ACUPUNCTURE today

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Speaking in Code

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At this point, I am certain everyone is aware of the CPT codes for billing acupuncture. However, there have been some recent cases where it is clear that not everyone is following the clear-cut rules on how to define and use these codes. Depending on your state laws, not properly coding can result in billing delay or denial, fines for wrong coding and fraud investigation.

Probably the most recognized code is 97810 – needle acupuncture without electrical stimulation. This is the code that is most applicable to most acupuncture practitioners. There has been some debate whether these codes cover non-needle acupuncture modalities – I would at least use one needle to contact a point to meet the literal requirements of using the code.

The other primary code – 97813 – is for needle acupuncture with the application of electrical stimulation. I personally use this code often, as I work with several orthopedists and treat post-spinal surgery patients. Needling the spinal huato points with stim has a very calming effect, and helps open up flow along the bladder meridian. I will also treat other distal points, but this is the primary code to use. Remember, *do not* bill 97810 and 97813 on the same visit – they are mutually exclusive. You may needle points without stim, but you can only bill one primary code. Both 97810 and 97813 are understood to cover at least 15 minutes of supervised needle therapy.

The next question is what happens when you treat a patient longer than the initial 15 minutes. The codes for extended time billing are 97811 for needle without stim, and 97814 for needle with stim. There are parameters for using these codes: to use this code you must treat the patient for an additional 15 minutes of care, and you must physically be in attendance for the entire treatment.

At one point in time, there were published guidelines for timed therapies that advised if you treated for more than eight minutes into a second time-unit of care, you could bill for a full unit. That thinking is no longer appropriate. *Do not* bill a full unit of extended treatment unless your notes clearly show that the treatment provided was the required time and you were physically in attendance for the full time.

There is now a modifier for a reduced time treatment -52, that can be used if you do not perform a full extra unit of care. For example, if you treated a patient with a needle-only protocol for 23 minutes, you could bill 97810 and 97811-52, but you would bill the 97811 at 50 percent as you only performed a partial unit of treatment and documented half the time. I personally do not bill the extended time codes as I am not comfortable with them. I might treat a patient for 15, 25, or 30 minutes or more, but I will only bill the primary code for the service I provide. That is my choice. If you are comfortable billing the extra time codes, make sure your documentation clearly delineates the treatment provided, the amount of time the patient received care and that you were in physical attendance for the duration of the treatment.

I hope this is old news to everyone reading, and no one is surprised by this concept. Unfortunately, I am aware of at least one case that proves not everyone pays attention to the rules. A practitioner documented treating a patient for a back injury. The file showed a number of modalities, including

acupuncture. The records showed the patient was in the office for less than an hour at a time, but billing included 97810, 97811, 97813, 97814, as well as other codes for massage, mobilization and exercise. Not only were codes billed together inappropriately, but the records clearly showed that the amount of care billed could not possibly have happened in the actual length of the visit. The practitioner went to court to argue the billing, and was torn apart by the attorney prosecuting the case. Not only was the billing summary dismissed, but a fraud investigation was initiated due to the blatant misconduct on the part of the practitioner.

One last thought on this subject. We all understand the concepts and principles of acupuncture. We have a vocabulary and nomenclature to define what we do – our own "code" if you will. Be very aware that not everyone speaks that language. At some point in time, other practitioners, doctors and possibly attorneys, will review your records. You don't have to like that idea, but in today's medico-legal society every practitioner – including you – is responsible for patient records. If they are poorly written, illegible or cryptic, they become of little value and quickly become a red flag. Don't fall into that trap. Make sure your records are concise, legible and contemporaneous to the care you provide. In the short-term it keeps you on track for your care plan, in the long-term it lets you look back and recall the care you provided. Take the time to keep good records, it's good practice and good business.

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