How to make your chiropractic
medical claims cleaner and improve cash flow

Researching unpaid or denied claims is a frustrating and time-consuming process. On average, more than 25% of lost practice revenue comes from poor medical billing and revenue cycle management practices. According to the Medical Group Management Association (MGMA), the average cost of reworking a claim is $25 to $30.

Closing these gaps requires spot-on attention to patient information, treatment and diagnostic codes, and evolving billing rules and insurance regulations. Trapping all the details so your chiropractic claims get submitted and paid correctly on time is a challenge for many practices.

Listed below are a few reasons a claim may get denied and how you can troubleshoot the denial.

Missing or invalid information

Verifying a patient's insurance eligibility for the date of service and benefits is a critical first step. Always confirm pertinent information from the patient at check-in or during the data entry process for the claim. Even one required field, such as an insurance plan ID or Social Security (SSN) number will trigger a denial. Fast Pay Health ensures demographic and insurance data is correct by verifying plan coverage before submitting a claim.

New or established patient not clear

Patients are considered new if they have not been seen by any physician with the same specialty and sub-specialty within a group practice in the last three years. For solo providers, this is simple—if the patient hasn't been seen in the last three years, they're considered new. But for larger group practices, it can get tricky. Keeping proper records can help avoid this type of rejection. In some instances, an insurance payer may incorrectly reject a claim for a new patient exam. Most of the time this can be cleared up with a phone call to the payer, though some cases may require an appeal with medical documentation.

Referring or ordering physician not listed

In most cases, the referring or ordering physician may be the same as the rendering physician. However, failure to include this information will result in a denial and delay payment. If a required referring physician is missing, Medicare will often split those codes from the rest of a claim to expedite payment.

Provider wasn't credentialed by insurance payer

Always make sure the provider has been credentialed by the insurance plan before submitting the claim, since some insurance payers may require providers to "credential (get on insurance panels/board)" with specific plans individually. Fast Pay Health can help simplify the credentialing process by reviewing documentation to determine the participation status in the health plan, then submitting and tracking provider credentialing applications based on insurance plan requirements.

Service wasn't medically necessary, covered or pre-approved

A service/procedure that was medically necessary last year may now be a non-medical necessity, which means it isn't covered by the insurance payer. For example, Medicare Part B only covers manual manipulations of the spine if it is medically necessary to correct a subluxation when prescribed by a physician and provided by a Medicare-certified chiropractor.

Another example is because extraspinal manipulations (98943) includes one or more regions, such as head, lower extremities, upper extremities, rib cage or abdomen, always check your Local Coverage Determinations (LCD) policies on the insurance payer's website for a list of covered diagnoses. Make sure the patient is eligible for

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extraspinal manipulations and it is covered by the insurance payer and, if needed, you obtain pre-approval from the insurance payer, especially if the person has an active worker's compensation claim.

Incorrect/missing CPT code, modifier, PIN or NPI or billing all services at one level

Did you submit an incorrect CPT code, modifier, Personal Identification Number (PIN) or National Provider Identifier (NPI) number?

For example, modifier 59 defines a "Distinct Procedure Service" and identifies procedures or services that are not normally reported together. Be careful though as modifier 59 is one of the most used modifiers, and one that is often used incorrectly. If you performed manual therapy (97140) on the same visit as an adjustment, submit modifier 59 to show that it was a "separate and distinct service" and performed in separate anatomical areas. Never attach modifier 59 to an E&M service. Depending on the local policy, if the tests are necessary due to two separately identifiable conditions, you may be able to link the appropriate diagnosis code to each CPT and add modifier 59 to the second procedure.

Another example is you must use the Acute Treatment modifier AT for spinal chiropractic manipulative treatment (98940-98942) to identify services that are active/corrective of acute or chronic subluxation or your claim may get denied. Not using modifier AT indicates the patient is on maintenance therapy.

One red flag that gets the attention of insurance payers and auditors is when a chiropractor provides all services at one level or always bills at the higher level. Because every patient you see may not require a top to bottom chiropractic adjustment, avoid billing for a 5-region adjustment (98942) or full spine x-rays for every visit.

Chief complaint was missing

When you document the chief complaint, provide a concise description of the problem or laboratory test—this will help you in case you are ever audited. A missing chief complaint can result in a claim denial based on incorrect levels of care.

Benefit exceeds allowed # of visits or services

Many insurance payers only allow a certain number of chiropractic visits or services that are covered within a calendar year, while some also have coverage limits in dollar amounts per year. Some insurance payers may also limit the number of visits within a 60-day period. However, according to CMS, there is no cap for Medicare Part B on the number of medically necessary visits to a chiropractor.

Services weren't bundled

There are some services you can't file separately and may require bundling. For example, Medicare considers hot/cold packs as "bundled" services.

Duplicate claim or service

Did you submit the same claim twice? This often happens if you didn't receive reimbursement within 30 days. Before you re-file a claim, always check with the insurance payer first since they may be processing the claim.

Filing deadline has passed

If a claim is not submitted to the insurance payer within the permitted time frame, it will probably get rejected. Sometimes you only have up to 90 days from the date of service. In addition, if a patient has secondary insurance, you can run into timely filing denials. Many payers require you to bill a secondary carrier within a specific period, after you receive the primary payments.