

Arm your staff to avoid common coding mistakes

by Debra P. Ferenc

Radiology practice revenue is greatly affected by coding mistakes.

Claims that contain coding errors can cause payment to be delayed, denied, or reduced.

Accounts receivable staff members can generally appeal these decisions. Unfortunately, pursuing an appeal takes time and costs money.

Also, keep in mind that coding errors could trigger an audit.

How do you eliminate this problem? The answer is to submit a clean claim the first time. Be sure coding staff members have access to all the necessary resources to code accurately.

Use the following information to avoid common coding errors in three significant areas: medical necessity, unbundling, and modifiers.



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Medical necessity

Medical necessity is the key to obtaining appropriate reimbursement because payers refuse to pay for services not considered medically necessary. It is the responsibility of the provider performing a study to make sure it has met medical necessity criteria prior to the study.

Therefore, physician documentation must explain the medical necessity for each ser-

Be sure coding staff members have access to all the necessary resources to code accurately.

vice performed. Diagnosis codes are assigned to establish medical necessity for each service submitted. Coders need to identify the diagnosis, condition, problem, or other reason for the radiology exam(s), or the definitive finding of the exam, which may help to demonstrate medical necessity. Below are some basic physician/outpatient diagnosis coding guidelines to help you avoid errors related to medical necessity:

- **Code to the highest level of specificity.** CMS instructs carriers to reject claims with invalid or truncated diagnosis codes. A diagnosis code is considered truncated when a fourth or fifth digit is available but is not submitted. A good example of this is 250.0. Diabetes can always be coded to the fifth digit.
- **Qualified diagnosis.** Do not code probable, suspected, questionable, rule-out, or other working diagnoses. Instead report signs, symptoms, or an appropriate V code to explain the reason for the visit.
- **Confirmed diagnosis.** Report diagnoses based on test results, as opposed to reporting the reason tests were ordered. Signs and symptoms may also be reported when appropriate.
- **Incidental findings.** If the record contains an incidental diagnosis, it should not be listed first. However, it can be listed as a secondary diagnosis.

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Common mistakes

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- **Coexisting conditions.** These should not be listed first as the primary diagnosis; they may be reported as additional diagnoses.
- **Screening exams.** In the absence of signs, symptoms, illness, injury, or a definitive diagnosis, a V code is required to explain the reason for the visit.
- **Acute versus chronic conditions.** Distinguish between acute and chronic conditions. Acute conditions are listed first as primary, particularly in emergency situations (e.g., coma). Chronic conditions may be reported as needed to explain medical necessity.

Policies regarding medical necessity vary by payer; therefore, it is important to review payer-specific guidelines regarding their medical necessity criteria. Many resources can be used to accomplish this, such as payer Web sites and radiology cross coders.

Coders can gain access to medical necessity criteria for the Medicare program at www.cms.hhs.gov/mcd/overview.asp. This site contains information regarding the Medicare coverage database. It allows coders to enter specific criteria, such as key word, coverage topic, or date, to search the National Coverage Determination and Local Coverage Determination databases for coverage information.

An alphabetical listing of coverage determinations can be accessed at www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd#PC. This is an excellent resource for coders as it contains indications and limitations of coverage for the specified service.

Unbundling

Unbundling occurs when more than one procedure code is submitted to describe a service that can be reported with one code. When this happens, the payer will process reimbursement based on the bundling of the services.

Take fluoroscopy for example. CPT guidelines indicate fluoroscopy should not be reported in conjunction with a TMJ arthrography. However, CPT does not always include this type of information.

Coders can use several resources to identify inappropriate code pairs. One resource is the National Correct Coding Initiative (NCCI), which was developed by a CMS contractor, Administar Federal, "to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims."

Many payers incorporate the NCCI into their claims processing edits. The NCCI tables can be downloaded from the CMS Web site at www.cms.hhs.gov/NationalCorrectCodInitEd/.

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The Web site contains a link to review edits for physician claims, and another for hospital outpatient claims.

The NCCI is a listing of code pairs organized in two columns in an Excel spreadsheet.

NCCI contains two tables: "Column 1/Column 2 Correct Coding Edits Table" and "Mutually Exclusive Edits Table." The tables outline code pairs that should not be reported together based on general correct coding policies outlined in Chapter 1 of the NCCI policy manual.

The Column 2 code will be denied when submitted with a Column 1 code. NCCI will help coders to identify

inappropriate code pairs, which will help to avoid unbundling.

Modifiers

Many coding situations require the use of a modifier to further explain circumstances that are not described in the code. Inappropriate modifier assignment can cause payment to be delayed, denied, or reduced. It is important for coders to recognize coding circumstances that require a modifier.

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National Correct Coding Initiative (NCCI)

Column 1/Column 2 Correct Coding Edits

Column 1	Column 2	* = In existence prior to 1996	Effective date	Deletion date	Modifier
				*=no data	0=not allowed 1=allowed 9=not applicable
70010	C8952		20060101	20061231	1
70010	G0001		19960101	19960401	1

Common modifier circumstances

Circumstance	Modifier(s) to consider
Procedure performed that is included in the surgical package, such as an E/M and a surgery.	Significant, separately identifiable E/M (-25) Decision for surgery (-57)
A service or procedure is more involved (greater) than normally required.	Unusual procedural services (-22)
A procedure may be partially reduced, eliminated, or discontinued.	Reduced services (-52) Discontinued procedure (-53)
The same procedure is performed on both sides of the body during the same operative session.	Bilateral procedure (-50) or (-LT, -RT)
Anatomic area must be indicated.	HCPCS Level II modifier such as (-LT, -RT, -TA, -T1-T4, -T5-T9)
The professional or technical component of a procedure is performed.	Professional component (-26) Technical component (-TC)
Multiple procedures, other than E/M, performed in the same session by the same physician.	Multiple procedures (-51)
Multiple procedures are performed on the same day by the same physician, and they are distinct or independent from each other.	Distinct procedural service (-59)
Procedure is repeated by the same physician or by another physician.	Repeat procedure by same physician (-76) Repeat procedure by another physician (-77)

Medicare physician fee schedule database

Modifier indicators

-26, -TC professional/technical component

1=Modifiers -26 and -TC can be used with these codes.

2=Modifiers -26 and -TC cannot be used with these codes.

3=Modifiers -26 and -TC cannot be used with these codes.

-50 Bilateral procedure

0=150% payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of (a) the total actual charge for both sides, or (b) 100% of the fee schedule amount for a single code.

1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means, base the payment for these codes on the lower of (a) the total actual charge for both sides, or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

2=100% payment adjustment does not apply. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means, base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code.

3=The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means, base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side, or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests that are not subject to the special payment rules for other bilateral surgeries.

-51 Multiple procedures

0=No payment adjustment rules for multiple procedures apply. Payment is based on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

1=This indicator only applies to codes with a status code of D. If the procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.

2=Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.

3=Special Endo rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day. If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

Source: CMS.

Common mistakes

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The sidebar on p. 3 outlines some common circumstances. It is important to remember payer guidelines regarding the use of specific modifiers may vary. Therefore, it is a good idea to check with your payer to ensure you are using the modifier appropriately. Another good resource is the NCCI. The table contains a "Modifier" column that is used to indicate when a modifier is allowed.

The Medicare Physician Fee Schedule Database (MPFSDB) (see the sidebar on p. 4) also provides information regarding modifiers at www.cms.hhs.gov/apps/pfslookup/step0.asp? The Web site provides options to search the database for physician or for hospital procedures. Detailed explanations of the table and each column can be downloaded from the Web site.

The table includes columns for procedure code, modifier, procedure description, fee, and status, and the last three columns contain modifier indicators, which tell the


coder whether the modifier is applicable or not. A complete listing of indicators for modifiers -TC, 26, 50, 51, 62, 66, and 80 can be downloaded from the MPFSDB. The table on p. 4 highlights the common indicators for modifiers -26, -TC, -50, and -51, in addition to an abbreviated description of their meaning. The complete descriptions can be printed from the Web site. ■

Editor's note: Ferenc, BS, CPC, CPC-H, CMSCS, PCS, FCS, AAPC-approved PMCC instructor and founder of the Gulf to Bay Local Chapter of the AAPC, is a senior consultant/educator at Medical Recovery & Consulting Experts, Inc., based in the Tampa, FL, area. She has more than 25 years of experience in healthcare administration in progressive leadership positions in hospital-based and private practices and auditing. She has dual coding certifications and has an extensive background in all aspects of health insurance billing and coding.

Payment differences between diagnostic and therapeutic radiopharmaceuticals in 2008

Editor's note: This Q&A originally appeared in the December 14, 2007, APCs Weekly Monitor. To subscribe to the Monitor, visit www.hcmarketplace.com.

How will CMS handle payment for radiopharmaceuticals in 2008?

 CMS will pay for diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals differently in 2008. Diagnostic radiopharmaceuticals are one of the categories of items that CMS will package, according to the outpatient prospective payment system final rule. All diagnostic radiopharmaceuticals will have status indicator N and be "unconditionally packaged" for 2008. In addition, CMS is creating new edits in the Integrated Outpatient Code Editor (IOCE) that will require providers to report diagnostic radiopharmaceutical HCPCS codes on all claims

for diagnostic nuclear medicine procedures. This is similar to the device-procedure edits. If a diagnostic nuclear medicine CPT procedure code is present on a claim, the hospital will also have to submit a diagnostic ra-

diopharmaceutical HCPCS code on the same claim with the same date of service. In contrast, CMS will continue to separately pay for some therapeutic radiopharmaceuticals. CMS will separately pay for those therapeutic radiopharmaceuticals with a mean per day cost of more than \$60 (the separate payment threshold for all drugs). Separately payable therapeutic radiopharmaceuticals will have a status indicator K with APC rates based on mean cost data from calendar year 2006. ■

All diagnostic radiopharmaceuticals will have status indicator N and be "unconditionally packaged" for 2008.

Ask the Insider

Start writing: Good documentation can help reimbursement in radiology department

Break out the pens and start writing. Physicians who document what they do in the radiology department and include it with the final bill increase their chances of obtaining the most accurate reimbursement possible.

During the November 29, 2007, HCPro audioconference "Optimize Your Billing Environment: New approaches to manage your chargemaster," **William L. Malm, ND**, practice director of revenue cycle management and director for the Center for Revenue Cycle Excellence at HCPro, Inc., in Marblehead, MA, and **Jessica A. Little, CPC-FP**, a coding and education specialist at Ohio State University Internal Medicine, LLC, division of hematology and oncology in Columbus, answered the following questions.

Q Can the charge for the ultrasound guidance of a procedure cover the equipment and hospital charge when a physician does not dictate that hard copies were obtained? The physician's report will mention that ultrasound guidance was used, but limits it to this statement only.

A I do not bill this charge on the professional side because it does not meet the guidelines. However, can I charge for this on the facility/technical side?

Malm: All procedures performed and charged must have a valid order with accompanying documentation. Ultrasonic guidance, like all radiology guidance, is a packaged service this year, and therefore could not be charged by itself to Medicare. It would be best if there is some documentation in the chart to prove that the pro-

cedure was done and for what reason. The issue is one of documentation, and without supportive documentation, charges may not be assessed.

Little: I agree that this is an issue of documentation. This is a great opportunity to increase a physician's revenue without changing the services they perform by simply changing how they document.

In order to do that, physicians need to be educated about what documentation is required to bill for this code. Permanent records of ultrasound examinations, such as description of anatomic region, measurements, obstructed view, and site to be localized for a guided surgical procedure, are required.

A written report of the exam should be included in the patient's medical record. Do not report an ultrasound without a thorough examination of the organ(s) or anatomic region, documentation of the image, and a final written report.

As far as the facility charge goes, this is a bundled/packaged charge for this year for ambulatory surgical center-covered surgical procedures, so it could not be billed in addition to the procedure that was performed.

0361 versus 0761

Editor's note: During the November 29 audioconference, a question was asked by one of the listeners about the difference between revenue codes 0361 and 0761 in interventional radiology.

Q You said to go with 0761 over 0361. Is this true only for the radiology codes and not the surgical procedure codes that are in addition to the radiology code (i.e., 61624 Embolization, and 75894 and 75898 radiology portion of procedure 47000 Core liver biopsy and 76942) ultrasound guidance? As far as reimbursement goes, what effect will 0361 play in payment versus 0761?

Questions? Comments? Ideas?

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Malm: The answer here is divergent. The example of 61624 poses special concerns as this is (for 2007) an “inpatient procedure only” C status indicator for outpatient prospective payment system (OPPS).

Therefore, if performed on an outpatient, it will not be reimbursed at all. For this procedure to be a properly admitted inpatient, the revenue code would be inpatient surgery, or 0360.

However, for non-C status indicators or those services that can be performed and billed as outpatients under OPPS, the most appropriate revenue code is used to reflect the area in which the costs were accumulated. Because this is clearly not the OR, then 0361 would not

be your most appropriate, and 0761 (by default) could be considered. Additionally, other payers may require that 0761 be used instead of 0361. Your reimbursement is based on HCPCS codes for OPPS and contractually by your non-Medicare payers. Use the revenue code that they specify. ■

Insider sources

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A controversial device: Opinions heat up about CAD; FDA keeps close watch, and radiologists should, too

To CAD or not to CAD? That is the question for those who use the equipment as a second pair of eyes.

John Smith, JD, MD, BA, a radiologist and partner at Hogan & Hartson in Washington, DC, who assists medical device companies with FDA regulations, is certain about one thing regarding computer-aided detection (CAD) systems: The FDA is watching closely.

“My crystal ball with the FDA is broken and has been for years,” says Smith. “But I would suspect what the FDA is going to do is increase, to some extent, its data requirements, and it’s particularly interested in the impact CAD has on clinical practices. The FDA takes its public health and safety role very seriously, and you can see why they’re concerned.”

Media scrutiny

Several articles and editorials that spoke unfavorably about CAD’s safety and financial implications for radiology facilities drew the FDA’s attention.

One of them—an article written by Joshua J. Fenton, MD, MPH, from the University of California, Davis in Sacramento, CA, and colleagues—sparked controversy about CAD.

CAD, approved for use by the FDA in 1998 and used at more than 30% of healthcare facilities, is used primarily to analyze digital mammograms and target questionable areas for the radiologist. Fenton and the other writers produced a survey, taken over four years and involving 429,000 mammograms and 2,351 cases of cancer at 43 facilities, that found the CAD technology did not help increase cancer detection.

It also leads, Fenton found, to more callbacks because of false-positive findings. That means more money out of the pockets of radiology facilities, which must account for additional fees and payments for diagnostic evaluations.

The implementation of CAD increased the sensitivity of cancer detection from 80.4% to 84%, Smith says. However, the rate of biopsy detection increased by 19.7%, which was statistically significant.

“As for the value of CAD, I’m on the fence,” says **Leonard Berlin, MD, FACR**, immediate past president of the Illinois Radiological Society and professor of radiology at Rush University Medical College in Skokie. “It helps occasionally, but my perception is that it is not of

> *continued on p. 8*

Controversial device

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great value to most mammographers. Of course, we have to realize that the technology is still advancing, so perhaps CAD's usefulness will increase in the future."

Smith agrees that CAD's a technological area that's evolving.

"Certainly the technology's gotten better," he says. "The software is more sophisticated, and there's more computing [involved]. Mammographies and x-rays to the chest, in many instances, now go directly to digital sources."

FDA intervention

The FDA reviews CAD devices prior to their marketing in the United States and must either clear or approve the CAD device in order for the product to be legally marketed under the Federal Food, Drug, and Cosmetic Act, Smith says.

"Manufacturing facilities for devices that are approved for market under the premarket approval pathway must be inspected prior to that approval," Smith says. "Following approval or clearance, the manufacturing of CAD devices is subject to the agency's Quality System Regulation in a process that involves regular inspections of manufacturing facilities."

The FDA staff that reviews CAD has seen a high turnover, Smith adds, making it unclear what the final results will be.

"With these new folks, it's hard to compare the new reviewers to the old reviewers," Smith says. "There are folks with different technological backgrounds, and all of this is combining to increase scrutiny."

Smith says the FDA's inquiries into CAD will not have an immediate effect on practicing radiologists. But it could eventually slow down the process of delivering CAD machines from the developer to the clinician, he says.


"Right now, it's kind of a bunker-to-bunker approach," Smith explains. "The FDA questions things on an individual basis. One gets the feeling [the] FDA is re-evaluating its whole approach to CAD, and it may put in a more formal policy . . . for looking at this technology. It's possible [it] may have to form an advisory committee of experts."

As for the benefits of CAD, Smith says, "It's the sanity check when you're going through stacks and stacks of film. That's where it's made the most difference. Many radiologists do rely on CAD because they just want to make sure." ■

Insider sources

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