Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: 13 Coding Opportunities You May Have Overlooked

You could be turning away your rightful reimbursement for 100s of services

Medicare coding rules are complex and challenging, and sometimes it's hard to know which services you can rightfully bill. But there are a number of codes and modifiers experts say you're frequently missing out on:

• **Modifier 59.** Some coders assume that if the Correct Coding Initiative forbids billing two codes on the same date, that's the end of the story. But in fact, you may be missing out on some legitimate cases where CCI allows you to use the 59 modifier to override an edit, says **Jim McNally**, third-party coding specialist with **Health Care Consultant Services** in Flushing, NY.

"That is a major problem I see everyday," McNally says. Always scan the CCI Edits to see which ones a modifier can override, he advises. Of course, you should only use the 59 modifier when the services are separate, distinct and medically necessary, he notes.

• **Modifier 50:** Many procedures are inherently unilateral, and you won't receive full reimbursement for bilateral versions of those procedures unless you append the 50 modifier, notes **Laura Siniscalchi**, manager of the Life Sciences & Health Care Regulatory Services Practice at **Deloitte & Touche** in Boston.

Watch out: Coders often forget the 50 modifier for bilateral spinal injection and diagnostic ophthalmology procedures.

• **Supervision & Interpretation:** For many invasive/diagnostic radiology codes, you need two codes, the S&I code plus a surgical code. Often, coders forget to append the surgical code, especially on outpatient hospital claims, says Siniscalchi.

Example: You may remember to report CT guided needle biopsy code 76360 but leave out the associated site-specific percutaneous needle biopsy code.

• **Graft preparation:** Many coders aren't aware they can bill 15000 for preparation of graft site when doing a delayed full thickness skin graft on a wound that you have allowed granulation tissue to develop in. You can bill this code prior to graft placement. "I know that I overlooked that code for many years," says Media, PA dermatologist **Arthur Balin.**

• **Colonoscopy:** Many payors want to bundle 45380-45385 with other codes, but you should be able to bill these codes separately, says **Jean Thompson**, administrator of **Consultants in Gastroenterology** in Inde-pendence, MO. She appeals these denials with a 99-percent success rate.

7 Add-On Codes You May Be Overlooking

Here are some other codes you might not realize you can bill for separately, according to Siniscalchi:

• **add-on code**

92974 (Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy). (Note: This code does not include the radiation oncology service for brachytherapy.)

• **add-on code**

92973 (Percutaneous transluminal coronary thrombectomy). You should report this in addition to the primary procedure, such as coronary angioplasty.

• **add-on code**

64872 (Secondary or delayed suture of nerve)

• **add-on code**

64874 (Extensive mobilization of transposition of nerve)

• **add-on code**

64876 (Nerve suture requiring shortening of bone of extremity)

• **add-on code**

95874 (Needle electromyography for guidance in conjunction with chemodenervation)

• **add-on code**

75998 (Fluoroscopic guidance for central venous access device placement, replacement, or removal).

She also says coders often overlook 51700 (Bladder irrigation).