Office of Billing Compliance
2016 Coding, Billing and Documentation Program

Diagnostic Radiology
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization
• To provide you with every tool you need to maximize compliance and get paid what you deserve
• To update you on the latest CMS/OIG activities
Question to CMS: “...confused concerning the timeliness of my documentation in connection with the provider signature and submitting the claim to Medicare, and the timely filing rule. Can you provide more information?

Answer: There are several provisions that may affect "timeliness" when talking about documentation.

• A provider may not submit a claim to Medicare until the documentation is completed.
  • Until the practitioner completes the documentation for a service, **including signature**, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.

• The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
  • CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.
Diagnosis Coding
International Classification of Disease (ICD-10)

• ICD-10 compliance –
  • Relying on the information that comes across with each order to dictate the clinical information section of reports.
    • Is that sufficient?
  • Using report templates that pull this information directly from the order.
    • For example, the text might read “Special instructions: r/o pulmonary embolism” along with the actual ICD-10 code.
  • What is the best approach?
# Radiology Tip Sheet for ICD-10

<table>
<thead>
<tr>
<th>Angioplasty (Non-Coronary)</th>
<th>Document site:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Head and neck</td>
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<tr>
<td></td>
<td>- Innominate</td>
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<tr>
<td></td>
<td>- Intracranial</td>
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<tr>
<td></td>
<td>- Lower extremity</td>
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<td></td>
<td>- Upper extremity</td>
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<tr>
<td></td>
<td>- Pulmonary</td>
</tr>
<tr>
<td></td>
<td>- Subclavian artery</td>
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<td></td>
<td>- Veins</td>
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<tr>
<td></td>
<td>- Visceral(trunk)</td>
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<tr>
<td></td>
<td>- Other upper arterial</td>
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<tr>
<td></td>
<td>Document type of intraluminal device:</td>
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<tr>
<td></td>
<td>- Non-Drug Eluting</td>
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<tr>
<td></td>
<td>- Drug Eluting</td>
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<td></td>
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<tr>
<td></td>
<td>Document approach:</td>
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<tr>
<td></td>
<td>- Open</td>
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<tr>
<td></td>
<td>- Percutaneous</td>
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<tr>
<td></td>
<td>- Percutaneous Endoscopic</td>
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<table>
<thead>
<tr>
<th>C.A.T Scan</th>
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<tbody>
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<td></td>
<td>Document type of contrast, if used:</td>
</tr>
<tr>
<td></td>
<td>- Low osmolar</td>
</tr>
<tr>
<td></td>
<td>- High osmolar</td>
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<tr>
<td></td>
<td>- Other</td>
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<thead>
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<th>Central Venous Catheter Placement</th>
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<tr>
<td></td>
<td>- Atrium</td>
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<tr>
<td></td>
<td>- Inferior vena cava</td>
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<tr>
<td></td>
<td>- Innominate vein</td>
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<tr>
<td></td>
<td>- Subclavian vein</td>
</tr>
<tr>
<td></td>
<td>- Superior vena cava</td>
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<tr>
<td></td>
<td>Document substance, if administered:</td>
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<td></td>
<td>- Antibiotics</td>
</tr>
<tr>
<td></td>
<td>- Antineoplastic</td>
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<tr>
<td></td>
<td>- Dialysis</td>
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<tr>
<td></td>
<td>- Nutritional substance</td>
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<td></td>
<td>- Other</td>
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<tr>
<td></td>
<td>Document approach:</td>
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<tr>
<td></td>
<td>- Open</td>
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<tr>
<td></td>
<td>- Percutaneous</td>
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<tr>
<td></td>
<td>- Percutaneous endoscopic</td>
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<td></td>
<td>- Guidance</td>
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<table>
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<th>MRI</th>
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<td></td>
<td>Document type of contrast, if used:</td>
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<td>- Low osmolar</td>
</tr>
<tr>
<td></td>
<td>- High osmolar</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
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<table>
<thead>
<tr>
<th>Thoracentesis</th>
<th>Document laterality:</th>
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<tr>
<td></td>
<td>- Left</td>
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<tr>
<td></td>
<td>- Right</td>
</tr>
<tr>
<td></td>
<td>Document device, if used:</td>
</tr>
<tr>
<td></td>
<td>- With drainage device</td>
</tr>
<tr>
<td></td>
<td>- Without drainage device</td>
</tr>
</tbody>
</table>
Choosing the Primary ICD-10 Code

• Confirmed Diagnosis Based on Results of Test
  • Report any confirmed diagnosis
  • Signs and/or symptoms may be reported as additional diagnoses
  • Signs/Symptoms

• If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

• “On the rare occasion when the interpreting physician does not have diagnostic information as the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient’s medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.” (Language removed in latest version of MCPM Chapter 23, Section 10.1.2)
Choosing the Primary ICD-10 Code

- **Uncertainty**
  - Do not code the following diagnoses:
  - Probable
  - Suspected
  - Questionable
  - Rule out
  - Working diagnosis
  - Other similar terms indicating uncertainty.
  - Considered by the ICD-10-CM Coding Guidelines as unconfirmed and should not be reported
  - Code to the highest degree of certainty (symptoms, signs, abnormal test results, or other reason for the visit)
Choosing the Primary ICD-10 Code

• Review of Documentation - Test order, radiology report, and any other pertinent documentation.
• Impression: Review the impression for definitive conditions
• Clinical indications: Determine if conditions listed in the impression are related to the exam or unrelated incidental findings
• Summary of findings: Review body of report to clarify impression, beware of incidental findings
• Select the primary diagnosis code in accordance with coding guidelines.
Code Changes
Radiology Code Changes

Total 2016 CPT Code changes for Radiology

- New Codes: 66
- Deleted Codes: 39
- Revised Codes: 19

<table>
<thead>
<tr>
<th>Radiology Specification</th>
<th>New</th>
<th>Deleted</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Radiology</td>
<td>14</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>31</td>
<td>13</td>
<td>5</td>
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<tr>
<td>Nervous System</td>
<td>10</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Category III Codes</td>
<td>4</td>
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<td>0</td>
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</table>
Medicare is bundling two or more codes that are frequently billed together into a single new code to describe the entire procedure. This process usually assigns a lower total value to the single procedure code than the multiple combined codes carried. On the positive side, there are now new codes to describe previously unlisted procedures, which will result in more reliable and appropriate reimbursement for those procedures.
Changes to the Diagnostic Radiology Section include deleted codes and new codes for spine, hip/pelvis, and extremity exams. New MRI codes were added for fetal evaluation. Several codes were revised to replace the term “films” with the term “images”. Urinary and biliary imaging radiological supervision and interpretation (RS&I) codes were deleted. Several parenthetical notes were added throughout the section to reflect changes in other procedures (e.g., new surgical procedures now bundling imaging).
• CPT® made some changes to a few commonly billed x-ray codes. Their rationale was based on the valuation process. The Workgroup marked codes 72170, 73500, 73520, and 73550 for “restructuring as bundled services for hip, pelvis, and femur.”

• As a result, CPT® added “a new family of six bundled codes (73501-73503, 73521-73523) for hip and pelvis radiologic examination with a specific number of views.”
  • These will replace deleted codes 73500, 73510, 73520, 73530, 73540, and 73550. In addition, “two new codes (73551, 73552) were established to describe the specific number of views of the femur... in order to more clearly define the work performed, and to reflect current clinical practice.”

• The thoracolumbar procedures have been updated with the addition of four new codes 72081-72084.
  • These will replace deleted codes 72010, 72069, and 72090; and the revision of code 72080.

• According to CPT®, “these changes simplify the reporting procedures for scoliosis evaluations and other studies; address current changes in clinical practice; and provide a coding structure similar to the structure of other imaging families”
<table>
<thead>
<tr>
<th>Deleted</th>
<th>New Code</th>
<th>Additional Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>73500 hip, unilateral 1 view</td>
<td>73501 Radiologic examination, hip, unilateral, with pelvis when performed; 1 view</td>
<td></td>
</tr>
<tr>
<td>73510 complete minimum of 2 views</td>
<td>73502 Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views</td>
<td>73503 min of 4 views</td>
</tr>
<tr>
<td>73520 hips, bilateral, minimum 2 views each hip</td>
<td>73521 Radiologic examination, hips, bilateral, with pelvis when performed; 2 views</td>
<td>73522 3-4 views</td>
</tr>
<tr>
<td>73540 pelvis &amp; hips, infant or child, minimum 2 views</td>
<td>73501 Radiologic examination, hip, unilateral, with pelvis when performed; 1 view</td>
<td>73502 2-3 views</td>
</tr>
<tr>
<td>73550 femur 2 views</td>
<td>73551 Radiologic examination, femur; 1 view</td>
<td>73552 min 2 views</td>
</tr>
<tr>
<td>72010 Radiologic examination, spine, entire, survey study, anteroposterior and lateral</td>
<td>72082 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 2 or 3 views</td>
<td></td>
</tr>
<tr>
<td>72069 Radiologic examination, spine, thoracolumbar, standing (scoliosis)</td>
<td>72081 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); one view</td>
<td>72082 2 or 3 views</td>
</tr>
<tr>
<td>72090 scoliosis study, including supine and erect studies</td>
<td>72081 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); one view</td>
<td>72082 2 or 3 views</td>
</tr>
</tbody>
</table>

**REVISIONS**

72080 thoracolumbar, 2 views (revised description in bold font) should include examination of the thoracolumbar junction*  

72080 thoracolumbar, 2 views (revised description in bold font) should include examination of the thoracolumbar junction*  

72020 spine, single view, specify level  

72020 spine, single view, specify level  

NOTE  

* The junction between thoracic & lumbar spine from 11th thoracic to 1st lumbar vertebra.
Four (4) new codes for renal pelvis catheter procedures will bundle the S&I and imaging guidance with the surgical procedure and will include the diagnostic nephrostogram and/or ureterogram.

In addition, a new code 50430 for injection for antegrade nephrostogram and/or ureterogram, complete diag. procedure including imaging guidance, (e.g., ultrasound & fluoroscopy) S&I and interpretation, new access. And 50431, for existing access.

<table>
<thead>
<tr>
<th>Description</th>
<th>Old Code(s)</th>
<th>New Code</th>
<th>Description</th>
<th>Old Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement of nephrostomy catheter, percutaneous</td>
<td>50392</td>
<td>50432</td>
<td>Exchange nephrostomy catheter, percutaneous</td>
<td>50398</td>
</tr>
<tr>
<td></td>
<td>74475</td>
<td></td>
<td></td>
<td>75984</td>
</tr>
<tr>
<td>Placement of nephroureteral catheter, percutaneous, new access</td>
<td>50393</td>
<td>50433</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>74480</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convert nephrostomy catheter to nephroureteral catheter, percutaneous,</td>
<td>50393</td>
<td>50434</td>
<td></td>
<td></td>
</tr>
<tr>
<td>via pre-existing nephrostomy tract</td>
<td>74480</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ureteral Stenting, Embolization & Dilation

The new codes below describe procedures for ureteral stenting, embolization and dilation. These include diagnostic imaging (such as nephrostogram) and all imaging guidance, supervision and interpretation.

<table>
<thead>
<tr>
<th>Description</th>
<th>New Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement of ureteral stent, pre-existing nephrectomy tract</td>
<td>50693</td>
</tr>
<tr>
<td>New access, without separate nephrostomy catheter</td>
<td>50694</td>
</tr>
<tr>
<td>New access, with separate nephrostomy catheter</td>
<td>50695</td>
</tr>
<tr>
<td>Ureteral embolization or occlusion (used in addition to code for primary procedure)</td>
<td>50705</td>
</tr>
<tr>
<td>Balloon dilation ureteral stricture (used in addition to code for primary procedure)</td>
<td>50706</td>
</tr>
</tbody>
</table>
Nuclear & IR Codes

• Nuclear Medicine subsection changes include two added and one revised code.
• Interventional Radiology was impacted most by new codes for urinary imaging and percutaneous drainage procedures, as well as biliary tract imaging and percutaneous drainage procedures.
  • As seen in previous years, these new codes now include imaging guidance and/or radiological supervision and interpretation.
• Additional instructional notes were added throughout the radiology section regarding guidance procedures now bundled into new surgical codes. The code specifics will appear later in this document.
Ordering Physician Must Give Reason for Diagnostic Test

• Neither the law nor Medicare policy says the ordering physician must give you the literal ICD code that corresponds to the reason the specimen is being sent: the narrative diagnosis is sufficient.

• Medicare permits the consultant or laboratory to “translate that narrative [diagnosis] to the appropriate [ICD] diagnosis code.”

• “The narrative does not have to exactly match the description of the [biller’s] submitted [ICD code]” but they must be sufficiently similar to enable the biller to defend that the code “provides the highest degree of accuracy and completeness.”

• Unfortunately, Congress didn’t provide for fines, penalties, or sanctions for referring doctors who persistently withhold the requisite diagnostic information from pathologists and labs.
76376: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation

76377: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; requiring image post-processing on an independent workstation
76376 and 76377 - LIMITATIONS

• In freestanding and independent diagnostic testing facilities, Medicare expects the referring physician to generate an appropriate written request indicating the clinical need for the additional 3D imaging, that a copy of that request be maintained by the interpreting physician and the interpreting physician’s report addresses those specific clinical issues. In the event that a 3D interpretation is deemed urgently needed by the radiologist and the referring physician is not immediately available, the radiologist must document the time of the study, the specific need for the study, and a summary of the findings that were urgently transmitted to the practitioner named as the referring physician on the radiology report.

• CPT codes 76376 and 76377 may be considered medically unnecessary and denied if equivalent information obtained from the test has already been provided by another procedure (magnetic resonance imaging, ultrasound, angiography, etc.) or could be provided by a standard CT scan (two-dimensional) without reconstruction.

• Medicare expects that no more than 20 percent of the total Computerized Tomography (CT) and Magnetic Resonance (MR) imaging of any practice be submitted with 3-D rendering or interpretation, with or without image post-processing. However, for cancer evaluation applications, such as staging/monitoring for pulmonary metastases, this threshold may be often exceeded. Therefore, if data suggests providers are billing at higher rates for other indications for 3D rendering, then Medical Review may do pre or post pay reviews to validate the use and medical necessity of the test.

• All imaging studies will be subject to the American College of Radiology Guidelines for reporting.

• CPT code 76376 can be reported when 3D rendering is performed by a radiologist or a specially-trained technologist at the acquisition scanner. However, CPT code 76377 is reported when the 3D post-processing images are reconstructed on an independent workstation with concurrent physician supervision. In order to report 76377, the supervising physician must provide concurrent supervision.
In order to report the correct CPT code for the 3D analysis (76376 or 76377), it should be documented within the radiology report as to whether the 3D was performed on an independent workstation or on the acquisition scanner. Making an explicit statement within the radiology report will avoid ambiguity, and aid the coder in accurately coding for the 3D reconstruction. Some practices may separately document this in the patient’s electronic medical record, but not actually in the report.

Imaging studies are complex with thousands of individual pictures. Beyond identifying a fracture in an emergency setting a discussion of treatment planning after the patient has left the department is common. 3D may be necessary to understand the anatomy for treatment planning. This discussion occurs after the acute event. Another vignette is an imaging study for stroke but later a seizure concern is identified subsequent to the emergency visit and 3D is applied to evaluate an anatomy of the hippocampus for a seizure focus.
ICD-10 Codes That Support Medical Necessity

**Group 1 Paragraph: Note:** All primary diagnosis codes must be related to the primary procedural code when rendered for the 3-D reconstruction. The use of these diagnosis codes implies the medical necessity of the 3-D rendering and interpretation, as outlined in this LCD, is documented in the medical record.

A written request for the study from the referring physician must also be in the medical record and made available upon request when performed in freestanding and independent diagnostic testing facilities.

The following lists include only those secondary diagnoses for which the identified CPT/HCPCS procedures are covered.

**Note:** If a covered secondary diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.
Medicare is establishing the following limited coverage for CPT/HCPCS codes 76376 & 76377:

### Group 1 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R90.82</td>
<td>White matter disease, unspecified</td>
</tr>
<tr>
<td>R91.8</td>
<td>Other nonspecific abnormal finding of lung field</td>
</tr>
<tr>
<td>R93.0</td>
<td>Abnormal findings on diagnostic imaging of skull and head, not elsewhere classified</td>
</tr>
<tr>
<td>R93.1</td>
<td>Abnormal findings on diagnostic imaging of heart and coronary circulation</td>
</tr>
<tr>
<td>R93.3</td>
<td>Abnormal findings on diagnostic imaging of other parts of digestive tract</td>
</tr>
<tr>
<td>R93.4</td>
<td>Abnormal findings on diagnostic imaging of urinary organs</td>
</tr>
<tr>
<td>R93.5</td>
<td>Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum</td>
</tr>
<tr>
<td>R93.6</td>
<td>Abnormal findings on diagnostic imaging of limbs</td>
</tr>
<tr>
<td>R93.7</td>
<td>Abnormal findings on diagnostic imaging of other parts of musculoskeletal system</td>
</tr>
<tr>
<td>R93.8</td>
<td>Abnormal findings on diagnostic imaging of other specified body structures</td>
</tr>
</tbody>
</table>
**Group 2 Paragraph:** Covered primary diagnosis for deep brain stem lead placement only (the above secondary diagnosis are not required.)

**Group 2 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G20</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>G21.4</td>
<td>Vascular parkinsonism</td>
</tr>
<tr>
<td>G24.1</td>
<td>Genetic torsion dystonia</td>
</tr>
<tr>
<td>G24.3</td>
<td>Spasmodic torticollis</td>
</tr>
<tr>
<td>G24.9</td>
<td>Dystonia, unspecified</td>
</tr>
<tr>
<td>G25.0</td>
<td>Essential tremor</td>
</tr>
<tr>
<td>G25.1</td>
<td>Drug-induced tremor</td>
</tr>
<tr>
<td>G25.2</td>
<td>Other specified forms of tremor</td>
</tr>
</tbody>
</table>
Local Coverage Determinations (LCDs)
Creation and Purpose of LCD

• **Local Coverage Determinations (LCDs) are created by the Medicare Administrative Contractor (MAC)**
  - Local contractor level
  - Contractor Medical Directors responsibility
• May or may not be associated with a National Coverage Determination (NCD)
  - Assist in determining reasonable and necessary criteria
• LCDs cannot restrict or conflict with an NCDs
  - Or any CMS interpretive manuals
Locating LCDs
Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record and made available to Medicare upon request.

- Use of one of the secondary diagnosis codes in this LCD implies medical necessity for 3-D rendering and interpretation.

- Documentation supporting medical necessity must be maintained in the medical record along with the written request for the study from the referring physician.

- 3D Reconstruction services are to be reported by a separate report or in a separate section of the base service report.

- A permanent archive of 3D studies of CTA studies is suggested by the ACR.
Tips for Catheter Placement

1) Code to the **highest order selective cath placement** within each vascular family

2) Code the **selective cath placement only** if both nonselective & selective placements are performed from one access point

3) Code **each separate access site**

4) **All vessels imaged with documentation of findings in the report** can be assigned the S&I codes more than once, even if they were not individually selected & if the code does not have the code narrative “selective” exceptions

5) **Aorta takes precedence** over other nonselective codes

6) Code **each vascular family separately**, using modifiers to distinguish the different vessels

7) **Code to where the tip of the cath is**, not to the tip of the wire

8) Do not code for injecting small amounts of contrast to localize a vessel for subsequent selection
Documentation of Device Position

• The final position of all devices inserted permanently or long-term with imaging guidance (eg, stents, endovascular grafts, central venous catheters, inferior vena cava filters, embolic agents, drainage catheters) should be documented with imaging.

• Benefits of documenting device position should be weighed against ionizing radiation risks of x-ray documentation (eg, in pregnancy).
ARCHIVING OF IMAGES

• General Principles

• All pertinent imaging data should be saved in permanently retrievable digital or hard-copy format. Examples of pertinent imaging data include:
  • The relevant anatomy that will affect patient management, device position, complications, and transient adverse events (such as emboli) that might have been successfully treated during a given procedure.
  • If ultrasound guidance is used to gain entry into a blood vessel, it is optional to save a sonographic image of this blood vessel.
Medical Necessity For Procedures

- What is Medical Necessity?
  - It is a concept of justification of medical services rendered to a patient
  - services deemed “not medically necessary” – ARE NOT reimbursable

- How does Insurance Carrier know if services were Medically Necessary?
  - ICD-10-CM diagnosis codes indicate the reason for the visit
    - Providers should choose only the diagnosis representing clinical conditions they are treating the patient for on a given date of service
    - Use most accurate dx code
Diagnosis Coding & Medical Necessity

• Justification of medical services rendered to a patient - Diagnosis codes indicate the reason for the encounter
  • Document the most accurate diagnosis or signs /symptoms representing clinical conditions rendering treatment / services on a given DOS to the highest specificity
  • Physician claims require diagnosis codes and are often utilized on reviews to support medical necessity through LCDs and NCDs, especially for radiology
  • If the clinical findings of the test are inconclusive or negative – code Signs or Symptoms which prompted the encounter
  • Do not choose diagnoses codes – if condition is described as “probable”, “possible” or “rule out”
  • All requests for diagnostic testing must be documented in the reports and specify:
    • diagnosis (if confirmed) or signs or symptoms
Modifiers
Consultation on Previous Interpretation

• **77 Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional**: It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier **77** to the repeated procedure or service.
“Second Reads”


“Generally, carriers must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier “-77”) only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician’s expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.” -
CPT Code 76140: Consultation on X-ray examination made elsewhere, written report

You should **only report 76140 if a physician from another institution requests your physician's opinion on a radiograph and you send that physician your interpretation.** You should not report 76140 if a physician within your practice or hospital asks you to reread an x-ray that was primarily interpreted by another physician within the same practice. Instead, report 76140 when you interpret an imaging study that was primarily obtained and interpreted by a physician from a different practice and with a different provider number.

Medicare and some private payers assign "0" relative value units to 76140 and will not reimburse you for this service. If your commercial insurer allows payment for this service, ask for the coverage guidelines in writing before billing 76140 to avoid unnecessary denials. **Your practice should establish a policy related to billing the patient for reinterpretations of outside films.** If you intend to bill for this service, you should obtain an advance beneficiary notice for patients whose payers do not provide payment for 76140.
Repeat Procedure by the Same Physician; use when it is necessary to report repeat procedures performed on the same day.

• **Appropriate Usage**
  • On procedure codes that cannot be quantity billed
  • Report each service on a separate line, using a quantity of one and append 76 to the subsequent procedures
  • The same physician performs the services

• **Inappropriate Usage**
  • Repeat services due to equipment or other technical failure
  • For services repeated for quality control purposes

• **Additional Information**
  • Medicare considers two physicians, in the same group with the same specialty performing services on the same day as the same physician
Referring/Treating Physician and Orders

• Orders must be specific to the diagnostic test requested.

• Diagnostic tests require documentation of the name of the referring/ordering provider.

  • Absent a valid ordering provider the claim will be denied.

  • Notations such as “Chest X-ray requested by Cardiology Service” are not acceptable – must be “person” specific.
Treating Practitioner to Order all Tests

• Limited exceptions:
  • Allows additional testing to be done by the radiologist prior to or without contacting the treating physician/practitioner, when the radiologist determines that based on the result of an ordered diagnostic test, an additional diagnostic test should be performed. All of the following criteria must be met:
    • The diagnostic test ordered by the treating practitioner is performed;
    • Radiologist determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;
    • A delay in additional diagnostic testing would have an adverse effect on the care of the patient;
    • The result of the test is communicated to and is used by the treating practitioner in the treatment of the patient; and
    • The radiologist documents in his/her report why additional testing was done.
The Interpreting Physician May:

- **Determine the test design, unless specified in the order.**
  - The interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).
  - An order for “MRI of orbit” without a specific contrast component would allow the interpreting physician to determine if contrast was medically appropriate for that specific patient without obtaining an updated order.

- **Modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that would be apparent to a reasonable layperson, such as the patient receiving the test (e.g., x-ray of wrong foot ordered).**
Conditional Orders

- CMS has approved the use of conditional orders as long as they are limited to a specific patient.
  - Example: a patient-specific order reads: “Diagnostic mammogram of right breast with ultrasound, as indicated,” the radiologist may add the ultrasound to characterize the mass.

- A standing order for all patients of a given treating physician/practitioner (e.g., “if gallbladder ultrasound for Dr. Smith is negative, do UGI”) is not acceptable. The conditional order process can be replicated across diagnostic testing modalities (i.e., CT; MRI; Ultrasound; etc) with the understanding that such conditional orders MUST BE patient-specific.
What Services Can Be in One Report

Combined services into one report is not restricted

• Each service included in the report must include all report components to be identified for review (essentially 2 diagnostic studies – interpretations in one report):
  • Clinical Information related to the specific area reviewed
  • Body of the report should include each anatomical area, modality, and use of contrast
  • Impression for each area reviewed

• Typically see combined reports included from one ordering practitioner.

• HOWEVER! When multiple are performed on the same day, a modifier has to be attached to the individual charge. An issue can arise with report accession numbers for billing in some organizations.
Components of Diagnostic Services

• Professional Component (-26)
  • Physician’s Interpretation of the test
• Appended to all codes for services rendered
• Technical Component (-TC)
  • Expense related to the cost and utilization of the equipment and technical staff.
  • Not reimbursable to physicians if place of service is inpatient or outpatient hospital setting
• Only when the equipment is owned by the Department of Radiology are entitled to reimbursement for both technical and professional component
Physician Supervision Of Diagnostic Tests

• Levels of Supervision when a technician is utilized:
  • **Personal** – Physician in the room
    • e.g. myelography, cisternography, dacryocystography
  • **Direct** – Physician in the suite (available)
    • administration of contrast media
  • **General** – Physician provides overall supervision
    • films

Supervision requirements apply to charges for global or technical component – It does not apply if Radiologist bills for interpretation and report only
Radiological Reports

• Elements of the report
  • Clinical Information must include
    • Referring/ordering Physician
    • Patient Demographics
    • Clinical signs or symptoms or personal history of disease
  • Body of the report should include
    • Description of the procedure including anatomical area, modality, and use of contrast.
    • Describes if and why additional testing was done.
  • Impression
    • Revises or confirms initial diagnosis
    • If findings are negative – coding is based on signs or symptoms

• All coding must be abstracted from the Body of the report and not from headers.

This becomes crucial in cases with negative or inconclusive findings!
Documentation Tips for Multiple Procedures

➢ List all of the radiological tests reviewed/performed
   • Indicate **pertinent history** of present illness
   • Specify anatomical **site(s)**
   • Include **number** of views if applicable
   • Indicate if **contrast** has been used

➢ Assure that **test-specific** interpretation is documented within the body of the report for all reviewed tests

• E.g. : Chest CT scan **w/o** contrast and Abdominal CT **with and w/o** contrast

Lack of documentation = loss of revenue
Provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time.

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made.
DEFINING START AND STOP TIME

“Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.” (Per CPT)

Thus, anesthesia services and time are considered completed when the patient may be safely left under the observation of a trained anesthesia assistant, and the doctor may safely leave the room to attend to other duties.

Per AMA clarification, in order to bill the threshold of 16 minutes must be met (15 minutes or < is not billable).

The AMA in 2012—asserted that "recovery . . . is not reported separately and is not included in the intra-service time.”

All providers should document sedation for every procedure if performed.
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Diagnostic Procedures

• RADIOLOGY AND OTHER DIAGNOSTIC TESTS

• **General Rule:** The Teaching Physician may bill for the interpretation of Diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

• **Teaching Physician Documentation Requirements:**
  
  • Teaching Physician prepares and documents the interpretation report.
  
  • OR
  
  • Resident prepares and documents the interpretation report
  
  • The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

• **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
**Minor** – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: ‘*I personally performed the procedure*’
Example: ‘*I was present for the entire procedure.*’
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.
“Whoa—__way too much information.”
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever – even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL
✓ module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

What is Fair Warning?

- **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.

- **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.

- **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.

UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  
  • Helenmarie Blake-Leger, Interim AVP of Compliance & Chief Privacy Officer
  
    Phone: (305) 243-6000

  • Iliana De La Cruz, RMC, Director Office of Billing Compliance
  • Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance
  
    Phone: (305) 243-5842
  
    Email: Officeofbillingcompliance@med.Miami.edu

Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week). Your inquiry or report may remain anonymous

• Office of billing Compliance website: www.obc.med.miami.edu