Healthcare Administrative Partners

OPTIMIZING PROVIDER PERFORMANCE

5 Top Radiology Documentation Errors

Key strategies to improve documentation, optimize revenue and ensure compliance

In today's complex healthcare environment, it's difficult to keep up. When the unrelenting pace of regulatory change is coupled with high volume procedures in radiology, it's easy to understand how errors and miscommunication occur. Charge capture and coding is a shared responsibility; but many physicians don't receive feedback about deficiencies in their documentation. Without this, an error or oversight can be repeated until it becomes routine.

Given these dynamics, physicians often produce unclear documentation for coders. This includes incomplete information, lack of specificity and conflicts between the ordered exam and final report.

Coders can only assign codes that are supported by the documentation. They cannot interpret physician meaning or intention. As a result, they're left to chase down physicians for missing details or file claims unwittingly fraught with coding inaccuracies. Claims that are not supported by adequate documentation can cost providers significant revenue and expose them to compliance violations that result in refunds and penalties.

Based on our experience serving a variety of radiology practices over many years, here are the 5 top documentation errors in radiology and our recommended remedies:

1. **CTA**

   CTA is a distinct service that requires 3D angiographic post-processing techniques.

   To create full and proper documentation, dictation must include specific language that describes the most common 3D post-processing techniques; for example, *maximal imaging projection (MIP) reconstructions, shaded surface rendering, or volume rendering.*

   Without this specific terminology the coder would code the exam as an ordinary CT, resulting in loss of the revenue a CTA would produce.

   The typical reimbursement level for a CTA is more than 33% greater than a CT.

Technology	Code	Professional	Technical	Global Reimbursement
CT Chest	71260	$63.75	$166.56	**$230.32**
CTA Chest	71275	$97.79	$208.11	**$305.90**

2. **Complete Abdomen Ultrasound**

   Proper documentation for a Complete Abdomen Ultrasound includes: liver, gallbladder, common bile duct, pancreas, spleen, kidneys, upper abdominal aorta and inferior vena cava (IVC).

   Radiologists must document for all eight structures including the aorta and IVC, which are the most frequently omitted because they're often considered irrelevant to the exam. In addition, if a structure cannot be visualized or was surgically removed, it needs to be noted in the report.

   Without all eight structures documented in the report, the study is considered to be a limited.

The typical reimbursement level for a Complete Abdomen Ultrasound is considerably higher than a Limited Abdomen Ultrasound.

Procedure	Code	Professional	Technical	Global Reimbursement
Limited Abdomen Ultrasound	76705	$30.09	$76.65	**$106.74**
Complete Abdomen Ultrasound	76700	$41.19	$88.83	**$130.03**

3. Digital Mammography

Radiologists must indicate the type of technology used and the purpose for the exam. If digital technology was used, it must be specifically stated in the report in order to be reimbursed appropriately. In addition, if computer aided detection (CAD) is applicable, it must be clearly noted in the report for the coder to apply the proper add-on code. For complete and proper documentation, dictation must include these specific terms: screening, diagnostic, unilateral, bilateral, digital, and CAD in order to receive optimal reimbursement.

The tables below illustrate the various types of mammography procedures, diagnostic codes and reimbursement levels.

Bilateral Mammogram – Screening

Technology	Code	Professional	Technical	Global Reimbursement
Film-based	77057	$35.82	$46.93	**$82.75**
Digital	G0202	$35.46	$99.59	**$135.05**

Bilateral Mammogram – Diagnostic

Technology	Code	Professional	Technical	Global Reimbursement
Film-based	77056	$44.42	$71.65	**$116.07**
Digital	G0204	$44.42	$120.36	**$164.78**

CAD add-on for Screening or Diagnostic Exam

Technology	Code	Professional	Technical	Global Reimbursement
CAD: Screening	77052	$3.22	$7.16	**$10.39**
CAD: Diagnostic	77051	$3.22	$5.74	**$8.96**

4. Inconsistent number of views

Radiology reports often state "multiple views" and not the number of views or type of views performed. To ensure optimal reimbursement, radiologists should specifically define the number and type of views visualized. If not, the coder has to seek clarification before coding or code to the documentation as provided, resulting in a reduced reimbursement.

Example - Lumbar X-ray: The typical reimbursement level is 40% greater with an additional view documented.

Procedure	Code	Professional	Technical	Global Reimbursement
Lumbar X-ray 2 or 3 Views	72100	$11.81	$23.27	**$35.08**
Lumbar X-ray 4 Views	72110	$16.47	$32.58	**$49.05**

5. PICC Line with Ultrasound & Fluoroscopic Guidance

It is appropriate for radiologists to document ultrasound and fluoroscopy together for the same procedural encounter, when both have been utilized. Permanently stored images for guidance (ultrasound and/or fluoroscopy) are required.

Here are examples of key phrases for proper documentation:

A) "Using ultrasound guidance, the vein was punctured and a wire was placed in the SVC. Permanent ultrasound images were stored and archived."

B) "Using fluoroscopy, the catheter tip was placed in the SVC (image on file)."

Procedure	Code	Professional	Technical	Global Reimbursement
Ultrasound Guidance	76937	$15.04	$17.18	$32.22
Fluoroscopic Guidance	77001	$18.97	$51.55	$70.52
Total		**$34.01**	**$68.73**	**$102.74**

These examples use Medicare's allowable fees for 2015 to illustrate the impact that improving your documentation can have on reimbursement. The incremental value for each procedure may seem small, but for commonly performed services the aggregate result can amount to a significant improvement in revenue. Inaccurate documentation can put an organization at risk for significant refunds and financial penalties if it's targeted for review by a Medicare Recovery Audit Contractor (RAC) or by any other payer's review process. Organizations should consider initiating an ongoing feedback program and regular documentation training for physicians.

Following these recommendations can help improve communication with referring physicians, provide clear direction for coders and result in appropriately higher reimbursement. All stakeholders benefit when documentation is clear, specific and complete.

Healthcare Administrative Partners (HAP) is a full service revenue cycle provider. HAP offers a full suite of integrated business outsourcing solutions or individual billing, coding or consulting services that complement the functionality provided by physician practice staff.

Disclaimer

The information provided with this notice is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is current as of the date indicated, and all coding and reimbursement information is subject to change without notice. Payers or their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer. Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity. The health care provider has the responsibility, when billing to government and other payers (including patients) to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or health care consultant, as well as experienced legal counsel.

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