Blog

Increased Therapy Denials Create Administrative Burden

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Recently, many healthcare providers have begun to experience a downpour of denials when billing therapy services. The states which seem to be experiencing the most difficulty are Illinois, Oklahoma and Texas, particularly for claims submitted to BCBS plans owned by Health Care Service Corporation (HCSC). Since HCSC also owns Blues plans in Montana and New Mexico, the problems may be extending there as well.

In August of 2017, there was an innocuous-looking announcement which stated that BCBS would be implementing a new "code-auditing enhancement" which would be "clinically validating modifiers". Unfortunately, last fall HCSC began using their new claim editing software which focuses on the use of particular modifiers (i.e., 25, 59, and X{ESPU}) which resulted in claim rejections for many services using these modifiers. Please note that these claim rejections include both E/M services and CMT, whether or not physical therapy services are included. It is modifier based and it is affecting many types of providers, not just doctors of chiropractic.

Claims using these modifiers are being denied at a high rate and the provided rationale for the denial sends some mixed messages. According to a blog post by the American Chiropractic Association (ACA), "In some cases, the denials state the modifiers are used inappropriately. In other cases, providers have received letters stating their utilization of the modifier is higher than average." Regardless of the denial reason shown on the EOB, it is based on the new claim editing software. Many state professional associations are trying to work with the payer to resolve the problem and we encourage you to work with them. It should be noted that as of the date of this article, the **only recourse** available is to **appeal** and keep appealing. Perhaps if HCSC is flooded with appeals, they may re-visit this erroneous edit.

APPEALS FOR THERAPY WITH CMT

Denials with therapy codes and CMT has happened before and ChiroCode originally created a sample appeal letter based on guidelines in the *March 2006 CPT Assistant* which stated that it can be appropriate to bill codes 97110-97124 with CMT even on the same region. However, the *November 2016 CPT Assistant (page 9c)* seems to have reversed their 2006 position, as indicated by the following Q/A (emphasis added):

> **Question:** Is it appropriate to report code 97140, Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes, with modifier 59, Distinct Procedural Service, appended for a separate procedure such as myofascial release, when performed by the same provider at the same session with chiropractic manipulative treatment (CMT), where both procedures are performed to the same spinal region?
>
> **Answer:** No, modifier 59 indicates that the procedure was provided to a separate anatomical body region. Given the similarity in the two procedures (CMT as compared to procedures described in code 97140), reporting of both procedures to the same body region is not appropriate.
>
> The rationale behind disallowing CMT and manual therapy techniques represented by code 97140 to be reported for the same anatomic site is due to overlap of preservice, intraservice, and postservice work that is inherent to both codes. The intraservice overlap occurs as the provider identifies the osseous, articular, and soft tissue restrictions. In addition, both procedures incorporate spinal and peripheral manual joint and soft tissue techniques.
>
> Under certain circumstances, it may be appropriate to additionally report CMT/OMT codes in addition to code 97140 if the procedures were performed on separate anatomical regions. In those cases, modifier 59 should be appended (97140-59) to indicate that a distinct procedural service was provided.

While these guidelines from the AMA are in reference to code 97140 only, it can be extrapolated to other

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therapy codes. Although the Q/A only discusses using modifier 59, modifier XS (if accepted by the payer) is more descriptive and thus provides a clear statement that the procedure was performed in a separate region.

Review the denied claim to ensure that the documentation clearly identifies two things: 1) this was a separate region and 2) the medical necessity (clinical rationale) of the physical therapy procedure performed. It is also essential to review the payer policy regarding separate and connecting regions because they could differ from Medicare or other payer guidelines. For example, a policy by Optum states that documentation must show that "Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous". That same policy also states, "The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present." Therefore, as long as the service and documentation meet all the criteria for that payer, then you SHOULD appeal. Be sure to include an appeal letter which states why the denial is incorrect. You may wish to review or use a sample appeal letter using one of the following for reference:

- ChiroCode's updated appeal letter (if you have a current edition of the *ChiroCode DeskBook,* see Resource 206)
- American Chiropractic Association (ACA Members have access to ACA forms which includes an appeal letter)
- State professional association (check to see if they have a sample letter they are asking you to use)

CAUTION: We have heard of a few interesting 'work arounds' which providers have used to get the claim paid. One involves splitting the claim and having the CMT on one claim and the therapy service on another claim, but we have concerns about that practice. While this may work in the short run to get the claim paid, the problem with splitting the claim is that **unless** HCSC changes their policy retro-actively, a post-payment review could result in a refund request and possibly allegations of fraud as well.

MODIFIER GP: Earlier this year we released some articles about Medicare requiring modifier GP on physical therapy services. While this appears to be unrelated to this current situation with Blue Cross plans, it is possible that there could be some connection in that therapy services are being closely monitored and the wording of the denials regarding inappropriate modifiers is similar. Additionally, we have received feedback that some providers who have submitted claims to Medicare with modifier GP in order to have it submitted to the secondary payer are being told that they need to have a referring provider for the outpatient therapy plan of care. **Continue to add both modifier GP and GY** to therapy services submitted to Medicare (e.g., 97110-GPGY). We will continue to monitor this situation and ask providers to forward any information they obtain from payers regarding this issue to us.

APPEALS FOR E/M WITH MODIFIER 25

When claims include both an E/M visit and CMT, modifier 25 may be added to the E/M service. Chapter 6.2 of the *2018 ChiroCode DeskBook* (see pages 347-348) discusses when it would be appropriate to report E/M with CMT (e.g., initial evaluation, new condition/ injury). As long as your documentation clearly meets all the requirements for reporting E/M and CMT, then denials SHOULD be appealed and include an appeal letter explaining the appropriateness of the service.

SUMMARY

At this time, the best course of action is to continue billing these services with the appropriate modifiers even though you know that there will/may be a denial. Just set up an appeal process in your practice to ensure that you are appealing every claim which is inappropriately denied. When the denial comes, appeal with supporting information and an appeal letter. Be sure to work with your state association in trying to resolve the problem. For example, Texas Chiropractic Association is asking providers to send redacted claim information to them so they can use those denials as an example(s) to find a permanent solution to this problem. Additionally, let us know if this problem is also linked to other payers.

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