Radiology Administrator's
Compliance & Reimbursement Insider

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Changes to CPT codes will require more documentation for ultrasounds

The new 2005 CPT® codes are out and there are a number of changes that will affect radiology. This month **RACRI** will focus on changes to the ultrasound codes, which will likely require your organization to provide additional documentation and training.

The 2005 edition of CPT includes new definitions for complete and limited retroperitoneal, pelvic, and abdominal ultrasound exams, says **Jackie Miller, RHIA, CPC.** This means radiologists now need to detail specific structures in order to bill for a complete exam.

In the past, CPT did not provide detailed definitions of a complete ultrasound exam, says Miller. This led to third-party payers instituting their own definitions of "complete" and "limited" exams. For example, different Medicare carriers used different definitions of complete abdominal and retroperitoneal exams.

Although the CPT changes likely will mean more work for radiologists initially due to additional documentation requirements, it may be a timesaver for your organization in the long run because having clearer definitions likely will result in fewer denials, says Miller.

Ensuring compliance

To ensure this new documentation requirement is met, you must ensure proper training. Your organization might also want to develop tools (e.g., checklists) to help radiologists comply (See sample checklist on p. 3). Checklists should include a list of structures needed to bill for a complete exam and can be used as a guide during dictation, says Miller.

A prebilling review of complete ultrasound exams might also be a wise step to take, says Miller, particularly during the first quarter of 2005, when radiologists will still be getting acquainted with the new criteria. If reports are incomplete, they can be sent back to the radiologist for addenda.

Miller advises radiology groups to work closely with their billing agents on this issue. The billing company should provide the radiologists with feedback as to how many of each radiologist's complete ultrasound exams are being down-coded to limited exams due to lack of documentation. With this feedback, the group can provide assistance (for example, additional training) to physicians who are having difficulty meeting the new criteria. ■

Insider source:

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Ultrasound documentation checklist

The report of a complete exam must include a description of each required structure OR an explanation as to why the structure was not visualized. If all required structures are not commented upon, the service must be billed as a limited exam.

Complete abdominal ultrasound (76700)		
Structure	**Described**	**Unable to visualize**
Liver		
Gallbladder		
Common bile duct		
Pancreas		
Spleen		
Right and left kidneys		
Upper abdominal aorta		
Inferior vena cava		
Demonstrated abnormalities (if any)		

Complete retroperitoneal ultrasound (76770)		
Structure	**Described**	**Unable to visualize**
Right and left kidneys		
Abdominal aorta		
Common iliac artery origins		
Inferior vena cava		
Demonstrated abnormalities (if any)		
Alternative definition for complete retroperitoneal exam in patients with urinary tract disorders:		
Right and left kidneys		
Urinary bladder		

Complete non-OB pelvic ultrasound (76856)		
Structure	**Described/ measured**	**Unable to visualize**
Uterus		
Adnexal structures		
Endometrium		
Bladder (when applicable)		
Demonstrated abnormalities (if any)		

Insider source:

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Technologist Training

Correct Coding: Modifier usage is a key component

Modifiers are listed in an appendix to the CPT (Current Procedural Terminology) book and are a small portion of the test for certified coders. Yet, they are an essential part of accurate coding.

They ensure that the coder or claim creator has accurately explained any extenuating or unique circumstances of the procedure or code usage. Without them, the claim is often rejected.

Because claims only have codes to represent what occurred during a 14-day hospital stay or during a 5-hour vascular procedure, codes and their modifiers must be as detailed as possible. Missing or incorrect usage of modifiers is the most common reason that claims are rejected by payers.

TIP: Often, coders extract code and modifier usage directly from an operative note rather than from a chargesheet or encounter form. This has been proven to lead to greater accuracy.

Background

The Healthcare Common Procedure Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT-4, a numeric coding system maintained by the AMA.

The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or modification of CPT-4 codes are made by the AMA.

The CPT-4 codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT-4 codes, does not include codes needed to report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the level II HCPCS codes were established for submitting claims for these items.

The development and use of level II of the HCPCS began in the 1980's. Level II codes are also referred to as alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT-4 codes are identified using 5 numeric digits.

Correct Coding

Correct coding should include a review of the following: (1) HCPCS (CPT Level I or Level II) choice; (2) modifier choice; (3) verification of bundling (code should not be reported because it is included in another code); and (4) review of supporting diagnosis code usage (does the diagnosis support the medical necessity of the procedure).

Importance of modifiers

Modifiers are two-digit numeric modifiers reported in the CPT manual. They are

- used in certain situations to describe a modification
- used to indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code
- used to identify a service or procedure has either a professional or a technical component
- used to identify a service or procedure was provided more than once
- used to identify a service or procedure has been increased or reduced
- used to identify only part of a service was performed
- used to identify a bilateral procedure was performed

Some modifiers affect reimbursement and others are for documentation purposes. ■

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ADMINISTRATIVE SERVICES AGREEMENTS (continued from p. <None>)

Modifier Application Chart: By Area

MODIFIER	E&M	MEDICINE	SURGERY	RADIOLOGY	LAB
21 (prolong E/M)	A	NA	NA	NA	NA
22 (extensive)	A	A	A	A	NA
25 (separate)	A	NA	NA	NA	NA
27 (multiple)	A	NA	NA	NA	NA
50 (bilateral)	NA	A	A	A	NA
51 (secondary)	NA	NA	NA	NA	NA
52 (reduced)	NA	A	A	A	NA
53 (discontinued)	NA	NA	NA	NA	NA
58 (staged)	NA	A	A	NA	NA
59 (distinct)	NA	A	A	A	NA
73 (discontinued)	NA	A	A	A	NA
74 (discontinued)	NA	A	A	A	NA
76 (repeat)	NA	A	A	A	NA
77 (repeat)	NA	A	A	A	NA
78 (return to or)	NA	A	A	NA	NA
79 (unrelated)	NA	A	A	A	NA
91 (repeat lab)	NA	NA	NA	NA	A
99 (multiple)	NA	A	A	A	NA
E1-F9 (lt/rt hand)	NA	NA	A	A	NA
GH (dx mammo)	NA	NA	NA	A	NA
LC/LD (lt coronary)	NA	A	NA	NA	NA
LT/RT (left/right)	NA	A	A	A	NA
RC (rt coronary)	NA	A	NA	NA	NA

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Auditing Tips

Cut claim denials by having compliance officer review denied claims

No radiology administrator likes denied claims. After all, each denial represents a financial loss to your facility.

While some denials may result from nothing more than technical errors in your billing procedures, others may indicate bigger problems at your facility, such as a failure of your coding and billing mechanisms or a problem in your compliance or auditing programs.

The bigger the problem, the bigger the financial loss your facility is likely to suffer. To help prevent such losses, consider having a sample of your denied claims routed to your facility's compliance officer on a regular basis.

If you don't already do so, you may be missing out on one of the most valuable compliance and teaching tools available. By having your compliance officer take a hard look at denied claims, you may avoid future mistakes and future losses of hard earned revenue.

Benefits of denied claim review

Having your compliance officer regularly review a sample of denied claims offers two big benefits. First, reviewing denied claims can help the compliance officer determine the extent of any billing problem. Claim denials may highlight not only an incorrect practice or procedure in your facility's coding or billing operations, but a deeper problem, such as a gap in your compliance or auditing programs or inadequate enforcement of existing rules.

This review may prompt your compliance officer to contact your auditor or legal counsel to see if a more formal investigation is required. Your compliance officer is in the best position to make these decisions.

The second benefit to having your compliance officer review a sample of denied claims is more practical. He or she can use the denials as a teaching tool.

Showing real-life claims to individual employees or an entire department can educate them about the errors they're making and how to avoid them.

One group that could particularly benefit from being shown denied claims is your billing and coding personnel.

If a claim is denied because of incorrect coding or billing procedures, your compliance officer (or the appropriate manager or supervisor) can sit down with the employees responsible for the error and review the claims. Then he or she can use your facility's coding policies and procedures and other resources, such as coding manuals, to show those employees how the claims should have been coded. Although it will cost you some time in the short run, it may mean fewer denials in the long run.

Schedule regular reviews

Your compliance officer's denied-claims review should be done on a regular basis, says compliance consultant Jennifer Small.

How often? Monthly or every two or three months, Small says. The frequency will depend on the facility's size.

Larger facilities might require more frequent reviews given the volume of claims involved.

The facility's size should also affect the size of the sample the compliance officer reviews. At larger facilities the officer should look at a larger sample of denied claims.

In addition, the compliance officer should examine a larger sample if an above-average number of claims are denied in a reporting period. "A particularly high number of denied claims could indicate a significant compliance problem," Small says. "Your compliance officer should then conduct a more thorough investigation." ■

Insider Source

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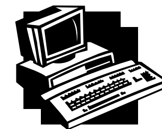

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Space Rental Agreement Between Radiologists and OB/G

Q We're a radiology practice with an office suite in the same building as a group of OB/GYNs. The OB/GYNs requested that we rent them our ultrasound suite two mornings a week for them to perform amniocentesis on their patients. That works for us, and the extra income would be welcome. Are there any legal impediments to an arrangement like this?

A There's nothing that would bar the arrangement, as long as your lease agreements and contracts meet certain requirements of Stark II, state laws, and CMS, says healthcare attorney **Matthew I. Kupferberg**. Here's what to look out for:

Stark II

Make sure your attorney is familiar with the new Stark II regulations so that he or she can draft lease agreements and contracts that fit within the Stark II exceptions for these types of arrangements. For example: You'll need a lease covering the office space the OB/GYNs want to rent. Stark II requires that any lease arrangement between physicians who may exchange referrals must be in writing, must be for fair market value (FMV), and must specify exactly what the arrangement covers.

• You'll need a similar lease for the ultrasound equipment the OB/GYNs will use. Have your attorney draw up an equipment lease that specifies exactly what equipment the OB/GYNs will be using and when.

Also, make sure you charge them FMV rent.

* Stark II also covers personal-services agreements, so if you'll be providing them with the services of your ultrasound technician as well, get that agreement in writing. Like Stark II's equipment rental and space rental exceptions, the personal services exception requires a written agreement for at least a one-year term, an explicit description of the services you'll provide, and an FMV payment for the services.

State laws

Have your attorney check whether there are any state laws or state licensing board rules about doing invasive procedures in medical offices. For instance, state law may require you to have certain equipment available that you may not have now if you normally don't perform invasive work. If that's the case, you can demand that the OB/GYNs supply that equipment when they're doing the procedure, Kupferberg remarks.

CMS physician supervision requirement

CMS's program memorandum on diagnostic tests requires personal physician supervision of most ultrasound-guided invasive procedures, including amniocentesis. CMS considers a procedure that isn't properly supervised medically unnecessary and won't reimburse it. Even though this isn't your problem—because you won't be billing for the procedures—you want to avoid the impression that you helped the OB/GYNs evade Medicare rules.

To protect yourself, Kupferberg says, your contract with the OB/GYNs should require them to bill for procedures performed in the space they rent from you. And the contract should require that one of the OB/GYNs be in the room with the patient whenever amniocentesis is performed. That way, if the OB/GYNs are ever investigated for billing improprieties, you can show that your relationship with them was on the up-and-up and that you attempted to ensure that Medicare rules were followed in your space. From a risk management perspective, the clause helps to establish that the OB/GYNs are the ones responsible for the patients who undergo amniocentesis in your office suite.

Insider Says: Run the lease agreements and contracts by your malpractice insurer to ensure you're covered and will be sufficiently protected if anything goes wrong during a procedure that the OB/GYNs perform in your office suite. If something does go wrong during a procedure, it's possible that your practice could be named in a malpractice suit. A patient's attorney, or even the OB/GYN's defense attorney, might try to say that the problem occurred because your equipment was faulty or improperly maintained. If your technician provides services to the OB/GYNs, your risk increases because your practice might be held responsible for your technician's mistakes. So your malpractice insurer may want you to include indemnification language in your contracts to make sure you'll be protected, Kupferberg adds. ■

Insider Source

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Don't Permit Techs to Administer Sedative

Don't let your radiology techs administer sedatives to patients. Some patients require a sedative before a certain procedure—like an interventional procedure. And some patients need a sedative before an MRI because they're claustrophobic. But even if the tech is qualified to perform the test or procedure that the patient is going to have, techs aren't trained or licensed to dispense or administer drugs. That's a job only for a physician—and in some states, a nurse practitioner or physician assistant, says radiology compliance expert Claudia Murray. Letting an unlicensed person prescribe or administer a sedative can endanger your facility's license to operate, Murray warns. Also, it can endanger the license of the radiologist who's supposed to be supervising tests at the facility. And it leaves the facility, the radiologist, and the tech vulnerable to malpractice suits, she adds. Plus Medicare and other payers can refuse to pay for a test if the rules aren't followed, she notes.

Insider Says: Check with your state's licensing board to find out which medical professionals can prescribe and administer sedatives in your state, Murray advises. ■

Insider Source

Claudia Murray: Provider Practice Analysis **LLC,** 2612 Greene Rd., Ste. 201, Baldwin, MD 21013.

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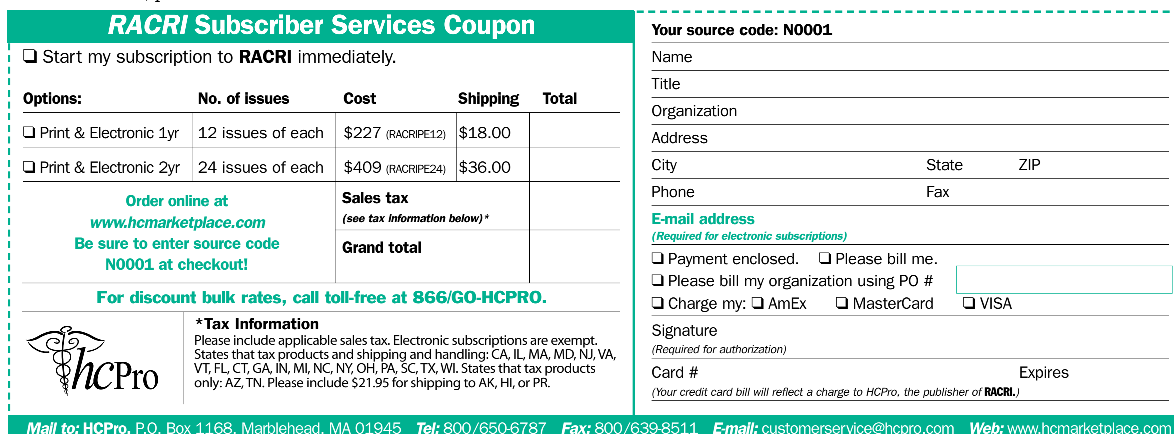

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