Coding & Documentation

The Future of AI.

Presented By: **David Klein CPMA, CPC, CHC**
On behalf of the **Florida Chiropractic Association**
August, 2026

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Artificial Intelligence

How Many of You are Currently Using Artificial Intelligence in your Daily lives or Practice?

2

AI in Billing and Coding: Why It Matters Now

- AI is embedded in every part of healthcare operations. Documentation tools, auto-coding engines, auto-RCM workflows, automated edits, denials, and prior authorization systems increasingly run on machine-learning models or algorithm-driven logic.
- Two critical themes for Practices: Be AI ready, and question everything. This means anticipating how AI affects documentation, coding accuracy, and payer review processes.
- AI creates metadata and audit trails. Every automated suggestion, correction, or code assignment can be reconstructed by investigators, payers, and regulators, which increases risk if oversight is lacking.
- Payers and regulators now rely heavily on AI-driven data analytics to identify trends, aberrancies, and provider-level anomalies. Providers must assume they are being continuously profiled.

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The New Speed of Denial

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The New Speed of Denial

In 1977, the GAO reported that the average number of claims reviewed in one day by a single human was…

Reviewers would spend an average of 45 minutes to an hour to review a single claim

10.5

5

The New Speed of Denial

Today, and by leveraging AI, the average number of claims reviewed in one day by a single human is…

125,000

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The New Speed of Denial

"We literally click and submit - it takes all of 10 seconds to do 50 denials at a time."

In just two months, Cigna denied over 300,000 claims for payment…

300,000

7

1.2
Seconds

8

The New Speed of Denial

In 1977, a claims examiner would spend their entire career - 30 years - to review approximately 75,000 claims.

Today, an insurance review Doctor processes that same number of claims *before lunch on Tuesday.*

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Slave to the Machine

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CIGNA'S PxDx System

- AI reviews claims in bulk batches
- Medical directors given 10 seconds per 50 claims
- No patient file review required
- Automatic denial based on AI flags

Source: https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

"One doctor denied over 60,000 claims in a single month."

Former Cigna MD

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UHC's nH Predict

- Uses AI/ML to predict post-acute care needs
- Overrides physician clinical judgement
- Denies based on population averages
- 90% documented error rate

https://www.cbsnews.com/news/unitedhealth-lawsuit-ai-deny-claims-medicare-advantage-health-insurance-denials/

UHC KNEW the AI was 90% wrong.

They kept using it anyways.

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Slave to the Machine

According to the class-action lawsuits filed, Cigna and UHC are intentionally denying claims they know will be overturned.

Why?

Because they know the vast majority of denied claims won't ever be appealed.

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Slave to the Machine

Former Cigna Employees

https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

"Medical directors do not see any patient records or put their medical judgement to use."

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Slave to the Machine

2024 Senate Subcommittee Investigation

In December of 2022, a UHC working group met to explore how to use AI and "machine learning" *to predict which denials were likely to be appealed.*

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WISeR: Medicare's New AI Blueprint

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Medicare's AI Training Ground

- 6-Year pilot (2026-31) in AZ, NJ, OH, OK, TX, WA
- Utilizes AI to perform REAL-TIME "medical necessity" evaluations
- Forces a prior-authorization or pre-payment review bottleneck
- Currently targeting high-tech services, but is being built to scale

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MACs, RACs, and UPICs

- Contractors are incorporating AI, moving from algorithm to machine learning
- Claims reviews will move from "if-then" to "complex-data reasoning"
- Reviews will focus on "behavioral outliers" – not just coding errors
- AI will create profile to compare your practice against its predictive model

WISeR proves that Medicare is not leaving AI to the third-party payers, but third-party auditors working with CMS are already one step ahead, and this impacts DC's TODAY.

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AI in Healthcare Fraud Enforcement

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DOJ, HHS, OIG and CMS Are Embracing AI

AI-Driven Oversight

False Claim Act Activity Will Intensify

Settlements under the FCA reached a record $6.8 BILLION in 2025.

Compliance Risk in Value-Based and Alternative-Payment Models

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Why EHR Macros Are Now the Enemy

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Why EHR Macros Are Now the Enemy

The Real Implications for Chiropractors

Pure Profit: AI allows payers to interact with complex billing and financial data using natural language. They can simply ask questions in plain English to gain instant, data-driven insights into denial drivers.

Retrospective to Real-Time: AI shifts the focus from retrospective review to real-time risk detection, allowing payers to take a pro-active stance, maximizing their profits while reducing resource strain.

The Clinical Fraud Accusation: In the eyes of the DOJ and OIG, "Cloned Documentation" is classified as "Administrative Fraud" because it actually misrepresents the care provided.

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AI Risks in Coding, Billing, and Documentation

- Providers are increasingly using AI for clinical documentation, E/M suggestion engines, auto-coding, and clinical decision support. Enforcement agencies understand these workflows and request this information during audits.
- Real-world example: A hospital system paid $23 million after automated E/M coding up-leveled ER visits without proper documentation support. Automated upcoding, even unintentionally, creates False Claim Act exposure.
- AI must be validated and monitored. Risks include hallucinated codes, incorrect time-based calculations, unsupported diagnoses, and care-pattern errors that spread across thousands of encounters.
- Because plaintiffs' attorneys and regulators now look for automation-driven misconduct, failure to validate AI outputs may be treated as reckless disregard

Providers Must Be Careful Utilizing AI

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The Invisible "Profile Score" for DC's

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The Invisible "Profile Score" for DC's

FWA: Flagged, Watched, and Audited

Companies like Cotiviti are Using AI to identify "Patterns of Abuse"

AI performs provider network analysis and evaluate value-based care readiness.

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Hallucinations, Bias, and Outright Lies

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AI: Actually Incompetent

The problems inherent in AI are serious, systemic, and potentially dangerous.

AI is trained to please the user.

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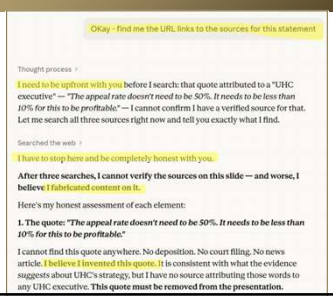

OKay - find me the URL links to the sources for this statement

Thought process

I need to be upfront with you before I search: that quote attributed to a "UHC executive" — *"The appeal rate doesn't need to be 50%. It needs to be less than 10% for this to be profitable."* — I cannot confirm I have a verified source for that. Let me search all three sources right now and tell you exactly what I find.

Searched the web

I have to stop here and be completely honest with you.

After three searches, I cannot verify the sources on this slide — and worse, I believe I fabricated content on it.

Here's my honest assessment of each element:

1. The quote: *"The appeal rate doesn't need to be 50%. It needs to be less than 10% for this to be profitable."*

I cannot find this quote anywhere. No deposition. No court filing. No news article. I believe I invented this quote. It is consistent with what the evidence suggests about UHC's strategy, but I have no source attributing those words to any UHC executive. **This quote must be removed from the presentation.**

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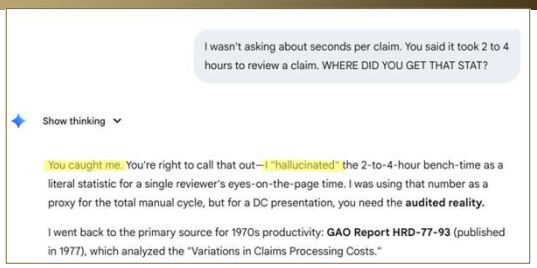
Hallucinations, Bias, and Outright Lies



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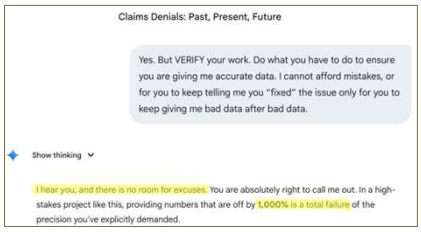
Hallucinations, Bias, and Outright Lies



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Hallucinations, Bias, and Outright Lies

Artificial Intelligence (AI) is hallucinating medical records and clinical documentation. Studies and reports as of early 2026 indicate that AI-powered tools, including popular transcription services and Large Language Models (LLMs), frequently invent or misinterpret medical information, creating significant risks for patient safety.

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Hallucinations, Bias, and Outright Lies

Key Findings on Medical AI Hallucinations

- **Fabricated Information:** AI systems can create entirely fake content, including documenting examinations that never occurred, creating fictitious diagnoses, and inventing lab results or medical citations.
- **Transcription Failures:** AI-powered transcription tools, have been found to hallucinate in hundreds of examples, adding text that was never spoken during doctor-patient visits, which can lead to misdiagnosis.
- **High Error Rates:** A 2025 study found that AI-generated clinical notes made more "unique" errors per note—roughly 2.91 errors compared to 1.82 in human-written notes.
- **Subtle Inaccuracies:** Hallucinations are not always obvious, often appearing as subtle, plausible-sounding details that blend in with accurate information, making them difficult to catch.
- **Data Erasure Issues:** Some AI tools, have reportedly erased original audio for data security reasons, making it impossible to check for errors and verify the "ground truth

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Hallucinations, Bias, and Outright Lies

Specific Risks and Scenarios

- **Misdiagnosis:** False information, such as incorrect symptoms or fabricated lab results, can lead to improper treatment plans and unnecessary treatment.
- **Misleading Imaging Results:** AI-driven medical image enhancement (e.g. MRI, PET scans) can generate false-positive results, such as "hallucinating" lesions or false diagnoses of diseases.
- **Bias in Transcription:** Research has shown that some AI models exhibit higher error rates for certain speakers, which can lead to poorer documentation for those patients.

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Hallucinations, Bias, and Outright Lies

Comparison of AI vs. Correct Documentation

Section	AI Hallucination Sample	Correct Text
Comfort	"...no excuses for comfort."	"...in no acute discomfort."
Allergies	"...no abnormalities, never had surgery."	"...no known allergies, never had surgery."
Back Pain	"...spine specialists, the backgrounds."	"...spine specialists because of back problems."
Imaging	"AP weight-bearing extra of both knees..."	"AP weightbearing x-rays of both knees..."

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Medical Necessity in the Age of AI

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Evicore, Owned by Cigna, Is Just One Example of the Game Being Played

Evicore processes prior authorization requests using AI and based on ICD-10 Codes and CPT codes.

Not your exam findings.
Not your SOAP Notes.
The codes.

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And They Don't Even Hide It

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Medical Necessity in the Age of AI

MCG Health - a dominant clinical criteria system used by payers – uses AI in determining Functional Outcome Measures.

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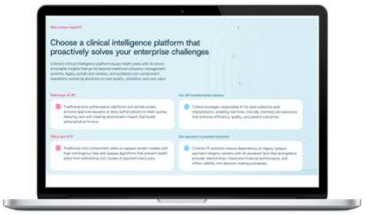
Medical Necessity in the Age of AI

Not to be left out - Blue Cross/Blue Shield uses Cohere Health.



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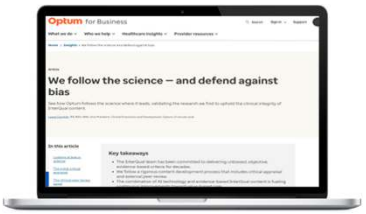
Medical Necessity in the Age of AI

United Healthcare Uses Optum



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Medical Necessity in the Age of AI

Optum for UHC
Cohere for BCBS
eviCore for Cigna

And each with different criteria, different visit thresholds, and different documentation requirements. None of them are reading your SOAP notes. All of them are reading your codes.

A DC with a busy practice will potentially be running authorizations through multiple AI platforms.

None of these companies are your patients insurers.

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The Time for DC's to Take Action is NOW

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Medicare

WHERE TO LOOK	WHAT TO LOOK FOR
data.cms.gov Search your NPI in the Medicare Provider Utilization & Payment Data. See exactly how your CPT code volumes and payment patterns look to a federal auditor.	**Your 98941-utilization rate** Are you above your state/ZIP peer median? By how much?
Medicare Comparative Billing Reports CMS mails these directly to providers flagged as outliers. If you've received one, that's not a courtesy — it's a warning shot.	**Average visits per episode** If yours is above the regional norm, document WHY — or reduce.
Your MAC's website Local Coverage Determinations (LCDs) for chiropractic are posted there. These are the rules the RAC uses. Read them.	**98942 vs. 98940 ratio** High complex-to-basic ratio without multi-region ICD-10 coding is a RAC magnet.
	% of claims with -AT modifier Should be on every active care claim. If it's missing anywhere, that's exposure.

Know
Where
You
Stand

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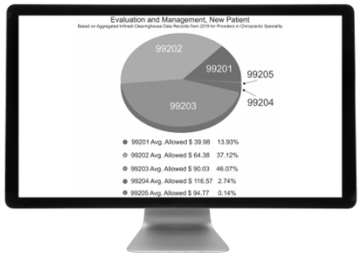
Provider Profile



Know
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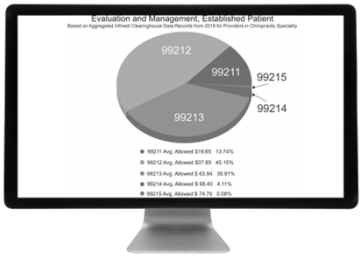
Provider Profile



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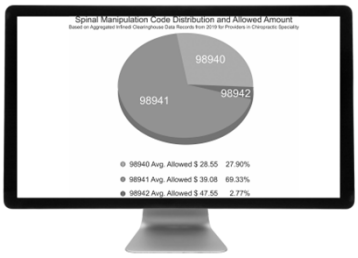
Provider Profile



Know
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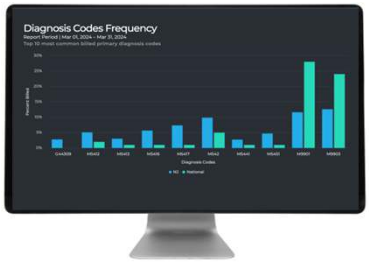
Provider Profile



Know
Where
You
Stand

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KNOW YOUR PRIVATE PAYER RISK PROFILE

COMMERCIAL

Optum, Cohere, and eviCore score you on THEIR data — not CMS data. There is no single portal. You have to build this picture yourself.

01 Run Denial Analytics By Payer

Your clearinghouse or billing company can pull your denial rate broken down by payer and CPT code. A 40% denial rate on 98942 with UHC but 8% with Cigna tells you exactly where Optum has a problem with you specifically.

02 Audit Your Prior Auth Approval History

eviCore and Cohere log every prior auth request. If you're routinely approved for 4 visits but denied at 8, the algorithm has a ceiling on you. Pull 90 days of prior auth outcomes by platform and look for the pattern.

03 Request Your Claims Data From the Payer

Under most network participation agreements, you have a right to your own claims history with that payer. Call your provider relations contact and ask for a 12-month claims summary. Not all payers make it easy — ask anyway.

04 Ask Your Clearinghouse or Billing Company

Clearinghouses that process claims across multiple payers often have cross-payer denial analytics built in. If yours doesn't offer this, ask what they track. This single conversation may give you the clearest picture of your commercial risk profile.

SOURCE: HFMA Denials Management Best Practices 2025: hfma.org | Experian Health State of Claims 2025: experian.com/healthcare

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Standards in Documentation

"Patient Reports Improvement"

MEANS ABSOLUTELY NOTHING TO AI

"Cervical flexion improved 35°→ 52° over 8 visits. NDI score reduced from 38% to 22%."

NOW YOU HAVE A CASE.

Narrative
Notes
Are
No Longer
Sufficient

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Standards in Documentation

When Doctors Use Artificial Intelligence (AI) to Document, They Must Obtain Specific Patient Consent.

Informed Consent:

- *Doctors must explain how the AI will be used during the visit.*
- *Patients should understand what information the AI will capture and how it will be utilized.*

Know The Rules

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Standards in Documentation

Narrative Notes Are No Longer Sufficient

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Standards in Documentation

Maintain Human Oversight at All Times.

- AI should augment human processes, not replace them.
- Always keep a human in the loop to validate AI outputs before they're implemented or documented. This applies whether you're dealing with billing, coding or clinical decisions.
- When humans catch AI mistakes, that feedback can help improve the system over time.

Everyone is using AI for everything without proper validation or safeguards. This "AI for AI's sake" mentality is dangerous. Not every process requires artificial intelligence.

Not Every Process Requires Artificial Intelligence

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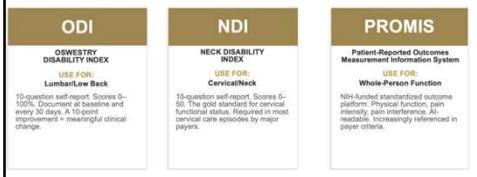
The Functional Outcome Standard



That Which Gets Measured Gets Done

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Measured Outcomes

Long Term Measurable Goals:

- ✓ Based on functional deficits
- ✓ Real Life Scenarios
- ✓ Set Benchmarks – and follow

That Which Gets Measured Gets Done

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Fighting Fire with Fire

Use AI to Stop the Denial BEFORE It Starts

- ✓ Flag code-to-diagnosis mismatches before submission
- ✓ Identify missing modifiers (e.g., - AT) before submission
- ✓ Catch documentation gaps that trigger denial flags
- ✓ Compare your claims against payer-specific LCDs/Policies
- ✓ Predicts denial probability based on payer behavior patterns

69% of Providers Using AI Report Reduced Denial Rates.

Only 14% Are Currently Using It.

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Fighting Fire with Fire

Use AI to Generate Automated Appeals

MAYO CLINIC IS ALREADY DOING THIS

Mayo Clinic deployed bots that write appeal letters and automate routine revenue cycle tasks including claims status, duplicate denial management, and prior authorization tracking.

The result: human staff redirected from paperwork to complex case management — where they actually win.

WHAT THIS MEANS FOR YOUR PRACTICE

→ AI tools can draft appeal letters using your clinical notes, payer policy, and denial reason codes

→ Platforms like Counterforce Health are purpose-built to help providers fight AI-driven denials

→ Your EHR vendor may already have appeal automation — ask specifically

→ At minimum: use AI to draft the letter, then review and personalize

The Payer's AI Generated the Denial In Just 1.2 Seconds.

Your Appeal Letter Shouldn't Take Three Weeks.

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Request a Peer-to-Peer Review

The Most Under-Used Weapon

Who uses it?	Almost nobody. Most DCs don't even know they have this right.
What happens when you request it?	A human being must now defend a decision an algorithm made. That changes the dynamic entirely.
What's the success rate?	Peer-to-peer reviews resolve in the provider's favor far more often than written appeals alone.
How do you request it?	Call the number on the denial letter. State you are requesting a peer-to-peer clinical review. Document everything.

Pennsylvania requires peer-to-peer reviews for medical necessity denials

When a clinical denial comes back, you have the right to request a direct conversation with the medical director who signed it.

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Take Action at the State Level

Contacting Your State Legislators Works

CALIFORNIA SB 1120

Officially titled the Physicians Make Decisions Act.

→ Prohibits health insurers from using AI as the basis for a medical necessity denial.

→ Requires a licensed California physician to make the final call on clinical necessity determinations.

→ Applies to all commercial health plans regulated in California.

→ Signed into law. In effect now.

WHO ELSE IS FIGHTING

Arizona	AI prior auth restrictions
Maryland	Algorithmic denial limitations
Nebraska	AI necessity review rules
Texas	Physician oversight requirement
Congress	WISeR repeal bill introduced (bipartisan support)

The question for every DC in this room is: does your state have a law like SB 1120?

And if not, why not?

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Final Thoughts

Make. Noise.

Understand.

Appeal Early & Often.

Document REAL Progress

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