

Radiology Administrator's

Compliance & Reimbursement Insider

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IN FUTURE ISSUES

- Take steps to avoid compliance problems when you perform IMEs

RTs play a critical role in the revenue cycle

In the initial phases of a patient's encounter at a facility, radiologic technologists (RT) must collect accurate information and question any discrepancies. Their diligence at this stage—on the frontlines of patient care—aids your facility in getting reimbursed properly for studies and complying with regulations such as Medicare. One mistake could cost the facility thousands of dollars.

RTs are often the only clinical individuals with whom a patient comes into contact during outpatient diagnostic testing. For this reason, RTs are key players in ensuring compliance regarding documentation and coding.

Because RTs possess clinical knowledge and insight that clerical personnel do not, it is their responsibility to document patient information with appropriate medical terminology and to question whether a specific diagnostic test is clinically appropriate or medically necessary based on a patient's history.

RTs' clinical knowledge and understanding of testing protocols allows them to raise questions regarding these matters and communicate effectively with physicians.

Obtain the patient's history

Obtaining and documenting the patient's history is important for diagnostic tests performed on an outpatient basis—particularly when ordering physicians have not provided a reason for the tests and you cannot reach them for additional information.

Therefore, before performing a diagnostic exam, RTs must take the following steps:

1. Query the patient about any symptoms he or she is currently experiencing; in other words, find out why the patient is having the test and ask about any past or chronic health conditions that may affect the exam
2. Ask whether the patient has had any adverse reactions to contrast materials during past exams

Handle diagnostic test orders

The treating/referring physician must order all diagnostic tests. According to CMS, any of the following may constitute an order:

- A written document signed by the treating/referring physician and hand-delivered, mailed, or faxed to the testing facility
- A telephone call from the treating/referring physician or

(continued on p. 2)

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RTs (continued from p. 1)

his or her office to the testing facility when both parties document both the phone call and the required information in their respective patient records

- An e-mail from the treating/referring physician or his or her office to the testing facility

When referring physicians do not provide diagnostic information that documents the reason for the test, the RT should ask the patient why his or her physician ordered the test or check the patient's medical record. If the RT takes information directly from the patient, he or she must make a concerted effort to verify it by contacting the referring physician.

Test ordering requirements

Technologists should also understand the following before completing a diagnostic study:

1. All diagnostic tests—including x-ray, diagnostic laboratory, and others—must be ordered by a physician who treats the patient—that is, a physician who furnishes a consultation or treats a beneficiary for a specific medical problem and uses the results when managing that problem. The *Code of Federal Regulations* (42 CFR 410.32) specifies this requirement. Tests not ordered by a physician treating the patient are not reasonable and necessary.

Note: If you work in an independent diagnostic testing facility (IDTF), the ordering physician must order all exams in writing. There are two exceptions to this rule. First, you do not need to have orders for screening mammograms signed, and second, some states allow allied health practitioners to sign orders for certain referrals. Check your state's requirements.

2. Ordering physicians must provide diagnostic information to the testing entity at the time the physician orders the test. However, physicians are not required to include actual diagnosis codes on referral slips or requests for radiological or other diagnostic tests. The RT should ensure that these referral slips or requests include a narrative description that notes the reason for the test.

3. Medicare requires all providers to report information about a patient's diagnosis when seeking payment. This information helps the government-contracted fiscal intermediary (FI) or carrier determine whether the ordered services were medically necessary. RTs play a pivotal role in medical necessity checks and balances.

In most cases, the Medicare FI or carrier makes a medical necessity determination based on the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) code that your facility assigns to signs, symptoms, or definitive diagnoses. This information often comes directly from the order for the test or service—and a valid order must contain a diagnosis, signs, or symptoms.

Test ordering requirements are more stringent for physician offices, imaging centers, and IDTFs than for hospitals. The rules in the following section do not pertain to hospital inpatients or outpatients.

Rules for modifying diagnostic test orders

A testing facility that furnishes a diagnostic test ordered by the treating

physician or practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy prevents testing facilities from routinely applying protocols that require performance of sequential tests. An order may conditionally request an additional diagnostic test only if

- the result of the initial diagnostic test ordered yields a certain value determined by the treating physician/practitioner. For example, ordering physicians may state the following on their order: "Mammogram followed by an ultrasound if indicated."
- you receive a test order and aren't sure whether the exam requested is clinically appropriate, do not modify the test without first consulting the referring physician.

Whether you or the radiologist determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal—and that a different diagnostic test should be performed—you may not perform the unordered test until your office receives a new order from the treating physician/practitioner.

For example, if you believe that a magnetic resonance imaging (MRI) text should be performed instead of the CT scan the physician ordered

because of the patient's clinical indication, talk to the radiologist and do not perform either test until the new order arrives.

Similarly, if the result of an ordered diagnostic test is normal and the radiologist believes that another diagnostic test should be performed, the RT should wait for an order from the treating physician before performing the unordered diagnostic test.

For example, if a renal sonogram was normal, but based on the clinical indication, the radiologist believes a MRI will reveal the diagnosis, the RT should follow the protocol above and wait for a new order before performing an MRI.

Unreachable physicians—how to proceed

If you cannot reach the ordering physician/practitioner to change an order or obtain a new one—and RTs document this attempt in the patient's medical record—then the RT may conduct the additional diagnostic test if all of the following occur:

- The testing center performs the diagnostic test ordered by the treating physician/practitioner
- The radiologist at your testing center determines and documents that because of the abnormal result of the diagnostic test per-

formed, an additional diagnostic test is medically necessary


- Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary
- You communicate the result of the test to the treating physician/practitioner, who uses it in the treatment of the beneficiary
- The radiologist at your testing center records in his or her report the reason for additional testing

Common situations you may encounter in which physicians may not be available include when

- the last cut of an abdominal CT scan with contrast shows a mass requiring a pelvic CT scan to further delineate the mass
- a bone scan reveals a lesion on the femur, requiring plain films to make a diagnosis

Follow the protocol above for these cases when you cannot reach the ordering/treating physician. ■

Editor's note: This story is an excerpt from HCPro's new book, Radiology Technologist's Coding Compliance Training Handbook, written by RACRI advisory board member Stacie Buck, RHIA, LHRM. To order a copy, call our Customer Service Department at 800/650-6787 or go to www.hcmarketplace.com.

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MEDICARE UPDATES

Stent and PTA placements: Code them correctly

Having trouble coding for stents and percutaneous transluminal angioplasty (PTA) together in your facility? **Susan Garrison, CPC, CHC, CCS-P, CPC-H, CPAR**, vice president of Healthcare Consulting Services with Magnus Confidential in Atlanta, offers the following guidelines to help you code this challenging area of interventional radiology. We then follow up with a case study that puts these guidelines into practice.

Stent guidelines

Stent placement includes angiography for guidance and documentation, so do not code this procedure separately.

Only true diagnostic angiographies where it is not previously known whether the patients need a stent are captured in addition to the stenting, says Garrison.

Code catheter placement in addition to the stent placement. "But don't code catheter placement twice, unless there is an additional puncture site," Garrison says.

If the stent is performed through an existing access,

- code diagnostic angiography even if it takes place on the same date. But do not code follow-up angiography.
- code stents for each vessel separately treated. Code multiple lesions in a single vessel only once.
- do not code inflation of a positioning balloon during stenting as balloon angioplasty. The only time you can code a stent and PTA of the same vessel is when "the angioplasty, if performed at the same time as a stent, was for therapeutic reasons and fails or doesn't give the level of flow

necessary and the physician decides intraprocedure to insert a stent," says Garrison.

- use radiology supervision and interpretation codes with both open and percutaneous stent codes.
- do not separately code angioplasty performed as a method of stent deployment.

Conditions for coding stents, PTAs together

Code both stents and PTAs if you meet one or more of the following conditions:

- One fails and the other is used to treat the patient
- If different treatment is provided for different sites (*note*: You can still code both if they are adjacent, provided the second site is documented as a different lesion)
- If a stent complication is repaired via balloon

"At least one of those has to be documented in the operative report," Garrison says.

"Let's say the intent of the physician when he or she starts the procedure is the angioplasty, but it does not succeed, and the physician takes a second reading and decides to place a stent," she explains. "If one fails and the other is used as treatment, you can code both and receive separate payment."

Case study: Stent and PTA placement

Indication: Stenosis brachiocephalic artery

Title: Arch aortogram, right brachiocephalic arteriogram, angioplasty, and stent right brachiocephalic

Details: The radiologist informed the patient of risks associated with the

procedure, including stroke, and he or she agreed to the procedure. The patient's right groin underwent sterile preparation and was draped in the usual fashion.

A 4Fr vascular sheath was inserted, via retrograde right femoral arterial approach. A 5Fr pigtail catheter was then advanced into the ascending aorta. The radiologist performed an arch aortogram in the left anterior oblique projection. A high-grade stenosis was demonstrated on the arch aortogram at the origin of the right brachiocephalic artery. A Simmons II catheter was inserted, and the catheter was reformed in the ascending aorta.

The radiologist selectively catheterized the right brachiocephalic, advanced asupracore guide into the right subclavian artery, and positioned the catheter within the subclavian artery. The radiologist advanced the guide wire into the axillary artery. He or she removed the catheter and advanced a 7Fr shuttle sheath to the origin of the right brachiocephalic artery. He or she then inserted a 8 mm x 2 cm-long angioplasty balloon. The patient received 3,000 units of heparin intravenously. Then the radiologist balloon-dilated the area of stenosis.

A repeat arteriogram demonstrated marked residual stenosis. The radiologist inserted a 12 mm x 30 mm-long Luminex stent and deployed it in the usual fashion across the area of stenosis. Then he or she inserted a 10 mm x 2 cm-long angioplasty balloon and the stent was further balloon-dilated to 10 mm in diameter.

A subsequent repeat arteriogram demonstrated good angiographic result with no significant residual stenosis identified. The radiologist removed the catheter and sheath and obtained hemostasis with a Perclose

suture device.

Impression: High-grade stenosis origin of the right greater cephalic artery. This was successfully angioplasted and stented to 10 mm in diameter as described above.

Coding the case study

Following are the codes that warrant assignment in the above case study and the lines from the documentation that support their use:

- **75650** (“5Fr pigtail catheter was advanced into the ascending aorta. Arch aortogram was then performed”)
- **36216-RT** (“right brachiocephalic artery was selectively catheterized”)
- **35475, 75962** (“8 mm x 2 cm-long angioplasty balloon was then

inserted . . . the area of stenosis was then balloon-dilated”)

- **37205, 75960** (“A 12 mm x 30 mm-long Luminex stent was then inserted and deployed in the usual fashion across the area of stenosis”)

Documentation do's and don'ts

Although the Simmons II catheter was reformed in the ascending aorta, you cannot code for it because it's incidental to the procedure. Also, you cannot code for the Supracore guide wire. “However, the catheter positioned within the subclavian artery gives us that level of selectivity,” Garrison says, and thus is an important piece of documentation to watch for.

A key missing piece to the docu-

mentation is the line that reads, “A repeat arteriogram was obtained demonstrating marked residual stenosis.” The physician must document how much stenosis remains, Garrison says.

“The guideline is that 30% must remain before we can capture it with a code,” she says. This percentage determines whether you can report codes 37205 and 75960.

Finally, do not code the 10 mm x 2 cm-long angioplasty balloon because it was inserted to assist in the placement of the stent. ■

Editor's note: The above article was adapted from the June 22 HCPro audioconference, “Interventional Radiology Coding: Solutions to Your Top Challenges.” To order, go to www.hcmarketplace.com/Prod.cfm?id=3393, or call customer service at 877/727-1728.

ASK THE INSIDER

Q: I know a dentist in private practice who treats multiple types of patients and frequently treats patients with dementia and disabilities. Taking x-rays of these patients is extremely difficult, if not impossible. When these patients require dental x-rays, he stands in the room with the patient. He doesn't wear a radiation badge and sometimes doesn't even wear a lead safety vest. How much danger is he putting himself in if he doesn't take x-rays of these patients very often? I know that any unnecessary exposure should be avoided, particularly in light of the recent study, reported in the August *RACRI*, which showed even exposure to small doses of radiation can increase the lifetime risk of cancer.

A: The likelihood of anyone developing cancer from dental x-rays is as close to zero as one can get. First, the strength of x-rays used in dental work is minimal. Second, the x-rays are aimed at the patient's teeth. It is true that there is “scatter,” which means that a tiny bit of radiation spills over to the immediate area, but this is minimal. Furthermore, the power of the x-ray drops with the square of the distance (e.g., the power at two ft. away is one-quarter [not one-half] of the power at one ft. The long and short of it is that there is no reason to worry about the dentist or any other bystander getting cancer from being near people who are x-rayed for dental purposes).

That being said, let me say that we live in a world today where “minimal” and “close to zero” may not convince some people. Who is able to prove that there isn't one chance in a million that the dentist won't get cancer? Some people may think no one can. Most people have the perception they can get cancer from dental x-rays, despite my explanation above. Therefore, it would be advisable for the dentist to have a lead shield (in the form of a lead apron) not only for the patients and any bystander who may be adjacent to the dental chair, but even for himself. Even though I do not believe he is at any risk, I suggest that he might want to set an example of appearing careful and prudent not only to his patients, but to his employees as well. ■

Insider sources

Leonard Berlin, MD, chair, radiology department and professor of radiology at Rush Medical College, Chicago

Melody Mulaik, MSHS, CPC; CPC-H, RCC, Coding Strategies Inc., Powder Springs, GA.

Understanding the new codes for cardiac CT

By Jackie Miller, RHIA, CPC

The American Medical Association (AMA) has released new Category III CPT® codes for CT and CT angiography (CTA) studies of the heart and coronary arteries.

Note: Category III codes are used to report new technology services that do not yet meet the criteria for inclusion in the main body of CPT.

Although these codes were released July 1, they do not take effect until January 1, 2006. Until that time, current coding guidelines remain in effect.

Code	Description
0144T	CT, heart, without contrast material, including image post processing and quantitative evaluation of coronary calcium. Do not report 0144T in conjunction with 0145T-0151T.
0145T	CT, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology. For cardiac structure and morphology in congenital heart disease, use 0150T.
0146T	CT angiography (CTA) of coronary arteries (including native and anomalous coronary arteries and coronary bypass grafts), without quantitative evaluation of coronary calcium.
0147T	CTA of coronary arteries (including native and anomalous coronary arteries and coronary bypass grafts), with quantitative evaluation of coronary calcium. Do not report 0147T in conjunction with 0144T.
0148T	Cardiac structure and morphology and computed tomographic angiography of coronary arteries, including native and anomalous coronary arteries, coronary bypass grafts, without quantitative evaluation of coronary calcium.
0149T	Cardiac structure and morphology and computed tomographic angiography of coronary arteries, including native and anomalous coronary arteries, coronary bypass grafts, with quantitative evaluation of coronary calcium. Do not report 0149T in conjunction with 0144T.
0150T	Cardiac structure and morphology in congenital heart disease.
+0151T	CT, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; function evaluation, left and right ventricular function, ejection fraction and segmental wall motion. (List separately in addition to code for primary procedure). Use 0151T in conjunction with 0145T-0150T.

Read about the new codes in the table below or find them on the AMA Web site at www.ama-assn.org/ama/pub/category/3885.htm/#schedule3.

How to use the new codes

At this time, coding guidelines have not yet been issued. However, based on the code definitions, the new codes are anticipated to be used as follows.

Code 0144T will be reported for CT/CTA of the heart **without** contrast. All of the other new codes (0145T–0151T) are for CT/CTA **without and with** contrast. The without-contrast exam (0144T) also includes calcium scoring.

For the exams performed with or without contrast

Report 0150T for evaluation of **heart structure and morphology** in patients with congenital heart disease. When this exam is performed in patients without congenital heart disease, report 0145T.

Report 0146T for evaluation of the **coronary arteries** without calcium scoring. For evaluation of the coronary arteries with calcium scoring, report 0147T.

Report 0148T for evaluation of **heart structure, morphology, and coronary arteries**. If the exam includes calcium scoring, report 0149T instead of 0148T.

Finally, if heart function evaluations such as ejection fraction and wall motion are performed in conjunction with any of the exams described by codes 0145T–0150T, code 0151T should be reported as an add-on code.

Current coding for heart CT

The new codes are a result of ongoing controversy over the proper coding for these services. Providers and their

Questions? Comments? Ideas?

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billing personnel have had to deal with conflicting and changing advice from payers and professional societies regarding proper code assignment for cardiac CT, coronary CTA, and CT calcium scoring.

The American College of Radiology (ACR) announced earlier this year that coronary CTA should be reported using the unlisted CT code (76497). These studies were previously reported as CTA of the chest (71275). The ACR now recommends that the chest CTA code be reserved for noncardiac studies (e.g., exams performed for pulmonary embolism or aortic dissection).

Cardiac calcium scoring involves quantitative evaluation of the amount of calcium in the patient's coronary arteries. This procedure is often performed for screening purposes on asymptomatic patients. The ACR recommends reporting calcium scoring with the unlisted CT code (76497).

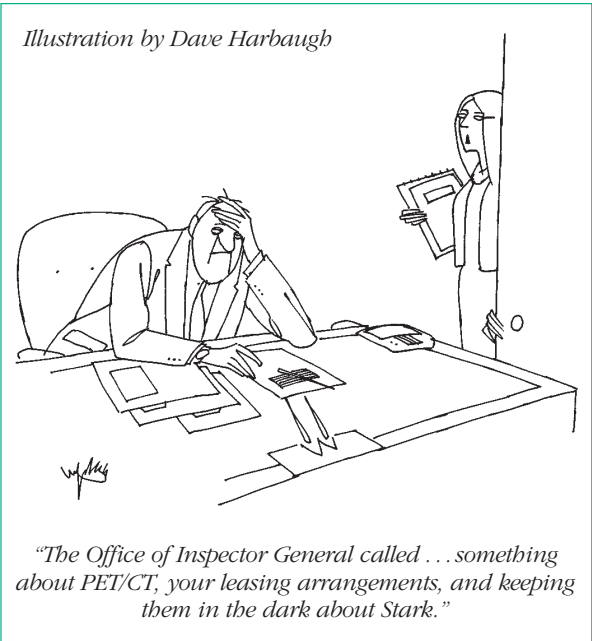
Other changes

In addition to the cardiac CT codes, there are several other new Category III codes of interest to the radiology community.

Use new code +0152T to report computer-aided detection for chest x-rays (e.g., two-view chest, 71020). Use new codes 0153T and 0154T for services involving aortic pressure sensors inserted at the time of endovascular repair. ■

Insider source

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INSIDER BRIEFS

SPECT effective in evaluating stem cell therapy in ischemic, coronary disease

Researchers from Seoul National University have found that single photon emission computed tomography (SPECT) is useful in evaluating stem cell therapy with ischemic or coronary heart disease, according to *Health Insurance Law Weekly*.

"Due to its noninvasiveness and convenience, peripheral stem cell therapy will be widely used in patients with ischemic heart disease," researcher Dong Soo Lee said according to *Health Insurance Law Weekly*.

"Gated myocardial SPECT will help evaluate treatment effect and suggest the underlying mechanism whereby the damaged heart muscles improve after stem cell infusion," Lee said.

Study: CT best to diagnose intracardiac tumors and thrombi

Researchers at Brigham and Women's Hospital in Boston say that although cardiac tumors are rare, they are challenging to diagnose. CT can be a useful diagnostic tool, according to *Managed Care Law Weekly*.

"New noninvasive CT and magnetic resonance imaging exams are changing the diagnostic approach. Echocardiography and angiography with or without coronary arteriography remain routine methods for evaluating cardiac neoplasms. However, CT provides additional diagnostic information and is regarded as essential for adequate staging and treatment planning, particularly when surgical resection is being considered," researchers said, reported *Managed Care Law Weekly*. ■

Tips to ease patient anxiety at your facility

Many patients experience anxiety when they come in for a diagnostic exam, but not all of them seem anxious. Some patients act angry and derisive. Others are overly chatty or appear absentminded or forgetful.

Patients often adopt these behaviors to cover up their anxiety about the exam, and if these behaviors aren't recognized for what they are, it can make for an unpleasant experience for all involved, says **Shirley Long, BApp SC, RTR, CBI**, mammography consultant and educator, and author of *The Handbook of Mammography*.

Often when a patient comes in for an imaging procedure, he or she has already set in his or her mind what is going to occur.

The patient anticipates an unfamiliar examination process, discomfort and uneasiness during the examination itself, and the anticipation of an unknown result with the very real potential for the loss of well-being," Long writes in her book.

Spotting anxious patients

Although radiologic technologists (RT) perform many exams each day, they should remember that the patient may only have one a year or that this may be his or her first exam ever, says **Joan Cesari, PhD**, a staff educator at Orange Regional Medical Center.

It's up to technologists to detect this anxiety and address it to help the patient get through the experience. Detecting anxiety can be tricky, but look for the following signs, Long says:

- Avoidance of eye contact
- Arms crossed across the chest
- Fidgeting with purse, tissues, or clothing
- Perspiring noticeably
- Shortness or holding of breath
- Talking excessively
- Not talking at all

- Blocking behavior, in which the patient does not seem to be taking in any information
- Nervous laughter
- Repeating questions
- Asking for reassurance that he or she is doing things correctly
- A "let's get this over with" message

Some people will also try to control the exam if they are anxious by demanding to speak to the physician or the RT's supervisor, for example, says Cesari.

It's important for the technologist not to take the patients' reactions personally. "They represent coping mechanisms that the patient is using in order to personally manage the experience of the examination at hand," Long says.

Understanding these reactions is the first step in responding to them, says Cesari. If you know the person is nervous, it will be easier to respond than if you take his or her emotions at face value and react on that level.

Soothing frazzled nerves

Once you've noted a patient's anxiety, take the following steps to help make the experience easier, which should also make the exam go more smoothly, she says:

- Acknowledge your patient's feelings. Don't just ignore his or her emotions and continue with the exam.
- Avoid jargon. Use terms that the patient will understand, which can help ease the process.
- Educate the patient. Help the patient through the process by letting him or her know what you are doing and why.
- Watch your tone of voice. When you repeat instructions all day long, it's easy to become monotonous.

If you sense that a patient is having

a difficult time with an exam, encourage him or her to breathe or to picture him or herself in a relaxing setting, Cesari says.

Following the four Cs

Long stresses the four Cs when it comes to reducing anxiety: competence, communication, comfort, and caring.

The following are steps you might take in each of these categories:

▪ Competence.

Technologists must come across to their patients as being experienced and confident in their skills. Demonstrate competence by displaying licenses, certificates, and educational degrees and by dressing professionally, says Long

▪ Communication.

Avoid personalizing and use broad terminology instead, says Long. For example, instead of saying, "You look scared," say, "Most patients are anxious about having a mammogram. Is there anything I can do to make you more comfortable today?" says Long.

▪ Comfort.

The facility's décor can make a strong impression on patients. Ensure that it is pleasing and comfortable to help put patients at ease.

▪ Caring.

It's possible to show patients that you care about them while maintaining appropriate professional boundaries.

For example, greet the patient with a two-handed handshake, which exudes warmth and caring. ■

Insider sources

Shirley Long, BApp SC, RTR, CBI, mammography consultant and educator, author of *The Handbook of Mammography*.

Joan Cesari, PhD, staff educator, Orange Regional Medical Center.