Dynamic Chiropractic

BILLING / CLAIMS

Medicare Advantage and Humana Claims Being Denied

Samuel A. Collins

Question: *I recently received a denial from Humana Medicare Part C or the so-called Advantage plan; the denial stated I was missing a modifier. I assumed I needed the modifier AT, as I typically do with Medicare and other Medicare Part C plans, but Humana indicated that modifier also was incorrect. What modifier is required for payment?*

Unfortunately, there are multiple modifiers now used for billing chiropractic claims and often one insurance may require a modifier that others do not. Medicare, for instance, has modifiers that are essentially unique to Medicare, such as the AT modifier for spinal manipulation to indicate active or corrective care.

Modifier GY

Additionally, for chiropractic claims billed to Medicare, modifier GY is required on any service other than spinal manipulation. This modifier indicates that it is an excluded service from Medicare reimbursement for chiropractic claims.

Modifier GA

However, that is not the end of it, as Medicare also uses modifier GA for spinal manipulation when the service is considered maintenance or nonpayable by Medicare and the patient has signed an Advance Beneficiary Notice (ABN). The GA modifier technically means the patient has signed the ABN or waiver.

Modifier GP

Medicare now also requires modifier GP, the "always therapy" modifier, on all physical medicine codes. Medicare does not cover physical medicine, but to receive a proper denial with patient responsibility for a secondary payer to make payment, the modifier must be included.

The GP modifier is also needed for UnitedHealthcare (and all its affiliates) and any Veterans Administration claims when physical medicine services are billed. The requirement for GP seemingly had been limited to those payers alone, but of special note, Michigan Blue Cross Blue Shield requires the GP modifier on therapy codes.

Modifier AT

Your assumption regarding using AT for Medicare Advantage plans is most often correct, as these plans typically require we follow the Medicare protocols for coding and billing – such as subluxation as the primary diagnosis for use of modifier AT with spinal manipulation.

Modifier 97

Humana is another story and unique for its modifier requirements. Humana Medicare Part C requires modifier 97 on all chiropractic manipulation or physical medicine codes. The requirement for the 97 modifier for Humana applies to services including, but not limited to: audiology, cognitive therapy, occupational therapy, physical therapy, speech therapy, and spinal manipulation. Therefore, to answer your question, you should rebill to Humana using modifier 97.

The 97 modifier is defined as rehabilitative services. When a service or procedure that may be either habilitative or rehabilitative is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate the service or procedure provided.

Using More Than One Modifier

Note: There may be instances in which there is a need for more than one modifier on a claim line. For example, when billing 97112, 97124 or 97140 on the same visit as spinal manipulation, you would need a 59 or XS modifier on the therapy codes. But for the carriers who require GP or 97, be sure both modifiers are used. The order of the modifiers does not matter; it could be 59 GP or GP 59, as long as they both are present. This is why there are four spaces for modifiers on the 1500 claim form.

Editor's Note: Have a billing question? Submit it via email to Sam at sam@hjrossnetwork.com. Your question may be the subject of a future column.

FEBRUARY 2021