THE NW REGIONAL BY FCA CHIROPRACTIC CONVENTION + EXPO

Overcoming Denials & Increasing Reimbursement: What Payers Don't Want You To Know

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Telling the Story:

It's not Just Documentation that tells the Story. Everything we do in Practice Tells a Story Including the CMS 1500 form:

- Procedure Codes,
- Diagnosis Codes,
- Modifiers,
- Frequency

The list goes on…

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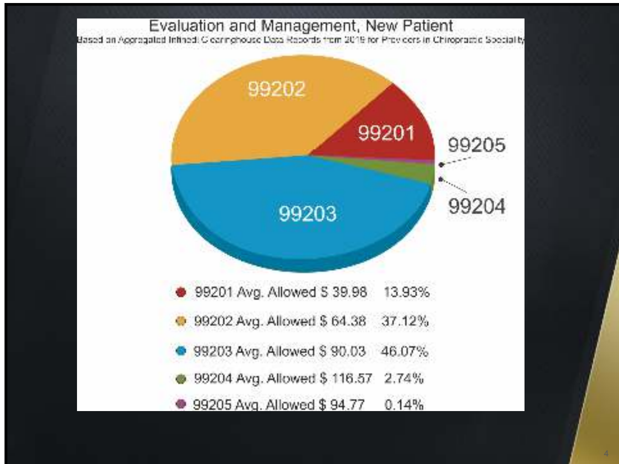

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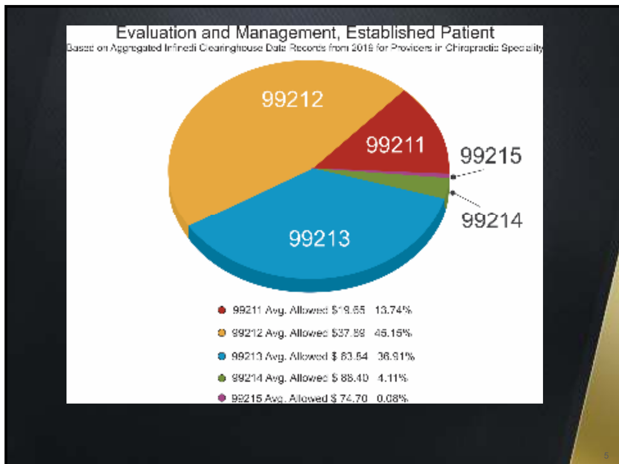

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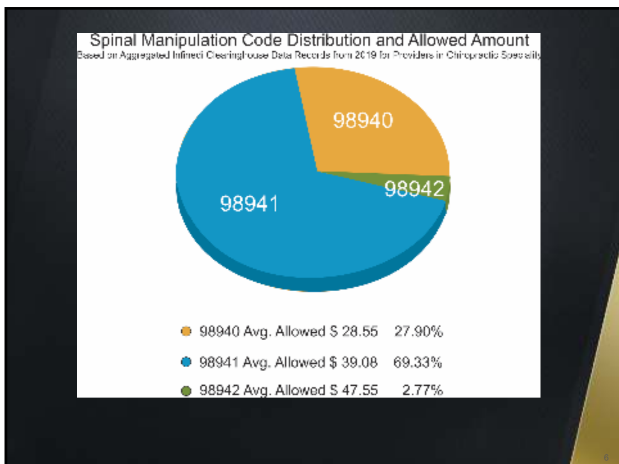

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Common Denials Overview

1. Office Visit denials
2. Manual/Massage Therapy Denials
3. Diagnosis Coding Denials

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Evaluation & Management Denials

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aetna

12/01/2022
Page 1 of 4

Sum of Overpayment: $103.23
Total Balance Due: $103.23
Letter ID:
Note: For specific Claim information please refer to the enclosed document.

Subject: First Request

ATTENTION BILLING SUPERVISOR:

As a result of a review of claim payments, we have found some differences between the amount paid to you and the amount which should have been paid in accordance with our contracts/policies.

1. Documentation did not contain a separately identifiable EM on the same date as another service or procedure performed by the same provider. 2. Documentation within the records provided did not include the patient date of birth on each page as required according to Aetna Provider Manual page 29

Please refer to the outlined document for the overpayment reason for the claim(s) indicated.

Please issue **a refund check payable to Aetna** in the amount of the total balance due as stated above. Please include a copy of this letter and enclosure with your payment to ensure proper identification and credit to your file and send to the following address:

AETNA
29436 RELIABLE PARKWAY
CHICAGO IL 60686-0294

If you are a **contracted provider** and disagree with our dispute/reconsideration decision, you can appeal using the information provided below.

To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

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Why Payers Deny Office Visits

- Providers don't understand when its appropriate to bill E/M with other services?
- Providers don't understand how to bill the appropriate levels of E/M services
- They just don't want to spend the money???

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Modifier 25

According to Current Procedural Terminology:

- "CMT codes include a pre-manipulation assessment. Additional E/M services….may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and post-service work associated with the procedure."
- Modifier 25 tells the payer that the E/M service is not part of the CMT service and should be paid separately.
- It is unnecessary if CMT is not also billed that day.

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Modifier -25

"**Significant, separately Identifiable Evaluation and Management Service** by the Same Physician on the same day of the procedure or other service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided… The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date."

This modifier would be used when CMT and Evaluation and Management services are performed on the same day.

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Assessment Included with CMT:

Pre-service Includes:
- physician review of the patient's records to establish a treatment plan and review previous treatment;
- review of prior radiologic imaging, test interpretation, and test results
- explain the potential procedures to the patient and obtain verbal consent; and to answer any additional questions, comments, and/or concerns.

Intraservice Includes:
- Pre-manipulation patient assessment, which includes an assessment of the patient's pain level;
- evaluation of interval changes in objective signs; and
- evaluation of functional changes that may include identifying asymmetry, assessing segmental mobility, and
- evaluating changes in tissue and tone in the affected regions.

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When Can You Bill for E/M Services?

In most cases, the following scenarios warrant an E/M service:
- New Patient Exam
- Re-Examinations (Check payer guidelines)
- Exacerbations
- Patient Presents with New Condition

How often should Re-Evaluations Be Done?
- Every 30 Days??? – See Horizon as example.

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Documentation Suggestions

- Any time a re-evaluation is performed, Providers must overtly state why the evaluation is necessary.
- Exacerbation document at a minimum:
  - An exacerbation occurred
  - How it occurred
  - Subjective and Objective comparisons
- New Conditions
  - History of new injury including how it happened
  - Necessary objective findings
  - Diagnosis for new injury

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Denial Sample

"Patient reports for re-eval and care complaining of low back pain radiating to bilateral legs and causing antalgic lean. The patient reports an increase in symptoms. Ms. as been able to work and has not lost any time at work due to her condition. She reports not being able to perform normal work activities at this time. The patient is having problems with standing, sitting, and driving. The patient has difficulty going to sleep due to her condition. She wakes up in the middle of the night because of pain. The patient reports having no prior sleep problems."

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Successful Appeal Sample

"History of Present Illness

Exacerbation: The patient complaint began approximately 9/11/2021. Patient states: Moderate left SI and left lumbosacral pain. Patient was lifting boxes improperly on Monday. Bending forward. Onset of moderate achy L8P. Some left LE radiation of pain and tingling. Pain has worsened. Worse with flexion". She has never experienced this condition before.

Primary Complaint: Left low back • Dull pain: 5/10 Described as intermittent (up to 50% of day) of moderate intensity (requires significant or complete modification to ADL); increased by flexion.

PAST, FAMILY, SOCIAL HISTORY

- Surgeries/Hospitalizations: None new.
- Allergies: None new.
- Medications: None new.
- Prior conditions: Right lateral thigh numbness and tingling. Patient denies any other pain, paresthesia, weakness, and numbness in either LE. No loss of bowel/bladder control. No urinary retention.
- A full re-examination for 25 minutes, as Indicated below, was performed today because the patient has: not been examined since October of 2020. A full examination was done with history and objective findings along with a new diagnosis found due to an injury that occurred ta the patient on Monday."

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Using CMS 1500 Form Properly

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Choosing the Proper Level of Evaluation and Management Service

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What Can Count Towards Time?

- Reviewing tests when preparing to see the patient
- Reviewing separately obtained history
- Performing an exam
- Counseling and education patient and family
- Ordering test or procedures
- Communicating with other healthcare professionals
- Creating the documentation
- Interpreting test results and communicating them to the patient and family
- Care coordination

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Documenting Time

- Document "in and out" time.
  Start 8:05am End 8:25am
  Total 20 minutes (99202 or 99213)
- Document "in and out" non-continuous time:
  Start 8:05am End 8:15am
  (provider took a call for 11 minutes)
  Start 8:26am End 8:39am
  Total 23 minutes (99202 or 99213)
- Statement:
  "24 minutes total was spent performing evaluation of the patient"(99202 or 99213)

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Services Reported Separately

- If you take and/or interpret x-rays, then report the radiology code, you can't count that time towards the E/M code.
- If you need to independently interpret some x-rays in order to manage the patient as part of the E/M service, but do not separately report it, it is part of medical decision making.

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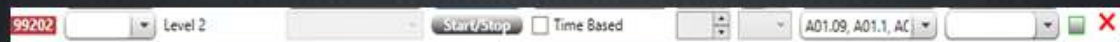
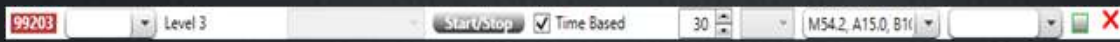
EHR Reporting Example

Scenario 1: The provider selects E/M Service code



Scenario 2: The provider selects time, the application suggests E/M code based on time



Scenario 3: The provider enters start/stop times, the application suggests E/M code based on total time

E/M Service Code Selector

Start Time	End Time	Total Time
2:32 PM	3:00 PM	28
3:00 PM	3:19 PM	19

Add

99204

OK

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Coding E/M

1. Document the medically appropriate history and exam
2. Document the time, choose the code
3. Document what was done to qualify towards time
4. If below the time threshold, code based on MDM instead*

*Using MDM is more complicated and requires a review of some definitions

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Keys To Avoid E/M Denials:

1. Understand that denials are computer driven.
2. Exacerbation often results in a new date of onset – box 14
3. New condition, often results in a new diagnosis
4. Change in the patient's condition, often results in new diagnosis hierarchy/order
5. E/M usually focuses on the new diagnosis – DX pointing
6. Make sure to choose the correct level

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Manual & Massage Therapy Denials -59

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NCCI Policy Manual For Medicare Services:

Chiropractic Manipulative Treatment

"Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. ***Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT.*** *If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59. "*

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Why Does Manual Therapy & CMT Bundle?

CPT® **97140 – Manual therapy techniques** *(eg, mobilization /manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.*

Manual therapy techniques consist of, but are not limited to, connective tissue massage**, joint mobilization and manipulation**, manual lymphatic drainage, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage. As the code descriptor states, "manual," providers use their hands to administer these techniques. Therefore, code 97140 describes "hands-on" therapy techniques.

Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling, inflammation, or restriction. These techniques also induce relaxation and improve contractile and non-contractile tissue extensibility.

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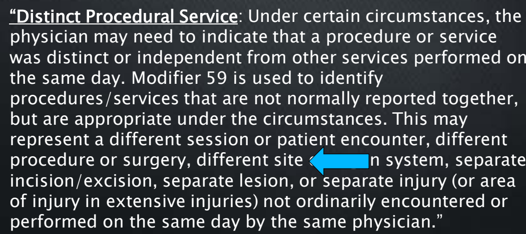
Modifier -59



"Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site n system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician."

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Does the Payer Require Medicare's Version of -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

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What is required to Report Manual Therapy (CPT® 97140) & CMT on the day?

- ✓ Treatment plan that includes Indications for manual therapy services and the specific type of manual therapy (e.g. trigger point therapy, myofascial release, etc.) as well as frequency and duration.
- ✓ Treatment goals associated with manual therapy services
- ✓ Objective measures used to ensure progress for treatment goals
- ✓ Specific site that was treated with manual therapy and specific segmental levels adjusted. These should clearly show a separate anatomical structure was treated and should not coincide.
- ✓ If all of the above is true, can you report both services together and append a -59 modifier to CPT® 97140.

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Example #1

Patient A is diagnosed with thoracic subluxation (M99.02) and muscle spasm of the back (M62.830). The Provider performs chiropractic adjustment (CMT; CPT® 98940- spinal, 1-2 regions) to T2, T3, and T4. He then performs trigger point therapy (manual therapy CPT® 97140) to the rhomboid muscles for 11 minutes.

In the majority of cases the manual therapy (97140) would not be reimbursable in this scenario because it would be considered the same anatomical 'region' as the adjustment.

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Example #2

Patient B is diagnosed with cervicalgia disc degeneration at C4-C5 (M50.321), cervical subluxation (M99.01) and adhesive capsulitis of the right shoulder (M75.01). The Provider performs chiropractic adjustment (CMT; CPT® 98940 - spinal, 1-2 regions) to segmental levels C2, C3 and C4. They then perform myofascial release (CPT® 97140) on the patient's right shoulder for 13 minutes.

The Manual Therapy would be reimbursable because it was performed to a separate anatomical region.

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How Should This Appear On The CMS-1500 Form?

- Diagnosis pointers are the numbers (now letters on the new claim form) in box 24E on the CMS 1500 form. Diagnosis pointers link the diagnosis to the applicable CPT® codes you are billing. For example, you can have three diagnosis on your claim forms and “point” each of them to only one of the CPT® codes you are billing for that day. It explains the reason you are performing the particular CPT® code.
- Certain payers require diagnosis pointing when billing CMT and Manual Therapy on the same date of service e.g. Aetna.

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Diagnosis Pointing

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Most common coding scenarios that require modifiers for DC’s.

99201-99215 + 98940-2	= 99213-25 + 98940 - 2
98940-2 + 97140	= 97140-59 + 98940 - 2
97140 + 97012	= 97140-59 + 97012
98940-2 + 97112	= 97112-59 + 98940 - 2
98940-2 + 97124	= 97124-59 + 98940 -2
97140 + 97530	= 97530-59 + 97140

Remember, the circumstances and your documentation must support the use of each modifier.

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Common coding scenarios that DON'T require a modifier based on NCCI:

- 97012 (traction) performed with CMT (98940-3)
- 97014 (electric stim) performed with CMT (98940-3)
- 97035 (ultrasound) performed with CMT (98940-3)
- 97110 (therapeutic exercise) performed with CMT (98940-3)
- 97140 (manual therapy) performed with Extraspinal CMT (98943)*
- 97530 (therapeutic activities) performed with CMT (98940-3)
- 98943 (extraspinal manipulation) performed with CMT (98940-3)

* Some payers do require -59 modifier

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Keys To Avoid -59 Denials:

1. Understand that denials are computer driven.
2. CMT bundles with 97112, 97124, 97140
3. CMS 1500 and Documentation must show Diagnosis that supports separate anatomical region
4. Diagnosis Pointing is a must
5. Same holds true for 98943 (except no modifier is required)

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Diagnosis Denials

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DX Denials

- Almost all payers are using established ICD-10 guidelines to deny claims.
- When a code includes an Excludes1 note, that means that the code that follows cannot be used with it. For example, M54.6 Pain the thoracic spine includes an Excludes1 note for M51 – *disc disorders*. These codes should not appear on the same claim, even though some of the M51 codes are for the lumbar spine.

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ICD-10 Conventions:

"Excludes"

Excludes1 – is used when two conditions cannot occur together or "NOT CODED HERE!" Mutually exclusive codes; two conditions that cannot be reported together.

Excludes2 – indicates "NOT INCLUDED HERE." Although the excluded condition is not part of the condition, it is excluded from, a patient may have both conditions at the same time. The excluded code and the code above the excludes can be used together if the documentation supports them.

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ICD-10 Conventions:

"Excludes"

Excludes1 – consider these codes *instead*
(you can only use 1)
(mutually exclusive)

Excludes2 – consider
these codes *in addition*
(you may use 2 or more)
(Not included)

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S33 DISLOCATION AND SPRAIN OF JOINTS AND LIGAMENTS OF LUMBAR SPINE AND PELVIS

Includes:
- *avulsion of joint or ligament of lumbar spine and pelvis*
- *laceration of cartilage, joint or ligament of lumbar spine and pelvis*
- *sprain of cartilage, joint or ligament of lumbar spine and pelvis*
- *traumatic hemarthrosis of joint or ligament of lumbar spine and pelvis*
- *traumatic rupture of joint or ligament of lumbar spine and pelvis*
- *traumatic subluxation of joint or ligament of lumbar spine and pelvis*
- *traumatic tear of joint or ligament of lumbar spine and pelvis*

Excludes1:
- *nontraumatic rupture or displacement of lumbar intervertebral disc NOS (M51.-)*
- *obstetric damage to pelvic joints and ligaments (O71.6)*

Excludes2:
- *dislocation and sprain of joints and ligaments of hip (S73.-)*
- *strain of muscle of lower back and pelvis (S39.01-)*

Code also any associated open wound

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DX Denials

- Pain diagnoses: Diagnosis codes such as M54.2 Cervicalgia, or M54.5 Low back pain are considered short term and are considered “symptom” diagnoses instead of “definitive” diagnoses.
- Providers should identify the cause of the pain and report a more definitive diagnosis instead. Reporting a symptom diagnoses does not do much to establish medical necessity.

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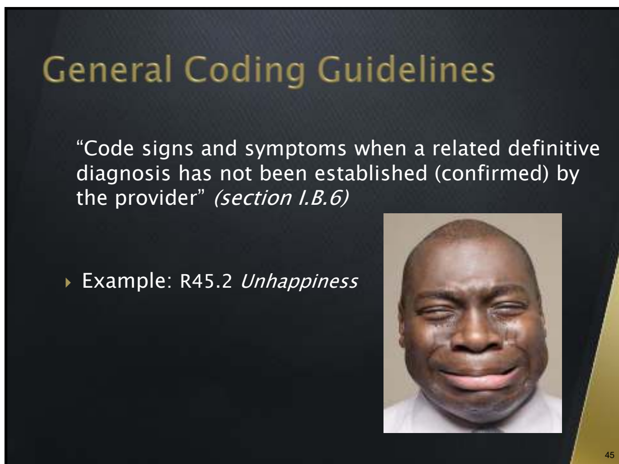

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General Coding Guidelines

- "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes" *(section I.B.7)*
  - Example: R68.84 *Jaw pain* would not be coded with M26.62 *temporomandibular joint arthralgia*
- "Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present." *(sectionI.B.8)*
  - Example: R11.0 *Nausea* and S13.4xxA *Sprain of ligaments of the cervical spine*

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General Coding Guidelines

- If the condition is bilateral and there is no bilateral code, then you have to list the left and right code separately.
- Sixth character (usually)
  - 1=right
  - 2=left

- List unspecified if laterality is not described

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Denial Examples

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Example 1

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Issue Identified (Medicare Patient)

Codes Billed:

- **M99.01** - Segmental and somatic dysfunction of cervical region
- **M50.20** - Other cervical disc displacement, unspecified cervical region
- **M99.02** - Segmental and somatic dysfunction of thoracic region
- **S33.5XXA** - Sprain of ligaments of lumbar spine, initial encounter
- **M99.03** - Segmental and somatic dysfunction of lumbar region
- **M99.04** - Segmental and somatic dysfunction of sacral region

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Example 2

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Issue Identified (Medicare Patient)

Codes Billed:

- M99.01 - Segmental and somatic dysfunction of cervical region
- M50.31 - Other cervical disc displacement, unspecified cervical region
- M99.02 - Segmental and somatic dysfunction of thoracic region

Only 2 regions diagnosed however 3-4 regions being billed

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Example 3

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Issue Identified (Non-Medicare Patient)

Codes Billed:

- M99.02 - Segmental and somatic dysfunction of thoracic region
- S33.5XXA - Sprain of ligaments of lumbar spine, initial encounter
- M54.16 - Radiculopathy, lumbar region
- M54.31 - Sciatica, right side
- M99.03 - Segmental and somatic dysfunction of lumbar region
- M99.04 - Segmental and somatic dysfunction of sacral region
- M99.05 - Segmental and somatic dysfunction of pelvic region

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Issue Identified

- Injury code listed as secondary diagnosis instead of primary
- Radiculopathy and Sciatica often bundles with Lumbar sprain
- Also, -AT modifier used

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Example 4

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Issue Identified (Non-Medicare Patient)

Codes Billed:

- **M99.01** - Segmental and somatic dysfunction of cervical region
- **S13.4XXA** - Sprain of ligaments of cervical spine, initial encounter
- **M99.02** - Segmental and somatic dysfunction of thoracic region
- **S23.3XXA** - Sprain of ligaments of thoracic spine, initial encounter
- **M99.03** - Segmental and somatic dysfunction of lumbar region

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Issue Identified

- Injury code listed as secondary diagnosis instead of primary
- Date of onset is after date of service?
- Also, -AT modifier used

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Example #5:

1. M54.12 Radiculopathy, cervical region
2. M79.2 Neuralgia and neuritis, unspecified
3. M99.01 Segmental and somatic dysfunction of cervical region
4. M54.2 Cervicalgia

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Example #6:

1. M99.03 Segmental and somatic dysfunction of lumbar region;
2. M54.41 Lumbago with sciatica, right side;
3. M99.04 Segmental and somatic dysfunction of sacral region;
4. M99.05 Segmental and somatic dysfunction of pelvic region;
5. M25.552 Pain in left hip;
6. M25.551 Pain in right hip

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Example #7:

1. M51.36 Other intervertebral disc degeneration, lumbar region;
2. M54.31 Sciatica, right side;
3. M54.5 Low back pain
4. M60.9 Myositis, unspecified;
5. G57.01 Lesion of sciatic nerve, right lower limb

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Tie the Treatments to the Diagnoses

- For example, the purpose of 97110 *Therapeutic exercise* is to develop/improve strength, endurance, range of motion, and/or flexibility
  - Diagnoses like M54.2 *cervicalgia* may not support this service
  - But diagnoses like M62.81 *muscle weakness* might
- 98943 *Extraspinal manipulation* should not be linked to spinal diagnoses
  - Such as M50.3- *Other cervical disc degeneration*

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How do I know which codes to use?

Follow payer guidelines for code sequencing. Diagnosis code hierarchy:

1. Neurological
2. Structural
3. Functional
4. Soft tissue

For example, sciatica (M54.31) and DDD (M51.35) will carry more weight than spasm of back (M62.830) or myalgia (M79.1). It is said that some software only looks at the first diagnosis when adjudicating a claim, so make it count!

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Diagnosis Hierarchy

1. Nerve related disorders (e.g. radiculopathy)
2. Acute injuries (e.g. sprains and strains)
3. Structural diagnoses (e.g. degenerative disc disease)
4. Functional diagnoses (e.g. difficulty with walking)
5. Symptoms (e.g. neck pain)
6. External causes (e.g. place and activity)

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Consider Novitas Solutions, Inc. LCD

- Twelve (12) chiropractic manipulation treatments for Group A diagnoses.
- Eighteen (18) chiropractic manipulation treatments for Group B diagnoses.
- Twenty-four (24) chiropractic manipulation treatments for Group C diagnoses.
- Thirty (30) chiropractic manipulation treatments for Group D diagnoses.

Example Group A Diagnoses:

M54.5 Low back pain
M54.6 Pain in thoracic spine
M54.89 Other dorsalgia
M54.9 Dorsalgia, unspecified
M62.40 Contracture of muscle, unspecified site

Example Group B Diagnoses:

M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M47.811 Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region

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Example: Group C Diagnoses

M48.01 Spinal stenosis, occipito-atlanto-axial region
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11 Cervical disc disorder with radiculopathy, high cervical region

Example: Group D Diagnoses

M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
M54.30 Sciatica, unspecified side
M54.31 Sciatica, right side
M54.32 Sciatica, left side
M54.40 Lumbago with sciatica, unspecified side

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Consider Using a Tool

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Keys To Avoid DX Denials:

1. Avoid unspecified codes, look out for Excludes1 and stay away from "Pain"
2. Review the code changes that affect your Practice – Free on the CMS Website.
3. Use the correct diagnosis hierarchy.
4. Remember – ICD-10 updates the codes October 1 and any changes are used for services RENDERED on, or later – not by submission date.

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Intersegmental Traction

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Roller Table/Intersegmental Traction Coding

- AMA states: "…the chiropractic roller table is a device that has adjustable mechanical rollers requiring stationary, supine positioning of a patient…A review of the literature at the time of this printing does not support a roller table meeting the requirement of autotraction, the use of the body's own weight to create sufficient force allowing for separation between joint surfaces…Therefore, code 97039, Unlisted modality (specify type and time if constant attendance), should be reported."
- CMS states: Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.
- Aetna considers autotraction devices experimental and investigational because there is insufficient evidence to support their clinical value in treating low back pain (LBP) or for other indications.

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How do you find out from a Payer how to code and bill for roller table? … i.e., procedure which may be deemed experimental/non-covered

This process does NOT apply to carriers that deem a service "not medically necessary"?

1. Consider using unlisted modality code – **97039**
2. Submit the procedure on paper claim form – include a description of the service in box 24D
3. Include attachments – see next slide
4. Send by Certified Mail or other verifiable means
5. Keep a copy
6. When EOBs come back and, if paid, attach them to the copy of the letter – File it.

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Items to Attach with Claim:

- ✓ Treatment Plan – not a schedule for care (optional)
- ✓ Daily Notes – Identify the device
- ✓ Include pictures of the device from Manufacturer's web site (optional)
- ✓ Brief description of care – don't give the care a name
- ✓ Cover Letter – please process my claims promptly

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Consider a Disclaimer

"This office submits services for Intersegmental traction utilizing the code 97039 (Unlisted modality) in anticipation of denial of payment from your insurance Carrier. The Provider will not submit the services to your Carrier as mechanical traction (code 97012) because, based on carrier policies, the intersegmental traction will most likely be deemed experimental/not Medically Necessary.

The patient has read, understood and acknowledges that the Patient will be solely responsible for payment and will waive any future claims or demands against the Provider for payments made in connection with this service.

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Thank You!

Contact David Klein

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