



October 2006

Legal Brief

## DON'T FALL INTO THE TRAP

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**Avoiding some pitfalls that can come from the latest personal-injury statutes can save you some headaches**

In recent years, many states have revised and changed the laws as they pertain to personal-injury statutes. Most changes have been in response to curbing fraud in the health care system and the way we deliver our services.

I have been treating patients for 23 years and I still evaluate my patients the same way, using established federal and state guidelines and standards.

In looking at an objective evaluation of a patient, you must describe, collect, and analyze the information in accordance with standards of care. Any deviation from these standards can get you in trouble with state law and your board. Every state has minimum standards as to documentation of each patient, no matter what type of case it may be.

Objectively evaluate a patient by getting a complete history that documents the patient's clinical status. Analyze the information in the history, examination, and other records to determine the nature and extent of injuries/illness. Lastly, compare the information you have collected in your evaluation and other medical-provider records.

A clear and accurate evaluation of the patient is essential to support medical necessity, need for care, and continued treatment. Your documentation must be consistent with practice parameters and guidelines set forth by state and federal standards.

On the opposite side of an objective evaluation that follows protocols are deviations from normal established standards. Fraudulent diagnosis or the misrepresentation of a diagnosis for reimbursement for a higher level of service accounts for 43% of all health care fraud. Billing for a service not rendered accounts for 34% of all health care fraud, and routine waiver of co-pays account for 21% of all health care fraud. All other circumstances account for 2% of health care fraud.

Here are the top traps that will get you in trouble.

### Write-offs

It shall constitute a material omission and insurance fraud for any physician or other provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the patient or intends to waive deductibles or co-payments, or does not for any other reason intend to collect the total amount of such charge.

All up-front reductions should be done post-settlement on a case-by-case basis. Do not make any agreements prior to resolution of a case.

Consideration shall be given to evidence of whether a physician or other provider makes a good-faith attempt to collect such a deductible or co-payment. This does not apply to a physician or other provider who waives deductibles or co-payments or reduces his bills as part of a bodily injury settlement or verdict.

### Lack of Documentation

Documentation shall include:

- the name of the person providing the service, the body parts treated, and the total time, including prep and

post services, for each therapy service; and

- change in diagnosis with a change in treatment or after a diagnostic test. This documents medical necessity and continued treatment care.

### Billing Exercise Codes

“Supervised” does not require therapists to be present throughout the entire service.

“Supervised” is generally billed at a lower cost than constant attendance. It is billed once per visit, regardless of the length of treatment or the number of body parts treated.

Examples of supervised modalities:

- 97010 hot/cold packs;
- 97014 electrical muscle stimulation; and
- 97012 mechanical traction.

Constant attendance requires therapist presence for the entire treatment. Only one patient must be present (one-on-one). Different codes and reimbursement rates exist for group activities.

Other constant modality codes are 97035, 97124, and 97110, all billed in 15-minute increments. Prep and post time is included in calculating total time when doing a time-sensitive code.

### Billing Massage Therapy

Massage and CMT codes billed together create problems. According to the American Medical Association (AMA), physical therapy service described by CPT code 97124 (massage) is not separately reportable when performed in a spinal region undergoing chiropractic manipulative therapy (CMT). Adjustments should be billed and documented to spinal sections. Massage will be paid with a –59 modifier if done on the same visit as CMT and documented as to muscle groups.



### New PI Law Changes

Many states have changed or amended their personal-injury (PI) law requiring physicians to perform more documentation in evaluating PI patients. Not all states have implemented these changes, so check with your particular state's requirements. Here is a list of new law changes that have been instituted in some states.

1) Solicitation in any form is illegal. It is unlawful for any person to have contact with an injured person within 60 days of the accident, directly or indirectly. This mainly pertains to obtaining police reports then soliciting patients for care in your office from those reports.

2) Health Care Financing Administration (HCFA) forms: They must be signed by the doctor. All boxes must be filled in. Any material omission means it's invalid billing.

3) Office procedures: The doctor must be present within the building where services are being performed or you cannot bill for it. A patient-disclosure acknowledgement form must be filled out on the first visit. It explains all procedure codes being billed.

4) Patient logs are mandatory for every office visit after the initial one. The log must reflect the date of service and must be consistent with the services provided.

Waiving balances/deductibles is now a felony if done up front and as a routine business practice. Exception: as done as a part of the patient's settlement.

### Billing Manual Therapy

According to the AMA, physical therapy services described by CPT code 97140 is not separately reportable when performed in a spinal region undergoing CMT.

### Billing Multiple Time Codes

Time is added together to determine units billed.

- 08–22 = 1
- 23–37 = 2
- 38–52 = 3
- 53–67 = 4

Reduced service modifier is –52.

For timed codes, use the combined time schedules and apply the modified to the remaining unit if between 8 and 14 minutes.

If total time equals fewer units than 1 unit per service, bill the appropriate number of units under the codes that represent the service where the most time was spent. For example: 8 minutes ultrasound, 10 minutes massage, 10 minutes therapeutic activities = 1 unit of massage and 1 unit of therapeutic activities.

### Office Visit Duplication

Adjustments and office visit (OV): Some E/M components are included in the adjustment code.

Range of motion (ROM)/muscle testing and OV: Evaluation of ROM is included in OV physical examination. Document the entire E/M service as required. Use a modifier on the OV code.

### Up Coding

Up coding is an action that submits a billing code that would result in payment greater in amount than would be paid.

- insurance fraud provisions: Systematic up coding by a physician with intent to obtain reimbursement otherwise not due from an insurer is guilty of insurance fraud.

### E/M Components

- OV matrix: The specific matrix in the CPT code matrix is based upon the extent of history and physical examination and the complexity of medical decision-making.
- time irrelevant in matrix.
- extent of history: comprehensive, detailed, expanded problem, and problem focused. One must be included for your history, using proper billing codes.
- extent of physical examination: This includes comprehensive, detailed, expanded, or focused physical examination, and must include body-part and organ systems.
- complexity of decision-making: Factors include the number of diagnoses and/or the number of management options to be considered; the amount of complexity of medical records; the diagnosis to be reviewed and analyzed; and the risk of significant complications, morbidity, and/or mortality.

All components must meet or exceed the appropriate E/M level for a new patient. Two of three must meet or exceed for established patients.

- time: Where 50% or more of face-to-face time is spent in counseling or coordination of care, time is a controlling element in setting the level. The extent of counseling and/or coordination of care must be documented in the medical records. Pre and post OV time is not included in the calculation of time for evaluation and management services.

### Patient Log

Not required in all states. For subsequent treatments or services, the provider must maintain a patient log signed by the patient, in chronological order by date or service, that is consistent with the services being rendered to the patient claim.

A fee slip is designed to comply with the patient-log request and must be signed by the patient.

### Patient Acknowledgement

This is not required in all states. The patient acknowledgement is sent to the insurance company on the initial visit only for services rendered by each physician for which a claim for a service for personal injury is based. The physician has the affirmative duty to explain the services rendered to the insured and that the form is

signed by the patient with informed consent. The physician rendering the service must also sign the form.

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