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 r physician offices. Although the errors were n intentional, the fines and penalties that could be assess are very real.

No one especially enjoys being proven wrong, but m physicians are pleased when a trusted adviser-not t Office of the Inspector General or an insurance compan can deliver a proactive message. By obtaining the exp advice of a certified coder, some logic and order can interjected into what is often a confusing and frustrati 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 mistak keep showing up in patient charts. Here are so

examples that are easily correctable:

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

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

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

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

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

Confusing verbiage about the type of patient visit. If t
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 crys
clear what type of service is being provided. Another ar
of confusion is whether it is a new patient or
established patient. Many notes do not state that t
patient is new to the practice and, in this event, an insu
may change the code to an established patient co
during an audit.

Coding signs and symptoms. A record declaring that t
patient has cancer after presenting for a lump in t
eyelid must include results of lab tests. A diagno
cannot be assigned before it has been confirmed. "Ru
out," "probably," and "suspected diagnosis" should nev
be coded. When not sure of the diagnosis, codes shou
be chosen to identify signs and symptoms from t
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 pro
that an opinion was returned to the requesting physicia
Without this complete information, a consultation cann
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 fema
while the documentation clearly states that the patient
male.

• A 99211 code was billed after the physician saw t
patient. A 99211 should only be used when ancillary sta
sees 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 encoun
on the billing worksheet. The code billed on the CM
1500 does not match the billing worksheet. The physici
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 bo
services to be paid.

• The CMS forms show a place of service code of 03
designate services provided in the office. This code h
not been used for many years. The correct code is 1
Incorrect codes may slow down payment or queue a fla

• The physician documents two or more diagnoses, b
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 t
patients in the practice.

• The CMS 1500 form does not reflect the sa
diagnosis order that is documented by the physicia
Again, this can skew the correct assignment of medi
necessity that should be communicated to the insur
Illness burden can affect bonus payments from ma
types 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 recor
are very difficult to read, but can be deciphered w
effort. However, too many charts are just flat-o
unreadable. 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. Bei accused of up coding is mortifying, especially when it not intended. Many times, up coding occurs a physicians are shocked because they assume th documentation in a prior encounter will provide t information needed to support their code selection.

In other instances, many physicians think they will avo 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 th 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 to loss 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 ch audits, is to clearly and thoroughly document the servic provided and then bill in accordance with th documentation. The best way to do this is to periodica perform a documentation audit of your own. A rando sampling of charts on a regular basis for each physici or mid-level provider can offer insight into problems th may be occurring in the practice. There are many au templates available to assist a practice in the proce

Regular review and education assist a practice to stay
compliance.

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