Coding Radiology Services

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Because coding and radiology departments often share accountability for the quality of outpatient radiology coding, it is important that coding professionals share coding issues and charge capture expectations with radiology staff. This article outlines methods to improve the quality of coded data from radiology services and highlights 2009 radiology compliance, coding, and reimbursement updates.

Radiology Coding Challenges

Coding radiology procedures poses unique challenges due to the high volume of procedures performed in hospital outpatient radiology departments and the multiple departments involved in charge capture and coding. Outpatient diagnostic radiology procedures can cause coding quality concerns because they are hard-coded (obtained from the chargemaster) by radiology department staff who usually do not have formal coding training.

Chargemaster management concerns arise from how modifiers are assigned and component coding in other radiology services such as interventional radiology. For example, a surgical interventional radiology service often has both surgical and radiological components. Coders and the radiology support staff should coordinate how the surgical component (soft-coded by HIM) and radiological component (hard-coded) will be reported accurately and linked for claim processing.

Medicare and other payers determine outpatient medical necessity based on the relationship between the patient's ICD-9-CM diagnostic code and the CPT/HCPCS level II procedure code. For this reason, it is important to develop an efficient and effective ICD-9-CM diagnostic radiology coding workflow.

The workflow will help clearly define the responsible departments for the radiology ICD-9-CM diagnostic coding and how the necessary radiology documentation will be made available at the time of coding (e.g., physician orders, radiology reports). A well-designed ICD-9-CM and CPT radiology coding workflow will prevent errors prior to reporting data and reduce the need for claim denial follow-up.

The most effective solution for bridging the radiology charge capture, coding workflow, and communication gap is to employ credentialed coding professionals within the radiology department. This ensures that coders have direct access to the radiologists, giving them the means to conduct concurrent queries and allowing them to become comfortable asking referring physicians for additional information required for coding purposes. Ultimately, a coder focused solely in radiology will develop a greater level of expertise and ownership, resulting in greater coding accuracy and improved reimbursement.

Opportunities for Education

Radiologists and radiology support staff often don't fully understand the role they play in coding and reimbursement systems. Coding professionals can provide education on these processes.

Coding professionals directly involved with outpatient radiology can initiate coding and reimbursement in-services or lunch-and-learn sessions with radiologists, radiology support staff, and outpatient registration staff members. Valuable radiology coding and reimbursement training topics include:

- Chargemaster training
- National correct coding initiative edits for hospital outpatient PPS
- Necessary clinical documentation for coding purposes
- Valid diagnostic testing order requirements

- National and local coverage determinations requirements on which diagnoses and conditions meet medical necessity for radiology procedures
- Procedures for obtaining valid advance beneficiary notices

A Team Approach

Source documents for radiology coding include physician orders, a list of exams electronically generated from the organization's registration or radiology system, or dictated reports. In many cases, the most important piece of documentation —reason for exam related to diagnosis—is often missing.

Chapter 15 of the *Medicare Benefit Policy Manual* provides valuable information on how to obtain valid orders before rendering radiology diagnostic testing. Departments should establish policies and procedures requiring a diagnosis or reason for procedure upon registration. National clinical documentation standards for each type of radiological procedure are available from the American College of Radiology.[1] Lack of clinical documentation is a primary contributor to the inability to meet medical necessity edits, which can result in denied claims and compliance concerns.

New technologies and coding standards are addressing the problem of missing documentation. With the widespread deployment of picture archival systems, clinical information systems, and speech recognition technology, report turnaround times have plummeted and complete information is becoming more available for radiology coding.

Radiology documentation and up-front information from referring physicians should be included as part of a comprehensive clinical documentation improvement program. A clinical documentation liaison for radiology can drive significant improvement in coding and reimbursement success for both the hospital and the radiologists.

HIM departments also should consider concurrent and retrospective radiology coding quality review audits. Using examples of inaccurate coding, denied claims, and lost revenue from real cases strongly demonstrates the rationale for improved coding quality.

The following additional tips can help HIM professionals improve clinical documentation:

- Meet with radiologists to discuss coding issues
- Provide radiologists examples of good and bad reporting and how they affect reimbursement
- Explain bundling and packaging rules
- Discourage the use of "rule out" for outpatient documentation practices
- Train new radiologists on the appropriate information to dictate
- Use standard report templates[2]

Compliance, Coding and Reimbursement Updates

The fiscal year 2009 Office of Inspector General Work Plan will continue the review of payments for diagnostic x-rays in hospital emergency departments to determine the appropriateness of payments. This decision is based on March 2005 testimony before Congress that reported increasing costs of imaging services for Medicare beneficiaries and potential overuse of diagnostic imaging services.[3]

Examples of fiscal year 2009 ICD-9-CM new and revised codes effective with October 1, 2008, outpatient service dates that hold particular importance for outpatient diagnostic radiology coding include:

- 339.00–.89, Other headache syndromes
- 346.0x–.9x, Migraine
- 599.70–.72, Hematuria
- 611.81–.89, Other specified disorders of breast
- 733.96–.98, Stress fractures
- 780.60–.65, Fever and other physiologic disturbances of temperature regulation
- V13.51–.59, Personal history of pathologic fracture, stress fracture, and other musculoskeletal disorders
- V15.51, Personal history of traumatic fracture

- V28.81, Encounter for fetal anatomic survey
- V89.01–.09, Suspected maternal and fetal conditions not found

For a complete list of ICD-9-CM code changes, go to www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp. There will be no updates on April 1, 2009. The next update will be October 1, 2009.

CPT Updates

As of January 1, 2009, the new calendar year 2009 CPT codes are required to report rendered radiology procedures. An editorial change has been made to the narrative description of code 74270, Radiologic examination, colon; contrast (e.g., barium enema) enema, with or without KUB, to clarify that it should be used to report any type of contrast enema procedure, such as barium, water-soluble contrast, or other contrast media.

The parenthetical statement for code 76998, Ultrasonic guidance, intraoperative, has been updated to indicate that it is inappropriate to report the intraoperative ultrasound guidance code in conjunction with endovenous ablation therapy codes (36475–36479).

Codes 77781–77784 have been deleted and replaced by codes 77785–77787, Remote afterloading high-dose rate radionuclide brachytherapy, differentiated by number of channels, to report the current physician practice.

Code 78808, Injection procedure for radiopharmaceutical localization by nonimaging probe study, intravenous (e.g., Parathyroid adenoma), was added to describe a nonimaging gamma probe procedure for which a radiopharmaceutical is prepared and injected. Codes 78890 and 78891 describing computer-generated data have been deleted.

Coding professionals should review the new codes related to radiological procedures if a provider reports category II codes, which are intended to facilitate data collection about the quality of care rendered and used in the Physician Quality Reporting Initiative.

Category III codes 0028T, Dual energy X-ray absorptiometry body composition study, and 0060T, Electrical impedance scan of the breast, have been deleted. Code 76499, Unlisted diagnostic radiographic procedure, should be reported when one of these procedures is performed.

For a complete list of the radiology 2009 CPT category II and category III code changes, refer to the CPT 2009 code book.

The 2009 HCPCS level II code set modifications have been posted to the CMS HCPCS Web site at www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS. All changes are effective January 1, 2009, unless otherwise indicated.

Medicare OPPS Updates

The Centers for Medicare and Medicaid Services (CMS) has established five imaging composite APCs for calendar year 2009. These composites will provide a single APC payment when two or more imaging procedures using the same imaging modality are provided in a single session.

The new multiple imaging composite APCs for calendar year 2009 are:

- APC 8004, Ultrasound Composite
- APC 8005, Computed Tomography (CT) and Computed Tomographic Angiography (CTA) without Contrast Composite
- APC 8006, CT and CTA with Contrast Composite
- APC 8007, Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) without Contrast Composite
- APC 8008, MRI and MRA with Contrast Composite

For 2009 CMS finalized the following four Hospital Outpatient Quality Data Reporting Program imaging efficiency measures for the calendar year 2010 payment determination:

- OP-8, MRI Lumbar Spine for Low Back Pain
- OP-9, Mammography Follow-up Rate
- OP-10, Abdomen CT—Use of Contrast Material
- OP-11, Thorax CT—Use of Contrast Material

CMS stated the adoption of these four imaging efficiency measures is appropriate for measurement of quality of care furnished by hospitals in outpatient settings.

Notes

1. American College of Radiology. "ACR Practice Guideline for Communication of Diagnostic Image Findings." Available online at www.isradiology.org/Reference/Guidelines.
2. Auster, Martin, Jeff Pilato, and Beth Friedmann. "Radiology Coding: Keys for Successful Documentation, Compliance and Reimbursement." AHRA 2008 National Convention. July 2008. Available online at www.hrscoding.com.
3. Office of Inspector General. "Work Plan Fiscal Year 2009." Available online at www.oig.hhs.gov/publications/workplan.asp.

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