



ACA Practice Advisory

Regulatory and Insurance Reimbursement Policies and Current Practical Applications

WINTER 2004

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ERISA CLAIMS PRACTICE TIPS:

Down-Coding, Bundling and Partial Claim Payments under ERISA Health Benefit Plans Can Establish Grounds For a Claim Appeal

According to the U.S. Department of Labor's "frequently asked questions," an "adverse benefit determination," which triggers the right of an ERISA plan claim appeal, occurs when the claimant receives "less than full reimbursement of the submitted expense." Down-coding, bundling and partial payment are all potential forms of "less than full reimbursement."

The full question and answer from the Department provides the following guidance:

Question: If a claimant submits medical bills to a plan for reimbursement or payment and the plan, applying the plan's limits on co-payment, deductibles, etc., pays less than 100 percent of the medical bills, must the plan treat its decision as an adverse benefit determination?

Answer: Under the regulation, an "adverse benefit determination" generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan's calculation of how much it is required to pay, the decision is treated as an adverse benefit determination under the regulation. Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide

whether to challenge the "denial," e.g., the failure to pay in full. This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. The fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule. This approach to informing claimants of their benefit entitlements with respect to specific claims, further, is consistent with current practice, in which "Explanation of Benefits" forms routinely describe both payable and non-payable portions of claim-related expenses. See Section 2560.503-1(m)(4).

For more frequently asked questions, go to <http://askpwba.dol.gov/faq-claims-proc-reg.html>.

For more information on ERISA claims procedures, go to ACA's website at www.acatoday.com.

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A Unique Coding Resource

ACA's coding manual is often compared with other chiropractic coding resources available on the market today. These coding resources are developed by outside organizations or companies. *ACA's Chiropractic Coding Solutions Manual* is the *only* chiropractic coding resource **developed for doctors of chiropractic by doctors of chiropractic.**

ACA's Team of Experts


ACA's coding manual is developed by a team of ACA experts that make up ACA's Coding Reimbursement Committee (CRC). The latest coding information from the American Medical Association (AMA) is supplied to the ACA firsthand as the CRC includes two doctors who participate in the AMA/CPT committee process. The CRC committee makes recommendations based on the latest code changes, terminologies and procedures, therefore determining any new sections, codes or updates that should be included in the ACA coding manual. The CRC is also responsible for developing the insurance-related template letters and talking points included in the CPT manual.

To ensure a complete production process, a separate coding book subcommittee was formed to develop the CPT manual. This subcommittee, comprised of ACA leadership, councils and staff, reports their recommendations for changes back to the CRC. This has helped to ensure that each year, the ACA coding manual is developed into an accurate and authoritative resource for doctors of chiropractic.

Completely Revised for 2004!

This year, the CRC and the coding book sub-committee approved a completely new revision of the manual. *ACA's 2004 Chiropractic Coding Solutions Manual* edition will be available as a smaller desktop 6 x 9 desktop reference tool and will include such new features as color-coded sectioned tabs, and a glossary of terms. Included **free** with your purchase, doctors of chiropractic will receive a CD-ROM and a subscription to ACA's popular newsletter, the *ACA Practice Advisory*.

How to Order

To order *ACA's 2004 Chiropractic Coding Solutions Manual* call 800-368-3083 or go to www.shopaca.com. 

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Claim Solutions Work Group VI

By ACA's Professional Development Department

On November 20, 2003, the ACA and the National Association of Independent Insurers (NAII) hosted a meeting at NAII Headquarters in Des Plaines, Illinois. Topics for the meeting included claim adjuster training on chiropractic care, unfair vendor edits, and the development of work group priorities in 2004. This meeting was the sixth in a series of forums that brought together leadership from the insurance and chiropractic professions. Together, these groups address and resolve numerous issues regarding administrative and expense costs for both professions. High-level claims executives from insur-

ers such as State Farm, Allstate, Geico, Erie, National BC/BS, and many others, have recognized the value in such forums and have consistently attended.

Previous meetings have yielded effective policy changes in the areas of clinical documentation, anti-fraud, medical review, and coding and reimbursement. These changes have resulted in an improvement in standards and a streamlining of the claim process benefiting both insurers and doctors of chiropractic. 

The Claims Adjuster Index

By ACA's Professional Development and Research Department


The American Chiropractic Association (ACA) is pleased to announce the *Claim Adjuster Index (CAI)*, an information resource designed to inform claims adjusters about chiropractic services and doctors of chiropractic. The primary goal of *CAI* is to provide basic, understandable information on chiropractic care and treatment principles with the secondary goal of reducing medical review expenses on chiropractic claims. Insurer and chiropractic leaders alike believe *CAI* will help answer many everyday claim questions associated with chiropractic billings.

CAI is available on the ACA website at: www.acatoday.com/insurance/p_a_education

The ACA developed *CAI* with the claim adjuster in mind. Representatives of more than 15 national insurers communicated their chiropractic information needs to the

ACA, based on their experience of managing claim processing centers across the country. A team of insurers, along with ACA's Insurance and Managed Care Committee, responded with this initial series of chiropractic education resources. Feedback from insurers on other areas of interest will be the topic of future releases.

The above resources have been sent to public and private insurers, managed care networks, and professional industry associations for internal distribution.

Please send comments for future topics to the ACA Department of Professional Development and Research at: PDR@amerchiro.org. 

The ACA Coding Manual Development Process

By ACA's Member Services and Business Development Department

ACA strives to provide accurate tools and resources necessary to help doctors of chiropractic succeed. In 1992, the ACA reviewed the CPT code changes, anticipated their impact on chiropractic providers and published their first ACA coding manual to educate and inform doctors of chiropractic and the insurance industry of these changes.

How We Got Started

Over the years, this publication continued to include recommendations for the uniform chiropractic use of those codes and any more CPT code changes that required additional clarification appropriate for chiropractic use. Today, ACA's *Chiropractic Coding Solutions Manual* has developed into an even more accurate, complete and user-friendly reference than ever before.

Continued on Page 4

What is Constant Attendance?

By Dr. Craig Little, Chairman, ACA Practice Advisory Editorial Committee

Supervised and Constant Attendance Modalities are used to report various modalities or agents applied to produce therapeutic changes to biological tissue. As is indicated in the guidelines listed in the CPT coding manual, these codes vary according to whether direct (one-on-one) or supervised contact is required for the treatment.

Direct one-on-one contact requires that the provider maintain visual, verbal, and/or manual contact with the patient throughout the procedure. Codes 97010, 97012, 97014, 97016, 97018, 97020, 97022, 97024, 97026 - 97028 identify supervised modalities, which do not require this type of contact. The remaining codes (97032, 97033, 97034, 97035, 97036 - 97039) do require direct one-on-one contact for treatment, and are categorized as constant attendance modalities. These are time-based codes that include the time required to perform all aspects of the service, including pre-, intra-, and post-service effort. The language in the constant attendance modality codes indicates that these codes are reported once for each 15 minutes of service. If less than 15 minutes of service is provided, then the reduced services modifier -52 should be appended to the code to identify the reduction of service.

Time is recorded based on constant one-on-one attendance. The appropriate code is used for each 15-minute interval. For example, if manual electrical stimulation is applied to four areas for a total of 30 minutes, CPT code 97032 is used two times, once for each 15-minute interval.

The definition of therapeutic procedures was added to CPT 1995 to clarify the differences between therapeutic procedures, modalities, and tests and measurements. These procedures require direct one on one patient contact by a physician or therapist. The descriptions for these procedures have been changed to reflect 15-minute intervals. If a procedure lasts more than 15 minutes, the CPT code can be reported for each 15-minute interval. For example, if therapeutic exercise is performed for 30 minutes, 97110 will be reported two times.

The therapeutic procedure codes (97110-) identify a manner of effecting change through the application of clinical skills and/or service that attempt to improve function. Common components included as part of the thera-

peutic procedures include chart reviews for treatment, setup of activities and the equipment area, and review of previous documentation as needed. Also included is communication with other health care professionals and discussions with the patient's family. Subsequent to providing the therapeutic service, the treatment is recorded, and typically the progress is documented.

Therapeutic procedures are intended to be performed with one-on-one patient contact. If a provider is performing therapeutic procedures in a group of two or more individuals, only CPT code 97150 will be reported. Time and/or the number of therapeutic procedures is not defined in this code.

For example, a practitioner spends 10 minutes working with patient X on therapeutic exercises to develop strength and endurance. The practitioner instructs patient X to continue the exercises for 5 more minutes and attends to another patient, patient Y, during this time, while continuing to supervise patient X. The practitioner returns to patient X and spends another 5 minutes directly working with him, and once again instructs patient X to continue a particular exercise for 5 minutes. The practitioner again attends to patient Y during this time, then returns to patient X to work directly with him for another 5 minutes. Should code 97150 be reported, or should code 97110 be reported twice?

From a CPT coding perspective, code 97110 requires the practitioner to maintain direct patient contact (i.e., visual, verbal and/or manual contact) during provision of the service. CPT code 97110 is to be reported when the practitioner is providing therapy to only one patient. When the practitioner is working with several patients at the same time, then CPT code 97150 should be reported. The specific type of therapy provided (e.g., 97110) should not be reported in addition to the group therapy code. 