Part B Insider (Multispecialty) Coding Alert

Time Is of the Essence With Prolonged Service Codes

This Part B MAC shares the biggest errors it sees--so you can avoid making them.

Part B practices need to keep a close eye on the clock when reporting prolonged service codes. That's the word from the May 24 education session, "Medical Review Error Webinar," presented by Part B MAC National Government Services.

Following are several issues that NGS found to be chronically miscoded, with tips on how to avoid making the same errors.

Prolonged Services Often Misbilled, NGS Notes

The payer found that a common error among Part B practices was that documentation did not support the medical necessity for prolonged E/M service codes. "Prolonged services of less than 30 minutes total duration on a given date are not separately reported," the NGS rep noted.

She reminded practices that although time spent with the patient does not need to be continuous, it must be clear and accurately documented in the medical record. You'll report +99354 for the first hour, followed by +99355 for each additional 30 minutes.

Example: A physician sees an established patient in a morning office visit for a level-three E/M to determine the cause of chronic heel and ankle pain. This visit lasts 30 minutes. At the end of the exam, the doctor orders an x-ray. The patient leaves to get the x-ray and returns that afternoon, and the physician reviews the x-ray with the patient and discusses his diagnosis and treatment options. This visit lasts 30 minutes.

Code it: You would use 99213 and +99354, even though the time the physician spent with the patient wasn't continuous.

NGS Focuses on Chiropractic Errors

NGS reminded chiropractic practices during the call that they must list two diagnoses on every claim--the precise level of subluxation listed as the primary diagnosis, followed by the resulting disorders listed thereafter. In many cases, diagnoses listed on Part B claims are "insufficient to support medical necessity," the NGS rep noted.

The facts: Medicare will not reimburse chiropractors for any treatment other than CMT using codes 98940-98942 (most Medicare carriers will not allow payment for extraspinal CMT [98943]). Section 2251 of the Medicare Carriers Manual (MCM) states, "Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, listing examples of manual manipulation as spine or spinal adjustment by manual means; spine or spinal manipulation; manual adjustment; and vertebral manipulation or adjustment."

In addition, Medicare and most private insurers require a diagnosis of subluxation of the spine to demonstrate medical necessity for CMT billing.

"The precise level of subluxation must be specified through use of the appropriate diagnosis code(s) on the claim," notes a policy from Palmetto GBA, a Part B payer in eight states.

"Secondary diagnoses must be present on the claim to indicate the significant neuromuscular health problem necessitating treatment," the policy indicates.

A similar policy from Noridian Medicare, another Part B MAC, advises chiropractors to enter up to four diagnosis codes in priority order (two primary and two secondary conditions). "If you need to document more than four diagnosis codes, as

will be the case any time there are more than two regions billed, the additional diagnoses must be present in the medical record," the policy states.

Here's how: Suppose a patient presents with a subluxation of the lumbar and sacral spine with degeneration of disc(s) in the lumbar region, and the chiropractor performs CMT to the lumbar and sacral spine (one to two regions, 98940). You'll report 739.3 (Nonallopathic lesions, not elsewhere classified, lumbar region) as the primary diagnosis, followed by a secondary diagnosis of 722.52 (Degeneration of lumbar or lumbosacral intervertebral disc), and a tertiary diagnosis of 739.4 (Nonallopathic lesions, not elsewhere classified, sacral region), advises **Kenny Marvin, DC, CCSP,** of Marvin Family Chiropractic in Pearl River, N.Y. "In the past, Medicare required that chiropractors needed to have an x-ray that demonstrated the subluxation, but that is no longer required," Marvin says. "You have to make sure you document all the essential features of your examination of the patient so you can demonstrate the diagnosis code choice (P.A.R.T.)," he says.

In black and white: According to CMS Transmittal 137, dated April 9, 2004, "Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes." In lieu of the x-ray, the transmittal indicates that the chiropractor must specify "the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms" in the patient's record.

Keep an Eye on Medical Necessity for Labs

The most common errors among diagnostic labs was that the documentation did not support the number of services submitted, that the lab failed to support medical necessity, and were unable to support the order for the services, the NGS reps noted.

Reminder: Lab requisition forms should be designed to capture the correct information to promote appropriate ordering of tests. For example, when ordering a Pap smear, the form should prompt the treating physician to designate whether it is a diagnostic test or screening test and inform the physician of the frequency constraints for screening tests. The requisition should also require the physician to submit diagnosis information as documentation of medical necessity.

If the treating physician doesn't accurately record the reason for the test, whether that be screening, presenting signs and symptoms, or known medical condition, the coder cannot apply the correct diagnosis code.

A vague sign or symptom is a perfectly acceptable reason for a test. Physicians need to know that it's acceptable to write down "abdominal pain" as a diagnosis if they don't know if the patient has gastroenteritis, colitis or appendicitis before performing the diagnostic tests.