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Part B Insider (Multispecialty) Coding Alert

Physician Notes: This MAC Warns Against Vague Unlisted, NOC Claims

Plus: Wrong surgery on a patient? There's a modifier for that.

Sometimes it's inevitableyour CPT® or ICD-9 manuals don't include the right codes to reflect what's in your physician's documentation. In those instances, you have to turn to unlisted CPT® codes or NOC (not otherwise classified) diagnosis codes. However, payers have specific requirements for submitting these codes and one Part B MAC recently sent out a warning about what to include on the claims for them if you don't want your payments denied.

"When billing NOC or unlisted codes, providers shall be prepared to explain the NOC or unlisted code," said Part B payer National Government Services, Inc. in a May 13 email to providers. NGS "will return claims as unprocessable if a NOC or unlisted code(s) is indicated, but an accompanying narrative or documentation is not submitted."

You should add your narrative description to item 19 of your claim form or electronic equivalent, but if you can't keep it brief, attach a supporting document to your claim. "Claims submitted with unlisted procedure codes and without supporting documentation will be rejected as unprocessable, and a new claim will need to be submitted with documentation to support the unlisted code(s)," NGS warns.

In other news...

You may have modifiers 59 and 25 committed to memory, but you've also got access to dozens of other, less-utilized modifiers that you may not even know exist. Such is the case with modifier PC (Wrong surgery or other invasive procedure on a patient), which CMS recently highlighted during a May 12 podcast called "Clarification of the Use of Modifiers When Billing 'Wrong Surgery on a Patient.'"

Unfortunately, some practices are erroneously assigning modifier PC to reflect the professional component of a service, which in actuality should be reported with modifier 26 (Professional component). "You need to be aware that the use of the PC modifier on Medicare claims will result in your claim being denied," CMS reps said during the podcast.

Because modifier PC leads to claim denials, you should think of it as an informational modifier to tell the payer that you made a surgical mistake. If, however, you're trying to report the professional component of a service (which would be vastly more common), stick to modifier 26.

Plus...

A Florida neurologist agreed to pay $150,000 to the government on May 20 to settle allegations of providing medically unnecessary services and drugs to Medicare and Tricare patients. The doctor is accused of deliberately misdiagnosing patients with neurological problems (including multiple sclerosis) so he could bill additional services and drugs.

"Physicians who knowingly misdiagnose serious illnesses and provide unnecessary services in order to bill federal healthcare programs violate the trust their patients and the taxpayers have in the medical profession," said **Shimon R. Richmond** of the OIG in a statement. "Our agency will continue to thoroughly investigate health care professionals involved in such duplicity and waste."

The physician was brought to the OIG's attention following a whistleblower suit by a former co-worker, who will collect $26,250 as her share of the settlement.

Resource: To read more about the case, visit
www.justice.gov/opa/pr/government-settles-false-claims-act-allegations-against-florida-neurologist-150000.

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