Eli's Rehab Report

READER QUESTION ~ Remember Modifier 59 for Gait Training

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Question: We are suddenly receiving denials on billing for gait training (**CPT 97116**) on our Medicare Part B patients. For example, on a single treatment session for April 20, we billed one unit of 97110 that was paid, one unit of 97116 that was denied, and one unit of 97530 that was paid. How should we code this correctly?
New Jersey Subscriber

Answer: You need to append modifier 59 (Distinct procedural service) to 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training [includes stair climbing]) because the National Correct Coding Initiative considers 97116 a component of 97530 (Therapeutic activities, direct [one-on-one] patient contact by the provider [use of dynamic activities to improve functional performance], each 15 minutes).
Documentation must support that both services were medically necessary and were done at separate and distinct times. To see the NCCI edits on the CMS Web site, go to www.cms.hhs.gov/National CorrectCodInitEd/.

Another reason could be that your Medicare contractor has a local coverage determination, and it may specify which ICD-9 codes support the medical necessity of each CPT code. If the ICD-9 code(s) on your claim do not support the medical necessity of 97116 per your Medicare contractor's LCD, the insurer may deny 97116.