Eli's Rehab Report

New Codes, Modifiers: Payment Methods Increase for Noncovered Services

Many PM&R practices that offer medical nutrition therapy to patients who are easing back into a normal diet (such as those rehabilitating from a stroke [436]) were pleased to see the introduction of codes **CPT 97802** -**97804** in CPT 2001. But these practices were quickly disappointed to find that Medicare does not yet cover these codes.

Unfortunately, many PM&R providers believe that inclusion in the CPT guidebook and a designation of a particular code ensure coverage of the service. "CPT codes are developed by the AMA, not by Medicare," says **Laureen Jandroep, OTR, CPC, CCS-P CPC-H,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J. "They are intended to report any services a physician provides. It has nothing to do with coverage."

You can get paid for these services, either by the patient, a secondary insurer, or a private payer. And, according to the CMS Web site (formerly HCFA), two new modifiers and HCPCS codes will be introduced in 2002 to help practices collect reimbursement for those codes that are not covered by Medicare.

The full text of Medicare's memorandum on these new modifiers and codes is available on the CMS Web site at www.hcfa.gov/pubforms/transmit/b0130.pdf.

Billing Private Insurers

"We have been performing prolotherapy for over a year now, and we have also just started offering acupuncture to our patients," says **Danielle Bryce,** billing supervisor for the Pain Center of Eastern Georgia, a practice with one physiatrist and one massage therapist. "The physiatrist wanted to offer acupuncture, and we knew it wasn't covered by Medicare, but we thought we'd have an easier time with private payers."

Although some private insurers still won't reimburse for acupuncture treatments, the growing trend is toward broader coverage for alternative medicine procedures, and acupuncture is now covered by many private insurers, not just the smaller carriers. For instance, Premera Blue Cross, which serves Washington and Alaska, covers acupuncture for up to 12 visits a year per insured patient for pain diagnoses. Premera also covers medical nutrition therapy, naturopathic services and massage with certain limitations on coverage and only for use with "preferred providers" in the plan.

This type of private or "secondary insurance" coverage is worth investigating for those practices that operate their acupuncture, prolotherapy and medical nutrition therapy businesses on a cash-only basis. The first step to attempting to bill for these services is to know the applicable codes:

97780 -- acupuncture, one or more needles; without electrical stimulation

97781 -- acupuncture, one or more needles; with electrical stimulation

M0076 -- prolotherapy (Note: Prolotherapy should never be coded using the trigger point injection code, 20550. Medicare considers this misrepresentation of fact, since prolotherapy is not covered by Medicare.)

Billing Secondary Payers for Medicare Patients

Most practices know that they should have patients sign advance beneficiary notices (ABNs) if they are unsure whether

the service being provided to the patient will be covered, but the rule of thumb is that noncovered services, such as acupuncture, do not require ABNs because they are never covered.

CMS previously requested that practices submit claims with modifier -GX (service not covered by Medicare) if they knew the service would not be covered but needed the denial letter so they could seek payment from a secondary insurer. However, an April HCFA memorandum announced the deletion of modifier -GX effective Jan. 1, 2002, and its planned replacement with two new modifiers and two new codes.

Beginning in January 2002, practices should report modifier -GY for an item or service statutorily non-covered and modifier -GZ for an item or service not reasonable and necessary.

HCFA also designated two new HCPCS codes in its April memorandum, which should be added to claims that are not covered and have no CPT code to represent them:

Q3015 -- item or service statutorily non-covered, including benefit category exclusion (used only when no specific code available)

Q3016 -- item or service not reasonable and necessary (used only when no specific code available).

"Our massage therapist has started offering patients a long, contoured body pillow to reduce back pain when they sleep," Bryce says. "We haven't been able to find a code for it and we don't even know whether a secondary insurer would cover it, but so many patients are having good results that we think it might be worth a try to see if anyone reimburses for it."

In this situation, the practice would bill Q3015, indicating on the claim that the service was for a pillow with no HCPCS code, which was offered to reduce back pain, and that the claim is being submitted to generate a denial for the secondary insurer.

Q3015 and Q3016 should only be used when all attempts to find an applicable code have been exhausted and when there is no other way to report the service.

Use of the ABN and the -GA Modifier

For claims using the -GZ modifier or Q3016, which are for services that are not reasonable and necessary, the practice should still ask the patient to sign an ABN because the services can be covered by Medicare, just not for the patient's condition or circumstances. Because the practice must inform CMS that the ABN has been signed, modifier -GA (waiver of liability statement on file) should be added to the claim **in addition to** modifier -GZ or Q3016.

Neither an ABN nor modifier -GA is required with claims using modifier -GY or Q3015 because those are for services that are never covered by Medicare.

Note: The Coding Institute's Web site has new information on ABNs. Go to www.codinginstitute.com and click on the News/Press Release Index in Hot Coding Bulletins. Then click on the New CMS ABN Form.