Codify
BY AAPC

Outpatient Facility Coding Alert

Policy Changes: Implement This Major Policy Change for Modifier 26, TC Billing

CMS is doing a complete overhaul of DOS billing.

Sometimes, policy changes within the coding world may leave you to wonder if the forces of the universe are simply out to get you. That's how many independent diagnostic testing facility (IDTF) coders are feeling following the updated policy changes on modifiers TC (Technical Component) and 26 (Professional Component) date-of-service (DOS) billing.

With the new changes being enforced by the Centers for Medicare and Medicaid Services (CMS), you'll have to be extra diligent making sure your claims' DOSs are appropriately dated.

Have a look at the new policy and what effect it will have on your day-to-day coding.

Break Down the New Policy Piece-By-Piece

On January 24, 2019, CMS published MLN Matters #SE17023, Guidance on Coding and Billing Date of Service on Professional Claims. In this article, CMS outlines the DOS you should be reporting on claims for various medical services. Included in these services are radiological services that are not being billed globally.

Refresher: When a radiological service is not billed globally, it's submitted to the payer by the hospital or facility using a TC modifier, indicating that they are billing for the technical component (equipment). The interpreting radiologist will submit claims using a 26 modifier, indicating that he or she is only billing for the professional service (interpretation).

Prior to 2019, when physician or hospital coders would submit a claim for an imaging service, they would submit the claim with the same DOS. Up until this point, this DOS has exclusively been the date that the patient received the imaging service. So, if a patient presents to the hospital for a chest X-ray on Wednesday, and the radiologist doesn't interpret the scan until Thursday, the DOS for both the professional and technical components would still be Wednesday prior to this new policy.

See How Physician Coders Are Affected

With the new CMS policy, physician coders are now required to bill the patient's DOS of the claim as the date that the provider interpreted the scan, not the date that the patient presented for the scan. However, for those hospitals or facilities billing the technical component, they will submit the DOS as the day the patient receives the imaging. CMS outlines the policy change in their own words here:

- "When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed."

While this might appear to be a minimal change on the surface, the impact on radiology coders can be profound depending on the type of claims they typically code. "In the radiology cases I work, I usually don't come across an issue with this new policy since the radiologist typically interprets the report on the same date that the patient undergoes the imaging," says **Lindsay Della Vella, COC, CMCS**, medical coding auditor at Precision Healthcare Management in

Media, Pennsylvania. "However, you'll have to be especially careful to look out for emergency room [ER] claims that occur close to midnight. In these instances, where the patient undergoes the imaging prior to midnight, and the radiologist interprets the report the next day, you'll have to make sure to document the DOS as the day the radiologist interpreted the report," explains Della Vella.

While the concept of double-checking to confirm the DOS matches the interpretation date is simple, the execution may take some time to fully integrate into your coding processes. On most dictation reports, you'll see the exam date and time documented at the top and the date and time of the interpretation at the bottom near the provider's electronic signature.

Get Some Important Physician Background

While ER and inpatient radiological services are the most likely to be affected by this new policy, you should not get accustomed to assuming that just because the patient presented during typical work hours, the case was definitively interpreted the same day.

"The determination of when an exam is interpreted is based on many variables," says **Barry Rosenberg, MD**, chief of radiology at United Memorial Medical Center in Batavia, New York. "For instance, any imaging ordered as STAT is read soon or immediately after the patient receives the service. That would mean ER, inpatient, or any instances in which a doctor sends a patient to the radiology wing with a concern for a potentially critical finding. These services can be considered outpatient, but are performed as STAT.

"The rest of the radiological services ordered are elective, and depending on how well staffed the radiology department is and how busy overall volume of flow is will determine whether the radiologist interprets those outpatient studies the same day or the following day. If an elective exam does not get interpreted on the same day it was performed, it is considered a priority the following day," Rosenberg explains.