Office of Billing Compliance
2014 Professional Coding, Billing and Documentation Program

Diagnostic Radiology

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April 2014

What is a Compliance Program?

7 Elements of an Effective Compliance Program

- A centralized process to promote honest, ethical behavior in the day-to-day operations of an organization, which will allow the organization to identify, correct, and prevent illegal conduct.
- It is a system of: FIND – FIX – PREVENT

The University of Miami implemented the Billing Compliance Plan on November 12, 1996. The components of the Compliance Plan are:

1. Policies and Procedures
2. Having a Compliance Officer and Compliance Committees
3. Effective Training and Education
4. Effective Lines of Communication (1-877-415-4357 or 305-243-5842)
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Detect Non-Compliance Issues and Develop Corrective Action Plans

The Government

- In order to address fraud and abuse in the Healthcare Field, the government has on-going reviews and investigations nationally to detect any actual or perceived waste and abuse.

- The Government does believe that the majority of Healthcare providers deliver quality care and submit accurate claims. However, the amount of money in the healthcare system, makes it a prime target for fraud and abuse.

Centers for Medicare and Medicaid Services (CMS) Estimates > $50 Billion In "Payment Errors" Annually in Healthcare

OIG reported that in FY 2013 that $5.8 billion was recovered from auditing providers

Health Care Laws

There are five important health care laws that have a significant impact on how we conduct business:

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  - Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.

False Claims Act : United States Code Title 31 §3729-3733
What is a False Claim?

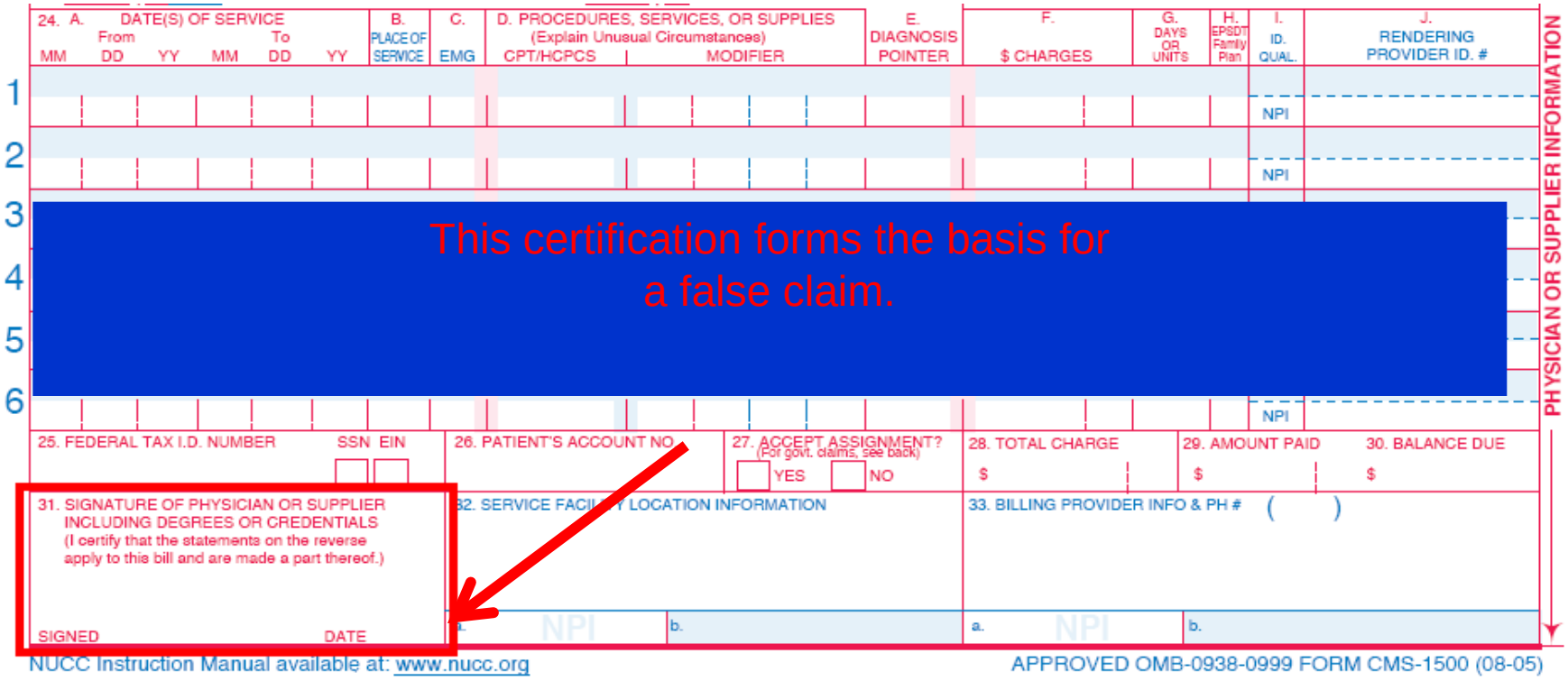
- A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false claim.

OR

- Reckless disregard of the truth or an attempt to remain ignorant of billing requirements are also considered violations of the False Claims Act.

How do you create a False Claim?

One method is to submit a claim form to the government



HOT TOPICS IN COMPLIANCE 2014

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-9-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

Example:

- patient with thoracic spondylosis– ICD-9 code 721.41
- patient with lumbar region spondylosis – ICD-9 code 721.42

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 thru 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

Quality & Cost: Emphasis on Pay-for-Performance PQRS & Meaningful Use

- Practitioner reimbursement will likely be tied to outcomes soon.
- Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely will be adopted by private payers.
- "I think we're slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost," says Miranda Franco, government affairs representative for the Medical Group Management Association. "The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them]."

Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts

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.**

Modifier GC

CMS Manual Part 3 - Claims Process - Transmittal 1723

- Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service.-- In item 24d of Form CMS-1500, the GC modifier must be entered by the physician for Teaching Physician Services rendered in compliance with all the requirements outlined in §15016 of the Medicare Carriers Manual.
- Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service, and were immediately available during the other parts of the service.
- The claim should have the GC modifier even if a RNFA or a PA is working with the resident and teaching physician

Radiological Interpretation

This becomes crucial in cases with negative or inconclusive findings!

- Elements of the report
  - Clinical Information must include
    - Referring Physician
    - Patient Demographics
    - Clinical signs or symptoms or personal history of disease/injury
  - Body of the report should include
    - Description of the procedure including anatomical area, modality, and use of contrast and **#of views performed and interpreted**
    - *ALL coding must be abstracted from the Body of the report and not from headers*
  - Impression
    - Revises or confirms initial diagnosis
    - If findings are negative – coding is based on signs or symptoms

Referring/Treating Physician and Orders

- Diagnostic tests require documentation of the name of the referring physician
  - Attending
  - Resident/Fellow
  - Voluntary Physician
  - Non-physician practitioner (NP, PA, etc.)
- Notations such as " Chest X-ray requested by Cardiology Service" are not acceptable – must be "person" specific
- Orders need to be specific to the diagnostic test requested.

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 and he or she is unable to reach the treating practitioner. 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 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.

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 hospital
- When the equipment is owned by the Department of Radiology they 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

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

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:
  - 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
- An order for each component included
- Typically see combined reports included from one ordering practitioner

Required Documentation - Catheter Placements

The access site

The route of the cath & the end position

Where & when injections were done

What images were taken

Any intervention performed

Ultrasonography

- Imaging of deep structures of the body by recording the echoes of pulses of ultrasonic waves directed into the tissues and reflected by tissue planes where there is a change in density.
  - Diagnostic ultrasonography uses 1–10 megahertz waves.
    - **Doppler:** the shifts in frequency between emitted ultrasonic waves and their echoes are used to measure the velocities of moving objects, based on the principle of the Doppler effect. The waves may be continuous or pulsed.
    - **Gray-scale:** B-scan technique in which the strength of echoes is indicated by a proportional brightness of the displayed dots.

What is the difference between a "limited" and a "complete" ultrasound? ACR Q&A's

3. If a large portion of the complete examination is performed, should that not count as complete with limited being left for one or two organs examined?

- Complete and limited ultrasound studies are clearly defined in the ultrasound introductory guidelines section of the *CPT* code book. Note that the report should contain a description of all elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent, etc). As stated in the guidelines, *If less than the required elements for a 'complete' exam are reported (eg, limited number of organs or limited portion of region evaluated), the limited code for that anatomic region should be used once per patient exam session*.

Limited or Complete Plethysmography Report

- Lower extremity require either:
  - (1) ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional Doppler waveform recording and analysis at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)** **or**
  - (2) ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)** **or**
  - (3) ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)**
- Potential levels include high thigh, low thigh, calf, ankle, metatarsal and toes.
- Alternatively, a complete study may be reported with measurements at a single level if provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia) are performed.

Limited or Complete Plethysmography Report

- Upper extremity require either:
  - Limited studies for upper extremity require either: (1) Doppler-determined systolic pressures and bidirectional Doppler waveform recording and analysis at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)** **or**
  - (2) Doppler-determined systolic pressures and volume plethysmography at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)** **or**
  - (3) Doppler-determined systolic pressures and transcutaneous oxygen tension measurements at **1-2 levels (LIMITED);** or **3 or more levels (COMPLETE)**
- Potential levels include arm, forearm, wrist, and digits.
- Alternatively, a complete study may be reported with measurements at a single level if provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with cold stress) are performed.

3D Rendering with I & R

- 76376 –of CT, MRI, US, or other tomographic modality; with image postprocessing under concurrent supervision;
  - not requiring image postprocessing on an independent workstation
- 76377 –
  - ;requiring image postprocessing on an independent workstation

The codes "require concurrent physician supervision of image postprocessing 3D manipulation of volumetric data set and image rendering."

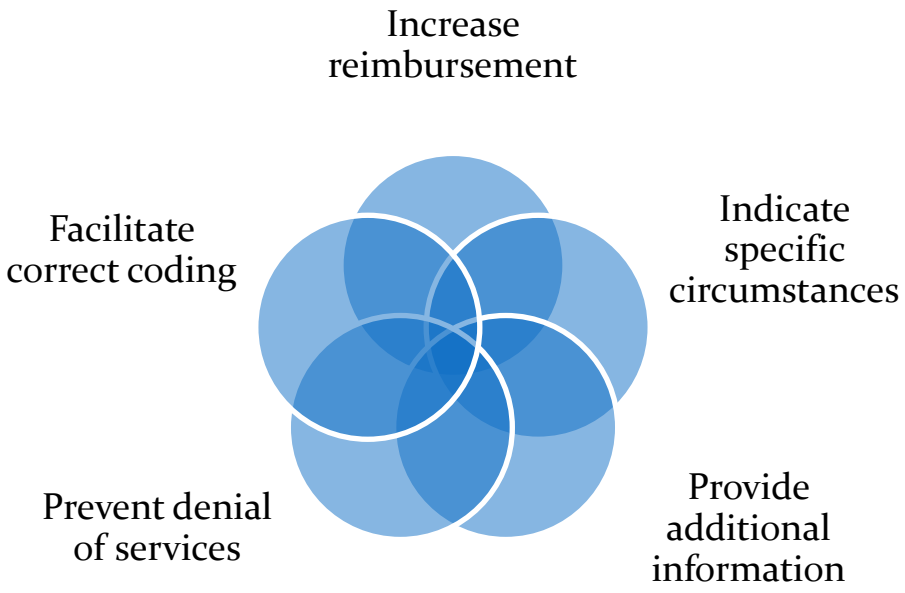
3D Concurrent Physician Supervision

- Concurrent means active participation in and monitoring of the reconstruction process that includes:
  - design of the anatomic region that is to be reconstructed;
  - determination of the tissue types and actual structures to be displayed (e.g., bone, organs, and vessels);
  - determination of the images or cine loops that are to be archived; and
  - monitoring and adjustment of the 3D work product.
- Concurrent does not relate to the definitions for general, direct, and personal supervision established by CMS which relate to the physical location of the physician with respect to the patient and would apply to the CT acquisition base procedure code.
- ACR states that for both codes, the presence of a physician is required for supervision of image post-processing, 3-D manipulation of volumetric data set and image rendering.

Modifiers

A billing code **modifier** allows you to indicate that a procedure or service has been altered by some specific circumstance but has not changed in its definition.

Modifiers allow to:



Documentation in the operative report must support the use of any modifier

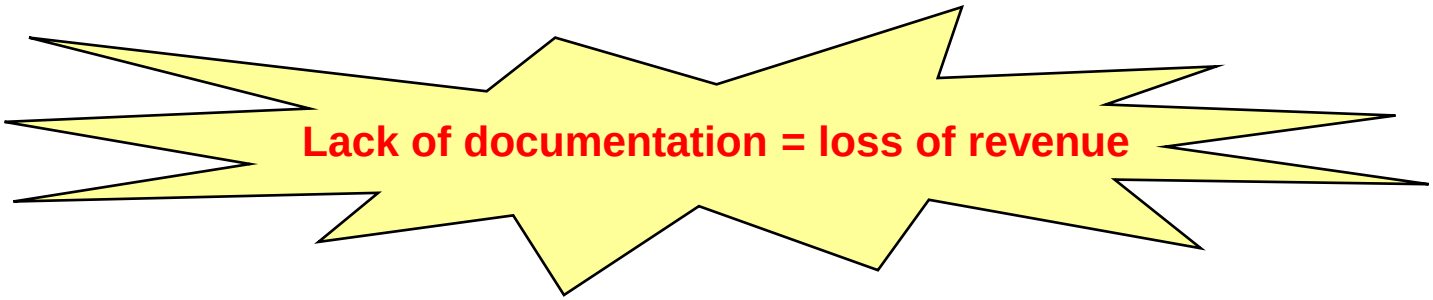
Repeat Procedures

- In cases when the same or mutually exclusive procedure was performed multiple times on the same day
  - Document TIME of each procedure
  - Document separate paragraphs describing each procedure
- Appropriate documentation:
  - Allows to avoid denials upon a review
  - Supports the charges
  - Accurately reflects rendered services
- Append appropriate modifier to the "second charge" for the day:
  - Modifier – 76 "Repeat Procedure by the Same Physician"
  - Modifier – 77 "Repeat procedure by Another Physician"

Example:

- **7 AM – Chest X-Ray 2 views CPT 71020**
- **3 PM – Chest X-Ray 2 views CPT 71020 – 76 or CPT 71020 – 77**

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

Place-of-Service (POS) on Claim

- Code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service.
- POS code assigned by the physician /practitioner will be the setting in which the beneficiary received the (Technical Component (TC) of the service. For example: A beneficiary receives an x-ray at an outpatient hospital. The hospital submits a claim that would correspond to the TC portion of the service. The physician furnishes the PC portion of the beneficiary's x-ray read from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the service, the TC, at the outpatient hospital.

Place-of-Service (POS) on Claim

- There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as:
  - A registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service.
  - The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22).

CMS Manual System **Transmittal 505 Date: 2/5/14:**

SUMMARY OF CHANGES: The purpose of this change request (CR) is to allow the contractors to make a decision or take action on claims that are not currently being under review.

- Auditors for The MAC, Recovery Auditor, and ZPIC have the discretion to deny other related claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Claims may be "related" in the following
- EXAMPLE situations:
  - An inpatient claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the physician claim can be determined to be not reasonable and necessary.
  - A diagnostic test claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the professional component can be determined to be not reasonable and necessary.

Radiology Helpful Hints

- Always document the numbers of views personally reviewed!
  - Don't assume because the technical services included 3 views that your professional billing does not need to specifically mention the # of views
- Always include ALL organs reviewed so services are not downcoded on an audit
- Always ensure an order is received for all services performed and billed. If there is a "protocol" to perform certain services together, there still must be an order for that patient.
  - If no order on an audit, it is the radiology who has the financial payback liability not the sending physician.
- ALWAYS DOCUMENT CONTRAST; BOTH WITH AND W/O!
- Common coding issues and new codes on the following slides

2014 CPT Code Changes Review

- Radiology
  - **72040** Radiologic examination, spine, cervical; 3 views or less
  - ***Revised – Radiologic examination, spine, cervical; 2 or 3 views***

Top Procedure Codes Billed in 2013

Top 10 CPT Codes	Description
71010	PR CHEST X-RAY 1 VW
71020	CHG CHEST X-RAY 2 VW
70450	PR CT SCAN,HEAD/BRAIN,W/O CONTRAST MATL
74000	PR X-RAY ABDOMEN 1 VW
74177	CHG CT SCAN,ABDOMENT AND PELVIS,W CONTRAST
76705	US, ABDOMEN LIMITED
71260	PR CAT SCAN OF CHEST CONTRAST
70553	PR MRI BRAIN COMBO
74176	CHG CT SCAN,ABDOMENT AND PELVIS,W/O CONTRAST
73130	CHG X-RAY HAND 3+ VW

ICD -10 and Clinical Documentation

- Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.
- Coding and documentation go hand in hand
  - ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
  - ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.
  - Will not change the way a physician practices medicine

ICD-10 Examples for Radiologists

- **ICD-9 code**: 820.8 – Fracture of neck of femur; unspecified part of neck of femur, closed
- **ICD-10 code**: S72.009A – Fracture of unspecified part of neck of unspecified femur, ***initial encounter for closed fracture***
  - For coding of fractures the "A" in the ICD-10 code is the indicator of the "episode of care" with "A" meaning it is the initial encounter for a closed fracture. With ICD-10, it will now be necessary for the radiologist to document the encounter type. The choices for fracture encounter types are:
  - A – Initial encounter for closed fracture
  - B – Initial encounter for open fracture
  - D – Subsequent encounter, fracture, with routine healing
  - G – Subsequent encounter, fracture, with delayed healing
  - J – Subsequent encounter for fracture with non-union
  - Q – Sequela (late effect)

ICD-10 Examples for Radiologists

- **ICD-9 code:** 729.5 – Pain in limb
- Best way to dictate and code "pain in limb" under ICD-10 is to report one of the 38 available ICD-10 codes (including unspecified codes) for that condition, as follows:
- M79.6 – Pain in limb, hand, foot, fingers and toes (not billable – only a title)
  - M79.60 – M79.609 – arm or leg and left or right
  - M79.62 – M79.639 – upper arm or forearm, left or right
  - M79.64 – M79.646 – hand or fingers, left or right
  - M79.65 – M79.669 – thigh or lower leg, left or right
  - M79.67 – M79.676 – foot and toes, left or right

Ortho			
842.00	Sprains and strains of wrist, unspecified site	S63.501A	Unspecified sprain of right wrist, initial encounter
		S63.501D	Unspecified sprain of right wrist, subsequent encounter
		S63.502A	Unspecified sprain of left wrist, initial encounter
		S63.502D	Unspecified sprain of left wrist, subsequent encounter
		S63.509A	Unspecified sprain of unspecified wrist, initial encounter
		S63.509D	Unspecified sprain of unspecified wrist, subsequent encounter
		S66.911A	Strain of unspecified muscle, fascia and tendon at right wrist and hand level, initial encounter
		S66.911D	Strain of unspecified muscle, fascia and tendon at wrist and hand level, right hand, subsequent encounter
		S66.912A	Strain of unspecified muscle, fascia and tendon at left wrist and hand level, initial encounter
		S66.912D	Strain of unspecified muscle, fascia and tendon at wrist and hand level, left hand, subsequent encounter
		S66.919A	Strain of unspecified muscle, fascia and tendon at wrist and hand level of unspecified side, initial encounter
		S66.919D	Strain of unspecified muscle, fascia and tendon at wrist and hand level, unspecified hand, subsequent encounter

HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

- **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.

Any Questions?

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:
  - ***Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy Officer; or***
  - ***Iliana De La Cruz, RMC, Director Office of Billing Compliance***
    - ***Phone: (305) 243-5842***
    - **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 (24hours a day, seven days a week).
- Office of billing Compliance website: **www.obc.med.miami.edu**