The Chiropractic Billing Guide

Insurance companies need accurate chiropractic billing and coding for timely payouts and revenue cycles. Healthcare providers must know chiropractic billing and coding to file insurance claims.

Did you know frequent chiropractor visits reduce hospital stays by 60%? Regular treatment can help reduce body inflammation. Thus, enabling the general public to use this service should be a top priority! Less strain on hospital employees nationwide would entail:

- Improved patient treatment
- Lower expenses
- Lower turnover/burnout

The use of insurance makes it feasible for the general public to have greater access to these services. However, billing for fully covered chiropractic treatments can be difficult.

Chiropractic CPT Codes

98940: Spinal manipulation

This code calls for one-to-two-region spinal manipulation. It typically denotes the main therapeutic procedure and is the code chiropractors use the most frequently.

98941: CMT Involving Three to Four Areas

This CPT code applies to spinal manipulations involving three to four spinal regions. A region may be pelvic, sacral, lumbar, cervical, or thoracic.

98942: CM Including Five Regions

This is the longest CMT code used when chiropractors manipulate five different spinal regions.

97010: Modality Use in Multiple Areas

This code is used when administering patient therapy with hot or cold packs.

97012: Therapy Using Mechanical Traction

This code is used when a chiropractor presses joints to loosen them and extend soft tissues.

97110: Rehab Activities

Rehabilitation sessions boost strength, endurance, range of motion, and flexibility.

97112: Muscle Therapy

Patients who need balance, coordination, kinesthetic sense, posture, and proprioception exercises are billed using this code.

97140: Methods of Manual Therapy

Chiropractors can use this code for mobilization/manipulation, lymphatic drainage, and traction.

97530: Rehabilitation Activities

Billing for direct (one-on-one) patient contact by the provider—using dynamic activities to enhance functional performance—is done with this code.

99215–99212 and 99202–99205: Evaluation/Management Services

Different levels of patient evaluation and management are billed using these codes.

Chiropractic Documentation Guidelines

Progress and processing of documents

These documentation requirements apply to both written and electronic formats:

- Keep a record of important details about the patient's condition at this visit, including their medical history.
- Keep records of the exam results, the body part treated, the tests carried out, and the objective conclusions.
- When providing a written interpretation of the patient's condition and physical findings, it is important to indicate a diagnosis code rather than a billing code and explain how the diagnosis aligns with the objective assessment.
- Procedure codes have to contain information about the specifics of the procedure, such as the area or region being treated, the exercises performed and the instructions given, the number of repetitions (if any), and the patient's reaction.
- Keep track of your treatment progress and how it relates to the care plan.
- Any expert interpreting services provided during the visit should be documented.
- Provide information about the injured worker's home environment and assistance with their recovery.
- Note the practitioner's name and qualifications for the treatment.

Reassessments

Clinical findings must be updated at every visit to justify medical necessity. Plagiarism in documentation does not indicate a reassessment or reevaluation of the state of affairs.

- Record the increase or decrease in functional status.
- Record changes to the diagnosis or treatment strategy, along with the justification for the change.
- The evaluation for that visit needs to include the response to the treatment.

Valid E&M visits with modifier 25

Changes in the care plan: Today is the patient's fourth visit for chiropractic care. Has not benefited as intended from prior treatment, and as of the third visit, flexion has decreased by 25%. A change to the treatment strategy consists of:

A new body issue: The patient is in today for their fourth cervical spine adjustment. After picking up something from the floor at work, the patient reports severe pain and trouble bending. A reevaluation was conducted today due to worsening lumbar spine pain and decreased range of motion.

- At the first session and for each subsequent session, there needs to be an objective, quantitative assessment of functional status to document progress.

Valid example

Baseline (flexion) lumbar range of motion: 30%; at the fourth chiropractic visit, ROM was 85% (ideal > 90%). Oswestry disability score: baseline = 16, disability score at chiropractic visit 4 = 11 (goal < 12).

The patient is approaching or has reached their goals and is making objective functional progress. The patient will reach their goals within the six-visit DOWC initial time-to-effect criteria. There will be an additional one or two chiropractic sessions available.

Records of the treatment plan

The physiotherapy plan documents:

- The exercise or therapy
- The time, place, body part, and frequency of follow-up exams
- The anticipated functional gain, as well as the short- and long-term objectives
- The prognosis, any diagnostic procedures, and the expected discharge
- Record the patient's exercises, ice/heat treatments, and home care instructions

Example of inadequate documentation: "Activities completed"

The following should be included in the documentation for each modality:

- The body part treated and the modality used
- The modality's duration of use and its intensity settings
- If anyone shows up for the session or not
- The relationship between the modality and the diagnosis

The medical decision-making process for each treatment must be recorded when utilizing several modalities.

Record the direct patient-physician time for each service rendered when using time-based modalities.

Strategies to boost chiropractic billing

Medicare, private insurance company policies, regulations, and new requirements have complicated chiropractic billing. In light of evolving circumstances, chiropractors must modernize their revenue-generating technologies and billing workflows to reduce the percentage of denied claims, provide clear and accurate claims, and receive payment.

To enhance the revenue cycle, consider the following chiropractic billing advice:

Optimization and A/R Review

Regarding reimbursements, one of the key components for physicians is their accounts receivable. They further recommended maintaining your A/R in the 0 to 30-day range. Days in A/R denote the typical duration required to retrieve payments due to practice. Days and payments are typically directly proportionate to one another. The longer the payment delays, the more days they take. Completing an A/R calculation will assist you in determining the effectiveness and efficiency of your practice's revenue management cycle processes. It will also highlight any issues that may have arisen with periodic payments.

You can improve your revenue cycle by analyzing and optimizing accounts receivable with these strategies:

• Distinguish patient receivables from insurance.

• Preserving connections with payers

• Assess and comprehend payer-refund trends to identify, categorize, and rank risks.

• Recognizing specific payer guidelines that may impact your management of accounts receivable

• Implement strict patient account collection procedures.

Proper Record-Keeping

In 2013, there were approximately 90% errors in imaging, lab tests, and chiropractic services due to inadequate documentation, according to the CMS report on improper payment. Furthermore, in 2013, the absence of proper documentation accounted for most improper payments. Therefore, to increase revenue and provide proof of the services rendered, it is necessary to have accurate documentation for every patient. Aside from that, the most common documentation errors include incorrect coding, insufficient documentation, and an absence of medical necessity.

Patient Education on Insurance Terms and Chiropractic Billing

Patients are seeing more co-pays and deductibles than ever because chiropractors do not know enough about these and other insurance terms and chiropractic medical billing. There is a daily increase in patients' awareness of healthcare issues and a growing sensitivity to the cost of healthcare. You must start talking to them about money.

In 2012, 14% of hospitals could estimate prices; in 2018, 44% could, according to JAMA Internal Medicine. Patients should know their financial obligations, insurance coverage, and chiropractic fees. Patients must know chiropractic care's financial obligations, insurance coverage, and expenses. In addition, a catalog or booklet with comprehensive and understandable information about the required billing requirements should be provided to the patient.

Review insurance agreements

Practices must carefully examine their agreements with payers to identify any differences in the insurance contracts compared to the prior year. This helps them create an action plan for workflow, procedure, and employee retention changes. Also, providers should remember next year's filing deadlines.

Compliance in Chiropractic Billing Services

Chiropractic billing services extend beyond the routine handling of financial transactions. Rather, they are part of an intricate process throughout the medical billing and coding regulatory system. It emphasizes CPT and ICD code use and requires professionals to follow coding standards and guidelines.

The major goal is to instill in billing organizations a culture of swiftly addressing and resolving instances of behavior that contravene Federal and State laws. The three types of compliance are as following:

Regulatory Compliance

Following all applicable federal, state, and private insurance company regulations and those set forth by Medicare, Medicaid, and other agencies. This kind of compliance guarantees that chiropractic billing practices meet the legal requirements established by regulatory bodies.

Coding Compliance

Coding rules and standards are important, especially when using ICD and CPT codes. Maintaining billing accuracy and accurately expressing chiropractors' services requires coding compliance.

Cultural Compliance

Fostering an environment in a medical billing business where instances of behavior that violate federal and state laws are promptly addressed and resolved. Establishing a setting that encourages moral billing practices and guarantees the avoidance, identification, and correction of non-compliant behavior is the main goal of cultural compliance.

Chiropractic Medical Billing System Types

Chiropractic billing services must use current and accurate CPT codes, with nearly 11,000 available. Chiropractic uses four main CPT codes: 98940, 98941, 98942, and 98943. These codes charge Medicare and insurers. Correctly using modifiers like 25 and 59 in chiropractic billing services is important because they help prevent claim denials. Chiropractic billing systems fall into three categories:

Closed Medical Billing Systems

These systems, like Electronic Medical Records (EMRs), limit collaboration with other healthcare entities because they are practice-specific.

Open Medical Billing Systems

Facilitate the exchange of information among healthcare practitioners, practices, and institutions to promote cooperation. Open systems are exemplified by electronic health records (EHRs).

Isolated Medical Billing System

Patients can manage their medical records independently with personal health records.

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