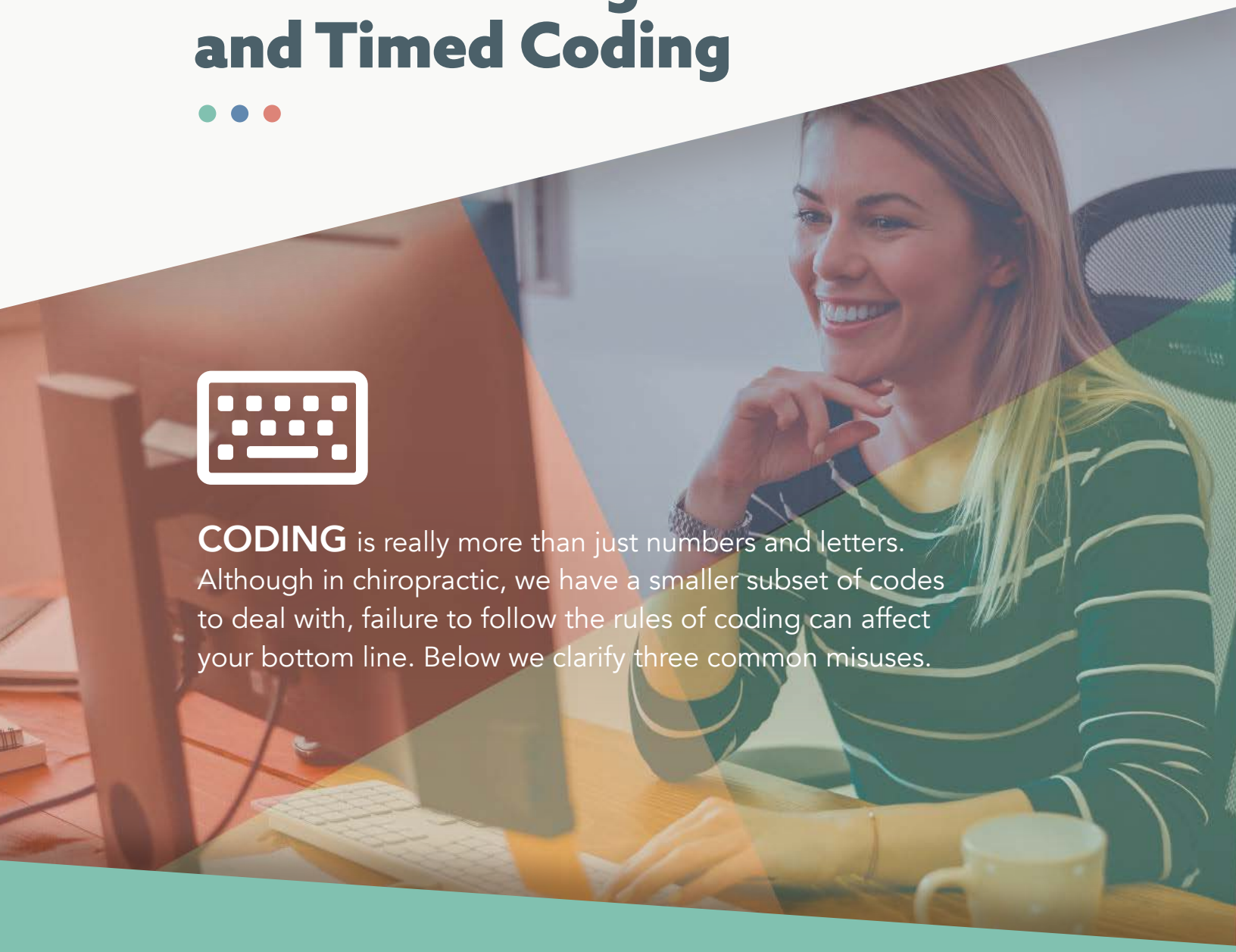
Presented in partnership with **CHIROTOUCH** and **KMC UNIVERSITY**

A QUICK GUIDE FOR CHIROPRACTIC BILLERS

# Understanding Modifiers and Timed Coding



**CODING** is really more than just numbers and letters. Although in chiropractic, we have a smaller subset of codes to deal with, failure to follow the rules of coding can affect your bottom line. Below we clarify three common misuses.

# X Codes

## USE INSTEAD OF MODIFIER 59

Modifier 59 is not only the most used modifier, but it's also the most abused. That's why CMS put four more specific modifiers in place to deter this abuse and reduce errors.

### WHEN TO USE X Codes

In chiropractic, X codes are most commonly used when billing neuromuscular re-education, therapeutic massage, and manual therapy.

### WHEN TO USE Modifier 59

Modifier 59 continues to be a valid modifier to indicate that two or more procedures were performed at the same visit but to different sites on the body. Check with your carrier's payment policy to confirm whether they prefer the 59 modifier or Medicare's X modifiers.

| MODIFIER | MEANS | USE |
|---|---|---|
| **XS** — Modifier most commonly used | **Separate Structure** | A service that is distinct because it was performed on a separate organ/structure or body region. |
| **XE** | **Separate Encounter** | A service that is distinct because it occurred during a separate encounter (e.g., two encounters on the same date). |
| **XP** | **Separate Practitioner** | A service that is distinct because it was performed by a different practitioner, with a different license (e.g., a PT). |
| **XU** | **Unusual Non-Overlapping Service** | The use of a service that is distinct because it does not overlap the usual components of the main service. |

# Medicare
## ABN SPECIFIC MODIFIERS

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When submitting charges to Medicare, there are four modifiers used to indicate whether or not an ABN was given to the patient.

## Medicare ABN Specific Modifiers

| CODE | DESCRIPTION | EFFECT ON PAYMENT |
|---|---|---|
| **GA** (ONLY USED WITH **98940**, **98941**, **98942**) | ABN on file for mandatory use. Indicated maintenance care or visits exceed carrier screen. | If patient selects ABN Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible. |
| **GZ** (ONLY USED WITH **98940**, **98941**, **98942**) | Indicates you failed to collect ABN for maintenance care as required. | Claim will be denied. Patient will not be deemed responsible for payment. |
| **GY** (ONLY USED WITH **statutorily excluded services**) | Indicates statutorily non-covered item/service is rendered by a DC. | Billing of these services is not required unless the patient requests. Patient is financially liable. |
| **GX** (ONLY USED WITH **statutorily excluded services**) | ABN on file for voluntary use. Only use with Medicare's official ABN form. | Claim will be denied/patient financially liable. Not recommended to use ABN for voluntary use. |
| **GP** (ONLY USED WITH **statutorily excluded services**) | PT service delivered under outpatient physical therapy plan of care. | When used with GY modifier claim will be denied to patient responsibility. |

# Timed Treatment
## CODING RULES

Constant attendance modalities, like laser, ultrasound, and attended muscle stimulation, as well as therapeutic procedures like therapeutic exercises, manual therapy, and massage, are time-based and require proper documentation of the time for each, as well as total time. Rules from the AMA/CMS state that you must perform at least half the time value of the code in order to bill for that code. For example, you must perform at least 8 minutes of a 15-minute timed code in order to bill for it.

### Eight-Minute Rule
### Single Procedure

| | |
|---|---|
| **< 8 Minutes** | Not Billable |
| **8-22 Minutes** | 1 Unit |
| **23-37 Minutes** | 2 Units |
| **38-52 Minutes** | 3 Units |
| **53-67 Minutes** | 4 Units |
| and so on, using 15-minute increments | |

### Eight-Minute Rule
### Multiple Procedures

- Add total time of all procedures
- Determine total number of units from "Eight-Minute Rule" chart.
- Compare number of units derived from total time above to determine proper coding.

**EXAMPLE:** 26 minutes of therapeutic exercise (97110) plus 25 minutes of manual therapy (97140) is a total of 51 minutes. Per these rules, bill a total of 3 units; two units of 97110 (assigning it more units because it took the most time) and only one unit of 97140. Document the exact number of minutes performed of each therapy in the patient health record.

# Timed Treatment
## CODING RULES

### 3 of 5
**DON'T KNOW REQUIREMENTS**

3 of 5 providers and CAs surveyed didn't know the documentation requirement for time-based codes or how to properly count units of time when multiple timed codes are performed on the same visit.

### At least 23 minutes
**TO BILL A SECOND UNIT**

When billing multiple, time-based service codes, total active time must equal at least 23 minutes to bill a second unit, and 38 minutes to bill a third.

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