Back To Chiropractic Continuing Education Seminars
Proper & Ethical Billing & Coding ~ 4 Hours

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This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

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1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
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5. Click on the Exam for the course you want to take. No passwords needed.
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If you get audited and lose your records, I'll have a copy.

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Introduction -

Above all else, the ultimate concepts of honesty, ethics, and integrity shape everything else. As licensed doctors of chiropractic in the state of California (by the State of California Board of Chiropractic Examiners, hereafter referred to as "Board"), we are ultimately responsible for everything that occurs in our chiropractic offices based on the Chiropractic Act and the associated rules and regulations. Being ultimately responsible for all that occurs in our offices is in addition to standard theories of legal responsibility. This ultimate responsibility concept is based on protection of the public, and it means that even if a doctor manages to avoid legal responsibility in any other way, this is the ace that the Board uses so as to maintain power over the doctor.

Honesty is truthfulness, sincerity, and freedom from deceit or fraud. Fraud, as will be explained in depth below, is the intentional misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another. As licensed doctors of chiropractic, it is expected that we be truthful and sincere with all of our professional actions, including insurance billing and coding. Truthfulness and sincerity are the polar opposites of fraud, with the key element being that of intent. Your actions are the result of your intent, and there is no substitute for honesty.

Ethics are rules of conduct (here related to chiropractic) and are based on values with respect to rightness and wrongness, and on the goodness and badness of motives. There isn't much that needs to be said in this area, as we all have a conscience with an internal compass, and you know when you are doing the right thing and when you're not. Obviously, as licensed doctors of chiropractic we are required to do everything in our professional realm with good if not exemplary ethics.

Integrity is the state of being whole, entire, or undiminished; it is also adherence to moral and ethical principles, soundness of moral character, and honesty. There is no substitute for doing things the right way based on goodness and honesty; it is the only way to be in regard to our professional duties and actions.

Overview of the Insurance Concept -

Insurance is a concept of shared risk for significant and sometimes potentially catastrophic losses. The risk for significant losses is shared between an insurance company and its insured by virtue of insurance contracts. Contracts in turn are legally enforceable agreements between different parties who each give the other something in exchange for their benefits received from the other party. With health insurance contracts, insureds pay a premium of money to a health insurance company in exchange for the protection and benefits they receive for potential losses to their health.

The amount of risk to an insured person is defined by the amount of the deductible which must first be satisfied prior to any benefits being received for covered losses, and then additionally by the amount of the co-payment (co-pay) paid by the insured person to a health care provider. Likewise, the amount of risk to a health insurance company is defined by various limitations - the amount of money they must pay for covered losses as well as total amounts paid in a defined time period (usually a calendar year), total number of visits for a given benefit per time period, and total lifetime dollar limitations.

For example, a person with a classic PPO (preferred provider organization) insurance policy might have chiropractic benefits limited by a $500 calendar year deductible, twenty visits per calendar year, and a $1,000,000 lifetime total benefit from that insurance company. Obviously, it would be impossible to amass $1,000,000 of chiropractic care in a lifetime; this limitation applies when there are other health care benefits such as medical care.

PPO (preferred provider organization) insurance has been in existence for a long time, and much longer than HMO (health maintenance organization) insurance. PPO insurance has the advantage for the insurance client/patient that they can choose any doctor they want to see, with the additional advantage for the doctor that any doctor for the given type of applicable care will be paid by the insurance company for the care they render to their insured patient. PPO insurance payment is typically based on fee for service, where the provider renders necessary services to the patient, bills itemized charges for these services to the insurance company, and then corresponding payment is made with an attached explanation of benefits. The focus of this program will be on PPO insurance.

HMO insurance was developed to be a cost-effective alternative to PPO insurance where the annual premium to buy the insurance is less than PPO insurance, but the benefits are correspondingly reduced by way of a gatekeeper doctor

who decides when and if a patient needs any type of care. HMO insurance takes the control of the insurance benefits away from the insured patient and puts it in the hands of the gatekeeper doctor. Modernly, the only California chiropractors who are paid HMO benefits are those who have chosen to be contracted with a corporation (i.e. ASHP) that simultaneously contracts with HMOs. There is a huge amount of paperwork involved for a limited benefit, and while some chiropractors have chosen to participate in this system, many chiropractors have decided that it is not worthwhile to do so.

Twenty years or so ago, about 85-90% of persons with insurance had PPO insurance. However, largely due to Kaiser (a huge HMO) as well as other HMOs, modernly about 85-90% of persons with insurance now have HMO insurance coverage. Any Medicare beneficiary who has HMO insurance benefits no longer has PPO insurance benefits, even though Medicare in its pure form is PPO insurance.

Secondary versus Supplemental Insurance -

Excess insurance is insurance that pays only after all other insurance has been billed and acted upon, with the proof being the explanations of benefits. Some excess insurance is secondary, while other is supplemental. Secondary insurance is insurance that pays its defined benefits regardless of what the previously billed, other insurance pays. In contrast, supplemental insurance pays only for their portion of the benefits approved by the previous insurance. This situation typically occurs with Medicare (and only when a Medicare beneficiary does not have HMO insurance) when a Medicare beneficiary buys insurance in addition to that of Medicare.

Approximately 95% of Medicare beneficiaries are on fixed income, and health care benefits are of extreme concern. At the time of this writing, Medicare pays for 80% of the approved amount of an unlimited number of chiropractic spinal adjustments (which they call manipulations) provided there is an acute condition likely to be helped with chiropractic, once the patient has first met their calendar year deductible, and only when performed by a doctor enrolled with Medicare as a provider of services. Many senior citizen/Medicare beneficiaries are very concerned with paying for the other 20% of Medicare's allowed amount, and thus they purchase excess insurance (either secondary or supplemental).

Medicare only pays chiropractors for spinal adjustments, and not for anything else. Secondary (to Medicare) insurance pays not only the 20% of the amount allowed by Medicare for spinal adjustments, but also pays for itemized billing for most other charges, such as exams, x-rays, and physical therapy. However, supplemental (to Medicare) insurance pays only the 20% not paid by Medicare for spinal adjustments only.

With personal injury, Medical Payments (Med Pay) coverage is usually primary, but sometimes is excess. When Med Pay is excess, all other insurance policies must be billed and the corresponding EOBs obtained with copies sent to the Med Pay auto claims adjustor. All other insurance policies includes even those insurance companies that don't pay chiropractic benefits, or those that won't pay chiropractic benefits to a given chiropractor (which is usually a contract issue, such as not being a provider in a given organization).

It is wise to call a patient's insurance companies and determine not only the standard limitations (deductibles, number of visits or dollar amount per year, etc.), but also whether the policy is an excess policy, and if excess whether it is secondary or supplemental.

Insurance Fraud and How to Prevent It -

Insurance fraud is the intentional misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another. Most crimes involve a concurrence of a mental state with a physical act. Here, there must be an intent to deceive an insurance company by way of misrepresentation of at least one material fact. Intentionally is essentially synonymous with knowingly, and many of the insurance fraud laws use the word "knowingly." Misrepresentation is deceit, which is the misleading by use of a false statement. Material facts are those facts which are significant (as opposed to insignificant). Justifiably relied upon means that the insurance company must have relied upon the material misstatements, which is shown by payment of money that would not have been paid had true statements been used. Property used here refers to money, and "of another" refers to insurance companies.

Insurance fraud is a significant problem for insurance companies, and it is both criminal and civil in nature. Criminal acts are those defined in both federal and state criminal statutes, are prosecuted by the district attorney's office, and subject the criminal to prison sentences, restitution of money, discipline by the Board including revocation of licensure, and loss of voting rights (for felony convictions). Civil wrongs often result in a defendant owing money to the plaintiff.

Under the California Insurance Code §1871.4, the following is made illegal: 1) making or causing to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation as defined in Labor Code §3207, 2) presenting or causing to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation as defined in Labor Code §3207, 3) knowingly assisting, abetting, conspiring with, or soliciting any person in an unlawful act under Insurance Code §1871.4, and 4) making or causing to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

California Penal Code §550(a) also covers insurance fraud and makes it unlawful to do any of the following: 1) knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss, including payment of a loss under a contract of insurance, 2) knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud, 3) knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim, 4) knowingly present a false or fraudulent claim for the payment of a loss for theft, destruction, damage, or conversion of a motor vehicle, a motor vehicle part, or the contents of a motor vehicle, and 5) knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or allow it to be presented, in support of a false or fraudulent claim. Cal. Pen. C. 550(a). It is also unlawful to assist, abet, solicit, or conspire with any person to perform any of these acts. Cal. Ins. C. §1841.4(c). Furthermore, if the claim or amount at issue exceeds $400, or if the aggregate amount of claims made in any consecutive 12 month period exceeds $400, the crime is punishable by imprisonment in state prison for two, three, or five years, and/or a fine of up to $50,000, or by imprisonment in the county jail not to exceed one year and/or a fine of up to $1,000. If the value of the fraud exceeds $50,000, the amount of the fine may be up to double the value of the fraud. Cal. Pen. C. §550(c)(2)(a).

Conviction of any felony (including insurance fraud) in any jurisdiction (whether federal and/or state) by a licensed doctor of chiropractic will result in revocation of licensure by the Board.

Proper written documentation and disclosure will prevent many if not most problems for doctors, so that even if there is a difference of opinion there won't be any bad intent able to be proven, and hence no insurance fraud.

There are many different ways to commit insurance fraud. The intention expressed here is to always do everything honestly and ethically. Sometimes doctors feel tempted to waive deductibles and co-pays so as to encourage patients to receive care or more care than they would otherwise receive. This is outright illegal and constitutes insurance fraud, unless the doctor submits a written statement to the insurance company that they are taking this course of action. Proper written disclosure will prevent many problems, but the consequence is that the insurance company will diminish the amount paid to the doctor. For example, when a patient has a PPO insurance plan that pays 80% of their allowed amount of charges and the deductible has already been met, the insurance company will end up paying only 64% of their allowed amount (80% of 80%, which is .8 x .8 = .64 = 64%). There are two undeniable correct ways in regard to deductibles and co-pays - 1) adhere properly to deductibles and co-pays by properly collecting them from the patient, or 2) notify the insurance company in a signed writing of any waiver of deductibles and co-pays.

Another form of insurance fraud is billing for services that never occurred, and a variation on this theme is to bill for more than what was actually done. As amazing as this sounds to the vast majority of us who are honest, sometimes there are a rare few people who actually try this; sooner or later they get caught, are prosecuted by the district attorney's office, become convicted felons, lose their voting rights as American citizens, and become court-ordered to pay restitution to the insurance companies from which they stole money. Obviously, this course of action is not recommended and is strongly discouraged.

Conspiracy is the agreement by two or more persons to commit a crime as shown by at least one overt act in furtherance of the conspiracy. Conspiracy is another legal theory used as a method to convict all involved in reference to

insurance fraud. One who conspires to commit a crime is guilty to the same full extent as anyone else who commits and/or conspires to commit the target crime. Although conspiracy to commit a target crime is a separate crime from that of the target crime (such as insurance fraud), it is a very powerful legal tool used by the district attorney's office to convict all involved. California Penal Code §182(a)(4) makes it a crime to conspire to cheat and defraud any person of any property by criminal means. The district attorney's office will need to prove that there was an agreement between two or more people to commit insurance fraud, and they must also prove that each involved person committed at least one affirmative, overt act in furtherance of the conspiracy. In relation to prove conspiracy to commit insurance fraud, proof of an overt act can be very easy (such as the signature on a billing form).

Aiding and abetting is the knowledge, intent, and active assistance toward another to commit a crime. Aiding and abetting is another legal theory used as a method to convict all involved in reference to insurance fraud. One who aids and abets a crime is guilty to the same full extent as anyone else who commits the crime.

Keep in mind that we as chiropractors (just like most any alternative health care) are always under the microscope by everyone. When a chiropractor does something wrong, the media enjoys publicizing the event. We have a duty to the profession of chiropractic to conduct ourselves in a professional manner, so that we are adding and not subtracting from the public's perception of our honorable field.

When Insurance is Applicable -

A patient's unstable condition is usually concerning acute, subacute, and rehabilitative care, and even chronic care but limited to restorative care. These unstable conditions are differentiated from stable conditions, which include maintenance, wellness, and chronic but supportive care. The line between chronic but restorative as compared to chronic but supportive can be difficult to differentiate, but it is honest, accurate documentation that will back up a claim. Insurance contracts typically pay only for unstable conditions, such as Med Pay on an auto accident policy paying up to the point in time where a patient has attained a pre-injury status. Unstable conditions are usually those that involve a loss from a better health status. It is therefore extremely important to document not only a current injury or condition with the given present signs and symptoms with their intensities, but also the signs and symptoms with their intensities that were present PRIOR to the current injury or condition.

Timely Filing of Claims -

To be eligible for Medicare (federal) reimbursement, claims must be filed with Medicare by Dec. 31st of the calendar year following a given fiscal year (Medicare's fiscal years run from Oct. 1 - Sept. 31). Therefore, you will always have at least 15 months from the date of service for Medicare to receive your bill. However, Medicare makes a small penalty deduction from the amount paid to the doctor for claims received one year after the date of service. For example, if a spinal adjustment was performed on Sept. 29, 2010, Medicare could be billed for this date of service as long as it is received by Dec. 31, 2011, but a small amount would be deducted for Medicare due to receiving the bill more than one year after the service was performed.

All bills other than Medicare claims are subject to state laws, which in California allow bills to be received by an insurance company up to 18 months following the date of service, unless there is a contract between a doctor and an insurance company which limits this time period. For example, Blue Shield of California preferred providers (doctors) are limited by their contracts to be reimbursed only if bills are received by Blue Shield of California within one year from the date of service.

Doctor Responsibilities -

Confidentiality of protected healthcare information (PHI) is an extremely important duty of doctors of chiropractic. There are both federal (the Health Insurance Portability and Accountability Act of 1996 - HIPAA) and state confidentiality laws; all doctors of chiropractic are subject to state laws, but only some are also subject to federal HIPAA law.

State confidentiality laws provide for release of a patient's confidential health information in three main ways - 1) appropriate signed consent, 2) judicial branch (court order or attorney subpoena), and 3) administrative branch apparent

(apparently valid) authority (such as the California chiropractic board and the California Dept. of Public Health, Radiologic Health Branch). Although appropriate signed consent by the patient themselves is the usual manner of consent, consent can also be given by either any person who is an agent, conservator, or guardian for the patient.

Advance Health Care Directives (AHCD) are usually drafted by attorneys and allow a person to make health care decisions while they still have legal capacity to do so. One type or subcategory of AHCD is the Durable Power of Attorney for Health Care (DPAH) where a principle (your patient) names their agent(s) to make health care decisions for them. Both of these written documents allow a patient to obtain chiropractic care either in an advance decision made by themselves, or by their agent who knows that your patient wants chiropractic care but is unable to legally make that decision for themselves. As long as the document (AHCD or DPAH) appears to be legitimate, the doctor is protected from any consequences for release of confidential health information, even if the document later turns out not to be valid. California Probate Code §4740 limits civil and criminal liability as well as professional discipline when a health care provider 1) complies with a health care decision of a person that the provider believes in good faith has the authority to make the decision for the patient, including a decision to withhold or withdraw care, 2) declines to comply with a health care decision on the basis of the agent lacking authority to make a decision for the patient, 3) complies with an AHCD assuming it to be valid and presently effective, or 4) declines to comply with a health care decision for reasons of conscience (Prob. C. §4734(a), etc. Prob. C. §4740.

Conservators are court-appointed persons who are legally responsible for an adult person (the conservatee) who is unable to legally make decisions for themselves. Upon showing proper identification as a conservator, the conservator's decisions related to health care of the conservatee must be respected. Similar to a conservator, a guardian is the court-appointed adult person who makes legal decisions for a minor, including health care decisions.

Attorneys as well as judges are all part of the judicial branch of government. Subpoenas from either an attorney or a court (judge) requesting records of a patient must be honored.

Similarly, requests to inspect records may be made by any pertinent administrative branch of the government. For doctors of chiropractic, the pertinent administrative branches include both the Board and the Dept. of Public Health, Radiologic Health Branch. Any apparently valid form of identification by either of these administrative branches entitles the holder to inspect records on the spot with no advance warning. It would be unwise to refuse a valid request.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. This is federal law, and in California is applicable in addition to state confidentiality laws only if a health care provider, facility, health plan, or billing agency is a "covered entity." Covered entities are those health care providers (such as doctors), facilities, health plans, and billing agencies that transmit health care information electronically, those that use such an electronic transmitter, those contracted to provide private healthcare information electronically, and all doctors who are in states with state laws that mandate HIPAA compliance. Electronically generally means that patient health information is being transmitted by use of computers. This includes accessing websites to verify patient eligibility, sending bills by computer, receiving explanations of benefits, etc. There are two types of fax (facsimile) machines - computer and conventional telephone. Faxing from a conventional telephonic fax machine does not constitute a HIPAA electronic transaction, but doing so via use of a computer does.

If you are subject to HIPAA laws, this is not the place to delve into detail on this subject, and you will have to get this information elsewhere. If you do not care to be subject to HIPAA laws, simply mail your bills by regular United States Postal Service 1st class mail, do not bill electronically, do not use a billing service that bills electronically, do not enter into any contracts requiring you to bill electronically or be HIPAA compliant, do not obtain or transmit any patient healthcare information by computer, and do not practice in a state that requires HIPAA compliance. At this point in time, California does not require HIPAA compliance for doctors of chiropractic.

ICD-9 – Special note about ICD-9 –

ICD-9 diagnosis codes remain in use for all dates of service prior to and including Sept. 30, 2015. There is a popular false belief that ICD-9 is supposedly obsolete, but it is not, and as just stated ICD-9 must be used for all dates of service prior to and including Sept. 30, 2015. In California, the statute of limitations for written contracts is four years, which means that unless shortened by other law (such as Medicare) or contract, providers will be able to bill dates of service prior to and including September 30, 2015 up to four years later. For example, unless shortened by other law or

contract, a doctor can bill for services rendered on Sept. 18, 2015 until Sept. 18, 2019. Medicare is the most obvious example of other law that shortens the time period to bill for chiropractic services, which are generally required to be billed within ONE year from the date of service. Contracts with a doctor and an insurance company or other entity can also reduce the time allowed for billing, and many such contracts limit the time to one year following the given date of service. **With personal injury in regard to billing first party medical payments of automobile insurance, the contract between the insurance company and the insured can also limit the time period for both the dates of service rendered eligible for payment as well as the total length of time after the date of service for submission of bills.** Therefore, **do not discard information pertaining to ICD-9, since it potentially can be used until Sept. 30, 2019**.

As far as ICD-10 is concerned, from a technical standpoint ICD-10 only applies to "covered entities" as explained in the following ICD-10 information. Realistically, the vast majority of doctors offices are "covered entities" and the effect is likely to be that many if not most insurance companies are likely to insist on ICD-10 being used in order for payment to be made (because consistency makes their business more efficient) for dates of service Oct. 1, 2015 and thereafter. Therefore, it is likely that ICD-10 will become universal for dates of service Oct. 1, 2015 and thereafter.

ICD-10 -

Overview (a more detailed explanation of ICD-10 is contained in another online billing seminar)-

The ICD-10 diagnosis codes have been implemented and are now in force and apply only for Oct. 1, 2015 and thereafter dates of service. ICD-11 is already is already being designed and is projected for implementation in the United States in the year 2023 (as of the time of this writing).

Do not mix ICD-9 dates of service and/or codes with ICD-10 dates of service and/or codes on the same billing sheet. Instead, use ICD-9 diagnosis codes with dates of service prior to and including Sept. 30, 2015 on a given billing sheet, and use ICD-10 diagnosis codes with dates of service Oct. 1, 2015 and thereafter on a different billing sheet. Mixing the information inappropriately will result in rejection of the claim.

All of the diagnosis codes for each of these ICD series pertain only to diagnoses, and do not pertain to procedures. A great website to learn about continuously updated issues concerning ICD-10 is www.icd10monitor.com, and another is that of the world health organization (WHO) at www.who.int. Some but not all of the ICD-9 codes covert easily to ICD-10 codes, and some do not. Conversation information is available from a number of sources. A thorough understanding of ICD-10 for most people will involve attendance at a seminar dedicating a significant amount of time to the subject, as many people learn new material easier at an in person seminar. An ICD-10 code book will need to be purchased by most doctors. This online course in part provides a clear, concise overview of the subject, but obviously does not provide the benefits of learning in the presence of a knowledgeable teacher.

Legal Authority -

Our United States Congress is the entity that writes the laws pertaining to the ICD diagnosis series, and it is Congress that can change written laws at any time. Congress' proposed laws become the law of the land once our President signs Congress' proposed laws. The law concerning ICD-10 is an addition to existing laws pertaining to federal HIPAA confidentiality. Congress did change the written law which would have implemented ICD-10 as of Oct. 1, 2014, and it was our United States President that signed Congress' proposed law which made it a reality. ICD-10 codes could not be used prior to its implementation, which occurred on Oct. 1, 2015. Any bills submitted with ICD-10 diagnosis codes prior to implementation resulted in rejection of those bills.

To Whom Will/Does ICD-10 Apply? -

ICD-10 laws are part of Federal HIPAA laws, which pertain only to "covered entities," which is the legal term for those doctors who bill electronically or hire a billing firm that files bills electronically.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. This is federal law, and is applicable in addition to state confidentiality laws only if a health care provider, facility, health plan, or billing agency is a "covered entity." Covered entities are those health care providers, facilities, health plans, and billing agencies

that transmit health care information electronically, those that use such an electronic transmitter, those contracted to provide private healthcare information electronically, and all doctors who are in states with state laws that mandate HIPAA compliance. Electronically generally means that patient health information is being transmitted by use of computers. This includes accessing websites to verify patient eligibility, sending bills by computer, receiving explanations of benefits by computer, etc. There are two types of fax (facsimile) machines - computer and conventional telephone. Faxing from a conventional telephonic fax machine does not constitute a HIPAA electronic transaction, but doing so via use of a computer does.

Determining whether you are or are not subject to HIPAA laws is discussed elsewhere. If you do not care to be subject to HIPAA laws, simply mail your bills by regular United States Postal Service 1st class mail, do not bill electronically, do not use a billing service that bills electronically, do not enter into any contracts requiring you to bill electronically or be HIPAA compliant, do not obtain or transmit any patient healthcare information by computer, and do not practice in a state that requires HIPAA compliance. At this point in time, California does not require HIPAA compliance for doctors of chiropractic.

As far as ICD-10 is concerned, from a technical standpoint ICD-10 only applies to "covered entities." Realistically, the vast majority of doctors offices are "covered entities" and the effect is likely to be that many if not most insurance companies are likely to insist on ICD-10 being used in order for payment to be made (because consistency makes their business more efficient). Therefore, it is likely that ICD-10 will become universal.

Personal Injury - There is confusion occurring as to payment of personal injury claims with the use of both ICD-9 and ICD-10 being used for appropriate dates of service. Many insurance companies are choosing their own method of operation in regard to both ICD-9 and ICD-10, despite a number wrongly doing so. Even though “covered entities” (doctors and billing services hired by doctors any of which bill electronically) are required to use ICD-10 diagnosis codes when billing for dates of service Oct. 1, 2015 and forward, a number of automobile insurance companies are wrongfully setting their own policy in regard to the use of ICD-9 and ICD-10 in defiance of the new federal law. For example, at the time ICD-10 was implemented, State Farm processed insurance claims with both ICD-9 and ICD-10, and for an indefinite period of time as to ICD-9 claims regardless of the date of service. In contrast, Progressive Ins. Co. rejects claims for dates of service Oct. 1, 2015 and thereafter using ICD-9. Even though it might be easier to call the given claims adjuster and ask what they will accept, the correct procedure for “covered entities” is to use ICD-10 for claims with dates of service Oct. 1, 2015 and thereafter, and to use ICD-9 with claims of service Sept. 30, 2015 and prior to that date. Doctors who are not “covered entities” (most of those doctors who do not bill electronically) are not required to use ICD-10 by federal law because the mandatory use of ICD-10 for “covered entities” has been added as an attachment to federal HIPAA law. However, doctors who are not “covered entities” are a minority and will probably discover that insurance companies eventually will insist upon all doctors using ICD-10 for dates of service Oct. 1, 2015 and thereafter in order to be paid.

When an insurance company including automobile insurers wrongfully insists upon the “covered entity” doctor using ICD-9 and/or ICD-10 incorrectly (in conjunction with the given date of service), the doctor should keep in mind that doing so would be illegal. Doctors like anyone else as well as business entities must abide by all laws. Using ICD-9 and/or ICD-10 incorrectly in regard to dates of service would be illegal as to “covered entities.” Federal laws become the law of the land when the president of the United States signs a bill authored by Congress. Congress’ most powerful ability to make laws is based on the Commerce Clause of the United States Constitution. No person or any business entity can interfere with any law. Even though ICD-10 and HIPAA law pertain only to “covered entities,” automobile insurance companies cannot rightfully insist in operating in violation of any law, and cannot force others to violate laws. “Covered entity” doctors should only use ICD-9 and ICD-10 properly with claims. If an insurance company does not pay bills, the solution is for the patient to sue the insurance company for breach of contract. In California small claims court, assignees (third party beneficiaries such as doctors) are not allowed to file a claim. Therefore, it is the patient who must file suit against the insurance company.

Negligence -

Negligence is conduct that falls below the standard of care that an objectively, reasonable person would use so as to prevent harm to others. Said in another way, negligence is breach of a duty that causes harm to others. This is the standard to which doctors of chiropractic are held, and it is based not on a so called average doctor, but on the standard of

care that a doctor of chiropractic would use from a national perspective. This means that local doctors do not determine whether negligence has occurred or not. For example, the now outdated belief that a rural doctor is not as sophisticated in their occupation in contrast to an urban doctor is irrelevant to determine whether or not a doctor has actually committed negligence. Modernly, all validly licensed doctors of chiropractic are expected to have minimum standards from a national perspective.

Negligence is based on good faith, but honest mistakes made by either taking action or by not taking action. Negligence is entirely different than intentional acts, as intentional acts are purposely done. Malpractice professional insurance only protects doctors from negligent acts, and not from intentional acts. Relative to insurance billing and coding, malpractice insurance will not protect a doctor from insurance fraud, because fraud is committed with an intent to deceive and is therefore not done by mistake.

Everyone makes mistakes, and no one is expected to be perfect. However, every doctor of chiropractic is expected to adhere to professional standards and perform their duty toward their patients at a minimum of an acceptable level of performance based on a reasonable, objective standard. Remembering that everyone makes mistakes, the breach of a duty alone does not constitute negligence. It is only when the breach of a duty also causes harm to a patient that negligence has occurred.

Reasonable Protective Measures to Prevent Negligence -

Common sense is the absolute best protective measure against committing negligence. A close second is thinking before doing. As a great example relative to insurance billing and coding, don't bill for service provided to a patient unless you have their signed, written consent to 1) treat the patient, 2) release confidential personal healthcare information to any applicable insurance companies or their affiliates, and 3) receive and deposit checks for services rendered to the given patient. Another example would be to make sure you have a signed, written power of attorney to sign a check or draft written to a patient before you actually do that.

Competence is having the requisite knowledge, skill, training, and experience sufficient to perform one's professional duties in a manner that an objectively reasonable doctor of chiropractic would do so. Competence can be thought of as being the polar opposite of negligence, because competence is the performance of one's professional duty toward another in an appropriate manner, whereas negligence is one's performance that falls below the standard of duty owed to another (your patient). Generally speaking, only use those chiropractic techniques in which you are adequately trained. If you are learning a new technique, it is best to inform your patient and obtain their permission to try aspects of this new technique.

Relative to insurance billing, the doctor is always ultimately responsible for anything submitted to an insurance company when accompanied with their signature. It is no excuse to claim ignorance. If you or a staff member are unsure of anything pertaining to insurance billing and coding, make sure you learn what to properly do before you do it. The doctor has an affirmative duty to submit proper insurance billing forms. If a mistake is learned after the billing has already been submitted to the insurance company, simply correct the mistake(s), and in box 19 put the words in capital letters "CORRECTED CLAIM." It is also a good idea to use a yellow highlighter to highlight any corrections so that the claims adjustor can easily make the necessary corrections.

Obtain Signed, Written Patient Consent -

As stated above, don't forget to get signed, written patient consent to do whatever you intend to do. The following is my Permission to Treat/Promise to Pay form; feel free to reproduce and use it for yourself and your patients:

Permission to Treat
Promise to Pay

I give Dr. XYZ, D.C. my full consent and permission to give treatment on myself and minors listed below. Minors listed are either my own children or my legal adoptees.

I authorize Dr. XYZ, D.C. to furnish complete information to my insurance carrier(s) and/or its (their) intermediaries and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier(s) and/or its (their) intermediaries to issue payment checks directly to this office for all services rendered. I understand that I am financially responsible to this office for

any balance not covered by this authorization. I understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable in full. If it is ever necessary for this office to employ collection counsel and/or take collection measures, I waive all rights to confidentiality, and I understand that I am responsible for those collection charges in addition to the fees for professional services, as well as 12% interest from the first unpaid date of service.

I give Dr. XYZ, D.C. my permission to release any x-rays taken of me to any radiologist, to release and forward any information in my chart(s) to that/those radiologist(s) necessary for the radiologist to bill myself and/or any insurance company, and I give that/those radiologist(s) permission to bill myself and/or any insurance company for their service.

MEDICARE patients: Medicare will reimburse/pay a majority of the spinal manipulation charges for an unlimited number of visits after your deductible has been met, as long as chiropractic care is "medically necessary" based on acute symptoms usually including pain where chiropractic care would be expected to benefit those symptoms, AND as long as the visits do not pertain to maintenance care. These are the only charges that Medicare will reimburse/pay. Medicare will not reimburse/pay for other services such as exams, x-rays, etc. – I, the patient must do so). Medicare will not pay for any other services performed in this office, and I realize I am responsible for payment of all services rendered to me, including those that Medicare will not reimburse/pay. I am aware that Medicare often changes its rules and regulations. I understand this is my informed consent as dictated by Medicare.

I understand that the only condition treated by Dr. XYZ, D.C. or this office is subluxation (misalignment of bones and attached structures) and directly related conditions (ex. strains, sprains, etc.). Additionally, the only diagnoses made by Dr. XYZ, D.C. or this office pertain only to subluxations and directly related conditions.

Although most patients find chiropractic to be beneficial, there are no cures, promises, or guarantees of any kind made by Dr. XYZ, D.C. or this office.

The majority of the charges incurred in this office are listed on the back side of this paper. I have reviewed them and have satisfactorily had a chance to ask about other charges not listed and have satisfactorily had all my questions and concerns answered including those of risks and billing.

Minors: Birthday:

_____

_____

_____

_____

_____

Women: In the event that x-rays are necessary, I certify that I am not pregnant today.

_____
Initials

_____
Printed Name

_____ _____
Signature Date

Proper Chart Recordkeeping and Documentation -

As professional doctors of chiropractic, we have an affirmative duty to properly document the history, exam, treatment, and billing records. This should have been learned in chiropractic college, and there is no need to repeat that here. However, there are certain key points that need emphasis that may not have been taught in school.

Make sure you perform a competent history and examination relative to the objective, reasonable person standard so as to prevent negligence (previously discussed). Generally, your history and exam should include all appropriate questions and tests learned in chiropractic college for a given problem as well as additional pertinent information (i.e. such as with a personal injury case). The history should include the chief complaint, additional complaints, OPPQRST (onset, palpation, percussion, quality of symptoms, radiation, severity of symptoms, time), past history (including prescribed medications, allergies to medications, surgeries, hospitalizations, previous traumas, and significant illnesses), family history (including diabetes, rheumatoid arthritis, cancer, myocardial infarction, and stroke), occupation, and social history (including smoking cigarettes, alcohol use, and exercise). The exam should include inspection of postural

markers, palpation, percussion, auscultation, range of motion, orthopedic tests, neurological exam (including deep tendon reflexes and sensory dermatomes), and x-rays if you determine in your professional opinion that they are needed.

List all interferences with daily activities as part of your history as well as the daily chart notes. You will need to affirmatively ask questions such as are their complaints interfering with their sleep (and if so, to what degree), do they have fear when driving across bridges or when approaching traffic lights (such as after an auto accident), and are their complaints interfering with their ability to exercise. Make sure you put their affirmative responses with appropriate qualifiers (to what extent are their activities curtailed?) in writing. The most appropriate qualifiers include frequency, duration, and severity.

On the topic of x-rays, there are probably just as many chiropractors who prefer to take x-rays as there are who prefer not to take them. You truly are entitled to your personal professional opinion, but make sure you can back up your opinion if necessary. Once you have decided to take x-rays, you are responsible for obtaining quality x-rays. Take as many retakes as is necessary to obtain quality films (so as to perform this duty competently), but preferably with as few attempts as possible. If you bill insurance for x-rays taken of a patient, you will need to write up your radiology report and include a copy of it with the bills submitted to the insurance company.

On the topic of diagnoses, it is important to list all pertinent diagnoses for a patient even though with group insurance you are likely to be paid with no problems when only listing a limited number of diagnoses. Listing all pertinent diagnoses is particularly important with personal injury cases. For those insurance companies which still accept older billing forms and since both the HCFA-1500 and older CMS-1500 billing sheets only allow for a maximum of four diagnoses per billing sheet, you will need to use as many additional billing sheets as necessary when there are five or more total diagnoses. The diagnoses are put in box 21 of the billing forms. The proper procedure is to complete all of the patient's basic information on the top half of the billing sheets, put diagnoses numbers 5-8 in box 21 of the billing form, circle the additional diagnoses with a dark pen (such as a black Sharpie), and with that dark pen write the words "Additional Diagnoses" all across box 24 (where you would normally list itemized charges - but do not list any itemized charges when putting additional diagnoses), have the bottom of the billing page be completed as normal with the doctor's name, address, phone number, etc., and sign the page at the bottom left. Use as many billing pages as necessary with the same procedure when listing diagnoses 9-12, 13-16, etc. Automobile insurers are playing a game where they only list all diagnoses (which are worth money for the pain and suffering of a patient when someone else is at fault) in their computer when you submit the additional diagnoses on additional billing sheets (sorry, but a simple cover letter will not suffice, so please take the extra 5-10 minutes to do this the right way). Similarly as to the newer version of the CMS-1500 billing forms which allow 12 diagnoses per sheet, additional forms will be needed to list additional diagnoses (diagnoses 13-24, 25-36, etc.).

Diagnosis codes should be listed in the following hierarchy: 1) trauma codes, 2) neurological conditions and symptoms, 3) all symptoms other than neurological symptoms, and 4) underlying conditions. Trauma ICD-9 codes include 338.11 (acute pain due to trauma for new pains), 338.21 (exacerbation of chronic pains worsened by trauma), and the E codes (such as E812.0 and E812.1 for two or more motor vehicles colliding, with the .0 for the driver and the .1 for any passenger), and the 800 series of codes (e.g. 847.0, 839.08, etc.). Do NOT use the 739 subluxation codes when there has been trauma, because the 739 series means there are subluxations NOT due to trauma. All neurological ICD-9 codes should be listed next (such as sciatica, cervicocranial syndrome, cervicobrachial syndrome, etc.). Thirdly, all symptoms other than neurological symptoms should be listed (such as pain in joints, etc.). Similarly with ICD-10 subluxation codes, it is far better to use the M99.1x series of codes (M99.10, M99.11, M99.12, etc.) because they are defined in terms of vertebral subluxation complex (which is consistent with chiropractic philosophy) and do not use the non-traumatic terminology of the ICD-9 739 series (segmental dysfunction) which is mimicked by the ICD-10 M99.0x series of codes (M99.00, M99.01, M99.02, etc.). Finally, all underlying conditions should be listed (such as fibromyalgia, degenerative disc disease, scoliosis, etc.).

List all recommendations you make throughout the entire length of care of each patient.

The proper way to release a patient for an automobile accident care when they have achieved as good a condition as possible (when their symptoms have reached a plateau) in reference to insurance billing is to state in writing that the patient has been released for treatment related to their automobile accident that occurred on (date) with residual symptoms of (specify the residual symptoms, their severity, frequency of occurrence, and duration, if appropriate) as the patient has achieved as good a condition as possible (or maximum medical improved has been achieved), but the patient is subject to

further treatment related to their automobile accident for flare-ups of their related signs and symptoms. This is a very fair way to only bill the insurance company for what is truly accident related, positions the doctor as being honest, and allows the patient to still be able to get insurance benefits for accident related care as necessary.

Proper Insurance Billing -

Medicare, MediCal, and Blue Shield of California require the use of CMS-1500 billing forms, but many insurance companies allow either the HCFA-1500, older CMS-1500, or the newer CMS-1500 billing forms to be used when billing with ICD-9 codes. Only the newer CMS-1500 billing form can be used with ICD-10, which is required by Medicare and most insurance companies for dates of service Oct. 1, 2015 and thereafter. Stated another way, the newer CMS-1500 billing forms are universal as they can be used when billing all insurance companies for all dates of service. Make sure that you pay attention to detail, and dot your i's and cross your t's when completing the billing forms. When filling the fields for dates, Medicare and Blue Shield of California require four digit years to be used (e.g. 1975, not 75). Medicare changes their rules every few years or so, and therefore you will periodically have to check with them for any changes they require. In box 12, you can print out the words "SIGNATURE ON FILE" and similarly in box 13 you can print out the words "SIGNATURE ON FILE" where signatures are requested. Although box 19 is normally left blank, for Medicare this is the box where subluxations seen on x-ray are listed, and the same box 19 is used to put the words "CORRECTED CLAIM" whenever a corrected claim is submitted. Box 21 is used for listing diagnoses as previously discussed.

Box 24 with all of its letters is used for itemized procedure codes and their associated information. When using the newer CMS-1500 billing forms, use only up to six lines of itemized billing, and list the information in the lower white half line. The upper pink area is used to list additional information in unusual circumstances. Box 24A is used for listing the date of service. List the date of service under the "From" column, and in the "To" column either leave it blank or repeat the same date as in the "From" column (assuming the procedure was performed within a single day). Box 24B uses a numerical code to list the place of service, with 11 being your office, 12 being the patient's home, and 15 being a mobile office. Box 24C is used to report services rendered in the event of an emergency; if there was an emergency use the letter "Y" to indicate yes, and leave the space blank if there was no emergency.

Box 24D is used for the appropriate procedure codes and their modifiers. The newer CMS-1500 billing forms have spaces for up to four modifiers, which are listed to the right of the corresponding procedure code. Always use only the appropriate procedure code that best describes the procedure actually performed, and make sure you can back up your use of the procedure code with your documentation in your chart notes. Insurance companies operate under the assumption that nothing happened if it wasn't documented.

Box 24E is the diagnosis pointer, and is used to indicate which diagnoses of those listed in Box 21 related to the treatment rendered with each itemized line of billing in Box 24. Do not use spaces, dashes, or commas; instead use whatever diagnosis codes numbers from Box 21 that are pertinent listed all together (such as "A").

In Box 24F, list the dollar amount of each itemized charge, but do not use any dollar signs or commas. Box 24G is used to report units of 15 minute time periods for timed procedures with at least half of any 15 minute period used. For example, if a procedure took 23 minutes to perform, 2 would be indicated in Box 24G to show that at least part of two separate 15 minute time periods were used (with at least half of the last 15 minute time period used). If you actually used less than one half of any time period (less than 7.5 minutes), do not bill for the last 1-7.5 minutes so as to prevent problems such insurance fraud allegations.

Box 24J is used to indicate the treating doctor's identifying numbers. On the newer CMS-1500 billing forms, the lower white area is used to report a provider's NPI number. The upper pink area is used to report one additional identifying number, if appropriate (such as Blue Shield of California's identification number with which you would also indicate "1B" in the pink area of Box 24I, or Medicare's Provider number with which you would also indicate "1C" in the pink area of Box 24I).

Box 25 is used to report the doctor's or facility's federal tax identification number (also known as TIN, Employer Identification Number, or EIN for short). For individuals, it is unwise to use a social security number with all of the identification theft occurring. It is a simple and quick procedure to obtain a federal tax identification number either over the telephone or on the internet by contacting the Internal Revenue Service. The IRS's phone number is (800)-829-1040,

and their website address is www.irs.gov. Make sure to check the appropriate box in Box 25 to indicate whether a social security or federal tax identification number (EIN) is being used.

Box 26 is used to indicate your own internal number assigned to your patient.

Box 27 is used to indicate whether or not assignment is accepted for Medicare purposes only. Both the yes and the no boxes will be blank for any billing other than Medicare. In reference to Medicare, doctors registered in the Medicare system are either participating or non-participating providers.

If you are a participating Medicare provider (generally not desirable other than receiving 5% more than non-participating doctors for spinal adjustment charges, because participating Medicare doctors are not able to elect whether or not to accept assignment on a billing sheet by billing sheet basis, which will have the horrible effect of precluding payment from excess insurance companies for anything other than spinal adjustments when services are rendered to a Medicare beneficiary), then you will always mark the yes box in Box 27 so that you (and not the patient) will receive the money that Medicare pays for the spinal adjustment charges.

Sometimes there will be a Medicare beneficiary who has been involved in an automobile accident. Some doctors may think that they can receive greater payment from an automobile insurance company for spinal adjustments than what Medicare allows and pays, but not only is this not true, it would also be illegal and insurance fraud to attempt to do so by billing only the automobile insurance company and not billing Medicare for spinal adjustments (unless the patient withheld their permission for you to do so), IF you are enrolled in Medicare's system as either a participating or non-participating doctor. To word this in another way, if you are registered with Medicare (as either a participating or non-participating doctor), you MUST bill Medicare for spinal adjustment charges (and can also bill any other insurance such as automobile insurance which is primary in an automobile case) unless the patient withholds their permission for you to do so, and the maximum amount you can accept for any given spinal adjustment in this situation is the limiting charge set by Medicare on a county by county basis, REGARDLESS of other money available from other sources. Doing anything other than this when registered in the Medicare system constitutes Medicare abuse, and additionally when done intentionally constitutes Medicare fraud and insurance fraud.

In contrast, a chiropractor NOT enrolled with Medicare as a provider of chiropractic services is NOT limited as to what they can collect when adjusting the spine of a Medicare beneficiary. Disregard the well circulated common and false belief that chiropractors not enrolled in the Medicare system cannot adjust the spine (or treat in general) of a Medicare beneficiary. That piece of misinformation is not true, generally has not been stated by attorneys (who have a duty to state legal issues correctly), and can be summarized as misinformed people continuing to circulate wrong, unverified information (the blind leading the blind, so to speak). The truth is that chiropractors not enrolled in the Medicare system can adjust the spine and do everything else in the chiropractic scope of practice on Medicare beneficiaries, but there are certain things that should be obtained in a writing signed by the patient prior to treating them to protect the doctor. Contact me if you are interested in further information on this topic.

If you are a non-participating Medicare provider (much more desirable than the participating alternative), you are able to in indicate either yes or no in Box 27 on any given billing sheet. You will only want to mark the yes box when billing for spinal adjustment charges, and only spinal adjustment charges should be on a given billing sheet where the yes box is marked in Box 27. Marking yes in Box 27 has the effect of Medicare writing their check to the doctor or the doctor's business (instead of being written to the patient) for amounts allowed by Medicare. Charges for itemized procedures other than spinal adjustments (which Medicare will not pay chiropractors) such as exams, x-rays, and physical therapy should be on separate billing pages where the "No" box is marked in Box 27. Only by doing this will chiropractors be paid by excess insurance (including automobile insurance when there is an automobile accident) for charges other than for spinal adjustments.

Box 28 is used to indicate the total of your itemized charges shown in all 24F boxes. Similarly, Box 29 is used to show the amount received from either the patient or other insurance companies as of the date of the billing. Also, Box 30 is no longer used. With all of Boxes 28, and 29, do not use dollar signs or commas.

Do not leave Box 31 blank which is the certification of the billing. It is ideal to sign and date each billing page in Box 31, although the doctor’s printed name and letters for credentials (e.g. D.C.) with the date is sufficient. Remember that doing so renders you fully liable for everything on the billing page.

In Boxes 32 and 33, put the name of the provider in the first line, the address in the next line, and lastly the city, state, and zip code in the last line. Do not use commas, periods, or other punctuation other than a hyphen when using a nine digit zip code. Box 32 refers to the physical location where services were rendered, and Box 33 refers to the specific provider requesting payment.

In Boxes 32A and 33A, put the provider's NPI number. In Boxes 32B and 33B, first put the appropriate two digit/letter qualifier, and then put the additional identifying number (such as indicating "1A" and then Blue Cross of California's identification number, indicating "1B" and then Blue Shield of California's identification number, or indicating "1C" and then the Medicare Provider number).

Denials and Appeals -

Medicare Reviews and Audits -

Do NOT ignore Medicare reviews or audits, and timely respond to it. The consequence of doing so is that a doctor will be kicked out of the Medicare system as a provider when there have been a certain number of adverse final decisions made against them. Decisions become final when either the appeals process has been exhausted, or a doctor fails to further appeal within the given time period for doing so. It takes time and effort to draft letters to appeal an adverse decision, but you should win an appeal provided there is adequate and justifiable documentation for the billing submitted, provided other Medicare requirements are met. Medicare has been overly aggressive in the last several years in their efforts to pay less money and recover money that they allege they should not have spent, and they continue to take this stance at the time of this writing. On Medicare's website, it is stated that allegedly there is an unusual high error rate pertaining to chiropractic billings. Medicare does have a web page that lists important information in regards to documentation, and it would be a good idea to read it. One major reason for Medicare denials and reviews is that Medicare now requires a legible (not illegible) signature made by the doctor on any paper other than the CMS-1500 billing forms (where authentic, illegible signatures are still okay).

There are different names for the different stages of Medicare review. First there is the redetermination (made within the Medicare system), then reconsideration (made by an independent organization outside of Medicare), then a hearing by an administrative law judge (employed by the Social Security Administration), then a review by the departmental appeals board (final review by the Social Security Administration), and finally a review in federal District Court.

One major trick currently being played by Medicare is that they require a signature that is both legible as well as authentic on any page other than billing pages. Legible is obviously a matter of perspective, but it would behoove the doctor to artificially use a signature so clear that anyone could easily read it. Putting such a signature on every page other than billing forms will prevent many Medicare audits. Of course, make sure you sign all billing pages, but billing pages may be signed in an illegible but genuine manner.

ICD-9 Diagnosis Codes -

Do not mix ICD-9 dates of service and/or codes with ICD-10 dates of service and/or codes on the same billing sheet. Instead, use ICD-9 diagnosis codes with dates of service prior to and including Sept. 30, 2015 on a given billing sheet, and use ICD-10 diagnosis codes with dates of service Oct. 1, 2015 and thereafter on a different billing sheet. Mixing the information inappropriately will result in rejection of the claim.

E (External cause) codes are used to identify external causes of accidents, injury, or poisoning. For chiropractic purposes, these codes are usually used in conjunction with personal injury cases, and especially with automobile accident cases. The E codes range from E810 - E829 and have 4th digits after a decimal point so as to be more specific. Keep in mind that throughout the entire use of ICD-9 diagnosis codes, 4th and 5th digits are different for various groups of codes, are used for greater specificity, and must be used when available. Leaving out 4th and 5th digits when required will result in a delay of payment with the bill being returned to the doctor so as to be corrected. Using the 4th and 5th digits when required is known as coding to the highest level of specificity. It is important to look up these codes and digits whenever you are not totally familiar with them so as to be accurate. If possible, generally try not to use .8 or .9 as these can be a

red flag for delay. However, sometimes they are necessary, such as when there are two or more cervical subluxations caused by trauma (839.08).

Diagnosis codes should be listed in the following hierarchy: 1) trauma codes, 2) neurological conditions and symptoms, 3) all symptoms other than neurological symptoms, and 4) underlying conditions. Trauma ICD-9 codes include 338.11 (acute pain due to trauma for new pains), 338.21 (exacerbation of chronic pains worsened by trauma), and the E codes (such as E812.0 and E812.1 for two or more motor vehicles colliding, with the .0 for the driver and the .1 for any passenger), and the 800 series of codes (e.g. 847.0, 839.08, etc.). Do NOT use the 739 subluxation codes when there has been trauma, because the 739 series means there are subluxations NOT due to trauma. All neurological ICD-9 codes should be listed next (such as sciatica, cervicocranial syndrome, cervicobrachial syndrome, etc.). Thirdly, all symptoms other than neurological symptoms should be listed (such as pain in joints, etc.). Similarly with ICD-10 subluxation codes, it is far better to use the M99.1x series of codes (M99.10, M99.11, M99.12, etc.) because they are defined in terms of vertebral subluxation complex (which is consistent with chiropractic philosophy) and do not use the non-traumatic terminology of the ICD-9 739 series (segmental dysfunction) which is mimicked by the ICD-10 M99.0x series of codes (M99.00, M99.01, M99.02, etc.). Finally, all underlying conditions should be listed (such as fibromyalgia, degenerative disc disease, scoliosis, etc.).

Use as many billing sheets as is necessary to list all diagnosis codes. Also as stated above, it is important to list all pertinent diagnoses for a patient even though with group insurance you are likely to be paid with no problems when only listing four diagnoses. Listing all pertinent diagnoses is particularly important with personal injury cases. Since both the HCFA-1500 and CMS-1500 billing sheets only allow for a maximum of four diagnoses per billing sheet and the newer CMS-1500 billing sheet use only allow for a maximum of 12 diagnoses, you will need to use as many additional billing sheets as necessary when there are five or more total diagnoses with the older forms (and 13 or more total diagnoses with the newer forms). The diagnoses are put in box 21 of the billing forms. The proper procedure is to complete all of the patient's basic information on the top half of the billing sheets, put diagnoses numbers 5-8 with the older forms (13-24 with the newer CMS-1500 billing form) in box 21 of the billing form, circle the additional diagnoses with a dark pen (such as a black Sharpie), and with that dark pen write the words "Additional Diagnoses" all across box 24 (where you would normally list itemized charges - but do not list any itemized charges when putting additional diagnoses), have the bottom of the billing page be completed as normal with the doctor's name, address, phone number, etc., but with no dollar amounts, and sign the page at the bottom left. Use as many billing pages as necessary. Automobile insurers are playing a game where they only diagnoses (which are worth money for the pain and suffering of a patient when someone else is at fault) as legitimate in their computer when you submit the additional diagnoses on additional billing sheets (sorry, but a simple cover letter will not suffice, so please take the extra 5-10 minutes to do this the right way).

Personal Injury diagnosis codes –

There is confusion occurring as to payment of personal injury claims with the use of both ICD-9 and ICD-10 being used for appropriate dates of service. Many insurance companies are choosing their own method of operation in regard to both ICD-9 and ICD-10, despite a number wrongly doing so. Even though “covered entities” (doctors and billing services hired by doctors any of which bill electronically) are required to use ICD-10 diagnosis codes when billing for dates of service Oct. 1, 2015 and forward, a number of automobile insurance companies are wrongfully setting their own policy in regard to the use of ICD-9 and ICD-10 in defiance of the new federal law. For example, at the time ICD-10 was implemented, State Farm processed insurance claims with both ICD-9 and ICD-10, and for an indefinite period of time as to ICD-9 claims regardless of the date of service. In contrast, Progressive Ins. Co. rejects claims for dates of service Oct. 1, 2015 and thereafter using ICD-9. Even though it might be easier to call the given claims adjuster and ask what they will accept, the correct procedure for “covered entities” is to use ICD-10 for claims with dates of service Oct. 1, 2015 and thereafter, and to use ICD-9 with claims of service Sept. 30, 2015 and prior to that date. Doctors who are not “covered entities” (most of those doctors who do not bill electronically) are not required to use ICD-10 by federal law because the mandatory use of ICD-10 for “covered entities” has been added as an attachment to federal HIPAA law. However, doctors who are not “covered entities” are a minority and will probably discover that insurance companies eventually will insist upon all doctors using ICD-10 for dates of service Oct. 1, 2015 and thereafter in order to be paid.

When an insurance company including automobile insurers wrongfully insists upon the “covered entity” doctor using ICD-9 and/or ICD-10 incorrectly (in conjunction with the given date of service), the doctor should keep in mind that doing so would be illegal. Doctors like anyone else as well as business entities must abide by all laws. Using ICD-9 and/or ICD-10 incorrectly in regard to dates of service would be illegal as to “covered entities.” Federal laws become the

law of the land when the president of the United States signs a bill authored by Congress. Congress' most powerful ability to make laws is based on the Commerce Clause of the United States Constitution. No person or any business entity can interfere with any law. Even though ICD-10 and HIPAA law pertain only to "covered entities," automobile insurance companies cannot rightfully insist in operating in violation of any law, and cannot force others to violate laws. "Covered entity" doctors should only use ICD-9 and ICD-10 properly with claims. If an insurance company does not pay bills, the solution is for the patient to sue the insurance company for breach of contract. In California small claims court, assignees (third party beneficiaries such as doctors) are not allowed to file a claim. Therefore, it is the patient who must file suit against the insurance company.

Medicare diagnosis codes –

Medicare ICD-10 Diagnosis Codes –

For dates of service Oct. 1, 2015 and thereafter, the only thing that has changed in reference to billing is the required use of ICD-10 codes. Just as with ICD-9, Medicare requires a primary diagnosis code and a secondary diagnosis code for each defined (cervical, thoracic, lumbar, sacrum, and pelvis) area with diagnoses. For dates of service Oct. 1, 2015 and thereafter, the primary diagnosis codes can only be from the following:

ICD-10 Primary Codes –

M99.00 Segmental and somatic dysfunction of head region
M99.01 Segmental and somatic dysfunction of cervical region
M99.02 Segmental and somatic dysfunction of thoracic region
M99.03 Segmental and somatic dysfunction of lumbar region
M99.04 Segmental and somatic dysfunction of sacral region
M99.05 Segmental and somatic dysfunction of pelvic region

One appropriate secondary code must then be selected to be used in conjunction with each primary diagnosis code. These secondary codes are to be chosen from one of three categories – category one indicates expected short term treatment, category two indicates expected moderate term treatment, and category three indicates expected long term treatment. It would be wise to perform sufficient testing and documentation especially when there is expected long term treatment to be rendered so as to avoid problems if ever audited by Medicare. The list for the choices for secondary codes is too long to be detailed here, and this long list is available along with other ICD-10 help on the CMS website at www.cms.gov/icd10. This web address has a variety of helpful tools to assist doctors' offices with the proper use of ICD-10.

Medicare ICD-9 Diagnosis Codes –

Since it is after Sept. 30, 2016, it will be too late to bill Medicare for dates of service Sept. 30, 2015 and earlier because Medicare does not accept billing when received greater than 365 days following the date of service. Therefore, ICD-9 no longer applies with Medicare.

Personal Injury cases with Medicare beneficiaries -

When there is a personal injury case with a Medicare beneficiary, there is usually insurance to bill in addition to Medicare. Medicare has a mandatory claims submission requirement in regard to an enrolled Medicare provider who renders services to a Medicare beneficiary. This mandatory claims submission requirement is federal law, and billing for spinal adjustments when rendered by a Medicare enrolled doctor when treating a Medicare beneficiary must be done with 365 days of the date of service UNLESS the patient withholds their permission for the doctor to bill Medicare (as previously discussed). Although Medicare is deemed secondary to automobile insurance, Medicare must also simultaneously be billed in conjunction with automobile insurance. Remember to send bills to Medicare with only two diagnoses per defined area treated on the billing sheets, but list all diagnoses when billing the other insurance companies or when sending bills to your patient's attorney. Also remember that the maximum amount that can accepted from all sources of money for chiropractic adjustments to a Medicare beneficiary when treated by a chiropractor registered/enrolled in the Medicare system is the limiting charge determined by Medicare. However, chiropractors can accept the full amount billed for any itemized charges other than spinal adjustments.

Remember that Medicare requires ICD-10 diagnosis codes to be used when billing Medicare for dates of service Oct. 1, 2015 and thereafter. Certain automobile insurance companies may not accept ICD-10 until they decide to do so. Therefore, it could be necessary when treating a Medicare beneficiary involved in an automobile accident to bill Medicare using ICD-10 codes and bill the given automobile insurance company using ICD-9 diagnosis codes. Make sure your office calls each automobile insurance company to determine whether or not they accept each of ICD-9 and ICD-10 diagnosis codes for dates of service Oct. 1, 2015 and thereafter. When billing Medicare using ICD-10 diagnosis codes and an automobile insurance company with ICD-9 diagnosis codes for the same dates of service, make sure you write a short explanation concerning this situation to the automobile insurance claims adjuster stating that limited few ICD-10 diagnosis codes are required to be billed to Medicare.

Procedure (CPT) Codes -

Evaluation and Management (E/M) codes are used when services rendered are significant and separately identifiable from routine chiropractic adjustments (Chiropractic Manipulative Treatment (CMT) 98940, 98941, 98942, & 98943) of both the spine and extremities, both with new and existing patients. CMT includes the routine use of evaluation and management, including pre-adjustment evaluation to determine subluxations and post-adjustment evaluation. Any evaluation and management over and above that of CMT is reported separately with the use of the -25 modifier (especially when used on the same date of service as an adjustment; otherwise the insurance company will not pay for the exam). E/M codes are commonly used with initial exams, re-exams, exacerbations or reinjury, counseling (previously known as a Report of Findings), and release or discharge from active care.

Selecting the appropriate E/M code requires determining the extent of the history obtained, the extent of the examination performed, and the complexity of clinical decision making. Both the extent of the history obtained and the extent of the examination performed are defined in terms of being either a) problem focused, b) expanded problem focused, c) detailed, or d) comprehensive.

For the extent of history obtained, problem focused includes the chief complaint and a brief history of the present illness or problem. Expanded problem focused includes the chief complaint and a brief history of the present illness or problem, plus a problem pertinent system review. Detailed includes the chief complaint, extended history of the present illness, a problem pertinent system review that also includes a review of a limited number of additional systems, and pertinent past, family, and/or social history directly related to the patient's problems. Comprehensive requires a chief complaint, extended history of present illness, review of systems which are directly related to the problems identified in the history of the present illness plus a review of all additional body systems, and a complete past, family, and social history.

For the extent of the examination performed, problem focused requires a limited examination of the affected body area or organ system. Expanded problem focused requires a limited examination of the affected body area or organ system and other symptomatic or related organ systems. Detailed requires an extended examination of the affected body areas and other symptomatic or related organ systems. Comprehensive requires a general multisystem examination or a complete examination of a single organ system.

Complexity of clinical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option based on a) possible diagnoses to be considered, b) the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed, and c) the risk of significant complications.

For a new patient, all of the key components (history, examination, and clinical decision making) must meet or exceed the stated requirements for a given E/M code. For an established patient, only at least two of the key components must meet or exceed the stated requirements for a given E/M code. The following chart summarizes the requirements for E/M codes:

New Patient

Code	Presenting Problem	History	Examination	Clinical Decision
99201	self-limited or minor	focused	focused	straightforward
99202	low to moderate	expanded	expanded	straightforward
99203	moderate	detailed	detailed	low
99204	moderate to high	comprehensive	comprehensive	moderate
99205	moderate to high	comprehensive	comprehensive	high

Established Patient

Code	Presenting Problem	History	Examination	Clinical Decision
99211	no key components are required for this coding level			
99212	self-limited or minor	focused	focused	straightforward
99213	low to moderate	expanded	expanded	low
99214	moderate to high	detailed	detailed	moderate
99215	moderate to high	comprehensive	comprehensive	high

The above components can be overridden based on face to face time between the doctor and patient, including the history, examination, clinical decision making, counseling (report of findings), and coordination of care. Counseling the patient must include at least one of diagnostic results, impressions, and/or recommended diagnostic studies, prognosis, risks and benefits of treatment options, instructions for treatment or follow-up, importance of compliance with chosen treatment options, risk reduction, and patient and family education. As long as at least half of the average time for the given E/M codes is used with doctor/patient face to face interaction specifically with COUNSELING and/or COORDINATION OF CARE, a higher E/M code may be used as follows:

Code	Average Time
99211	5 min.
99212	10 min.
99213	15 min.
99214	25 min.
99215	40 min.

For example, if use of the key components determines a proper E/M code of 99212, but 13 minutes of doctor/patient face to face interaction was utilized, it is appropriate to bill the 99214 code. It is therefore important to document the actual face to face time spent with a patient, especially when billing for a higher E/M code than would normally be appropriate.

Radiology (Diagnostic Imaging) -

Radiological billing codes are in the 72000 and 73000 series, and there are too many to list here. Some radiology procedure codes have recently been changed. You will have to look up specific codes if you are not 100% certain that you are using the correct one.

Make sure you obtain diagnostically readable films once you have made the decision to take radiographical films of a patient. Any necessary retakes do not count as extra films for billing purposes. In California, at least three lines of collimation must appear on a radiographical film to be proper. Remember that collimation is required so as to show proof of minimizing x-ray exposure to patients, which is one aspect of professional competence.

Make sure you bill the correct radiological billing code for the films actually taken. For example, if you take sectional films of each of the cervical, thoracic, and lumbopelvic regions of a patient, it is wrong to bill using the code for full spine films because the individual sectional films are the most accurate codes to indicate the work performed.

Adjusting Codes -

Modernly, there are now four (98940, 98941, 98942, and 98943) chiropractic adjustment codes. Following the general billing and coding rules, doctors and facilities must bill by using the most appropriate code for each corresponding procedure performed on a patient. Therefore, even though there are osteopathic adjustment codes that formerly could and were used by chiropractors in the past, this is no longer allowed because the chiropractic codes are specific to chiropractors.

There are five anatomically defined areas pertaining to the chiropractic spinal adjustment codes (98940, 98941, and 98942). The first four are self-explanatory with the fifth area having to be inferred from the fourth area. The five areas are defined (obviously not by a chiropractor) as follows:

cervical spine (plus the atlanto-occipital joints)
thoracic spine (plus all rib joints)
lumbar spine
sacrum (which also includes the coccyx by inference, since it is closer to the sacrum than to the iliae)
pelvis (which really means iliae by inference, since the sacrum has its own separate area)

Using these five defined areas as a reference, the definition is as follows for the following chiropractic adjustment codes (pelvis used in the following definitions is the real life definition of the word which includes the sacrum and both iliae):

98940 chiropractic adjustment of 1 or 2 defined areas of the spine and/or pelvis
98941 chiropractic adjustment of 3 or 4 defined areas of the spine and/or pelvis
98942 chiropractic adjustment of 5 defined areas of the spine and pelvis

For example, if you adjusted atlas, C5, T2, T12, and L5 on a patient during a given office visit, the proper chiropractic adjusting code would be 98941.

Be sure to adjust only what is needed, and of course don't falsify any information in order to bill a code with more defined areas, as this would constitute insurance fraud. Furthermore, insurance fraud would still be committed by falsely billing a code with more defined areas that those actually needing to be adjusted regardless of the amount of money paid by the insurance company, because insurance fraud is based on the intent to wrongly obtain the property (money) of another by using false material information in order to induce their justified reliance on this false material information. For example, if a doctor adjusted only C1 and T6, but indicated in their chart notes that they adjusted C1, T6, and L5, and billed 98941 as their adjusting code, they have committed insurance fraud because they are attempting to obtain a greater amount of money from the insurance company for 98941 as compared to that paid for 98940. There is just no reasonable explanation for listing a vertebra not actually adjusted as having been adjusted, because doing so is unprofessional conduct in itself, and an honest person would only show what was actually done.

Finally, there is only one chiropractic extremity adjusting code for any and all extremity bones being adjusted, and that code is 98943. This code applies for any and all extremities other than ribs - upper extremities, lower extremities, skull, etc.

If the same doctor adjusts two different extremity bones on the same patient during the same calendar day, they could bill 98943 for the first extremity bone adjusted, and 98943-76 for the second extremity bone adjusted. Keep in mind that your chart notes must clearly indicate all that was performed, include a copy of all pertinent parts of the chart that pertain to billing submitted, and these same chart notes will protect you from any inference of insurance fraud provided that they are clear, legible, accurate, with the work done based on actually being necessary, and the billing being consistent with the chart notes.

Physical Therapy Codes -

Modalities have two subcategories - a) supervised (but does not require direct patient contact by the doctor) and use the codes 97010 - 97028, and also b) direct supervision (constant attendance by the doctor or their assistant) is required, and they use the codes 97032 - 97039.

Therapeutic Procedures attempt to improve function of a patient, and require direct supervision by either a doctor or their assistant. Therapeutic procedures codes vary from 97110 - 97799.

Make sure you accurately and fully report the particular physical therapy performed on a patient with a clear indication of the given body parts where the work was performed, and that the most accurate billing code is used.

Modifiers -

Modifiers are the equivalent to adjectives and suffixes. Just as the word suggests, modifiers change the meaning of the itemized procedure code to which they are appended. They make minor changes to the larger, majorly defined itemized procedure code. Keep in mind that the entire CPT system is medically oriented; don't be dissuaded from using certain modifiers just because they are defined in a medical way.

For example, the -76 modifier is used to indicate a repeat procedure on the same patient by the same physician. We chiropractors can never refer to ourselves as physicians because the word physician means a type of doctor who is able to prescribe medications. However, the instructions in the CPT book instruct the biller to use the best applicable code and/or modifier. Since there is no similar modifier specifically applicable to chiropractors for the same procedure performed twice or more in the same calendar day, chiropractors may appropriately use the -76 modifier when performing the same procedure twice or more on the same calendar day on the same patient. If you performed an adjustment on three defined areas, you would bill 98941 for the first time performing that service on a given patient, and also bill 98941-76 for performing the same procedure later on the same patient by the same doctor.

Another interesting (as interesting as this subject could possibly be) example would be performing an adjustment on three defined area on a given patient, and then later the same calendar day performing an adjustment on only one or two areas by the same doctor. Obviously, the first itemized billing code would 98941, but what should or could be used for the second billing code (98940 or 98940-76?)? There is truly an ambiguity in this situation, as an adjustment over one or two areas is probably contained within the three or four defined areas of 98941, and will actually be defined with your chart notes indicating what areas were actually adjusted. Assuming you adjusted atlas, a thoracic vertebra, and a lumbar vertebra on the given patient for the first visit, and later on the same calendar day and on the same patient you again adjusted only their atlas (or any cervical vertebra, for this example), your ambiguity exists. Your atlas adjustment comprised your entire second adjustment, and was also part of the first adjustment, thereby indicating a repeat procedure by the same doctor. However, atlas alone justifies only a 98940 itemized CPT code, which is technically different than the 98941 code, thereby indicating no need for the -76 modifier. The solution: the choice is yours. Since both ways of reporting the second adjustment (98940 and 98940-76) are essentially equivalent, either can appropriately be used.

With Medicare patients, make sure you have a signed, written statement stating that they are aware that Medicare is not expected to pay for non-spinal adjustment charges. Doing so will enable you to use the modifier -GA, which will in turn enable you to be paid by any excess (either secondary or supplemental) insurance coverage. I use the following statement in my permission to treat form, and feel free to replicate and use it with no restrictions:

MEDICARE patients: Medicare will reimburse/pay a majority of the spinal manipulation charges for an unlimited number of visits after your deductible has been met, as long as chiropractic care is "medically necessary" based on acute symptoms, it is reasonable expected that chiropractic will alleviate the symptoms, AND as long as the visits do not pertain to maintenance care. These are the only charges that Medicare will reimburse/pay, and Medicare will not reimburse/pay for any other charges to chiropractors – I, the patient must do so). Medicare will not pay for any other services performed in this office, and I realize I am responsible for payment of all services rendered to me, including those that Medicare will not reimburse/pay. I am aware that Medicare often changes its rules and regulations, and at any point in time parts of this paragraph may not be current. I understand this is my informed consent as dictated by Medicare.

The following is a list of commonly used CPT modifiers:

-22 Unusual procedural services

-25 Significant, separately identifiable Evaluation and Management service by the same doctor on the same calendar day as another procedure or service failure to appropriately use this modifier will typically result in non-payment of the E/M code

-26 Professional component (e.g. interpretation and report of radiographs)

-TC Technical component -
this modifier replaced the formerly used -27 modifier
Why is there an inconsistency with -26, -TC? (Why was this not done in the manner of either -26, -27 OR -PC, -TC? - Answer: obviously this was done by someone other than a D.C.)

-32 Mandated services

-50 Bilateral procedure (How ambiguous is this? Isn't every adjustment affecting every side of every bone? I've never used this modifier, nor have I ever not gotten paid for an adjustment from not using this modifier).

-52 Reduced services -
This one is extremely important so as to accurately report any timed CPT code that took less than 7.5 minutes of any 15 minutes to perform, as well as to negate any inference of the intent element of insurance fraud. The rule for this modifier is that the number of timed units billed is the sum of complete 15 minute units PLUS one extra timed unit ONLY if at least half of an additional 15 minute period is used. For convenience, and simplification, some recommend the one extra timed unit is used only when 8-15 minutes is used. Of course, bill the highest paying codes. For example, if you mechanically stretched a patient for 1 minute and performed massage for 19 minutes you would bill the code 97124-52 with only 1 unit, because less than 8 minutes was used in the next period of time after the first 15 minutes.

The -52 modifier is used to indicate a significant decreased level of service from the usual level of service, such as when explaining a home exercise regimen that the patient is to perform on their own at home.

-59 Distinct procedural service -
Although this code should be self explanatory and generally not needed to be used, it has become a necessity when billing Blue Shield of California for trigger point therapy on the same date of service as any other procedure performed. Even a person of even less than average intelligence should recognize that 98941 and 97140 are different numbers, which means that they are different procedures. Blue Shield of CA will only pay for trigger point therapy when the -59 modifier is used with 97140 (e.g. 97140-59), and further requires all bills to be sent on the newer CMS-1500 billing forms.

-76 Repeat procedure by the same doctor

-77 Repeat procedure by another doctor

-90 Reference (outside) laboratory

-99 Multiple modifiers

-AT Acute treatment (also known as Active treatment with Medicare, which the required affirmative assertion/declaration that the patient is an active/corrective phase of care - for use with CPT codes 98940, 98941, and 98942)

-ET Emergency services provided

-GA Waiver on File - This is doctor's declaration to Medicare that there is a signed, written statement on file by the given patient that they are aware that Medicare is not expected to pay for the given itemized CPT code

-GP Services delivered under an outpatient physical therapy plan of care for use by physical therapists

-GZ Item or service expected to be denied as not reasonable and necessary - Don't ever use this modifier, as it infers that some paper reviewer's opinion trumps that of you, the treating doctor. You obviously would only do what is reasonable and necessary.

-LT Performed on the left side of the patient's body

-RT Performed on the right side of the patient's body

Supplies -

There are a number of various supply codes, and they can start with three different letters - A, E, and L. The letter E appears to be a poor choice, since that is the same letter used for external causes of conditions. Just be sure to pay attention to detail so as to list these as well as all codes accurately. There are too many supply codes to list, but as an example as to how it is important to read all of several different possible codes that could apply to the given situation, the following are the two codes most pertinent to shoe (foot) orthotics):

L3020 Foot insert, removable molded to patient model, longitudinal/metatarsal support, each
L3030 Foot insert, removable, formed to patient foot, each

For example, if you used a deformable substance that upon which the patient steps, which you then send to an orthotic company for them to custom make shoe inserts for that patient, the proper code to bill is L3030.

Correct Answers to Tough Questions -

What would you do if you were the associate doctor and learned that the doctor in charge of the chiropractic business tells the chiropractic assistant and all the patients not to worry about the deductible and co-pays, and in no uncertain terms accepts in full whatever the insurance company pays?

This raises a number criminal, civil, and professional ethics issues. First, there would be no problem if that doctor in charge stated in writing to each insurance company billed this policy of theirs of waiving deductibles and co-pays. Doing so would be the only proper legal way to waive deductibles and co-pays, but will have the financial consequence of each insurance not paying an initial amount equal to the given patient's deductible, and then reducing the amount the insurance company pays by the co-pay amount. If the co-pay amount is a flat, defined amount of money (such as a $15 per visit co-pay), then that amount of money would be deducted from the amount they are required to pay. Alternatively, if the co-pay was defined in terms of a percentage (such as an 80%/20% policy where the patient has a 20% co-pay), then the insurance company would reduce the amount they pay by the percentage of the patient's co-pay. In this example of an 80%/20% policy, after the amount deducted for the deductible, the insurance company would then pay 80% of 80% (or 64% overall after the deductible) to account for the 20% that the patient should be paying.

Not informing each insurance company of every waiver of deductible and co-pay constitutes a separate count of insurance fraud as well as unprofessional conduct from an ethics standpoint for each and every time it occurs. As stated above, insurance fraud is the intentional misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another. Most crimes involve a concurrence of a mental state with a physical act. Here, there must be an intent to deceive an insurance company by way of misrepresentation of at least one material fact. Intentionally is essentially synonymous with knowingly, and many of the insurance fraud laws use the word "knowingly." Misrepresentation is deceit, which is the misleading by use of a false statement. Material facts are those facts which are significant (as opposed to insignificant). Justifiably relied upon means that the insurance company must have relied upon the material misstatements, which is shown by payment of money that would not have been paid had true statements been used. Property used here refers to money, and "of another" refers to insurance companies.

Assuming that the doctor in charge is not informing each insurance company of every instance of their waiver of deductibles and co-pays in a signed writing, there are serious potential problems for every doctor of chiropractic who works on the premises, regardless of who is actively, passively, or even unknowing involved, and regardless of the IRS classification of employment (independent contractor versus hired employee).

Based on California's Chiropractic Act and its Rules and Regulations of doctors of chiropractic, every licensed doctor of chiropractic who works as a doctor of chiropractic on a given business premises is fully responsible for everything that occurs on that business property. This means even if the associate doctor was totally unaware of the insurance fraud occurring, they would still be accountable for professional discipline from the Board for the other doctor's insurance fraud to the full extent as the other doctor, because they are a licensed doctor of chiropractic working on the chiropractic premises.

Criminal insurance fraud charges are serious and carry heavy penalties, including imprisonment and restitution of money wrongfully obtained. The district attorney's office prosecutes crimes at its discretion and does so with technically unlimited taxpayer money, which means that the prosecutor has a huge advantage in paying for investigation of witnesses, collecting evidence, etc. The prosecutor will proceed to obtain an indictment of an alleged criminal when they feel they have sufficient information to obtain a conviction based on the evidence they have. Once bills and chart notes have been submitted to an insurance company, the insurance company will gladly provide a prosecutor with copies so as to prosecute an alleged crime of insurance fraud. The insurance company as well as the district attorney's office are motivated by sending a loud and clear message to others that crime doesn't pay, and it's not worth it to even try.

Once a criminal conviction has been obtained against a doctor of chiropractic, that doctor will automatically have their chiropractic license revoked by the Board based on the conviction of any felony. Felonies are those crimes that carry jail or prison time of over one year, and includes insurance fraud. However, even if there is insufficient evidence of a criminal conviction, an insurance company can still file suit against the doctor in charge in civil court in order to recover its losses. Civil courts usually require a burden of proof of only a preponderance of the evidence (anything over 50%), although fraud requires a burden of proof of clear and convincing evidence (about a 75% certainty), which is still less than the criminal standard of proving a case beyond a reasonable doubt (about a 95% certainty).

The absolute best thing the associate doctor could do to protect themselves would be to confront the doctor in charge and determine whether there will be a change of behavior or not as well as to make it clear that they will not participate in any wrongdoing. If the doctor in charge will not change, then it is necessary for the associate doctor to dissociate themselves from the other doctor and their practice and to operate in a different location, and to do this immediately.

If the doctor in charge does agree to do things correctly, it would be wise to inform the staff that the associate doctor will not participate in any waiver of deductibles and co-pays. Doing this will prevent a conspiracy to commit insurance fraud charge from being successfully prosecuted against the associate doctor, but will not prevent professional discipline from the Board for past wrongful occurrences that happened on the premises, nor will it prevent discipline for wrongful occurrences in the future should the doctor in charge continue to do wrong.

The bottom line is the only way to best protect oneself in this situation is to first inform all other doctors and staff that you (the associate) refuse to have anything to do with any wrongdoing, and it is best to immediately leave and find another location to work.

What would you do if you receive a letter from Medicare informing you that you supposedly owe them money based on an alleged overpayment because you should have known that payment would not be expected to be made, and the amount is only a little over $75?

Despite the amount being small, do NOT ignore a Medicare post-payment audit. Their detailed letter will be both offensive (calling you a debtor to the United States), and will list deadlines for appealing their decision (along with listing the address where to send the appeal), etc. Once there have been a certain amount of adverse decisions made against a given doctor, the doctor will be forced out of the Medicare program as a provider of services, and this can haunt the doctor when applying to be a provider with other groups.

About the Author -

Dr. David H. Hofheimer, D.C., Esq. is committed to the empowerment and service to others by actively and enthusiastically practicing personal injury and trial litigation law, continuing to practice chiropractic since 1991 and practicing law since 2010, and teaching continuing education relicensing seminars as an attorney to fellow chiropractors. With his major emphasis as an active full time personal injury and trial litigation attorney, he is at the present time the only active plaintiff personal injury attorney in all of northern California who is concurrently licensed in the state of California as both a doctor of chiropractic and an attorney at law. Dr. Hofheimer has as his purpose as a practicing lawyer the intention to empower the chiropractic profession and to maximize and protect peoples' legal rights, including those of fellow chiropractors and their patients. He has as his purpose as a practicing chiropractor the intention to have patients be well naturally through chiropractic. He makes himself available to all good chiropractors for anything related to chiropractic and law, as he would much rather have doctors of chiropractic prevent problems than have to deal with them. Feel free to contact Dr. Hofheimer at (707)-745-9700.

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