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A "Good" Diagnosis Can Improve Reimbursement

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It's not enough to pick a diagnosis just because it "seems" right. For your services to be considered reimbursable, insurance companies are requiring that your diagnoses are valid compatible with your CPT (procedure) codes, and substantiated by your documentation. The clinical rationale for choosing a diagnosis must be in writing and entered in the patient chart notes.

Box 21

The "pecking order" in which you place your diagnoses in box 21 of the CMS-1500 claim plays a role in the way insurance companies interpret the severity of a patient's condition and ultimately, how much they'll pay. For example, in most states, Medicare will pay your claim **only** if a primary/subluxation diagnosis (739 or 839 series) is in position number 1.

21. Diagnosis or Nature of Illness or Injury, (Relate Items 1,2,3 OR 4 to Items 24E by line)					
1. _____	←	Position 1	3. _____	←	Position 3
2. _____	←	Position 2	4. _____	←	Position 4

Unfortunately, there are only four positions on the CMS-1500 claim form. In box 21, it states "RELATE ITEMS 1,2,3,OR 4 TO ITEM 24E BY LINE." It's difficult to tell a patient's "entire story" in four spaces. For example, it's impossible to fully report 98941 (3-4 region adjustment), 97140-59 (manual therapy techniques) and 98943-51 (extraspinal adjustment) in four positions. In this scenario, you would need at

least five spaces to be able to link the CPT codes to the proper *ICD-9 (International Classification of Diseases - 9th Edition)* codes. This doesn't mean you won't be reimbursed if you report the above-mentioned procedures; you'll just need to substantiate the clinical rationale for performing them in your chart notes. You should try and fill all four positions in box 21 whenever applicable.

Accuracy

The diagnoses you choose represent your patient's condition to the insurance company and must be extremely accurate. If a patient presents to your office with severe low back pain, severe leg pain, constant leg numbness and foot drop, don't automatically assume and report disc involvement without a diagnostic test to substantiate it. Just because it "walks and talks" like a herniated disc doesn't mean it is a herniated disc. Additionally, a patient presenting with pain, numbness and tingling in the thumb, index and middle finger doesn't automatically mean it's carpal tunnel syndrome. If a herniated disc or carpal tunnel syndrome is reported without confirmation and consequently doesn't exist, it could hurt the patient's ability to get health insurance or employment in the future.

Additional accuracy is needed when utilizing certain rehabilitation procedures. For example, if you plan on utilizing myofascial release (97140) on the shoulder, a soft tissue diagnosis such as 719.51 (shoulder stiffness) makes sense.

Specificity

Many insurers require that the diagnoses submitted be to the highest level of specificity, with five digits being the most specific. For example, 722.52 (degeneration of the L5-S1 disc) is more specific than 724.5 (unspecified backache). Many chiropractors make the mistake of just adding a zero to the end of any diagnosis code that only has four digits. **Do not do this!**

Sprain and Strain

Sprain and strain diagnoses are often misused and can prevent the patient and/or doctor from getting reimbursed properly. Many insurers process sprain and strain diagnoses as relating to an injury (i.e. auto-accident, slip and fall). This signals the insurance company to mistakenly request accident details from the provider and/or patient. If no accident or injury occurred, it will obviously delay payment and cause unnecessary confusion. Also, sprain and strain diagnoses are frequently looked at by insurance companies as "self-limiting" conditions. Simply put, they'll pay for only six to eight visits and then start denying all

subsequent claims.

V and E Codes

V codes are typically utilized when a problem is present that influences the patient's health status, but it is not in itself a current illness or injury. V codes can be used for a patient who is not sick, but is acting as a donor of an organ or tissue. V codes can also be used for a patient with a known disease getting treatment, such as dialysis or chemotherapy.

E codes are typically utilized to permit the classification of environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. E codes are used as an addition to the main *ICD-9* codes.

If you plan on incorporating V and E codes, I recommend purchasing a quality reference book that explains these codes in detail. V and E codes are not utilized that often in the typical chiropractic office.

General Recommendations

- Try not to use *ICD-9* codes that are considered unspecified, not otherwise specified or not elsewhere classified.
- The treatment plan should be updated at least every 30 days, every 12 visits, or any time there is a change in condition (i.e. exacerbation, new condition, exit exam).
- Any change in diagnosis must be noted in the chart notes.
- All providers rendering therapy must document the appropriate history, examination, diagnosis, functional assessment, type of treatment, body areas to be treated, date therapy was initiated, and expected frequency, duration and anticipated goals of treatment.
- Functional measurements that change the diagnosis after the initial assessment must be recorded in such a way as to clearly document the patient's actual progress (or lack thereof).
- When the services exceed the expected recovery period as it relates to the reported diagnoses, the chart notes should include documentation of progress being made and anticipated prognosis or duration of treatment. There should be an indication that the patient still requires treatment, and the care plan should be amended to include the expected duration and frequency of additional services.
- Review your *ICD-9* coding approach with your office compliance officer and all billing staff members.

Table 1 lists the most common *ICD-9* codes used by chiropractors for low back conditions with lower extremity involvement. Of course, these are not all the codes that can be reported, just the most common ones

Table 1: Low Back Conditions With Lower Extremity Involvement

Instructions: Pick one diagnosis from each of the following four positions and place in box 21 of the CMS-1500 claim form.

Position #1: Neurological and Pain Syndromes

353.1 Lumbosacral plexus lesions
355.71 Causalgia of lower limb
719.06 Swelling of joint, lower leg
719.45 Pain in joint, pelvic and thigh
722.10 Herniation or displacement of lumbar intervertebral disc without myelopathy
724.2 Low back pain
729.81 Swelling of limb
782.0 Numbness

Position #2: Subluxation

739.3 Lumbar and lumbosacral region subluxation (segmental dysfunction)
739.6 Lower extremities subluxation (segmental dysfunction)
839.42 Sacral and sacroiliac subluxation (ill-defined dislocation)
839.69 Pelvic subluxation ill-defined dislocation)

Position #3: Structural

718.45 Contracture joint, pelvic and thigh
718.46 Contracture joint, lower leg
721.3 Lumbosacral spondylosis without myelopathy
722.93 Lumbar intervertebral disc cartilage calcification
733.01 Osteoporosis, postmenopausal
737.21 Lordosis, postlaminectomy

Position #4: Muscular Conditions, Unspecified Conditions and Congenital Anomalies

353.4 Lumbosacral root lesions, not elsewhere classified
715.05 Osteoarthritis, generalized, Pelvic region and thigh
720.2 Sacroiliitis
722.32 Schmorl's Nodes, lumbar region
781.2 Abnormality of gait
953.5 Injury to lumbosacral plexus
956.0 Injury to sciatic nerve

Many reliable sources within the chiropractic industry feel that each position in box 21 of the CMS-1500 form should fall within a categorical ranking. For example, position 1 is neurological; position 2 is structural, etc. On the other hand, Medicare requires that position 1 contain the primary/subluxation diagnosis and positions 2-4 contain secondary diagnoses codes, based on the level of expected treatment (i.e. short, moderate or long term).

Based on my experience with more than 300 chiropractic and multispecialty offices, I find the following diagnosis hierarchy most efficient:

Position 1: Neurological and Pain Syndromes

Position 2: Subluxation

Position 3: Structural and Functional Disorders

Position 4: Muscular Conditions, Unspecified Conditions and Congenital Anomalies

Important: Do not use certain **ICD-9** codes just because they will increase the amount of reimbursement. Use the diagnoses codes that accurately depict the patient's presenting complaint and underlying condition.

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