**Coding Do’s and Don’ts**
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**Question:** I’ve been in practice about seven years and have been billing and coding the same way since I opened my office. I want to make sure that I’m billing properly and coding compliantly. Can you provide me with some general guidelines?

**Answer:** You are making a wise decision to learn as much as possible about CPT coding. Every year (yes, every year) changes occur to CPT codes and ICD-9 (diagnosis) codes.

Here is a list of the most common CPT Coding and Compliance Do’s and Don’ts:

1. Don’t bill 98941 or 98942 on every patient on every visit (unless you can absolutely, with 100% accuracy, prove medical necessity in your notes).
2. Do incorporate re-evaluations as much as possible. The doctor, the insurance company and the patient need to be kept aware of the patient’s progress.
3. Do create a written treatment plan for every new patient.
4. Don’t routinely and automatically waive co-pays, deductibles and co-insurance.
5. Don’t tell the patient that you will accept the co-pay amount listed on their insurance card if you are out-of-network,
6. Don’t use “ACTIVE” therapy codes for Spinal Decompression Therapy.
7. Don’t use “ACTIVE” therapy codes for Low Level Laser Therapy.
8. Don’t use “ACTIVE” therapy codes for the AquaMed/Hydrobed devices.
9. Don’t automatically bill insurance companies for the amount of visits they cover. Example, just because an insurance carrier covers 20 visits does not mean you should bill them for all 20 visits. Bill only for those that are “medically necessary.”
10. Do know how and when to code and bill for group therapy, CPT code 97150, vs. individual therapy.
11. Don’t bill 97140 if you’re really doing a 98940.
12. Do make sure your new patient intake questionnaires are properly completed and make sense. For example, if the intake questionnaire only relates to one region of the spine – it is nearly impossible to bill a 98941 or a 98942.
13. Don’t bill for a “report of findings.” If you choose to bill for counseling/coordination of care, make sure you can substantiate it in your documentation.
14. Do try your best to re-evaluate your CPT/ICD-9 codes every month or whenever clinically necessary.
15. Do exercise caution when billing modifiers -25 & -59. Two HHS Office of Inspector General reports stated that each modifier was used incorrectly nearly 40% of the time. Both modifiers -25 and -59 are used to alert the payer that a second service should be paid separately, due to special circumstances.

Dr. Marty Kotlar, president of Target Coding, has helped chiropractors during the last 12 years to improve reimbursement through proper and compliant CPT coding. You can also sign up for webinar presentations. For more information call 800-270-7044 or visit www.targetcoding.com.