

Eli's Rehab Report

Reader Question: Here's How To Bill Secondary Insurance

Question: I am an OT in private practice, and I'd like to bill Medicare to get a denial on a patient who has exhausted his Medicare benefits and wants us to bill his secondary insurance. Which modifier do I need to attach to get a denial so I can bill the secondary?

-- New York subscriber

Answer: First you need to determine if the care you'd like to bill for is medically necessary. If this patient still requires skilled therapy services, use modifier KX (Specific required documentation on file) after each CPT® code. This will indicate to your Medicare contractor that you have documentation on file to support the patient receiving an exception to the Medicare therapy cap. Always use this modifier when billing for an exception to the therapy caps.

If the patient simply wants maintenance therapy, which wouldn't be covered by Medicare anyway, provide the patient with an advanced beneficiary notice (ABN). On the ABN form, document the CPT® codes you expect the Medicare contractor to deny and in layman's terms explain why you feel the Medicare contractor will deny these services.

If the patient signs the ABN, bill the CPT® codes to your Medicare contractor as you normally would, but in addition append modifier GA (Waiver of liability statement on file) to each CPT® code on the claim form that you have listed on the ABN form. Modifier GA will notify your Medicare contractor that you expect it to deny the service and that you have a signed ABN on file. Once you get the denial, you can bill the patient for your charges for the denied codes.

Resource: Get more guidance on modifier GA at <http://www.cms.gov/transmittals/downloads/R1921CP.pdf>.