not reflect the sandiagnosis order that is documented by the physicial Again, this can skew the correct assignment of medianecessity that should be communicated to the insural Illness burden can affect bonus payments from mattypes of insurance plans.
- Lab tests are performed and documented, but they a not billed. This is a clear loss of revenue for the practic
- The handwriting in the chart is illegible. Many recordare very difficult to read, but can be deciphered we effort. However, too many charts are just flat-ounreadable. If audited, an unreadable record may 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. Bed accused of up coding is mortifying, especially when it not intended. Many times, up coding occurs a physicians are shocked because they assume the documentation in a prior encounter will provide information needed to support their code selection.

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

For starters, it costs the practice money. One example an audit of 10 charts with a total charge amount of \$50 An audit showed that down coding accounted for a toloss of \$125—25 percent of the total billed. In toda atmosphere of low reimbursement, a 25 percent loss revenue is unacceptable.

Solutions

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

Regular review and education assist a practice to stay compliance.

Tracey Glenn, CPC, CCS-P is Senior Analyst of PMSCO Healthcare Consulting, and Sharon Ryan, Mis President and COO at PMSCO.

Online URL: https://posturepro.phpkb.cloud/article.php?id=115