

## Part B Insider (Multispecialty) Coding Alert

### Reader Question: Boost Medicare Reimbursement Understanding With These Coding Tips

**Question:** I've heard conflicting views on what's more critical to include on Medicare claims to ensure swift and accurate payment - CPT® codes or ICD-10 codes. Does the CPT® code determine the reimbursement rate or does the ICD-10 code? I thought it was the CPT® code, but I keep hearing that our practice's pay could suffer if we don't use the right ICD-10 codes, so I'm confused.

North Carolina Subscriber



**Answer:** The CPT® code on your claim determines your reimbursement rates under Part B Medicare.

On the other hand, ICD-10-CM codes support medical necessity for every procedure code on your claim - without them, insurers can't justify paying your practice for the services the physician performs. Therefore, if you use nonspecific or incorrect diagnosis codes, your pay definitely could suffer.

**Why?** Your insurer might determine you didn't perform a medically necessary service and thus aren't entitled to payment for it.

Sometimes an ICD-10 code will be the cause of non-payment. Consider this scenario: An asymptomatic Medicare patient makes a visit prior to a colonoscopy to discuss arranging for the procedure. In absence of symptoms or disease to justify the visit, reporting the colon cancer screening code would not be a Medicare-covered service. The patient could be required to pay for the visit by use of an Advance Beneficiary Notice (ABN).