Part B Insider (Multispecialty) Coding Alert

PART B SELF-TEST ANSWERS: Check Your Skills Against the Answers to Our Quiz

Determine whether you can ace this test

Our quiz was a mixed bag of questions that covered everything from coding to documentation to HIPAA. Read on to determine how you scored.

Answer 1: Why Can't We Code Probable Diagnoses?

Answer: The ICD-9-CM Official Guidelines for Coding and Reporting, Sections II.H. and III.C., guidance for -Uncertain Diagnosis-says:

If the diagnosis documented at the time of discharge is qualified as -probable,- -suspected,- -likely,- -questionable,- -possible,- or -still to be ruled out,- or other similar terms indicating uncertainty, code the condition as if it existed or was established.

Note: This guideline is applicable only to **inpatient admissions** and not medical practices or clinics. Therefore, you cannot code -uncertain- diagnoses in the Part B setting.

Answer 2: Determine Which Infusion is -Initial-

Answer: For coding purposes, payers consider the initial infusion the -main reason- the patient presents. When you code for multiple substances, the infusions- administration order takes a back seat to the infusions- importance.

In your case, the chemotherapy is the main reason the patient is having infusion therapy. Thus, you should code the chemotherapy infusion first, as follows: 90765 (Intra-venous infusion-) for the first hour of chemotherapy, +90766 (- each additional hour) for the remaining 55 minutes of chemotherapy, and +90767 (- additional sequential infusion, up to one hour) for the antibiotic infusion.

Answer 3: Determine When SNF Should Document Therapy

Answer: The bare minimum documentation requirements from CMS say you need daily notes, which must include the date, specific interventions and modalities you provided that support the CPT codes you-re billing, along with the therapist's signature. In addition, you must document the total time spent, which is the summation of timed and untimed interventions.

Your daily treatment grid may be sufficient, depending on what it includes, but most experts recommend that you use more than just a grid for daily notes. Therapists should write the patient's response to treatment after every treatment in addition to any progression/modifications of the treatment plan.

Answer 4: HIPAA May Be Out of the Spotlight, But Still on Minds

Answer: The key is to remove all identifying information from the report before you send it.

Only send the portions of the report that describe the procedure and findings and include a confidentiality notice on your e-mail.

Example: Before you send out the report by e-mail, you remove the patient's name and Social Security number. You

also remove geographic identifiers, dates, phone, fax, and e-mail information, and medical record and device serial numbers. Option: For extra security, you can send an encrypted e-mail to keep information safe.

Answer 5: Which Modifier Applies to Dual Injections?

Answer: You are right to report 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa) for the injection procedures. You should leave modifier 59 (Distinct procedural service) off of this claim, however, and choose another modifier instead.

Here's why: Modifier 59's description specifically states, -Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.-

Because your provider performed the injection procedures on mirror image or bilateral locations, you should report the injections as bilateral procedures with one of these coding tactics:

Option 1: Most Medicare carriers request bilateral procedures with modifier 50 (Bilateral procedure) and one unit of service (billed as 20605-50).

Option 2: Other payers require that you append modifiers LT (Left side) and RT (Right side) instead (billed as 20605-LT and 20605-RT as separate line items with one unit of service each.