ACUPUNCTURE Today

BILLING INSURANCE

This Is Why Your Claim Is Being Denied

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Question: I mostly provide and bill insurance claims for acupuncture services; however, there are times that I bill therapies. Although I was being paid without issue, I have recently noticed a rash of claim denials for my physical therapy (physical medicine & rehabilitation) codes, indicating a missing modifier. I re-billed, assuming that it was modifier 59, but the claim was still denied, noting a missing or improper modifier. What am I doing wrong?

This is an issue that is happening with some carriers (although not all) and began in later 2019 when UnitedHealthCare (Optum and UHC affiliates) required that a particular modifier be appended to all physical medicine services. This modifier was also made a requirement for Veterans Administration (VA) and Medicare claims.

GP: The "Always Therapy" Modifier

GP is termed the "always therapy" modifier, and this was the statement from UnitedHealthCare regarding its use: "Effective April 1, 2020, we're updating the Procedure To Modifier Policy, Professional to require the GN, GO, or GP modifier on 'Always Therapy' codes to align with the Centers for Medicare & Medicaid Services (CMS). This modifier is classified as a Level II HCPCS (Healthcare Common Procedure Coding System) modifiers: These are two-letter codes used by Medicare as well as some Medicaid and commercial plans. HCPCS modifiers are letters and not numbers.

According to CMS, certain codes are 'Always Therapy' services regardless of who performs them and always require a therapy modifier (GP, GO, or GN) to indicate that they are provided under physical therapy, occupational therapy, or speech-language pathology plan of care. 'Always Therapy' modifiers are necessary to enable accurate reimbursement for each distinct type of therapy in accordance with member group benefits."

Note the statement that regardless of provider type the modifier is necessary. GP is the most appropriate for acupuncture claims, as it aligns with the therapy provider "physical therapy"; as opposed to GO, which is used by an occupational therapists, or GN by speech therapists.

It is meant to allow tracking for physical medicine services by provider type and not simply to add a layer of confusion to coding and billing protocols. This does not mean Medicare is paying acupuncture providers for therapy; GP is a necessary modifier to assure a proper denial for a secondary payer to make payment.

Other Plans Requiring GP

So, that explains those plans, but what about others? Modifier GP is being adopted by additional carriers as a requirement for reimbursement of physical medicine services. This includes physical medicine services billed to Blue Cross Blue Shield of Michigan, Blue Cross of California (*Note*: This

does not include Blue Shield of California), BCBS plans of Indiana, Kentucky, Missouri, New Jersey, New York (Empire), Ohio, Vermont, and Wisconsin. Based on what I have reviewed, if it is an Anthem policy there will also be a need for modifier GP.

Therefore, all physical medicine codes 97010 through 97799 (PT codes) for these plans must be appended with a GP or will be denied as having a missing or incomplete modifier.

In cases in which you need an added modifier such as 59, you would use both modifiers on the claim. Note the order of the modifiers is not important as long as both appear. So, if you do GP 59 or 59 GP, either would be acceptable. (However, modifier 59 would rarely or likely never be necessary for an acupuncture claim; it is common for chiropractic claims to demonstrate the separate region for chiropractic manipulation and manual therapy. No such designation is required for acupuncture codes billed with manual therapy.)

Why Not Always Use GP?

I know what you may be thinking: *Why don't I just put a GP on all PT codes?* Do not blanket all payers with GP for physical medicine services. Payers that do not require the modifier may deny your claim, and I would certainly not risk a denial. However, if you do get a denial indicating a missing modifier on a physical medicine code, adding GP may be the likely fix. Finally, please note that use of the modifier does not alter the price or reimbursement of services provided / billed.

Editor's Note: Have a billing question? Submit it to Sam via email at sam@hjrossnetwork.com. Submission is acknowledgment that your question may be the subject of a future column.

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