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BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Dodge Double-Billing Interp Claim Mishaps With This Advice

You may not always be able to report the CPT® code, but discover this big benefit.

When your orthopedic surgeon does the interpretation for magnetic resonance imaging (MRI), computed tomography (CT) scan, or other diagnostic test, you may run into hospital policy specifying only a facility radiologist can perform the interpretation. If so, coding your orthopedist's interpretation would mean you're guilty of double-billing.

But it's not all bad news. When the orthopedist cannot bill separately for the interpretation, you can still consider the test as a factor in medical decision making when assigning an E/M level.

Avoid This Double-Billing Danger Zone

Before billing for any diagnostic test interpretations in an inpatient setting, be sure that another physician hasn't already laid claim to the service.

Scenario: A patient gets a concussion, so to check for internal injuries and aneurysm, an orthopedic physician orders a CT scan (70460, Computed tomography, head or brain; with contrast material[s]). The test reveals no evidence of serious injury, and the patient is admitted for observation. Can you bill for the interpretation?

Solution: No. In a hospital or other inpatient setting, a facility radiologist or other physician may provide interpretations for all ordered tests as a matter of policy.

Important: Only one person should do the reading of the diagnostic test, and the person billing for it should have a complete report, experts say. If your orthopedist reads the films/fluoros and bills for them, then you need to have a separate note with a separate signature at the end of the op or office note.

In other words, if one physician interprets a test and provides a report outlining the result, no other physician can bill for the same service because this would constitute double-billing.

You probably could not report the CT scan interpretation for the orthopedist in the above scenario because, very likely, the hospital radiologist would prepare the initial report for the CT scan. Even when the orthopedist provides the immediate interpretation used for treatment and the radiologist provides an -over-read- (secondary quality assurance review), hospital rules may give the charge to the radiologist.

What if your physician disagrees? Some coders and physicians think that if the ordering physician disagrees with the radiologist's interpretation, and if the physician writes his own full report of the test, the ordering physician's report counts as a correctly formatted radiological report with a conflicting outcome. If this is the case, you may attempt to bill for the ordering physician's interpretation. But the payer will likely deny the charge, and you will be forced to appeal with the documentation.

Add Test Result Interpretation to E/M Level

Although the orthopedist may not be able to claim separate reimbursement for a test interpretation if another physician has already provided a report, the orthopedist can consider her own reading of the test results as a component of medical decision making, which may affect the level of any E/M service she provides.

In other words, a radiologist can, in his/her interpretation, describe what the finding is, but it is the physician who looks

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at the films to determine the course of treatment.

Reason: The amount and/or complexity of medical records, diagnostic tests, and other information that the physician must consider when examining the patient is a key component of medical decision making, according to CPT® guidelines and reading test results falls into this category. For instance, if the physician documents that the actual image was reviewed, you can typically increase the Amount and/or Complexity of Data from "minimal" to "moderate."

Example: In the common scenario described above, the test results become part of the medical record that the orthopedist must consider when diagnosing and treating the accident victim. Based on the key components of history, exam, and MDM (which includes consideration of the test results), the orthopedist documents a level-three observation admission (99220, Initial observation care, per day, for the evaluation and management of a patient ...).

You Can Bill Interpretation? Append 26

In cases in which the orthopedist legitimately provides the only interpretation and report for a diagnostic study, you must still remember to append modifier 26 (Professional component) to the appropriate CPT® code to describe the test.

CPT®'s Appendix A (Modifiers) notes that some procedures contain a technical component and a physician (or professional) component.

If the physician provides both components of the service, he may report the appropriate CPT® code with no modifiers. But "when the physician component is reported separately," CPT® specifies, "the service may be identified by adding modifier '26' to the usual procedure number." In the latter case, the facility providing the equipment may claim the "technical component" of the service (the cost of equipment, supplies, technician salaries, etc.) by reporting the appropriate CPT® code with modifier TC (Technical component) appended.

Therefore, if the orthopedist in our common scenario provides the initial interpretation and report for the CT scan on the head-injury patient, you are justified in reporting 70460 in addition to any E/M services the surgeon provides. Remember to include documentation to support this service.

You should append modifier 26 to 70460, nevertheless, to show that the surgeon did not provide the equipment.

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