CE CODING CASES

THE NEW MODIFIER MAZE

And avoiding denials in 2023

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TIME TO READ: 6-8 MIN.

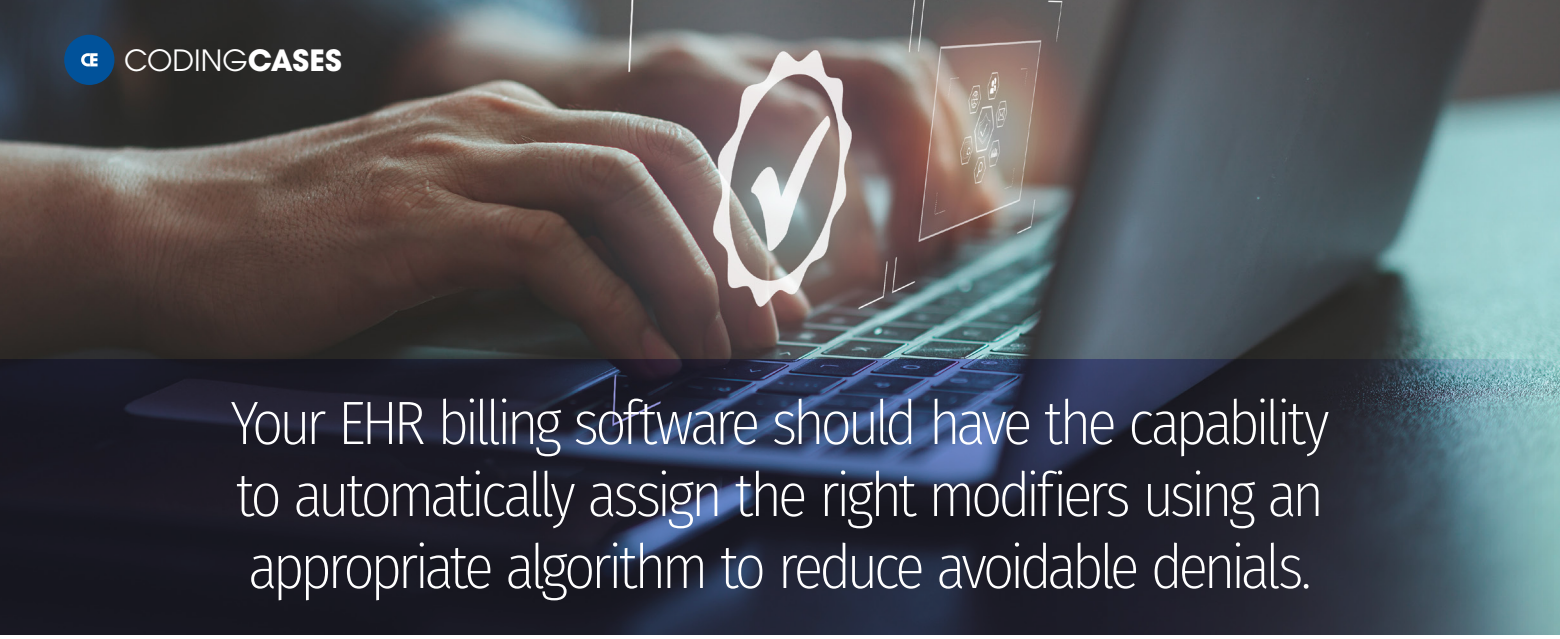
THE TAKEAWAY

Navigating the different definitions by insurance companies and providing full context to CPT codes for maximum reimbursements.

HAVE YOU HAD CLAIMS denied stating "missing" or "invalid modifiers"? Or sometimes denied and you cannot figure out why? Modifiers have been in effect for a long time, but each insurance company chooses when they will start enforcing the usage.

Claims you were getting paid last year are now denied, but you are billing the same codes. Every year, rules change, and insurance companies get more specific in what they require. Insurance modifiers are used to provide additional information or adjustment descriptions regarding a procedure/service provided by a health care provider. Ultimately, modifiers provide further context to a CPT code entered on the claim form, without changing its definition.

So, let's take a quick look at modifiers, and start with Medicare since they set the guidelines.



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Medicare modifiers

Medicare is actually very simple in its guidelines. For the chiropractic adjustment CPT codes (98940, 98941 and 98942) there are three common modifiers:

- AT – Acute Care. Medicare will only pay for a service if there is a medical necessity.
- GA – This specifies you know it is not acute care, but you have an ABN (Advance Beneficiary Notice), also known as a waiver of liability, so you can charge the patient if Medicare does not pay because they cannot see the patient has made progress through treatment.
- GZ – This specifies an ABN has not been given to the patient and therefore no charges can be transferred to the patient. The GZ modifier must be used when you want to indicate that you expect Medicare will deny an item.

Code 98943 is sometimes billed with an AT modifier or no modifier. The AT modifier is incorrect since this is already a statutorily non-covered code and not an adjustment of the spine. Also, having no modifier is incorrect. Code 98943 should have the GY modifier since we need to tell Medicare we know this is a non-covered service.

Physical medicine codes

Physical medicine codes such as 97530, 97012, etc., must always have the GP modifier. This modifier tells Medicare and other insurance companies that we know it is a PT code. We also must add the GY modifier since we know these codes are non-covered by Medicare.

For example, we would bill a 97530 GP GY, or 97012 GP GY. All PT codes must have these two modifiers to be correct for Medicare. Codes 97140, 97112 and 97124 are PT codes that require an additional modifier. We must use the 59 or XS modifier when billing these codes on the same visit as an adjustment to signal these are distinct services and should not be bundled with the adjustment.

Which modifier should you use, the 59 or the XS? Well, currently both are correct. However, the description of the 59 states you can use this modifier when no other more specific modifier is available. In most cases, the XS is the more descriptive and correct code to use. It indicates the service was provided on a different structure.

X-ray codes are another place where we see no modifiers being used. This is incorrect as they should also have the GY modifier. So, when billing an X-ray code, you would have the GY and any other modifier needed. Examples are 72100 GY or 72100 TC GY. This denotes you are billing this X-ray for the technical component, meaning you perform the test but not the interpretation or report, and you know it is non-covered by Medicare.

In short, all codes billed to Medicare will have at least one modifier.

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General insurance, WC and PI modifiers

In general, all modifiers will be the same for these categories of payers. The difference between these payers and Medicare is we will not use the GY modifier.

We will, however, use the GP, 59 or XS modifier along with any other code-specific modifiers you may need, such as LT for the left side (only when required). The GP modifier is also required by UHC, BCBS and several other insurance companies.

Some do not require it (yet). But the good part is no one denies the code for having the GP. So, to make it easier, bill all insurances with this code.

Examples:

- 98940 — no modifier needed
- 97530 GP
- 97140 GP 59 (XS)
- 72100 — no modifier unless you are specifying TC or 26

For X-ray CPT codes (72040, 72100, etc.), understanding the appropriate use of modifiers 26 and TC is quite important to avoid denials for duplicate billing. As mentioned, the modifier TC will be used if you only provide the technical component. In such cases, the provider is reimbursed for the equipment, supplies and technical support. It is about 60% of the amount covered. Modifier 26 will be used if you only provide the interpretation of the results and the report. If you provide both components, then do not use modifiers.

GY

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Humana

Finally, let's look at Humana since they have different requirements — to be noted, some states also use these requirements for UHC. Humana requires either the 96 modifier to state the service was habilitative or 97 to state the service was rehabilitative. Rehabilitative helps patients restore functions, whereas habilitative helps to develop skills and functions.

Examples:

- 98940 97
- 97530 97
- 97140 97 59 (XS) — we still need to tell the insurance it is separate

Of course, there are more modifiers and situations. However, these are the most widely used. CE

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