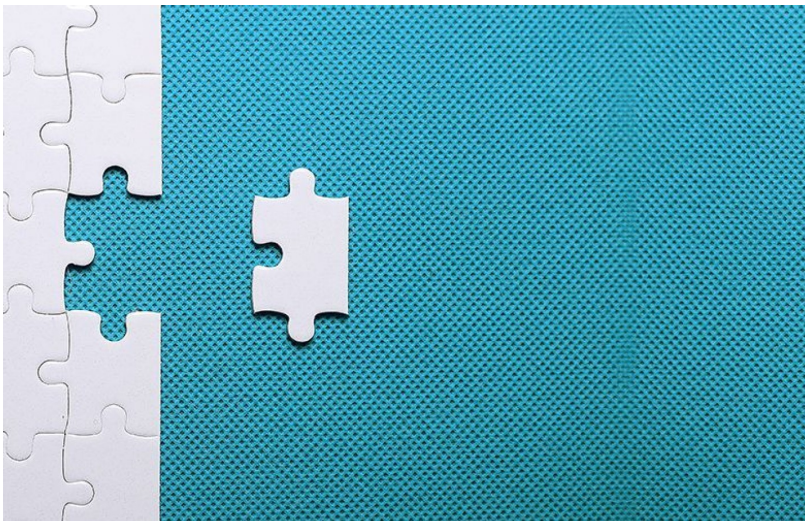
Dynamic Chiropractic



BILLING BASICS

Getting Claims Paid: Common (& Not-as-Common) Modifiers

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QUESTION: *I am having problems getting claims paid, and it appears to always be related to a missing modifier. Could you provide a common list of modifiers for DCs?*

You are definitely not alone; many providers experience denials related to lack of or improper use of a modifier. Here is a primer on the use of modifiers in the chiropractic setting.

Current procedural terminology (CPT) modifiers (also referred to as Level I modifiers) help further describe a procedure code without changing its definition. CPT coding modifiers (two-character appendages; can be numbers or letters) are used to communicate that something is *atypical* about a particular claim. Circumstances warranting the use of a modifier include:

- If the service has either been increased or decreased
- If the service has a professional and a technical component
- If only part of the service was performed
- If an independent or adjunctive procedure was performed
- If unusual events occurred
- If the service / claim is expected to be denied as not appropriate and/or necessary

Modifier 25

The most common modifier for chiropractic claims is modifier 25. This modifier is appended to the evaluation and management (E&M) codes 99201-99215 to indicate the E&M being reported is separate and distinct from the inherent evaluation associated with the chiropractic adjustment or other treatment of the day.

Any time you are billing an E&M on the same date with treatment, the E&M must have a 25 modifier; otherwise the E&M code will be denied as inclusive to the other services provided.

Modifier 59 and Subsets (X)

Another common modifier is modifier 59. This modifier is to be appended to massage 97124, manual therapy 97140 or neuromuscular re-education 97112 when done on the same visit as chiropractic spinal manipulation.

The reason this modifier is required is to demonstrate that the services noted above were provided to a region *not* part of the spinal CMT; for instance, if the CMT was done to the cervical spine and myofascial release to the lumbar spine.

Modifier 59 indicates that the procedure represents a distinct service from others reported on the same date of service. This modifier was developed explicitly for the purpose of identifying services not typically performed together. In the event that a more descriptive modifier is available, it should be used in preference to modifier 59. The documentation in the medical record should clearly support the separate and distinct procedures; i.e., the location (different region), procedural description (technique) and time.

There also subsets for modifier 59 that can be used as replacements. However, I have not noted any carrier that makes deference or pays better for one modifier versus the other. CMS has established the following four HCPCS modifiers (referred to collectively as X [EPSU] modifiers) to define specific subsets of the 59 modifier:

- *XE Separate Encounter*: a service that is distinct because it occurred during a separate encounter
- *XS Separate Structure*: a service that is distinct because it was performed on a separate organ / structure

- *XP Separate Practitioner:* a service that is distinct because it was performed by a different practitioner
- *XU Unusual Non-Overlapping Service*: the use of a service that is distinct because it does not overlap usual components of the main service

Based on the DC's need to demonstrate that a separate region was addressed, the most likely used subset is XS.

Medicare Modifiers: AT, GY, GP, GA

Medicare also has specific modifiers for chiropractic claims that are required for reimbursement and/or proper denial so a secondary payer will make payment. The AT modifier is appended to the chiropractic manipulative treatment code to indicate that the care is deemed "medically necessary" and the provider expects Medicare to consider the treatment for payment.

Medicare will only cover spinal adjustments billed with the AT modifier. In other words, no modifier AT, no reimbursement for spinal CMT. Note that this modifier is also to be used for any Medicare replacement or advantage plan for spinal CMT.

Medicare also requires modifiers on services that are statutorily not covered for chiropractic claims. Those services are everything other than spinal manipulation codes 98940, 98941 or 98942. Any other code must have the excluded services modifier GY. If it is not spinal manipulation, it always has a modifier GY when billing to Medicare to indicate an excluded service and that it will be indicated by Medicare as the patient's responsibility. GY is necessary to establish patient responsibility on the EOB and is required so a secondary payer, when available, will make payment for those services.

Medicare also requires modifier GP for physical medicine services. According to CMS, a GP modifier means services are delivered under an outpatient physical therapy plan of care.

For Medicare claims, chiropractors must include modifier GP on all physical medicine codes to receive a proper denial of patient responsibility so a secondary payer may make payment. This means physical medicine services require two modifiers (GP and GY) and in some instances a third, such as 59 (e.g., 97110 GP GY or 97124 GP GY 59). *Note: The order of the modifiers does not matter.*

The GP modifier is also required on VA claims through VA Choice and PC3 plans on physical medicine codes billed by a chiropractor. Failure to add the modifier will result in a denial of the physical medicine services, even though they were authorized.

The final Medicare modifier commonly used is GA, used when a voluntary waiver (ABN) is used to inform the patient that CMT of the spine is not going to be covered by Medicare. This is required when the care is maintenance under Medicare guides, and indicates the patient has understood and taken financial responsibility of the services.

Modifier 22

Though not common, modifier 22 is also viable for a chiropractor in some circumstances. Modifier 22, Increased Procedural Services, is used as follows. Add this modifier to a code when the work required to provide a service is substantially greater than typically required. Documentation must support the additional work and extra payment (e.g., increased intensity, time, technical difficulty of the procedure, the severity of the patient's condition, physical and mental effort required).

For instance, a patient with a disability may create a situation whereby manipulation takes far greater time to perform that what is typical needed; or the patient is in such severe pain that performing the CMT takes far greater time to get the patient properly positioned. *Note that the OptumHealth policy indicates a 50 percent increase in the fee allowed when this modifier is used.*

Modifier 51

A modifier that was once common to chiropractic claims, but is no longer, is modifier 51. Some payers required this modifier for an extraspinal CMT when done the same date as a spinal CMT. When multiple procedures other than E/M services, physical medicine and rehabilitation services, or provisions of supplies are performed at the same session by the same provider, the primary procedure or service may be reported, and additional procedures should be appended with modifier 51, as long as they are not considered incidental or bundled.

These services are subject to multiple procedure fee reductions to reflect their secondary nature. Eligible procedures or services appended with modifier 51 are reimbursed at 50 percent of the allowable payment schedule. *Note the 50 percent reduced payment for 98943; however, that modifier is no longer required for extraspinal CMT with spinal CMT.*

Knowledge Is Power

One of the biggest frustrations when it comes to billing (besides being denied) is that often a denial states there is an improper or lack of modifier. Even worse, when you inquire as to what the missing or improper modifier is, you are generally not informed. (As you can imagine, insurance companies tend not to give billing advice.) I hope this primer gives you a leg up on billing and coding, particularly when a modifier is necessary.

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