Questions & Answers from Webinar

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

-

Thank you to everyone that attended the December 13, 2023, Webinar for Modifier -25 and Modifier -59. Below are the questions asked during that session and the responses. If you have any questions, please contact your provider relations consultant. If you are not sure who that is, please email providerrelations@bcbsvt.com or call (888) 449-0443 option 1 and you will be directed.

A recording of the Webinar is located on our provider forms and resources page: https://www.bluecrossvt.org/providers/provider-forms-resources under the coding link.

Questions and Answers:

Q: For instance, patient presents for preventative exam and chronic conditions-such as ADHD, Depression, Hypertension are discussed and reviewed. Or migraines etc. It is clearly documented that this was reviewed and discussed.

A: It is important to note that these chronic conditions can be reviewed as part of the preventative exam as a preventive visit includes a review of patient history (past and current) and an examination. Just because the conditions are chronic does not make reviewing them a diagnostic exam. Did the discussion go above and beyond a check of the condition(s)? Was there a change in the condition or medical decision making for the condition(s)? Was the time and content spent on the review and discussion enough to support a significant, separate encounter apart from the preventive visit? As always, the documentation must support the coding.

If the service is separate and distinct and supported by the medical documentation a modifier -25 can be billed. However, it will go through coding validation. If you receive a denial on your provider voucher for the use of the modifier -25 you can submit for a coding validation review. Please review the details in Section 6.4 of our on-line provider handbook: www.bluecrossvt.org/documents/provider-handbook under "Cotiviti Coding Validation (CV) Review Process" for details on how to initiate a review.

Q: I am getting a flat denial for e/m visit our any visit where I permed acupuncture on the same day despite meeting the criteria you have delineated. what do I do then?

A: Please contact your provider relations consultant and provide a few examples. These may qualify for a Cotiviti Coding Validation (CV) Review Process. Your provider relations consultant will be able to assist you.

Q: Need more information on these preventatives with E&M please

A: This is a very broad statement. We recommend reviewing the Section guidelines in the CPT manual to help gain perspective on coding preventive and diagnostic evaluations together.

Q: Double documenting is a lot of extra work for the provider. Shouldn't it be on the reviewer to sort that out?

A: The preventive and diagnostic encounters contain many of the same elements. The reviewer will sort out the medical decision making (MDM) to verify what is supported. However, the code levels they come up with might not match what was billed or they might not see the level of necessity in the documentation to support the additional diagnostic visit. Many medical records are heavily templated and/or carry over (copy-paste/clone) information from one date of service to the next making it questionable that the information is specific to the visit on that date of service. If creating a separate diagnostic report is too much work, then I recommend clearly documenting the necessity and the decision making for the diagnostic portion under the diagnosis (') it is meant to support.

Q: Can modifier -25 be used for mental health services?

A: This is a very broad question. I am unsure exactly what is meant by it. Modifier -25 is specifically used for evaluation and management (E/M) codes. Please contact your provider relations representative with more details and it can be reviewed further.

Q: Could you please elaborate on the other modifier you would use in the example of the E/M leading to the need for a procedure performed on the same day? You mentioned this was a different modifier. What about the example of a mole check finding a suspicious mole that needs to be removed.

A: Modifier 57 is for an E/M leading to the decision for surgery. This is for surgery with a 90-day global period. Your example would more than likely not fit this scenario. However, depending on the circumstances you could possibly bill an E/M with a -25 modifier. If this is a mole you have been watching for a while and you previously suspected it would need to be removed, then an E/M might not be warranted. However, if it is a new mole and a separate and significant work up is performed that meets the -25 modifier requirements, then it is possible the E/M would be supported.

Q: What about using -59 with 97110, when CPT® code 97113 pool therapy is used at the same time? Would you put modifier GP with -59 on 97XXX codes?

A: The use of modifier -59 with 97110 and 97113 is appropriate if the documentation supports it. Yes, the GP modifier is appropriate in the secondary position.
However, it will go through coding validation. If you receive a denial on your provider voucher for the use of the modifier -59 you can submit for a coding validation review. Please review the details in Section 6.4 of our on-line provider handbook: www.bluecrossvt.org/documents/provider-handbook under "Cotiviti Coding Validation (CV) Review Process for details on how to initiate a review.

Per the Blue Cross VT Physical Therapy Medical Policy, the modifier -GP must be reported when physical therapy services are provided. The modifier -GP is an informational modifier and therefore, does not need to be reported in the first modifier position if another modifier is present.

Q: Would you put modifier GP with -59 on 97XXX codes

A: Per the Blue Cross VT Physical Therapy Medical Policy, the modifier -GP must be reported when physical therapy services are provided. The modifier -GP is an informational modifier and therefore, does not need to be reported in the first modifier position if another modifier is present.

Q: When a patient comes in for a preventative service if other issues are documented such as migraine, ADHD, hypertension and if any of them are exacerbated would this support an additional E/M?

A: Based on information provided in the question, we would say yes, it sounds like the medical decision making would go above and beyond that performed for just a preventive service. The documentation in the medical record should support the diagnosis and its exacerbation and the decision making for the diagnostic conditions.

Q: When working with kids: session with the child that ends up needing safety planning. A telehealth session must be done later that same day with parent/s to inform of safety plan, etc. Are these separate and distinct?

A: An E/M service requires a face-to-face component with the patient. We are not sure that an E/M service is billable for the telehealth session as it is performed with the parent just to update the parent. It is unable to be determined what is appropriate in this scenario without further information or codes billed. Please contact your provider relations consultant with more details and they will have it reviewed.

Q: Blue Cross VT always denies payment for 97110 when it's billed with 97113 which is aquatic therapy.

A: It is possible to bill for land and aquatic-based physical therapy services on the same day, but documentation must support the medical necessity of the treatment and therapists should consult each payer's policy on reimbursement for both services in a single day. In addition to the documentation being present, modifier -59 must be appended to 97110 and the claim must have an appropriate ICD-10 diagnosis.

Our Corporate Medical Policy for Physical Therapy/Medicine defines the criteria that must be met in order for the services to be considered medically necessary: https://www.bluecrossvt.org/sites/default/files/2023-06/Physical%20Therapy_Medicine%20-%202023%20-%20PUBLICATION_0.pdf

Q: Can Blue Cross VT please clarify their policies and procedures for appeals off denials. Please be specific. Additionally, please describe who is doing records review and appeal rights for discrepancy between your reviewer and a certified coder.

A: These denials do not allow for appeal, per provider contracts. Do not submit as an appeal or your request(s) will be returned to you. These denials are eligible for a Coding Validation Review. Details are located in Section 6.4 of our on-line provider handbook: www.bluecrossvt.org/documents/provider-handbook under “Cotiviti Coding Validation (CV) Review Process.

The reviews are done by nurses who are also certified coders.

Q: Clarifying- modifier -59 should be used with code 96160?

A: As noted during the Webinar, when 96160 is performed alongside 96127, and the documentation and scoring instruments support two distinct services, then CPT 96160 would be billed with a -59 modifier. This is based on edits and American Academy of Pediatrics.

However, it will go through coding validation. If you receive a denial on your provider voucher for the use of the modifier -59 you can submit for a coding validation review. Please review the details in Section 6.4 of our on-line provider handbook: www.bluecrossvt.org/documents/provider-handbook under "Cotiviti Coding Validation (CV) Review Process for details on how to initiate a review.

Q: Is it appropriate to use mod -59 with 96161 for post-partum depression screening? We are having trouble getting reimbursed from Blue Cross VT for this.

A: We need to know the additional codes billed to answer this question. If it's billed with an E/M code only, then modifier -59 would not be appropriate. Please contact your provider relations consultant with more details and we can have it reviewed further.

Q: The 99394 would be the well E/M code for the visit that had the screening codes 96160, 96127 or 96110 with it, so- do we need a modifier -25 on the E/M code when we are also billing 96160, 96127 and 96110? and do we need modifier -59 on 96160, 96127, 96110? or do we just put number of units on those codes if we do more than one? and is there a limit on any of the codes with the number we can do?

A: There are no edits between the preventive and the screenings. Modifier -59 is not required on the screening codes against preventive visits. However, there are edits between the 3 screenings that would require the modifier if the documentation and screening instruments support all three screenings.

Reminder, Blue Cross VT follows standard MUE allowances. All services could be subject to MUE limits.