Dynamic Chiropractic

BILLING / FEES / INSURANCE

Billing Q&A: ROM Testing, Record-Keeping, Consultations and More

Samuel A. Collins

Author's note: Thanks to all of you who read this column and have taken the time to correspond to me with inquiries. And yes, I do get a lot of questions. This month, I'd like to answer several questions I recently received.

Q: How much time do I have to file a claim for insurance and Medicare? I understand there was a change.

Claims to general health insurance and now also Medicare are valid one year from the date of service. Any claim sent after that time will be rejected for untimely filing. For insurance, this has been the rule for many years, but the shorter time frame was recently enacted for Medicare as well.

Be aware that some carriers have even shorter periods to file a claim. Certain union plans, self-insured or similar can have as little as 90 days from the date of treatment to file the claim. Also, some states require much shorter time periods to file claims for personal-injury claims. For instance, in Florida a PIP claim will be rejected if not billed within the first 75 days. And in New York, a claim under no fault must be sent within 45 days after the date of treatment.

Due to potential variances, it is wise for an office to include, as part of its insurance verification, specific inquiry as to the time limit to submit a claim. My personal billing rule is that a claim for a date of service should never be delayed more than three days from the date it was delivered.

Note that standard medical practices bill out each date of service the same or following day and never hold a claim to allow multiple dates to be billed at the same time. This is a smart practice on two levels: 1) Claims are much less likely to be considered untimely filed; and 2) Cash flow improves when claims are sent on a daily basis.

Q: I have been doing ROM testing with inclinometers attached to a computer that gives a report. The manufacturer stated I would be paid separately for doing the ROM studies, but I have not been paid once. Is there something I am doing wrong or is this simply not a payable service?

Range-of-motion testing is a separately billable and reimbursed service. The codes are 95851 for a ROM study and report, each extremity or trunk section (spine); and 95852, which is the same as 95851 except it includes the hand with or without comparison to the normal side. These services are payable; however, there is provision for payment that the ROM must be done on a separate day from the examination (evaluation and management service) to be reimbursed.

It is likely that you have been providing these ROM studies as part of the overall exam, and therefore they have not been paid. However, if you were to do the ROM test the day following the exam, it would be separately reimbursed. In short, ROM testing done the same date as the exam is considered part of the overall exam and has no separate payment.

Q: I've heard there are codes for phone calls with a patient. How can I use and bill these?

Yes, there are codes for phone calls to a patient. They are defined as non-face-to face evaluation and management services to a patient using the telephone. The codes are 99441 for 5-10 minutes, 99442 for 11-20 minutes and 99443 for 21-30 minutes. But before you jump for joy, bear in mind that there are specific parameters to be met in order to qualify.

The phone call must be initiated by the patient and not the provider. If the telephone call ends with a decision to see the patient within 24 hours or the next available urgent appointment, the phone call code is not separately reported and is instead considered part of the pre-service work of the subsequent visit. Further, if the phone call refers or relates to a previous evaluation or chiropractic treatment within the past seven days, it is also considered part of the post-service of the prior visit and is not separately billable.

Considering chiropractic care and how it is commonly delivered, it is not likely these codes would be used. Chiropractors take action (hands-on care) to treat; seldom would they tell the patient to not come in and only do something at home. An MD certainly may have the patient call and do a phone evaluation to re-up a prescription or make a referral as part of a treatment protocol. This style would be consistent with the proper use of the code and the situations in which it would be most typically utilized.

Q: How long must I keep records of a patient? I have heard it is now 10 years.

Record-keeping is for seven years, meaning records must be maintained a minimum of seven years from the patient's last visit. This seven-year rule is a federal HIPAA regulation and supersedes any state regulation that may note a lesser time frame. However, note that if your state regulation is greater than seven years, you must comply with the state mandate.

This means if you have seen a patient once a year for 10 years, you must have all of their records, as records may not be destroyed until there is a gap of seven years or greater. Like nerve activity, it follows the "all-or-none" rule. You must have all the records or none of the records, and cannot discard records of a patient who is active just because a portion of said records may be more than seven years old.

That being said, there are two exceptions: Medicare record-keeping is now 10 years and a minor's (patient under 18) records must be kept until their 19th birthday or seven years, whichever is greater. That means if you see a 3-year-old, you must maintain those records for approximately 16 years, even if the patient never returns for care.

Q: I see there are codes for consultations, 99241 through 99245. Can I use these instead of an evaluation and management code? I do spend a lot of time consulting with my patients explaining their condition and how it should be treated; this code seems to be what I should use. And/or can I use it for a "report of findings"?

Outpatient consultation CPT codes are used to describe services provided by a physician or chiropractor whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (insurance carrier). It is not appropriate to bill for consultation when initiated by the patient or the patient's family. Simply stated, consultation services as defined by CPT are designated for exams done for second opinions and include a written report.

In referencing your specific statement about "consulting" with your patient, what you seem to be indicating is "counseling," which is integral and a component of the exam (evaluation and

management) and therefore included. You should not use consultation codes for exams or reports of findings.

Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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