Diagnostic Services Coding Tips for Physician Offices

by Rita A. Scichilone, MHSA, RRA, CCS, CCS-P

Coding for diagnostic services performed in physician offices and clinics requires an understanding of some special reporting guidelines. Here are some helpful tips.

The Question of Ownership

Reporting laboratory and radiology procedures depends on ownership of equipment and what portion of the tests the physician will be billing the patient or the insurance company to perform.

Some physicians own diagnostic equipment and interpret test results themselves, while others may use hospital-owned equipment or have arrangements with other physicians for interpretive services. How an office is organized as well as ownership of equipment will affect which CPT codes and modifiers are used for reporting on the HCFA 1500 form.

Modifiers are used with testing codes to explain conditions that may affect payment of a claim. Many CPT codes are considered "complete" procedures that represent the ownership of equipment, the skills of a technician to use the equipment, and the professional interpretive skills used to produce meaningful results. If only a portion of the procedure was provided to a patient, a modifier is used with the code so the service is not misrepresented as complete.

CPT uses modifier -26 to represent circumstances in which the physician provides only the professional component of a test. When a physician does not own the equipment or provide the technical portion of a diagnostic procedure, this modifier is appended to the usual procedure code.

CPT does not have a modifier for the technical portion, since it is a coding system designed for physician services. In the HCPCS system, a modifier has been created to report circumstances where technical services are rendered, and someone else will report the professional component. Hospitals or physicians that own equipment used by other physicians will use modifier -TC appended to the usual procedure code. The Medicare fee schedule for physicians has separate payment amounts for CPT codes with modifier -26 and modifier -TC.

For laboratory tests, CPT codes are reported for tests performed or for collection of specimens to be sent to an outside lab. Special HCPCS codes are required for specimen collection for Medicare patients. When a test is performed by a reference laboratory (off site) but billed by the physician's office, modifier -90 is appended to the CPT code. Medicare does not allow billing for procedures by anyone but the provider who rendered the service, so modifier -90 would not be used for Medicare patients. For Medicare, a physician office may report collection of the specimen only. Rules for specimen handling and billing for laboratory procedures not performed within the office vary by third-party payer policy.

Coding Examples

A cardiologist provides cardiac catheterizations. This will probably require modifier -26 when reporting the physician's services, because it would be unusual for a cardiologist to own a catheterization laboratory. If the codes were submitted to a health plan without a modifier, significant overpayment could occur and the physician would be guilty of filing a false claim by misrepresentation of the extent of service provided. The hospital owning the lab reports the codes with modifier -TC unless the physician is employed by the hospital, and then the hospital would qualify for the complete procedure reimbursement.

A radiology group maintains an office in the same building as a multispecialty clinic. Other physicians in the building refer patients for selected procedures. The films are read by radiologists in the group that owns the equipment. This practice uses the complete procedure codes when possible or selects codes that represent both professional and technical components for these office-based procedures.

When this same radiology group performs services at the hospital or a free-standing MRI/CT facility, they report codes with modifier -26, since they do not own the equipment or provide technical services to the patient but rather provide only the physician interpretation part of the service. Hospitals that do not employ radiologists append the -TC modifier to these procedures for reporting.

A physician office collects a blood sample for testing at the hospital. For Medicare, HCPCS code G0001 is reported for the collection of specimen, since the hospital will be reporting the actual test. Other payers may or may not allow reporting of the test with modifier -90 appended. For non-Medicare patients, the physician has an arrangement with a lab for providing tests but bills for the test along with the office services to the health plan involved using the modified code.

References

American Medical Association. *Current Procedural Terminology*. Chicago, IL: 1999, Appendix A.

American Medical Association. *CPT Assistant* 6, no. 6 (1996): 10.

American Medical Association. *CPT Assistant* 6, no. 4 (1996): 11.

HCFA. *Medicare Carriers Manual* (HCFA Pub. 14.3). Section 5114.1, Payment for Outpatient Clinical Diagnostic Laboratory Test using Fee Schedules and for Specimen Collection.

Kuehn, Lynn. From "Know the Code: Enhance Your CPT Skills for Diagnostic and Therapeutic Procedures." AHIMA Audio Seminar Series, May 4, 1999.

Rita Scichilone *is a coding practice manager at AHIMA.*

Article Citation:
Scichilone, Rita A. "Diagnostic Services Coding Tips for Physician Offices." *Journal of AHIMA* 70, no. 7 (1999): 60.