Part B Insider (Multispecialty) Coding Alert

IMAGING: SPECT Coding Tops CMS' List of 'No Documentation' Errors--Now Medicare Is Watching

CMS overpaid $15.2 million last year for 78465--we-ll show you how to avoid several common mistakes

Fail to maintain documentation for your SPECT claims, and you could be a Medicare statistic.

Last week, we told you about some of the most egregious errors that CMS found as part of its CERT review (Insider, Vol. 9, No. 20, pages 153-154).

Today, we-re focusing on code 78465, which was the number-one procedure code that CMS found had no documentation to back up the claims, resulting in more than $15 million in improperly paid claims.

The CERT report's focus on 78465 (Myocardial perfusion imaging; tomographic [SPECT], multiple studies [including attenuation correction when performed], at rest and/or stress [exercise and/or pharmacologic] and redistribution and/or rest injection, with or without quantification) was just one of many alerts that practices may be billing this code incorrectly.

For example, in 2005, Louisiana Medicare flagged 78465 as a code that providers in four different states were billing more than twice as often as practices in the rest of the nation, stirring the suggestion that practices were reporting the code improperly.

The fact that hundreds of practices billed Medicare for SPECT imaging but did not have documentation to support the claim does not necessarily mean that they lost the documentation, says **Heather Corcoran** with **CGH Billing** in Louisville, Ky.

- -No documentation- can also mean that the practice didn't have the appropriate documentation to back up the claim,- she says. -The practice may have had a notation that a SPECT image was performed, but no record of the radiological report, no images, and no documentation of the reason, so they didn't send the Medicare contractor anything in response to a documentation request, knowing that they weren't able to support the code.-

Avoid Billing 76376 With SPECT

A common mistake when reporting 76376 is to bill it with 78464 or 78465.

-This year, new and revised text has been documented in the 2008 AMA CPT book,- says **Christina Neighbors, MA, CPC, ACS-CA**, of **Franciscan Health Systems** in Tacoma, Wash.

The new advice states that you should not report 78465 with 76376 (3-D rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation) or with 76377 (... requiring image postprocessing on an independent workstation).

-SPECT produces a 3-D dataset (an electronic device that provides an interface in the transmission of data to a remote station); therefore, it is not appropriate to code CPT 76376 in addition to 78464 or 78465,- Neighbors says.

Report 1 Code for Resting/Stress

Often, your practitioners will perform two scans during the same visit: an at-rest scan and a stress scan. But these don't

warrant two codes. Instead, report a single unit of 78465 to cover both the resting and the stress images.

In black and white: Different Medicare carriers use their own verbiage to confirm this instruction, but as an example, HealthNow's policy states, -Studies that involved multiple imaging must be billed only once, whether the service is completed on the first day or on a subsequent day. Use the initial date of imaging as the date of service.-

To read the full CERT results, visit the CMS Web site at www.cms.hhs.gov/CERT, then click on -CERT reports,- followed by -2008 Mid-Year Improper Medicare FFS Payments.-