

Radiology Administrator's

Compliance & Reimbursement Insider

NOVEMBER 2005

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RFPs can keep your purchases on track and help you keep your job

Using a request for proposals (RFP) when making purchases or deciding on new services can reduce your susceptibility to smooth sales pitches, help you weed out unsuitable choices, and ultimately help you keep your job, said **Patricia Kroken, FACMPE, CRA**, during a presentation at the Radiology Business Managers Association's June conference in Las Vegas.

An administrator who makes a bad purchasing decision might saddle the department with equipment that slows productivity or creates headaches for the staff, and, as a consequence, he or she might end up in the unemployment line.

But using an RFP to guide purchasing or contracting decisions allows for more accurate comparisons between products and services, Kroken said. An RFP also provides a layer of protection for the administrator so if the final decision turns out to be the wrong one, he or she won't be the only one left holding the bag.

You can use an RFP to make a number of key purchasing or contracting decisions. Some appropriate uses include

- buying a practice management system
- buying a radiology information system or PACS system
- choosing a billing company
- choosing teleradiology services or purchasing-related equipment
- buying large-scale data storage
- purchasing medical equipment

Once you decide to use an RFP, include several pieces of information in the documents to receive the best proposals possible.

A profile of your practice

"Traditionally, radiology has had an adversarial relationship with vendors," said Kroken. "We don't want to tell them anything, but we want them to give us exactly what we need."

If you provide vague information about the needs of your practice, it will lead to vague price quotes and information about the system or service you are purchasing. For this reason, an accurate practice profile is a key component of your RFP. Kroken recommended including the following information in your profile:

- 1. The size of your practice.** Often, pricing is based on the number of physicians in a practice, said Kroken.

(continued on p. 2)

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Radiology Administrator's Compliance & Reimbursement Insider is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$227/year; back issues are available at \$25 each.

Postmaster: Send address changes to **Radiology Administrator's Compliance & Reimbursement Insider**, P.O. Box 1168, Marblehead, MA 01945

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RFPs

(continued from p. 1)

2. Your facility's sites of service and types. For example, are they hospital-based? How many of them have downloads? Make sure that whom ever you deal with has worked with organizations of similar sizes and types.

"A system can have a lot of user-friendly functionality, but if [the company hasn't] dealt with hospital downloads and the volume and issues associated with it, [it] can be overwhelmed," said Kroken.

3. Future growth expectations. Providing information about potential future growth is key, because whatever system or service you decide on has to be able to accommodate that growth.

Kroken suggests that you focus on growth trends from the past few years to make predictions about the future. Will you continue to grow at the same rate? Or will market factors make you grow faster or slower than in the past? Getting a grip on this information can help you to negotiate solid deals that will allow you to add on to the system in the future.

4. Managed care profile. Some systems will verify payment amounts to ensure that your organization isn't being shortchanged. Providing information about your payers can help vendors determine your needs.

5. Information about employees/system users. Include information about employees, such as how many there are and whether they work on- or off-site.

6. Details about other systems that you will need to integrate. For example, if you have a solid system for mammography reporting that you don't want to replace, you'll have to find out whether it is compatible with whatever new system you want to install.

7. Data storage requirements. Outline your current storage needs and anticipate what you might need in the future. Also look at issues related to how data is backed up and how it would be recovered if lost.

The vendor profile

In addition to providing information about your own facility, request information about the vendor. Kroken said that knowing the following information can give you a good snapshot of a vendor or service provider's qualifications:

- **The type of company—publicly traded or private.** "It's good to know whether a company is publicly traded because you can get more information about that company," said Kroken. For example, you can find out if the company is involved in any shareholder suits or if it is profitable.
- **Location of the company and its service center.** If you are a West Coast practice and the service center is on the East Coast and has service hours of 8 a.m. to 5 p.m., you might run into problems.
- **The company's radiology and imaging experience.** A company can develop a great system that has worked well in numerous settings, but if it has never been used in radiology, you might be taking a big risk.
- **Details about the system.** Ask where and when the current software version was developed. When were the most recent updates added and were they based on an older or newer platform? "Make sure a new face wasn't just plunked on an old system," said Kroken.

- **HIPAA and regulations compliance.** Ask whether the system complies with HIPAA and other applicable regulations. Does the organization have a compliance plan?
- **System audit features.** Examine what audit features the system has.
- **Disaster planning.** Find out what the company will offer in the event of a disaster. Can the vendor help replace hardware? Does it offer support plans? "What happens if something blows up?" said Kroken.
- **Company representation.** Who from the company will handle your case and what are his or her qualifications?

Developing selection criteria

Establishing selection criteria for your RFP will help your organization avoid being swayed by a smooth-talking salesperson, said Kroken. It gives you a concrete wish list that you can use to make objective comparisons.

The first step in developing these criteria is to focus on your needs versus your wants.

Ask these key questions:

- What features should the technology have?
- What requirements do you have regarding service?
- What problem are you trying to solve with this purchase or service? To determine this, Kroken draws a work flow diagram and looks for areas of process duplication.
- What improvements do you want to make to your organization?

Some examples of "must have" items you may want on your wish list include the following:

- Secured report delivery on a radiology information system
- Hospital downloads on a practice management system
- Experience in radiology, for consultants and billing companies
- Guaranteed "up" time on a PACS system

When it comes to these "must have" items, ask detailed questions. For example, if you are looking for a billing service, you might want it to use radiology-certified coders.

Kroken said she encountered one billing firm that said it had all radiology-certified coders, but further questioning

revealed that the coders weren't certified through an external organization, rather internally through their own process. "These are the kinds of details you want to have," she said.

After setting your selection criteria, develop a submission packet for the vendors. This should include a cover letter along with the following information:

- Project overview
- Proposal due dates
- Estimates on the dates that decisions will be made
- How many proposals to submit
- Whether the facility will accept electronic submissions
- That a price quote is required
- Practice profile
- Vendor profile
- Specifications for the technology or service

Once the responses come in, compare them and eliminate the unqualified candidates. Then schedule demonstrations with the finalists.

At this stage, include the people who will use the new equipment or service in the decision-making process, said Kroken. Those people should test the

equipment for usability and have input into the final purchasing decision.

Kroken gives an evaluation form to staff who test new products and asks them for a final recommendation on what to buy. Ultimately, the facility may go with a different option for cost reasons but either way, the input is critical.

Site visits are also a good idea. Don't let the vendor or service provider take you to a site that performs well but isn't similar to your organization. Ask to see a site that looks like your own. ■

Establishing selection criteria for your RFP will help your organization avoid getting swayed by a smooth-talking salesperson.

Insider source

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In the battle between digital and analog, digital comes out on top in certain groups of women

The results of the highly anticipated Digital Mammographic Imaging Screening Trial (DMIST) are in, and digital mammography outperformed film in detecting cancers in women under age 50 and women with dense breasts.

However, it wasn't all good news for digital equipment. "[Looking at the study population as a whole] there was no significant difference between digital and film," says **Etta Pisano, MD**, principal investigator for the trial. This means that for the majority of women in the screening age group, there is no particular advantage to receiving a digital mammogram.

However, researchers encouraged women under the age of 50 and women with dense breasts to seek out digital mammograms, and the mainstream press widely publicized that message. This may put more pressure on your facility to purchase digital equipment if it hasn't already.

Many facilities have considered going digital but were waiting for some hard data before making the leap. This trial may give them the validation they need to make the purchase, says Pisano.

Trial background

The American College of Radiology Imaging Network conducted the study, which was designed to compare the performance of digital to film mammography. Nearly 50,000 women participated in the trial and, as part of the protocol, underwent two screening mammograms—one digital and one film.

Breast cancer was confirmed by either a biopsy within 15 months after the subject entered the trial or by a follow-up mammogram at least 10 months after study entry, according to the authors.

The trial began in 2001 and manufacturers updated digital equipment throughout the course of the trial to ensure that the most state-of-the-art equipment was used, says Pisano.

The digital advantage

Although digital imaging provided superior cancer detection only to certain groups of patients (which included perimenopausal and premenopausal women), the researchers noted that the technology had other more universal advantages, such as

- easier access to images

- easier use of computer-assisted diagnosis
- improved transmission of images
- improved retrieval and storage of images
- lower average dose of radiation exposure for the patient while maintaining the same level of image quality

"In a digital image, the x-ray transmission can be manipulated to enhance visualization of subtle structural changes in tissue over the entire breast," the authors wrote in the study. "For mammograms, the most problematic areas are those in which cancers can be hidden by adjacent dense tissue owing to small differences in contrast between lesions and the fibroglandular background. The visibility of a subtle mass or cluster of calcifications present in the image can be increased if the image contrast is adjusted."

Although digital technology can detect some cancers that film misses, neither modality is able to detect all breast cancers. Therefore, it is also critical to evaluate any palpable finding detected after a negative screening mammogram, study authors wrote.

The digital disadvantage

However, despite the advantages of digital equipment, one main drawback exists—the cost. Digital systems typically cost about \$500,000. This is one-and-a-half to four times the cost of a film system, according to the study. (Pisano says the study authors plan to complete a cost-effectiveness analysis of digital mammography soon.)

Although reimbursement is also higher for digital procedures, some sites may not have enough volume to justify purchasing a system, says **Bonnie Rush, RT(R)(M)(QM)**. This is true even though digital systems can also increase productivity.

Pisano says that she hopes digital manufacturers will lower their prices in coming years. Mammography sites can help that process along by negotiating with manufacturers for price reductions, she says.

For sites that make the digital purchase now, she says it is critical for them to try the equipment before they buy. "Make sure it is comfortable," says Pisano. "You need to test it out."

Film is not obsolete

Although mammography seems to be going all digital, RTs should be certain to let the public know that film equipment is still a powerful cancer detection tool,

says Pisano.

It is critical that women don't decide to skip a mammogram if they don't have access to digital equipment, says Pisano, especially because many of them may not have access to digital equipment for some time. Currently, only 8% of mammography facilities have digital equipment and until prices come down, many more may be without it for years to come.

The study, called *Diagnostic Performance of Digital*

versus Film Mammography for Breast-Cancer Screening, will appear in the October 27 *New England Journal of Medicine* and is posted on the journal's Web site at www.nejm.org. ■

Insider sources

Etta Pisano, MD, principal investigator, DMIST.

Bonnie Rush, RT(R)(M)(QM), president of Breast Imaging Specialists, San Diego.

Fast facts about the DMIST trial

Name: Digital Mammographic Imaging Screening Trial

Conducted by: American College of Radiology Imaging Network

Purpose: To study the "small but potentially clinically important differences in diagnostic accuracy between digital and film mammography," wrote study authors.

Enrollment: 49,528 women

Average age of women: 54.6

Eligibility: Women who came in for a screening mammogram at the study sites were eligible to participate unless they

- had symptoms of breast cancer
- had breast implants
- thought they might be pregnant
- had a mammogram for any reason in the past 11 months
- had a history of breast cancer treated with a lumpectomy and radiation

Ethnic backgrounds of the women in the trial:

- White, 81.9%
- Hispanic or Latina, 4.1%
- Black or African American, 11%
- Native Hawaiian or other Pacific Islander, 0.1%
- Asian, 1.9%
- American Indian or Alaskan Native, 0.1%
- Other, 0.1%

Menopausal status of women in the trial:

- Premenopausal, 10.5%
- Perimenopausal, 8.7%
- Postmenopausal, 59.9%
- Unknown or data missing, 2.3%

Breast density of women in the trial:

- Almost entirely fat, 10.5%
- Scattered fibroglandular densities, 42.9%
- Heterogeneously dense, 38.7%
- Extremely dense, 7.5%
- Data missing, 0.4%

Study sites: 33 sites in the United States and Canada

The digital equipment used: Five different types of digital equipment were used in this trial. They included the following:

- SensoScan, Fischer Medical
- The Computed Radiography System for Mammography, Fuji Medical
- The Sensographe 2000D, General Electric Medical Systems
- The Digital Mammography System, Hologic
- Selenia Full Field Digital Mammography System, Hologic

The process: Women underwent both a digital and film mammogram in random order. Two radiologists independently interpreted the examinations for each woman. Readers rated the mammograms using the seven-point BI-RADS malignancy scale. Breast density was also recorded using the BI-RADS scale.

When a woman had a suspicious finding, she underwent a biopsy or aspiration of the suspicious-appearing lesion. All participants were asked to return for a follow-up mammogram after one year.

A participant was considered to be positive for cancer if the cancer was verified within 455 days of the initial study mammogram. A participant was considered to have a negative finding if tests on a pathology report were normal or if the follow-up mammogram at one year did not show any cancer.

Note: Because the length of time allowed for cancer detection, the sensitivities of both digital and film equipment appeared lower than sensitivities in other similar studies.

Cancers diagnosed: During the course of the trial, 335 cancers were diagnosed. Of these cancers

- 75.8% were diagnosed within 365 days of the study mammogram
- 81% were diagnosed within 455 days of the study mammography ■

Fourth quarter coding correct edits released

By Jackie Miller, RHIA, CPC

CMS has released version 11.3 of the National Correct Coding Initiative (NCCI) edits. These edits took effect October 1 for claims filed to Medicare carriers. Hospital claims will not be subject to the version 11.3 edits until January 1.

Diagnostic radiology edits

Reconstruction (76375) is now a component of all the diagnostic nuclear medicine studies listed in CPT with the exception of dual photon absorptiometry bone density exam (78351), which is not covered by Medicare. These edits can be overridden with a modifier, which would be appropriate if reconstruction of a tomographic exam (e.g., CT) were performed on the same day as a nuclear medicine study.

Subcutaneous or intramuscular injection (HCPCS code G0351) is also a component of most nuclear medicine studies under the new edits. The edit can be overridden with a modifier (e.g., if a patient receives an injection that is unrelated to the nuclear exam).

CT without contrast is now a component of PET (78811–78813) and PET-CT (78814–78816) tumor imaging studies. For example, CT of the brain (70450) is now a column two code for column one codes 78811–78816. CT with contrast and CT without and with contrast are not included in this batch of new edits. The edits can be overridden with a modifier, presumably if a diagnostic CT scan is performed on the same day as a PET or PET-CT study.

Limited area PET tumor imaging (78811) is now a

component of the skull base to mid-thigh exam (78812) and whole-body exam (78813). It is also a component of all the PET-CT exams (78814–78816). Similarly, skull base to mid-thigh PET (78812) is a component of whole-body PET (78813) and all of the PET-CT tumor imaging exams (78814–78816).

Whole-body PET (78813) is also a component of all the PET-CT codes. These edits *cannot* be overridden with a modifier.

Limited-area PET-CT (78814) is a component of the skull base to mid-thigh PET-CT exam (78815) as well as the whole-body PET-CT (78816). Skull base to mid thigh PET-CT is a component of whole body PET-CT (78816). These edits *cannot* be overridden with a modifier.

Interventional radiology

Subcutaneous or intramuscular injection (G0351) and IV push (G0353–G0354) are now components of various interventional radiology procedures, including

- endovascular repair of thoracic aneurysm (0033T–0037T)
- endovascular repair of abdominal aneurysm (0078T)
- vertebral stent placement (0075T)
- fine-needle aspiration (10022)
- venous and arterial catheter placements (36000–36247)

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- declotting of vascular access device (36550)

All of these edits can be overridden with a modifier.

Percutaneous transluminal angioplasty (PTA) (35458 and 35475) is now bundled into cervical carotid stent placement (37215–37216).

This edit makes sense because by definition, carotid artery stent placement includes PTA. The edit can be overridden with a modifier for PTA of other locations.

Various injection and infusion codes (including G0345, G0347, G0351, G0353, and G0354) are now components of bone marrow aspiration and biopsy (38220–38221), posterior fossa myelography (70010), and cisternography (70015). These edits can be overridden with a modifier.

Radiation oncology

Clinical brachytherapy services (77750–77790) now include various additional evaluation and management (E/M) services such as hospital discharge day management (99239) and neonatal intensive care (99298–99299).

CMS has deleted edits that bundled E/M services into stereotactic radiosurgery (code 61793). Also gone are edits that bundled actinotherapy (96900) and photochemotherapy (96910–96913) into radiation treatment delivery (77402–77416) and port films (77417).

CMS has also deleted edits that bundled confirmatory consultations and prolonged E/M services into simple interstitial radiation source application (77776). Additionally, photodynamic therapy (96567) no longer includes radiation treatment delivery (77401–77416) or port films (77417).

The modifier status has been changed from 0 (no modifier will override the edit) to 1 (modifier is allowed) on edits that bundle various E/M services into simple interstitial radiation source application (77776). Among the E/M services affected by this change are nursing facility assessments and subsequent nursing facility care. ■

Insider source

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NEWS YOU CAN USE

Assistance for those hit by Hurricane Katrina

Facilities that were in the path of Hurricane Katrina have suffered many losses, among them paperwork regarding the qualifications of employees.

On September 16, the FDA announced plans to provide temporary documentation to any employee at a facility that had its initial employee qualification records damaged. The FDA will provide a letter verifying the initial qualifications of the employee based on information from the facility's most recent inspection.

All Mammography Quality Standards Acts (MQSA) inspectors have been told to accept the letters from the FDA as adequate verification that the employee's initial qualifications were met at the time of the last MQSA inspection.

The letters may also be used for employment purposes, although personnel who use one must provide a copy of the state license or certificate at the next annual inspection.

To request a letter from the FDA, fax a request to 410/290-6351 or e-mail MQSAhotline@SSSI.net, attention: Hurricane Katrina.

Free book for best radiology report documentation

HCPPro, Inc., is currently developing a radiology billing/coding reference devoted to all modalities—sort of a one-stop-shopping guide. We are seeking “real life” radiology reports done by physicians—both the good and the bad—to use as case scenarios. We are looking for examples of any radiology procedures.

What's in it for you? If you share your reports, we will take out any identifying information, including the doctor's name/name of your organization. In exchange for your contribution, you will automatically receive a special discount on the reference once it's published and be acknowledged in the publication (if you choose). If you submit one of the top 10 reports as judged by our authors, you will receive a complimentary copy of the book and be acknowledged for your efforts.

If interested, please submit your reports privately—as many as you want—one of three ways: by e-mail to editor Bryan Cote at bcote@hcpro.com; by mail to HCPPro, 200 Hoods Lane, Marblehead, MA 01945; or by fax to 781/639-2982. Include your name and phone number with all submissions. If possible, please remove all demographic information before sending to ensure confidentiality. ■

ASK THE INSIDER

All your toughest coding questions answered

Q: Our interventional radiology department performs an angiogram in conjunction with aortography (peripheral or otherwise). Can we bill CPT code 93544 for the aortography in conjunction with the surgical and radiology CPT codes?

A: You can only use CPT code 93544 for a cardiac catheterization procedure because it is indented and the code description before the semicolon states "injection procedure during a cardiac catheterization procedure." The aortography performed during an angiogram (peripheral or otherwise) is included as part of the angiogram procedure, so do not code it separately.

Q: If you code from the final result on a radiology report, do you also code what is on the script? What if you use what is on the script for medical necessity but the final result is different and therefore does not pass medical necessity?

A: Medicare is explicit about correct diagnosis coding for outpatient services. The applicable CMS program memorandum is AB-01-144. It explains that you must code the final diagnosis on the radiology report. Refer to Section 10.1.1 in Chapter 23 of the *Medicare Claims Processing Manual*, item A.

If the physician confirms a diagnosis based on the diagnostic test results, the physician interpreting the test should code that diagnosis. The signs/symptoms that prompted the physician to order the test may be reported as an additional diagnosis if they are not fully explained or related to the confirmed diagnosis.

Although it is not incorrect to assign a sign or symptom as an additional code along with the first listed code (as determined from the result of the radiology report), establish a policy at your facility governing whether to report additional diagnoses. This procedure will ensure consistency of code assignment by your staff.

The program memorandum provides specific clinical examples as well as the *Claims Processing Manual*. If the final diagnosis is "routine" or "normal," code the sign or symptom from the script.

Q: How do you bill appropriately for CT scans that are initially ordered without contrast and later with contrast? For example, a patient comes to the emergency department with abdominal pain and, after an examination, the physician orders an abdomen CT scan without contrast to check for renal stones. Then, after further examination and additional symptoms, the physician orders an abdomen CT scan with contrast to check for an aneurysm.

May we bill both the 74160 (with contrast) and 74150 (without)? If so, do we need to attach modifier 59? Or do we have to change the code to 74170 (without "followed by contrast")?

A: Given the scenario provided, bill using 74170 based on the current Outpatient Prospective Payment System/*Outpatient Code Editor (OCE)* payment logic. This is true even though it appears that the physician ordered both examinations separately, the examinations were performed separately, and the results were reported separately with distinct individual reports.

When you bill for both exams separately using 74150 and 74160 (with or without modifier-59 present), they trip Edit 20 of the *OCE*, which states, "Code a pair that is not allowed by NCCI, even if an appropriate modifier is present."

Until such time as CMS deems this scenario appropriate and removes it from the *OCE*, failure to bill in this manner will result in the line item rejection of CPT 74150. ■

Insider source

Glenn Krauss, RHIA, CCS, CCS-P, CPUR, independent consultant, Maryville, TN.