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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Auditing Tool-- 3 Can't-Miss Radiology Coding Lessons

Will Medicare be asking you to return part of the $59 million overpaid to radiologists?

CMS is watching your claims, but the errors the agency is targeting may not be the ones you expect.

Medicare's Comprehensive Error Rate Testing (CERT) scoured diagnostic radiology backup documentation and uncovered documenting disasters and an estimated $59 million in overpayments. But downcoding also made CERT's list of diagnostic radiology mistakes.

Here are examples of the problems CERT found and how you can avoid them--so Medicare won't be asking you to repay part of that $59 million next time.

1. Try Checklists for Adequate Documentation

CERT uncovered multiple cases of insufficient documentation for billed services.

Example: One provider billed cervical myelography radiological supervision and interpretation (72240), but the documentation did not mention contrast or fluoroscopy.

Protect yourself: If trying to code from inadequate documentation is one of your greatest frustrations, you aren't alone. Try educating physicians about the precise documentation you require to do your job accurately and efficiently--and to get the doctor the reimbursement she earned.

Strategy: Gather information on documentation guidelines for the procedures your radiologists perform most often and create a documentation checklist to guide their reports.

For example, for digital bilateral diagnostic mammogram with CAD, you should report the following codes, says **Barbara Rutigliano, MS, RT(R), CPC, RCC,** coding manager for Jefferson Radiology in Connecticut:

- G0204--Diagnostic mammography, producing direct digital image, bilateral, all views

- +77051--Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure).

A typical report for digital bilateral diagnostic mammogram with CAD should specify using these technologies and may look like this, Rutigliano says:

- Direct digital imaging was used for this exam
- Computer-aided diagnosis was used for this exam
- Comparison is made to film dated ____________
- Right breast findings: ___________
- Left breast findings: ____________
- Impression: __________

Remember: A checklist can help remind the physician about what he needs to cover in his report, but the interpretation

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should be specific to the patient who underwent the service. Payers come down hard on physicians who use cloned documentation in their reports.

2. Stop Little Details From Causing Big Problems

Medicare's focus on technicalities came through loud and clear in the CERT review.

Example 1: CERT found fault with a chest x-ray billed with modifiers 26 (Professional component) and 77 (Repeat procedure by another physician) because the report didn't have a radiologist's name or signature. Without this information, CERT had no indication that the billing provider performed the billed service.

Example 2: One provider billed a CT of the maxillofacial area but told CERT, -We have no records documenting the date(s) of service- for the CT.

Protect yourself: Don't put yourself at risk by submitting claims for reports missing these small, but crucial, details.

CPT guidelines require -a written report, signed by the interpreting physician- as an integral part of any radiologic procedure or service. And you can't fill in the service date on your claim if the provider hasn't documented one in the chart.

To get the information you need, you may have to get creative. One coder reports leaving the incomplete chart with a chocolate candy to get the radiologist's attention. And to be sure providers take documentation seriously, you can share the tale of the auditor who took a patient's chart, shook it to remove all the papers that weren't firmly attached in the file and only counted the attached pages as documentation.

3. Eliminate Undercoding or Pay the Price

Poor documentation can lead you to another of CERT's danger zones: undercoding.

Example: A provider billed 72100 (Radiologic examination, spine, lumbosacral; two or three views) for an initial reading during an emergency department encounter, but the documentation (an undated addendum from the same provider) actually supported billing the higher-level code (72110, - minimum of four views).

Protect yourself: If you undercode, you aren't being overpaid, so payers won't care, right? Wrong.

Consistent undercoding can get you in trouble the same as consistent overcoding, says **Susan Ward, CPC, CPC-H**, approved PMCC instructor, AAPC National Advisory Board member, and coding and billing manager for Travis Holcombe, MD.

If an auditor sees that you-re consistently undercoding, she's going to wonder why, Ward says.

The auditor will delve deeper into your charts to see, for example, whether you-re using the wrong code to increase your chances of getting paid for a particular procedure or to avoid a frequency cap.

The consequences: If a Medicare auditor finds you consistently undercoding, the contractor will likely make your practice carve out some time for documentation and coding education, Ward says. You may also face fines and penalties, she adds.

Communication with your doctors is crucial to correcting this problem, Ward says.

Try this: Suppose the radiologist's documentation says, -complete abdominal ultrasound,- but she does not mention the patient's gall bladder or spleen. You leave the following:

- a note specifying exactly what you need clarified

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- a copy of the doctor's documentation

- a copy of the AMA's CPT guidelines for abdominal ultrasound, which require discussion of the -liver, gall bladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava including any demonstrated abdominal aorta.-

You can also point out that if the documentation doesn't meet CPT guidelines for 76700 (Ultrasound, abdominal, real time with image documentation; complete), which garners about $120 global, you-ll have to report 76705 (- limited), which brings in approximately $30 less.

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