Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: NGS Reviews Show 80 percent of Vascular Study Claims Are Improperly Coded

Here's an outline of duplex scan coding to help you avoid denials.

If you report non-invasive vascular studies, it's time to take a closer look at your coding. A National Government Services (NGS) prepayment review resulted in that Medicare payer reducing or denying more than 80 percent of claims in January, February, and March.

Good news: NGS supplied the reasons for reduction and denial, and we've got tips to help you avoid the same fate.

Here Are the Codes the Review Focuses On

NGS is conducting a service-specific prepayment review for JK Part B claims billed with the following duplex scan codes (checking in particular for multiple same-day codes, which should be rare):

- Extracranial arteries: 93880, 93882
- Lower extremity arteries: 93925, 93926
- Extremity veins: 93970, 93971.

NGS listed nine reasons for reducing or denying the claims, all explained below.

Reasons 1-2: Know What Supports Medical Necessity

Check out these two related reasons for denial and reduction:

- **1:** Documentation did not meet the LCD requirements
- **2:** The documentation lacked clinical indications to support the medical necessity of the study.

To help ensure your claims meet Local Coverage Determination (LCD) and medical necessity requirements, review your MAC's LCD. Your coding software may provide access, or you can find LCDs online by searching the Medicare Coverage Database at www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Example: NGS LCD L33627 provides information on indications (like signs of vascular disease and an expectation that the outcome will affect patient management), limitations (such as, multiple same-day studies should be rare with medical necessity carefully documented), and ICD-10 codes that support medical necessity. The policy even offers help with which code you should use for certain cases, such as R09.89 (Other specified symptoms and signs involving the circulatory and respiratory systems) for carotid bruit.

Tip: Many practices are performing these scans before and after Endovascular Ablation Therapy (EVAT) to justify those highly reimbursed services, says **Terry A. Fletcher BS, CPC, CCC, CEMC, CCS-P, CCS, CMSCS, CMC, ACS-CA, SCP-CA,** a healthcare coding educator, auditor, and management consultant.

She has seen for herself the issues practices have with documenting the correct information to support medical necessity in line with LCD requirements.

"I've seen many reports that are routine computer-generated reports with no physician detail on indications and findings. When the findings (results) are normal, and there are no indications listed in the same report, these will be denied. The auditor should not have to go back to the original E/M service to find the order and indication. It should be clearly listed

in the vascular study report," Fletchers says.

Reason 3: Watch for Unilateral vs. Bilateral

If you don't read to the end of each code's descriptor, you may find yourself getting a denial based on reason 3:

- **3:** A bilateral study was billed but the documentation supported a unilateral study.

The codes that the review focuses on essentially come in pairs: two codes for extracranial arteries, two codes for lower extremity arteries, and two codes for extremity veins. The distinguishing feature within each pair is whether the service is bilateral (complete) or unilateral (or limited):

- **Complete bilateral study:** 93880, 93925, 93970
- **Unilateral or limited study:** 93882, 93926, 93971.

Remember: If the provider documents a bilateral service, but the services do not meet the requirements for a complete study, you should report the limited study code rather than the complete bilateral study code.

Reason 4: Put Plan in Place to Avoid Duplicates

If you double up on your claims, you may see a denial based on reason 4:

- **4:** Duplicate services/claims were billed/submitted.

Your approach to dealing with reason 4 depends upon whether you submit a duplicate claim or a legitimate second service.

If you submit a duplicate claim (a second claim for a single service), then the denial makes sense. You should not submit duplicate claims to Medicare. If you haven't been paid for a first claim, then check the status with the MAC. And if you discover an error on your initial claim, follow the MAC's instructions on how to correct the error rather than submitting a second claim for the same service.

Another possibility is that your provider performs two distinct services, so you report the same code twice. "The X modifiers should help with this issue," Fletcher suggests. For medically necessary vascular studies at separate same-day encounters, append modifier XE (Separate encounter).

Reasons 5-7: Don't Let Details Be Your Downfall

To be sure reasons 5-7 don't land your claim in the unpaid pile, you'll need to double check your own work and be sure the whole team is doing their part for several non-coding requirements, too:

- **5:** The documentation was incomplete or missing information in regards to the beneficiary who was being treated
- **6:** The rendering physician submitted on the claim form was not the physician who performed the service(s) per the submitted documentation
- **7:** Missing or illegible provider signature: Documentation must be legible and include a provider's signature. The signature can either be electronic or handwritten; however, stamp signatures are not acceptable.

For reason 5, you need to be sure all required information for the beneficiary is properly completed in the documentation and in the claim. If the claim is correctly filled, the problem may be with the documentation. If so, be sure to put beneficiary information on the agenda for the next documentation training session.

You can prevent denials based on reason 6 by adding to your pre-submission checklist confirmation that the claim's rendering provider matches the provider in the documentation.

If you're seeing denials due to reason 6, problems with signatures, you'll need to be sure your providers understand Medicare's signature requirements. Tip: Medicare provides many resources on the topic, such as MLN Matters SE1419

(www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1419.pdf).

Reasons 8-9: When CMS Sends a Request, Answer

The final two reasons for denial should be the simplest for your practice to correct:

- **8:** No response to request for medical documentation
- **9:** No documentation was submitted for the billed CPT® code(s).

When your MAC is performing a prepayment review or audit and requests documentation to support your claim, be sure you understand which code the payer needs to see support for, get the right documentation in, and submit the information on time.