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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 96000-96004 Survival Guide: 3 Simple Rules for Claims Success

Hint: Don't bill the gait analysis code if the physician only performed one component of the procedure.

For physicians, a gait analysis claim is not always a walk in the park. For a successful claim, you've got to know the codes, know your carrier's rules, and know exactly which services your physician provided.

Study this gait analysis billing scenario to prevent your office from taking a fall when reporting these diagnostic services.

Question: We billed a motion analysis with dynamic plantar measurements (96001) and the doctor's interpretation and report of the results (96004) to Blue Cross Blue Shield. The carrier denied the claim. We performed the test here at our facility, and the doctor reviewed and interpreted the results. Are we billing the codes incorrectly? Should we append a modifier to 96001?

Answer: No, you are not billing the codes incorrectly. The problem is that Blue Cross Blue Shield considers gait analysis an "investigational procedure" and does not provide coverage for the service. Several other carriers have specific policies in place that state gait analysis is investigational and therefore not covered.

Good news: Some insurers do cover some or all gait analysis services. Prevent denials and delays on your gait analysis claims by following these three rules:

Rule #1: Know the Codes

Gait analysis measures and evaluates the walking patterns of patients with gait-related problems such as tripping and joint pain. To study a patient's gait, a doctor may use one or more of the following methods: video cameras to record a patient's walking pattern, dynamic electromyography techniques (EMG) to monitor a patient's muscle activity, and a pedobarograph to measure the pressure distribution of the patient's foot.

You report gait analysis using only five codes: 96000-96004. The first four are laboratory test codes. You may report one or more of these codes at the same time, depending on the tests the lab performs:

- 96000 -- Comprehensive computer-based motion analysis by video-taping and 3-D kinematics
- 96001 -- ... with dynamic plantar pressure measurements during walking
- 96002 -- Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
- 96003 -- Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
- 96004 -- Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report.

Note: You should report 96004 when the doctor reviews the test results and provides a written report.

Make sure you link your CPT® codes to a diagnosis code on the carrier's list of diagnoses that prove medical necessity for gait testing -- such as cerebral palsy, spina bifida, stroke, or myelomeningocele.

For Medicare claims, contact your Medicare Local Coverage Determination to determine what diagnoses are covered.

Rule #2: Check With Your Carrier

To bill for gait analysis, insurers often require the provider to exhaust every other available treatment option first. Before

performing a gait analysis, check with the patient's carrier to make sure the service is covered. If the carrier denies after appeal, the bill is then the patient's responsibility.

Different Medicare carriers follow different rules, warns **Arnold Beresh, DPM, CPC,** of Peninsula Foot and Ankle Specialists PLC in Hampton, Va. So always check with your local carrier, so if Medicare's auditors come calling, you can prove your billing was justified.

Checking with the carrier every time is important because there may be certain circumstances under which a carrier may cover gait analysis even if it normally denies coverage.

Rule #3: Bill Only for Services Provided

Coders sometimes make the mistake of reporting a gait analysis code to bill for one component of the service the code describes. Doing this means your claims won't stand up if the carrier requests documentation.

For example, suppose your facility performs a videotaping and 3-D kinematics with dynamic plantar pressure measurements during walking, and a fine wire electromyography on two muscles, and your physician interprets the tests. You should bill 96001, 96003 x 2 and 96004.

If the physician outsources the tests to a motion analysis laboratory, however, you should only bill for his interpretation and written report of the results with 96004.

Be aware: You may not bill gait analysis codes twice if the provider performs the test for two different scenarios.

For instance, suppose the lab performs 96002 twice, once with the patient wearing his orthoses, and once without. You may not bill 96002 twice because the code reports the number of test sessions, not the number of conditions under which the provider runs the test.