Part B Insider (Multispecialty) Coding Alert

Part B Quiz: Answer These 5 Questions to Test Your Expertise

Is a modifier required when reporting 20610? The answer may surprise you

It's time again to determine whether you're a coding ace or if you still need some assistance with your coding and billing skills.

Last month, you took our Part B challenge seriously. Many of you wrote in with questions for a future quiz, and today we're putting you to the test with a few more reader-submitted questions.

After you review these four test questions, turn to page 212 to see how you fared.

Insurer Wants Joint Injection Modifier

Question 1: Empire Medicare Services (a Part B payer in New York and New Jersey) recently began denying payment for injection code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]). The carrier's denial reason notes, "A required modifier is missing or the claim is inconsistent with modifier used."

We are confused because this payer has never required a modifier for this service before. Can you advise on what we may have done wrong?

Modifier 51 Musts

Question 2: Our Medicare carrier no longer requires us to append modifier 51 (Multiple procedures) to our claims (the carrier adds it during processing). However, I noticed that the Medicare payer is now discounting the second procedure. Is Medicare no longer paying the full amount for subsequent procedures when they append modifier 51 on our behalf?

How to Find Fees

Question 3: How can I determine the Medicare fee for G0372 (Physician service required to establish and document the need for a power mobility device)? We've researched this code and can't seem to find any allowable fee for it.

Does Medicare Allow 'Balance Billing?'

Question 4: We've had a lot of success with balance billing in our practice. During this process, we charge full fees over and above the carrier-covered amounts, and bill the patient for the portion that the insurance company or medical plan does not pay. We have used this process with private payers and have had very few problems. Can we apply this practice to our Medicare patients? Our physician wants us to start doing this, but I think Medicare doesn't allow it. Can you advise?