Red Flags of Insurance Billing

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There are many errors that can cause your insurance forms to be rejected and/or denied for payment. The following are some common mistakes that can occur in insurance billing.

1. Billing for more than three to four modalities/procedures per visit. The therapeutic encounter for a patient is to be 30 minutes based on the insurance company's perspective. In that time, three to four therapies is more than adequate. There is also a phenomenon called a diminishing return of the therapies given to benefit the patient. Therefore, anything above this will have questionable value. Similar therapies given on the same visit may also be questioned. For example, a patient may receive a hot pack, moxa and infrared on the same visit. The question asked by the insurance company could be, "How much temperature heat to be placed on this patient before he is well-done?"
2. Billing an evaluation and management (E/M) on each patient encounter in addition to the therapy. This looks like the provider is trying to inflate the bill. If one were to look at the components that need to be present in the history, exam and medical decision-making to bill and E/M, the typical daily progress notes do not rise to this level. The daily progress notes are included in the therapy codes like acupuncture, etc.
3. Total charges for daily treatment are not reasonable in the area. Your charges for workers' compensation, personal injury and health insurance should be the same. Just because a case is a personal injury case does not mean you can inflate the bill. This is a red flag to the insurance company; besides, it is illegal to have multiple fee schedules.
4. Treatment for soft tissue injury exceeds three months. If a patient with a soft tissue injury such as a sprain and/or strain is not treated, the condition will reach maximum improvements in three months. Therefore, if a patient is being treated for a soft tissue injury for more than three months, the question arises: what therapeutic benefit are you offering to the patient's recovery? If the patient has not been afforded Oriental medical care during the previous treatment, it may be worth trying a short therapeutic trial to see if there is any improvement. Continue if there is measurable improvement; discontinue if there is no change.
5. The records do not support the diagnosis or treatment plan. If the history and examination findings do not support the diagnosis, the treatment is not supported. This is why tongue, *shen* and pulse diagnosis is not adequate. A more thorough history and examination needs to be performed so the patient's progress can be monitored objectively through re-examination.
6. The patient is seeing multiple doctors and has duplicate services on each day. Be careful when you are treating a patient being seen by other providers. What may happen is that other providers are giving the same therapy (ice, heat, massage, etc.) as you on the same day. The question of diminishing therapeutic benefits arises.
7. Diagnostic tests are not supported by the chief complaints, exam findings or diagnosis. Diagnostic tests such as MRI, x-ray, laboratory tests and bone scans must be supported by the history and examination findings. These two components lead to the type of diagnostic tests. It is inappropriate to order an MRI of the neck, midback and low back when there was only an injury to the neck, with no radiation in the extremities, muscle weakness or other reasons indicating such a test. It could look as if the final bill has been inflated.
8. The property damage to the car is not proportional to the medical treatment given. When evaluating a personal injury case, look at the dollar damage to the car: sometimes, it

indicates the severity of injury sustained by the patient. For example, if the patient was in a vehicle that had $1 damage, but the patient received $10,000 in medical care, is this appropriate? Conversely, a patient is in a vehicle that sustained $5,000 in damage, and the patient received $3,000 in medical care. The second situation appears more reasonable. There are always exceptions and, if so, each case can (and should) be argued. I had one case in which there was $200 in damage to the cab of the patient's pickup truck, but the patient had $5,000 in diagnostic tests and treatment. On the surface, this looks inappropriate; however, the pickup truck had 2x4 lumber handing a few feet out of the back. The car behind the pickup truck did not stop in time and hit the lumber, forcing it through the truck cab where it impacted with the patient's lumbar and sacral regions. The cost of fixing the hole in the metal cab was minimal, but the physical and financial impact to the driver was severe.

These are a few red flags that may get your claims denied. Remember, there is usually some logic behind the denial. Try to put yourself in the insurance company's shoes. This can help you anticipate and avoid potential claims denials.

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