McLaren HEALTH PLAN

Provider Network Update
February 2022

Clinical Editing System Updates

1. Chiropractic Claims to deny without appropriate modifier

Effective May 1, 2022, McLaren Health Plan will implement a claim edit for the below CPT Codes for all lines of business to appropriately deny chiropractic claims missing the AT modifier.

CPT Code	CPT Code Description
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

Claims will deny if the above CPT codes are inappropriately billed without the AT modifier, which identifies the service as being acute treatment instead of maintenance therapy.

The chiropractic care benefit is generally limited to acute treatment of a condition. Chronic ongoing manipulative treatment is considered maintenance treatment and not covered.

2. Pathology Claims to deny without appropriate primary diagnosis

Effective May 1, 2022, McLaren Health Plan will implement a claim edit to appropriately deny professional pathology claims for the below CPT codes for all lines of business when billed with an R code in the primary diagnosis position and outpatient pathology claims billed with R codes in all diagnosis positions.

CPT Code	CPT Code Description
88302	LVL II-SURG PATH GROSS&MCRSCP XM
88304	LEVEL III-SURG PATH GROSS&MICROSCOPIC XM
88305	LVL IV-SURG PATH GROSS&MCRSCP XM
88307	LVL V-SURG PATH GROSS&MCRSCP XM
88309	LVL VI-SURG PATH GROSS&MCRSCP XM
G0416	PROSTATE BIOPSY, ANY MTHD

The primary, or first-listed diagnosis position is important from a payment integrity standpoint. Following ICD 10 guidelines for coding, this spot will not only maintain a high degree of data integrity and provide accurate information, it also enables McLaren Health Plan interventions such as disease management, complex care management, etc., to be implemented earlier.

R Codes are used for signs and symptoms instead of diagnoses. ICD 10 allows these codes in a primary spot when a diagnosis has not been established by the provider. However, if the patient is receiving diagnostic services only (particularly those needing interpretation by a physician), the confirmed or definitive diagnosis should be coded. In these cases, related signs and symptoms should not be coded as diagnoses. In the pathology realm, once pathology codes are submitted, a definitive diagnosis is typically determined. Therefore, that defined diagnosis should be provided in the first position as opposed to a symptom-based diagnosis.

If you have a question regarding these edits, please contact Customer Service at 888-327-0671 (TTY: 711) for assistance.