Dynamic Chiropractic

BILLING Q&A

Insurers Are Contacting DCs About Their Coding Patterns

Samuel A. Collins

Question: *I received two letters from Anthem: one indicating my utilization of 98941 and 98942, and the other about my use of modifier 59. Both indicated I am higher than the average for my peer group. Is this something I should be concerned about and does it mean I will be audited?*

Multiple providers have contacted me about this and I have seen this type of letter throughout most states' Blue Cross and Blue Shield plans. It is a very generic letter and identical for all providers who've received them.

This letter begins by indicating a review of your coding pattern for 98940-98941-98942 and/or use of 59, XE, XP, XS, or XU modifiers, which are likely related to the billing of massage 97124, manual therapy 97140 or neuromuscular re-education 97112. The latter also requires a separate region of application from chiropractic manipulative therapy (CMT) and hence the use of the modifier to indicate such. Medicare is also sending some providers a comparative billing report (CBR) highlighting higher-than-average use of 98941 and 98942.

Each of these letters is for the most part education and informational, and *does not* indicate a pending audit; however, I believe it is an opportunity to ensure that your coding and documentation practices are compliant.

The letters in fact state that many factors may impact the coding of services, whether it be level of CMT or use of modifiers. But being you are higher than average does give some pause that if files were to be audited, your pattern of use would be the more likely to be requested.

Higher-Than-Average Use of Codes

Of course, many factors might influence higher-than-average use of a certain code, based on the severity of the conditions of the patient and multiple regions having to be treated. However, we have to ensure that the documentation does indeed match and is not just a pattern based upon a technique or style.

For example, it is considered that use of 98941 will be higher than use of 98940 and 98942, considering many patients have complaints to multiple regions. However, average use is about 55-60 percent per the Centers for Medicare and Medicaid Services, and I suggest that holds true outside of Medicare as well.

Keep in mind that your technique or style is not what dictates use of the CMT code, but the number of regions diagnosed and manipulated. If you are a diversified type of adjuster, it is not uncommon that you may adjust multiple body regions including the full spine. However, if all you diagnose is cervical, the appropriate code would be 98940 – regardless of the number of regions you have manipulated.

Use of 98941 requires a minimum of 3-4 regions of complaint and diagnosis, along with manipulation to those same regions. For example, note how Optum Health (United Health Care) describes the use of 98941:

98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions

Documentation must support that manipulative treatment occurred in three to four regions of the spine (region as defined by CPT) and one of the following:

- validated diagnoses for three or four spinal regions
- validated diagnoses for two spinal regions, plus one or two adjacent spinal regions with documented soft tissue and segmental findings

Ensuring Compliance: Consider Regions and Documentation

Coding with 98941 may require a three-area complaint, but note that this takes into consideration adjacent regions. This may be why the use of 98941 will be greater as well, but you must be conscientious to assure that the 98941 matches the notes for regions of diagnosis and regions manipulated.

If you are substantially higher than 60 percent, I would review your coding protocols to assure you can defend its use. I had a provider who billed exclusively 98941. He noted that he did adjust all three regions, but an audit revealed that 35 percent of his use of 98941 was incorrect, requiring a revision and recoupment of payments.

Please take a moment to review your ratio and assure compliance with the number of regions. Is it possible to have 90 percent of your patients with 98941? Yes, but it's likely, not probable based on documentation for complaints, findings and diagnoses. Again, many factors may be in play, but be sure you can justify the why. It is never based on technique or style alone, and must be diagnosed regions and regions manipulated.

An audit is not bad assuming you can justify your care, of course, but be sure your documentation is order and not putting you in jeopardy.

In relation to the use of the 59 modifier codes, there can be many reasons to perform those services with CMT, but the bigger issue is that you are demonstrating they are in different regions.

Assuming that is the case, the purpose and goals of the services with modifier 59 are distinct and separate. As always, documentation is what will justify care ... or sink it.

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. Note that submission of a question is acknowledgment that it may be referenced (anonymously) in his column.

MAY 2022

©2024 Dynanamic Chiropractic™ All Rights Reserved