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Part B Insider (Multispecialty) Coding Alert

Answers To Part B Quiz: How Did You Fare in Testing Your Part B Billing And Coding Skills?

If you answered all three questions correctly, you're a Part B ace

Are your Part B skills up to snuff?

Now that you've reviewed the questions on page 250, read on to find out how you fared in our quiz.

Is Seen And Agreed Okay?

Answer 1: The consultant is correct. Although you've accurately noted that a rubber stamp stating "Seen and agreed" is not acceptable, neither is a handwritten notation with the same phrase, CMS says.

According to CMS' Internet-Only Manual (IOM) Section 100-04, 12, 100, "Seen and agree," followed by a legible countersignature or identity, is an example of unacceptable documentation.

Other examples of unacceptable documentation in this scenario in-clude, "Rounded, reviewed, agree," and "Discussed with resident. Agree," the IOM indicates.

Better way: Your documentation might read, I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs," according to the IOM.

"How much time does it really save?" asks Washington, DC-based coder **Sami Martukas**. "You'll spend maybe an extra 90 seconds writing it the proper way and you're in business if someone ever reviews your records."

To read the IOM's take on stamped signatures, visit the CMS Web site at http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf.

Are New Modifier 59 Edits Here?

Answer 2: You can rest easy, because although the OIG recommended that CMS institute such an edit via the Correct Coding Initiative (CCI), CMS has not done so.

In 1996, the OIG found a 40-percent error rate on claims that contained modifier 59 (Distinct procedural service) and encouraged carriers to institute a claims edit that would allow payment only for specific code pairs when practices appended modifier 59. CMS, however, has not implemented such an edit.

"It would be very tough for a carrier to make that type of edit stick," says **Kurt Clawson,** biller with **CGH Billing** in Louisville, Ky. "There are just way too many claims that include modifier 59, and that type of edit would slow things down almost to a screeching halt."

How Do I Bill An Unlisted Claim?

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Answer: You've done the right thing by reporting an unlisted code rather than a code that's "close" to the procedure you performed. You're just missing one step.

An insurer will decide to pay an unlisted procedure claim by comparing your procedure description to a similar, listed procedure with an established reimbursement value.

Rather than leaving it up to the insurer to determine which code is the "next closest," you should explicitly make reference to the nearest equivalent listed procedure. After all, the treating physician is best equipped to make this determination.

You also should note the specific ways that the unlisted procedure differs from the next-closest procedure listed in CPT.

Example: CPT does not include a code to describe qualitative sensory testing (QST). This test is similar to motor and sensory nerve conduction velocity tests (95900-95904) in that it measures function in both large-caliber nerve fibers. But QST differs in that the procedure also provides small-caliber nerve fiber testing.

To report QST, you may list 95999 and include an explanation with the claim stating, "Physician performed qualitative sensory testing, which is similar to nerve conduction testing, but provides additional data. The work involved was roughly 10 percent greater than that described by 95904 (Nerve conduction, amplitude and latency/velocity study, each nerve; sensory)."

This will help connect the procedure performed to an existing procedure as support for reimbursement. And explain how your procedure differs to show why you didn't choose the existing code.

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