Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Quiz Answers

Quiz Answers

Did you come up with the same answer as our coding expert?

If you had perfect documentation, you would be able to report the following, says radiology coding consultant **Cheryl Schad, BA Ed, CPC, ACS-RA**, owner of **Schad Medical Management** based in Mullica Hill, NJ:

1. CT chest with IV contrast--71260 (Computed tomography, thorax; with contrast material[s]) and 197.0 (Secondary malignant neoplasm of respiratory and digestive systems; lung)

2. CT abdomen with IV contrast--74160 (Computed tomography, abdomen; with contrast material[s]) and 153.3 (Malignant neoplasm of colon; sigmoid colon)

3. CT pelvis with IV contrast--72193 (Computed tomography, pelvis; with contrast material[s]) and 153.3

4. 100 units of contrast--Q9949 (Low osmolar contrast material, 300-349 mg/ml iodine concentration, per ml).

Limit Code Choices Based on Documentation

Because you can only separately identify the CT chest in the physician's documentation, that's the only one you should code, Schad says. The CT chest is described in the first paragraph of -Findings,- she says. But the next two paragraphs discuss elements of both the abdomen and pelvis. The two exams -must be separately discernable,- Schad says.

Don't Overload Claim With Background Codes

Outpatient note: You don't need to include a code to indicate that the patient has been undergoing radiation therapy. Unlike hospital medical records abstraction, -with outpatient reimbursement coding, we must establish medical necessity, and once that has been established, there is no reason to add anything to give the insurance carrier an excuse to deny our claim for submitting ICD-9 codes that do not appear on their payable diagnosis list,- Schad says.

You also don't need to change your coding just because this is a follow-up exam. -The findings confirm the reason for these studies,- Schad says.

Count Up the Cost of Poor Documentation

-The very first problem with the documentation is the fact that there are three studies documented as one continuous report. This does not meet Medicare's (and many private insurance carriers-) requirement for -separate and distinct- documentation for each CPT code you are going to bill,- Schad says.

If you report all three studies, an insurance auditor who reviews the report during a post-payment audit would likely only approve payment for the CT pelvis because it has the lowest RVUs of the three exams, Schad says. That means the payer would demand its money back for the chest and abdomen CTs.

Helpful: Let your physician know that documenting each exam as a complete and separate report will earn him roughly $960 for three exams instead of just $311 for the pelvis exam.

-At the very least, they should be dictated as though they were on separate reports,- Schad says.