Part B Insider (Multispecialty) Coding Alert

Part B Quiz Answers: Can You 'Balance Bill' Medicare? Check Your Answers Here

Discover how you fared in our coding and billing challenge

Are your coding and billing skills up to snuff?

Now that you've reviewed the questions on page 210, read on to find out how you fared in our quiz.

Insurer Wants Joint Injection Modifier

Answer 1: Without seeing the complete chart note, it is difficult to specifically determine the denial reason. However, the Correct Coding Initiative (CCI) bundles code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) into several different CPT codes. This could be one explanation for the denial, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO,** with **MJH Consulting** in Denver.

In addition, the answer could depend on the substance that your physician injected. For instance, Empire Medicare published an article regarding injection of Hyaluronan that requires you to report either modifier RT (Right side), LT (Left side), or 50 (Bilateral procedure) with code 20610. The article stated, "Claims without a modifier will be returned to the provider unprocessed." The article is available at http://www.empiremedicare.com/newjpolicy/policy/l25820_att10.htm.

Perhaps Empire's claims processing software logic deduced that this modifier reporting requirement (i.e., RT, LT or 50), applies to any claim with code 20610 rather than just those that are reported for the injection of Hyaluronan, Hammer says.

"If the line item denial indicated that the claim was 'unprocessable,' then the provider needs to resubmit the claim line item (20610) with one of the three applicable modifiers appended," Hammer says. "Unprocessable claims do not have appeal rights within Medicare."

Modifier 51 Musts

Answer 2: Modifier 51 (Multiple procedures) is an informational-type modifier for use on the second, third, etc., surgical procedure performed on the same day, says **Heather Corcoran** with **CGH Billing.**

Medicare's payment policy for modifier 51 is to reimburse the first procedure at 100 percent, and then to reimburse the subsequent procedures at 50 percent.

How to Find Fees

Answer 3: Payment for code G0372 (Physician service required to establish and document the need for a power mobility device) will vary based on where you live, but the 2008 Medicare allowable for G0372 averages around $15.00 nationally.

"It is my understanding that the provider can also bill the appropriate CPT E/M code for the required face-to-face evaluation of the patient," Hammer says.

Does Medicare Allow 'Balance Billing?'

Answer 4: Balance billing refers to the practice of charging full fees over and above the carrier-covered amounts, and billing the patient for the portion that the insurance company or medical plan does not pay.

Because your physician participates with Medicare, you cannot balance bill for services to those patients. Medicare requires a participating provider to accept assignment for all Medicare claims, and the patient must pay his 20 percent co-insurance at the time of service.

Keep an eye out: The AMA disagrees with the government's position that non-participating providers can balance bill but those who participate in Medicare cannot do so. To that end, the AMA is working on legislation "that would allow Medicare balance billing," according to a May 1, 2008 AMA eVoice article. Keep reading the Insider for more on this legislation as it develops.