BCBSIL Modifier Denials

By

Dr. Ron Short, DC, MCS-P, CPC, CPCO

In the August 2017 issue of Blue Review™ Blue Cross Blue Shield of Illinois (BCBSIL) announced:

Code-Auditing Enhancement

Effective Nov. 12, 2017, Blue Cross Blue Shield of Illinois (BCBSIL) will be implementing a code-auditing enhancement to its claim system.* This software will help improve auditing of professional and outpatient facility claims that are submitted to BCBSIL by clinically validating modifiers submitted on such claims. Upon implementation of the code-auditing enhancement, providers may use the Claim Research Tool, available on the Availity™ Web Portal, to research specific claim edits. For additional information, watch the *Blue Review*, as well as the News and Updates section of our Provider website.

The above notice does not apply to government programs claims.

The result of this code auditing enhancement has been the wholesale denial of claims with the 25 and 59 (including XE, XS, XP, or XU) modifiers. This is not just affecting chiropractors but medical doctors and physical therapists too.

A quick review of these modifiers and their usage would be appropriate.

The 25 modifier is defined as: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

You would use this modifier on the E/M code when you perform and initial exam or a re-exam on a patient the same day that you would perform an adjustment.

The 59 modifier is defined as: Distinct Procedural Service.

Modifiers XE, XS, XP, XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.)

XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.

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"

You would use one of these modifiers when you perform a service with the adjustment that would normally be disallowed by the National Correct Coding Initiative edits. The service must be performed on a separate anatomical area and your documentation must reflect that.

Now, what do we do about it? It should be standard practice in your clinic to appeal all denials and you should do that in this case. BCBSIL refers to this as filing a claim inquiry. You can link to a tip sheet to help you through the process here. To summarize:

1. Open Availity and select "claims" from the top menu.
2. Next select "Refund Management-eRM" from the drop-down menu.
3. You next select "Claim Inquiry Resolution" from the menu bar. This will open a box with all of your previous claim inquiries.
4. At the bottom of this box you should select "Create New Claim Inquiry". This will open a new box.
5. Complete the information requested. In the "Claim Inquiry Reason Codes" box select "Additional Information".
6. In "Supporting Documentation" attach the medical files for the date in question. Make sure that you documentation supports the validity of your claim.
7. Use the "Comments" section to state your appeal instead of attaching a separate letter. Depending on the code(s) and modifier(s) used your appeal should contain the following information:
    a. 97140 with modifier 59 (or XE, XS, XP, XU). State which type of manual therapy was provided and that it was applied to a separate anatomical area from the adjustment (9894X). State that the use of modifier 59 (or XE, XS, XP, XU) was completely appropriate and consistent with coding requirements to indicate that the procedure was performed in a separate and distinct anatomical area from the adjustment (9894X). Then ask that the claim be reviewed and processed according to the beneficiary's benefit plan.
    b. 97110-97124 with modifier 59 (or XE, XS, XP, XU). State what therapy was provided and that it was separate and distinct form the adjustment (9894X). State

that the use of modifier 59 (or XE, XS, XP, XU) was completely appropriate and consistent with coding requirements to indicate that the procedure that was performed was separate and distinct from the adjustment (9894X). Then ask that the claim be reviewed and processed according to the beneficiary's benefit plan.

c. Evaluation and Management (E/M) service with the 25 modifier. State that the E/M service performed was a higher level service that the pre-adjustment evaluation bundled with the adjustment codes (9894X). Then ask that the claim be reviewed and processed according to the beneficiary's benefit plan.

If you are successful with this strategy you should receive your payment within 1-2 months. However you may not always be successful. The point is to make BCBSIL deal with each denial. This is not an ideal strategy but it is the best we have at this time.