Dynamic Chiropractic

BILLING / FEES / INSURANCE

Top 5 Billing Issues for 2014

FORM UPDATES, NEW CODES, MEDICARE, AND WHY ACCURATE DOCUMENTATION IS ESSENTIAL TO THE HEALTH OF YOUR PRACTICE.

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Chiropractic billing and reimbursement can often appear simple at one moment, but then become maddeningly complex the next. Most chiropractors are familiar with the codes required for billing, but often are not fully aware of the complexities and nuances that lead to reimbursement or denial. In this installment of "Ask the Billing Expert," let's look at the five biggest issues chiropractic offices should watch out for in 2014.

1. 1500 Form Update

There is an update to the 1500 form for 2014. The updated form, I am very pleased to announce, allows 12 diagnoses in block 21. Frankly, I never understood why block 21 was limited to four codes when there was clearly enough space to add more. This change, of course, is to accommodate the ICD-10 CM coding set; providers will likely use more codes, as this code system is more granular and specific.

CMS has reported that the new form (2/12 revision) can be used Jan. 6, 2014, but that providers may continue to use the existing 1500 (8/05) edition through March 31, 2014. As a consequence, there can be dual use of either form during this period. However, beginning April 1, 2014, the new form is mandatory.

This is a CMS timeline and it is anticipated that other carriers will follow Medicare's lead. However, verify with your common payers as to their specific plans and time frame for use. Based on past experience with updates to the 1500, it is likely most, if not all, carriers will follow Medicare's time frame.

While you need not change immediately, the change must be made. Verify what will be required to upgrade or purchase if a new program is needed. If a billing service or clearinghouse is utilized, ensure it is aware of the update and what changes, if any, you are required to make.

2. The Expanded ICD

While ICD-10 does not take effect until Oct. 1, 2014, it is something you must be prepared for early, as it changes all the codes used for diagnosis. The ICD-9-CM codes number about 13,000 and are numerical in value. They range from three digits to as many as five. ICD-10-CM has more than *68,000* codes and range from three to seven characters in length, but all have an alpha beginning. The codes are much more specific in the ICD-10 and providers will enjoy a much greater ability to give more exacting diagnoses.

For instance, codes for extremities can be designated for left and right. In addition, there are separate codes for myalgia (M79.2) and fibromyalgia (M79.7), as well as codes for general muscle spasm (M62.838) and spasm of the back (M62.830).

It is a fact that 5 percent of diagnosis codes represents 70 percent of claims. The average chiropractic office more than likely uses no more than 25 codes on a regular basis and chooses from a code set of about 50-75 codes in most instances. But even this number of codes may triple and could increase as much as 10-fold for certain code sets.

Each provider/office must take it upon themselves to prepare for this transition. First and foremost, make sure there is an adequate resource to convert and add new codes to the office "cheat sheet" list. In addition, any software or billing program should be updated to the new code set; ascertain whether this can be done with the software directly or if it is dependent upon the provider to make the changes.

Of course, there is likely some cost to this, whether it is an update to the program or simply a new system. I would also suggest you verify whether the update will have to be done a second time if you change computer platforms at a later date, as the new system may have separate requirements. If an outside billing service or clearinghouse is used, inquire if it is updating its

system, and whether it will be supplying codes versus requiring it to come from the provider.

Some code transitions are very straightforward. For instance, neck pain 723.1 will update in ICD-10 to M54.2; thoracic spine pain 724.1 updates to M54.6; and low back pain 724.2 updates to M54.5.

But cervical radiculitis 723.4, and thoracic or lumbar neuritis 724.4, update in ICD-10 to M54.11 cervical radiculopathy occipito-atlanto-axial region, M54.12 radiculopathy cervical region, M54.13 radiculopathy cervico-thoracic region, M54.14 radiculopathy thoracic region, M54.15 radiculopathy thoraco-lumbar region, M54.16 radiculopathy, lumbar region, M54.17 radiculopathy lumbosacral region and M54.18 radiculopathy sacral-coccygeal region.

Similar designations for the spine exist for disc degeneration, disc displacement, spondylosis, kyphosis, lordosis and enthesopathy. Additionally, sprain and strain of the spine 847.0, 847.1 and 847.2, now will have separate coding to designate a sprain from a strain. And these new codes also have extensions to indicate whether the visit is an initial visit, subsequent visit or sequelae (residual effect).

There are also codes in ICD-10 specific for strain of the hamstrings, quadriceps or adductor muscle groups; and new code sets for iliotibial band syndrome, gluteal and psoas tendinitis, anterior tibial syndrome, and posterior tibial tendinitis – with each of the aforementioned having separate designation for right or left side (meaning if bilateral, you would use two codes to indicate such).

It is my belief that the use of these codes will aid providers in indicating necessity for care more easily due their detailed nature, not to mention that issues of claim scrutiny, as discussed in the next section, can be mitigated by their use. I say let's embrace the new codes and lead the health care arena by utilizing them in an accurate, timely fashion.

3. Claim / Visit Scrutiny

Claim and visit scrutiny will reach a level that has never been witnessed by the chiropractic profession. With 39 of 50 states having mandatory chiropractic benefits, clearly more people will likely seek chiropractic care. This is a very positive change for the chiropractic profession and frankly, for insurance companies. The reason it is positive for insurance carriers is chiropractic is a less-costly expense than traditional medical care including medication, physical therapy and surgery, which means lower costs for claims.

However, insurance plans such as Blue Cross, Blue Shield, CIGNA, et al., are using outside review sources such as Optum Health, American Specialty Health, OrthoNet and others who review chiropractic claims for necessity and often require authorization beyond a certain amount of visits. It is not that they will not allow care, but that they will scrutinize more closely the number of services and visits.

Many chiropractic patients and chiropractic providers often languished in abundant benefits that were available. For instance, when 24 visits were allowed per plan year, they could use those 24 visits seemingly at their convenience. Let's face it, chiropractic treatment "feels good" and often is sought even when there is no disability, as the patients will report it makes them "feel better." For this reason, patients would seek to use all 24 visits, and in many instances, these plans paid with minimal diagnosis and documentation of necessity.

That protocol is coming under analysis now, as these plans will review more closely the progress and need for additional care. It is not that the patient cannot receive the number of visits the plan allows, but they must have a reason or condition that warrants those visits. In simple language, if

24 visits are to be used, there has to be a 24-visit condition.

This will be a protocol the chiropractic profession will have to take some leadership in with their patients to explain what the patient's insurance benefits really are. It is not preventative services, but corrective services. There has to be a significant neuromusculoskeletal condition warranting the necessity of care.

Based on evidence-based guidelines, chiropractic care demonstrates tremendous efficacy for common spine and back ailments. But many of these sources indicate that the initial treatment plan intervention is adequate to resolve most conditions. In fact, I have heard and read many studies and guides that indicate uncomplicated conditions need no more than 6-8 visits to resolve with chiropractic care.

The chiropractic profession should be proud of this fact; chiropractic care is considered that effective. However, when there are instances in which care goes beyond the "typical" requirements, keep in mind the following:

- Does the diagnosis (primary, secondary and complicating) correlate with the number of visits requested?
- Is the provider using objective measures on exams for "functional" change to demonstrate the necessity and ongoing need of care?
- Were functional outcome assessments used to further quantify the necessity and progress of the care plan? (Use of outcome measures is a CMS requirement under PQRS reporting. Chiropractors should take advantage of the acceptance of these measures, as chiropractic care readily and clearly results in greater function, even in as little as one visit.)
- Are there chronic factors that can be identified, whether by diagnosis or documentation in the chart, as chronic conditions by definition require increased care?
- Does the treatment plan have a focus on active care and rehabilitation? Note the following statement relating to active care, taken from the *Chronic Pain Medical Treatment Guidelines*: "There is strong evidence that exercise programs, including aerobic conditioning and strengthening is superior to treatment programs that do not include exercise." This language is in all of the aforementioned carriers' chiropractic treatment policy standards.
- Do your notes, under a critical review, demonstrate functional improvement and a discharge when maximum therapeutic benefit has been achieved?

These are some of the factors review services are utilizing and referencing for the necessity of ongoing care. It is to a provider's advantage to be proactive in the notes and treatment plan, answering these questions before requesting additional visits.

4. Manual Therapy 97140

Manual therapy 97140 is a payable service for a chiropractor; however, if it is done the same date of service and to same region as chiropractic manipulation, it is considered part of the manipulation. This service has been contentious in terms of use and payment since it was implemented in 1999. Manual therapy may encompass a myriad of services in the chiropractic setting and most commonly is used to indicate myofascial release, joint mobilization or manual traction.

When billing this code to indicate that is payable and separate from chiropractic manipulation, it must be appended with modifier 59. This modifier should only be used in cases in which a different region of the body received the service. Of course, many payers, upon seeing the 59, will pay, assuming the service was to a different region. However, if the claim is later reviewed or audited, and it is determined that the service was not done to a separate region, it will result in a refund or

deduction from future payments.

Whether you or I agree with this rule is of little consequence; the rule is in place. The CPT position paper on 97140 states the following "Under certain circumstances, it may be appropriate to additionally report CMT/OMT codes in addition to code 97140. For example, a patient has severe injuries from an auto accident with a neck injury that contraindicates CMT in the neck region. Therefore, the provider performs manual therapy techniques as described by code 97140 to the neck region and CMT to the lumbar region. As separate body regions are addressed, it would be appropriate in this instance to report both codes 97140 and 98940. In this example, the modifier -59 should be appended to indicate that a distinct procedural service was provided."

Aetna went so far as to not pay for 97140 done with chiropractic manipulation regardless of separate region. Aetna's policy was made based on the following: "Aetna revealed that their investigative audits found that 90 percent of the time that modifier -59 was used, manual therapy was performed in the same region as the CMT. They also found very poor or lack of documentation. Aetna's need to make such a strong policy change was due to what they considered to be excessive and improper use of modifier -59."

Fortunately, with diligent fighting by the chiropractic profession and the American Chiropractic Association, Aetna did change this and will allow the payment of 97140 with chiropractic manipulation when the medical necessity of separate regions is necessary and clearly documented.

Many carriers are making provisions with outside review agencies such as American Specialty Health, OrthoNet and Optum, who are reviewing claims and chart notes more closely to be sure the 97140 services were provided to a different body region from the chiropractic manipulation and medically necessary.

While this is a needed and necessary service, the recommendation of evidence-based care plans indicates reduction in the provision of passive care and increase in the provision of active care or simply exercise.

5. Medicare 101

Medicare, a love / hate relationship for some, is here to stay and essentially involves everyone over age 65. Bear in mind that the baby boomer generation is turning Medicare age at a clip of 10,000 per day for the next 15 years. That is too many people to ignore, particularly when Medicare pays more per visit than most of the managed care plans ... even though it only pays for spinal manipulation.

It is also ironic how some believe Medicare is the strictest on medical necessity, yet it is not uncommon to have Medicare allow and pay for 20 to 30 visits when managed care plans, as noted above, are tightening. However, let's also not forget Medicare patients generally have more chronic and severe conditions that require greater care, which is most commonly disc degeneration.

It is my belief that providers who are disillusioned with Medicare are mostly frustrated due to their lack of knowledge of Medicare requirements for billing and documentation, which definitely has some nuances. If these nuances are not followed, claims will be denied or when reviewed, will result in further denial or requests for refunds.

Medicare is straightforward for chiropractic: It pays for spinal manipulation only and subluxation must be the primary diagnosis. However, beyond the subluxation, there must be a secondary neuromusculoskeletal condition associated. The subluxation must be demonstrated in the file by an

X-ray or physical examination and the specific vertebrae must be documented. It is not adequate to simply denote cervical subluxation.

The secondary diagnosis must also be indicated and it is imperative to have the most specific diagnosis or reason for the encounter indicated. While it is acceptable to use as simple a diagnosis as cervical pain 723.1, it is best to differentiate the causation of pain with myalgia 729.1, disc degeneration 722.4, disc displacement 722.0, strain and sprain 847.0, etc., whenever possible. Codes that have greater differentiation and severity clearly will result in a greater allowance of treatment, as the condition coded clearly warrants such.

Chiropractic manipulation codes must be appended with modifier AT to indicate the care is corrective or active. Omission of the modifier will result in an automatic denial of services with no patient responsibility.

If the patient chooses to receive care beyond what Medicare allows, he/she may do so and pay out of pocket for those services. What is required is that the patient sign the Advance Beneficiary Notice (ABN), accepting responsibility; and that the chiropractic manipulation code be billed with modifier GA. Use of this modifier will result in a denial of payment from Medicare, but does allow and make the patient responsible for those services.

For services that are excluded for chiropractic (everything but spinal manipulation), the chiropractic provider need not bill to Medicare. The patient is liable for those services and they cannot be provided at no charge or discount, as Medicare views this as inducement. However, there can be instances whereby the patient has a secondary insurance that will pay not only the 20 percent not paid by Medicare for manipulation, but also has provision for excluded services. When that is the case, those services would be billed to Medicare; however, they are appended with modifier GY (97035 GY, 97124 GY, G0283 GY, etc.).

This GY modifier indicates it is an excluded service and will result in patient responsibility for those services and allow payment from the secondary payer. Note that in most instances, Medicare will also forward the claim directly to the secondary payer, meaning no additional work by the chiropractor. Also note that this secondary insurance information should be included on the claim block 9a-d.

There are claim form nuances for Medicare as well. Block 11 should have "none" indicated, as this is the indication that there is no other insurance primary to Medicare. If this is left blank, Medicare will deny the claim, indicating it cannot ascertain the primary insurance.

Block 14 must have a date, and it is not necessarily a date of injury or first symptom, but the date of the first visit for the current episode. For instance, a patient has an injury on a Saturday and visits your office on the following Monday. The date in block 14 should reflect Monday's date and the date they were injured.

Medicare is also doing more review and audits of chiropractic providers (and others; it is not picking on chiropractors) and these are common issues with provider documentation.

A few other billing considerations to keep in mind, particularly when it comes to Medicare:

- Illegible notes: If you cannot read them, neither can anyone else. Make sure if notes are requested, someone other than you can read them.
- Missing signature: All notes require the signature, not initials, of the chiropractor.
- Specific level of subluxation must be indicated in examination and treatment notes.
- Specific areas of manipulation must be documented on each visit.

- Treatment plans must also be evident, indicating level of care including frequency and length.
- If treatment continues without evidence of improvement or the clinical status remains stable for a given condition, further manipulative treatment is considered maintenance therapy and is a non-covered benefit.

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