2025 UVCA SPRING CONVENTION

BILLING & CODING CHALLENGES:

PANEL DISCUSSION

YOUR PANELISTS

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Angela Santiago, CPCO

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YOUR MODERATOR: Dr. Eric Carlsen

INTRODUCTION

- Introduction of Panelists
- Panel Discussion Format
- UVCA Anti-Trust Disclaimer

BILLING CHALLENGE 1

Navigating UHC Medicare Advantage Plans Prior Authorization Requirements for Chiropractic Services

Lead Panelist, Marilyn Porras
President/Owner
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Lead Panelist, Jennifer Lahm, CMIS
General Manager
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2024 PRIOR AUTHORIZATION GUIDELINES FOR UHC MEDICARE ADVANTAGE PLANS

Starting on September 1, 2024, prior authorization is required for chiropractic services under United Healthcare Medicare Advantage Plans. You can submit a prior authorization request up to 10 business days after the initial consultation. Optum Physical Health reviews these requests to determine if the services are medically necessary, using Medicare guidelines and other standard criteria.

WHAT'S CHANGED IN 2025?
UHC MEDICARE ADVANTAGE PRIOR AUTH RULES EXPLAINED

Starting on Jan. 13, 2025, UHC has amended their requirements for prior authorizations due to feedback from providers. According to the updated policy, authorization is not required for the first six visits (VIS) if the following conditions are met:

- The member is new to your office
- The member presents with a new condition
- There has been a cap in care of 90 days or more

However, we have recently experienced a significant number of claim denials. After multiple discussions with UHC and Optum, it has been clarified that although authorization is not immediately required for these visits, an authorization request must still be submitted for the claims to be paid. Up to the first 6 visits within 8 weeks will be covered regardless of the status of the authorization request.

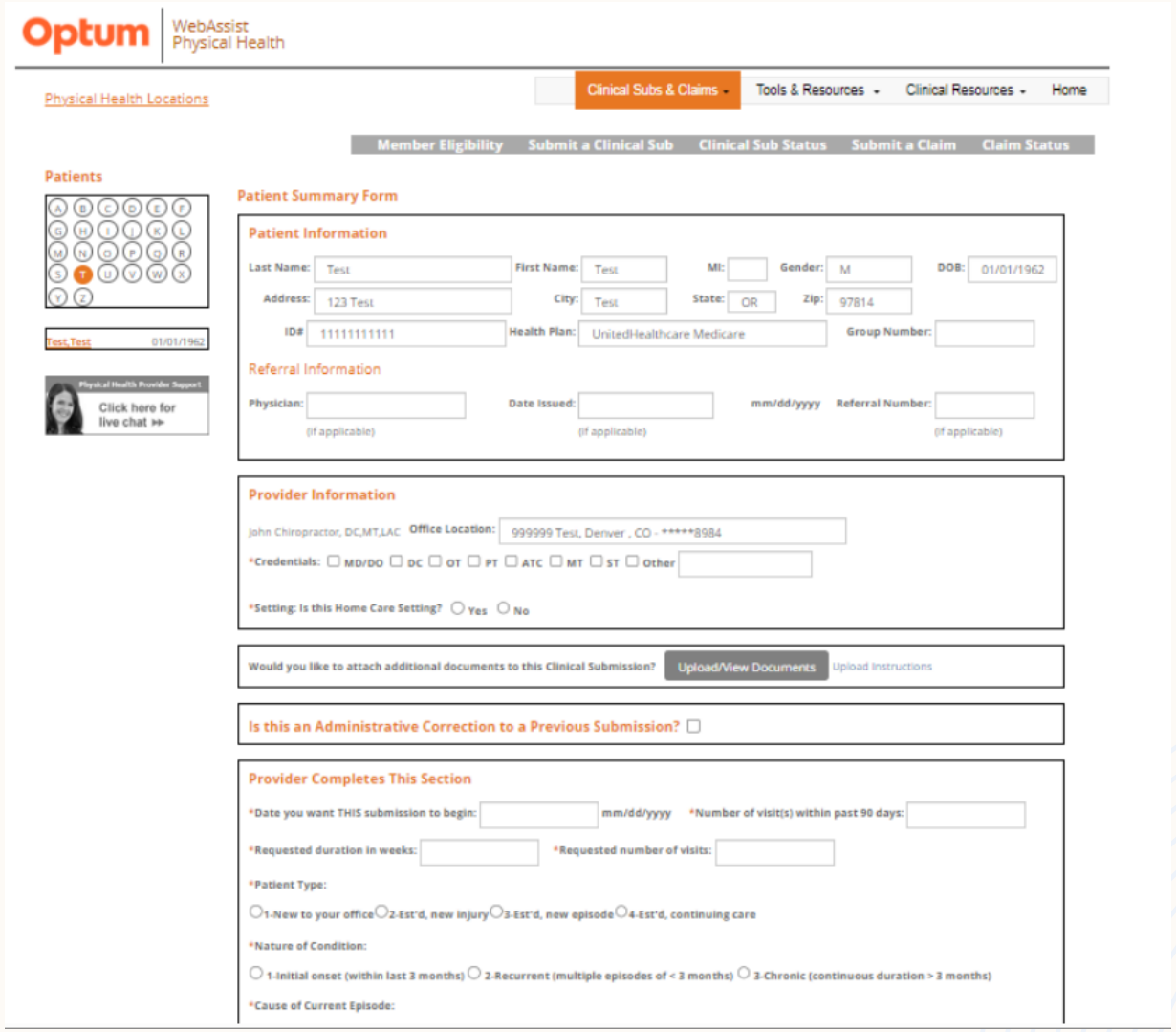
The key change relates to the timing: if the criteria are met, the provider has a longer window to submit the authorization request. This is intended to allow patients to begin care more promptly without having to wait for prior approval.

Recommendation: To avoid delays and claim denials, we strongly advise submitting an authorization request for all UHC Medicare Advantage Plans, even when the patient meets the criteria for the initial six visits.

HOW DO I OBTAIN A PRIOR AUTH?

https://www.myoptumhealthphysicalhealth.com/

In Virginia, prior authorizations for UnitedHealthcare are managed by Optum Physical Health and are obtained by completing a Patient Summary Form. For chiropractic care, the Patient Summary Form can be accessed through the Optum provider portal. Providers may either download and complete the form manually or submit it electronically through the portal. Electronic submission is recommended, as the online system verifies that all required information is included which helps to prevent delays and ensure accuracy.



Optum

UnitedHealthcare® Commercial & Medicare Programs

Chiropractic Plan Summary
Revised: 8/1/2024

- This OptumHealth Care Solutions, LLC (Optum) Plan Summary is applicable to UnitedHealthcare Commercial and Medicare programs noted below.
- Reimbursement associated with this Plan Summary is subject to the plan limitations and provider's scope of practice, up to the fee schedule maximum, per the attached applicable fee schedule(s): Optum® UnitedHealthcare Commercial and Medicare
- Malpractice coverage: $1,000,000 per incident/$3,000,000 aggregate is required for participation, unless otherwise noted on page 2 of this Plan Summary or allowed by law or plan.
- Optum's Clinical Submission Process is described in the Optum Provider Operations Manual (myoptumhealthphysicalhealth.com). See instructions on page 2 of this Plan Summary. Payment for services not covered by a valid clinical submission, when required, may be denied.
- UnitedHealthcare Navigate, Compass, Charter and NexusACO™ products require a referral from the member's primary care physician, as allowed by state regulations.
- For UnitedHealthcare programs that do not require an Optum clinical submission, a UnitedHealthcare prior authorization still may be required. Call the Eligibility/Verification number noted below or on the member's ID card to obtain any necessary authorizations.
- For more information on UnitedHealthcare programs, visit unitedhealthcareonline.com, go to Tools and Resources → Policies, Protocols and Guidelines.

UnitedHealthcare Programs	Optum Clinical Submission	Eligibility/Benefit Verification	Claims Submission	Claims Inquiry
UnitedHealthcare Commercial and Medicare plans, including: • Choice Plus • Options PPO • HMO • Medicare Solutions • AARP and Medicare Complete • UnitedHealthcare® Compass • UnitedHealthcare® Charter • UnitedHealthcare Navigate® • Erickson • UnitedHealthcare® NexusACO™	• To determine if Optum clinical submissions are required, use the "Quick Group Check" utility at myoptumhealthphysicalhealth.com or call "Quick Group Check" at 1-800-873-4575. See Clinical Submission Process instructions on page 2 of this Plan Summary. • To determine if Optum clinical submissions are required for Medicare plans visit myoptumhealthphyscialhealth.com, go to "Clinical Subs & Claims" → "Member Eligibility". See Clinical Submission Process instructions on page 2 of this Plan Summary.	• unitedhealthcareonline.com (website assistance available at 1-866-842-3278) • UnitedHealthcare / UnitedHealthcare Navigate® / UnitedHealthcare® NexusACO™ provider services: 1-877-842-3210 • When calling to verify member eligibility, verify if a PCP referral is required.	Submit claims to: • Electronic claims: Emdeon® payer ID:87726 or unitedhealthcareonline.com • Paper claims to the address on the back of the member ID card. Timely Filing: • Claims must be received within 90 days from the service date, unless otherwise allowed by law. Claims submitted late may be denied. Claims Inquiries: • UnitedHealthcare: 1-877-842-3210 • For questions concerning non-payment for reasons related to the Optum Clinical Submission Process, contact Optum at 1-800-873-4575.	

BILLING CHALLENGE 2

How to Handle Claims that are being denied due to “code bundling”

Lead Panelist, Angela Santiago, CPCO

Senior Account Manager

Director of Account Manager Support and Oversight

Gold Star Medical Business Services

COMMON BUNDLING DENIALS

- 9894x coded with 97140, 97124, 97112, 97530
- 9894x coded with E/M (9920x, 9921x)
- Claims that are billed with Multiple Modalities (over 4 per DOS)

UNDERSTANDING NCCI

- **NCCI = National Correct Coding Initiative**
- CMS developed the NCCI program to promote national correct coding of Medicare Part B claims. 99% of all payers have adopted these edits into their claims processing systems
- Two Basic Types of Edits
  - **MUE** – Medically Unlikely Edit (example an anesthesiologist bills for 8 units of moderate sedation [2 hours] for a routine colonoscopy that normally takes less than 30 minutes to complete)
  - **PTP** – Procedure to Procedure Edits (**when 2 codes are closely related or have similar descriptors**) Codes with PTP edits will routinely deny. Either one code pays and the other doesn't, OR both codes are denied

https://www.cms.gov/medicare/coding-billing/ncci-medicare

UNDERSTANDING NCCI

- Most of the bundling denials in Chiropractic are due to PTP edits
- If you look up the code pairs in NCCI, they will either have an indicator of

0 = these two codes may NEVER be coded together

(example, 98941 and 98942 in the same encounter)

1 = these two codes may be unbundled with a proper MODIFIER, AND the intent of the modifier is accurately reflected on the claim

(example 98940 and 97140. Both codes have the description of "joint mobilization".

https://www.cms.gov/medicare/coding-billing/ncci-medicare

MODIFIERS THAT "UNBUNDLE"

-**59 Distinct Procedural Service.** Must prove the Distinctiveness of the services.

-"X" Modifiers

XS = Separate Structure (98940 was performed to Cervical area and 97140 was performed to the low back)

XP = Different Practitioner (both must have NPI numbers and be credentialed with the payer)

XE = Different Encounter

XU = Unusual Circumstance

https://www.cms.gov/medicare/coding-billing/ncci-medicare

BILLING TIPS

- Make sure dx codes are properly pinpointed on the claim. Will reduce first pass denials.
- Make sure documentation supports the unbundling of the codes (claims are routinely denied initially, but can be appealed by sending in notes)

WHY ARE EXAM CODES DENIED WHEN BILLED WITH A CMT?

- NCCI edits allow for these code pairs with proper modifier. (-25 on the Exam Code) HOWEVER,
- Medicare has assigned a “zero day” global indicator to CMT codes in the Physician fee schedule.
- Codes with a “zero day” global have a restriction on Exams being reimbursed the same day as the procedure
- This is actually a faulty edit. Many Chiropractic State Associations and Supporting organizations are fighting to have this edit removed.

MULTIPLE MODALITY REDUCTIONS

- Many payers restrict the number of modalities that can be billed in a day
- Some payers will deny after a certain number of modalities are billed
- Some payers will pay for all the modalities, but cut the fees on more than a certain number
- Know your payer guidelines
- In Network providers may not balance bill patients for multiple modality reductions.

BILLING CHALLENGE 3

How HEDIS Measures for Low Back Xrays are causing denials and what to do about it.

Full Panel Discussion

WHAT IS HEDIS?

- The **Healthcare Effectiveness Data and Information Set** (HEDIS) is a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service.
- There is a HEDIS Measure that guides medical necessity of X-Rays for ACUTE Low Back Pain. **IN PATIENTS BETWEEN THE AGES OF 18-50**
- The Measure states that unless there are documented “red flags” that could warrant an x-ray being taking at the onset of care, providers should wait 28 days (4 weeks), and reassess the patient at that time for medical necessity of an X-ray.
- Anthem of Virginia is using this HEDIS measure to decide if claims for Low Back X-rays will be paid.

https://odphp.health.gov/

For the HEDIS® measure on "Use of Imaging Studies for Low Back Pain (LBP)," providers should avoid ordering imaging studies (X-rays, CT scans, or MRI) within the first 28 days of a new diagnosis of low back pain in patients aged 18-50, unless clinically indicated.

HEDIS LOW BACK MEASURE
RED FLAGS THAT WOULD WARRANT INITIAL XRAY BEFORE 28 DAYS

- History of cancer
- Unexplained weight loss
- Immunosuppression or IV drug use
- Fever/chills (possible infection)
- Recent significant trauma
- Neurologic deficits (e.g., foot drop, loss of bowel/bladder control)
- Osteoporosis or history of fractures
- Age >50 or <18 with severe symptoms

https://odphp.health.gov/

Thank you for your attendance!!

For More Information:

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