

DOCUMENTATION DILIGENCE

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Is the Key to
Radiology Practice
Reimbursement



Medicare's required changeover to ICD-10 diagnosis coding has shed more light than usual on a topic that requires constant diligence by radiology practices. Regardless of the payor being billed, good procedure coding and diagnosis coding are a must, and the source material for that coding is the documentation found in the radiologist's report of the imaging examination.

In our preparation for ICD-10,¹ we learned the importance of including as much precise and detailed information about the exam as possible, including the laterality of the body part and as much patient history as possible. These are important general rules for all exams, but certain studies require very specific elements

to be included or reimbursement will be diminished. The following are a few examples of studies that often lack complete documentation.

Duplex doppler ultrasound

A complete study includes bilateral upper or lower extremity imaging; otherwise it will be considered a limited study with lower reimbursement. All of the relevant vessels must be imaged and described in the report to bill for a complete exam. For a lower extremity exam, the entire femoral vein, saphenous vein, and popliteal vein on both legs are needed. For an upper extremity exam, the subclavian, jugular, axillary, brachial, basilica, and cephalic veins of both arms are needed. The calf or forearm veins, respectively, may be included but are not required. A limited exam

must be billed if one or more of these elements is omitted, or in the case of a unilateral exam or a focused pre-operative venous mapping study.

In either a limited or complete examination, all three duplex techniques (gray scale imaging, spectral analysis, and color Doppler flow) must be performed and documented in the report. The Coding Committee of the RBMA has developed a table of buzz words for Duplex Imaging that radiologists can keep handy while dictating these exams.²

Breast imaging

BREAST ULTRASOUND

This is another area where the distinction between complete and limited billing hinges on including all of the required elements to maximize reimbursement. The difference in Medicare reimbursement for a complete vs. limited exam is seven percent in the professional component, and 30 percent in the technical component.

A complete study requires examination and interpretation of all four quadrants of the breast and retroareolar region. If the axilla is examined on ultrasound, it must also be included in the report. Axillary ultrasound is not separately billable when a breast ultrasound is performed at the same time.

DIGITAL BREAST TOMOSYNTHESIS (DBT)

Documentation of DBT must be included in conjunction with either a screening or diagnostic digital mammogram for reimbursement under the latest Medicare rules, since the codes are defined as add-on codes. There is no reimbursement from Medicare for a stand-alone DBT exam.

The radiology report must include a separate description and interpretation of the tomosynthesis. For example, a diagnostic mammogram report might include language such as: “Additional and tomosynthesis views of the left breast are obtained. Tomosynthesis reveals that fibroglandular tissue in the lateral left breast is displaced in multiple directions by a fatty lobule. This is seen on both views. There is no evidence of a worrisome mass which is at the center of an architectural distortion.” In a screening mammogram report, the reference can be as simple as, “Tomosynthesis was performed.”

3D reconstruction in CT imaging

Radiologists sometimes balk at the idea of 3D reconstruction as part of a CT Angiography (CTA) exam when they feel that it doesn’t add anything to the particular case, but if the intent is to bill a CTA then 3D reconstruction is required. Without it, the study must be billed as a plain CT. This will result in lower reimbursement, or possibly,

a denial for the billed procedure code not matching the authorization.

In other types of CT exams, when it is medically necessary and a written order is received, 3D reconstruction can be billed as an additional charge. Whether billing for a CTA or as an add-on, make sure managed care authorizations match the final coding of the exam. Adding 3D reconstruction following an abnormal initial exam will most likely require additional authorization from the payor.

The documentation for 3D reconstruction is very specific. The report of the radiologist’s concurrent participation in, and monitoring of, the reconstruction process has to include a description of:

- the design of the anatomic region that is to be reconstructed;
- the determination of the tissue types and actual structures to be displayed;
- the determination of the images that are to be archived; and
- the monitoring and adjustment of the 3D work product.

In addition, the procedure report must include:

- whether or not an independent workstation was utilized;
- which techniques were used, such as:
 - Maximum intensity projection;
 - Shaded surface rendering;
 - Volume rendering; and
- what the 3D rendering showed independent of the original exam.

When a separate report is issued, the location and time of the original exam should be included, especially in those uncommon circumstances where reconstruction is done from a different facility. The American College of Radiology recommends that an archive of the reformatted images should be retained as part of the permanent record of the study using the same guidelines as for retention of any other study.

Abdominal and retroperitoneal ultrasound

The accepted guideline for the performance of a complete abdominal ultrasound includes imaging of all of the following:

- Liver
- Gall bladder
- Common bile duct

- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta
- Inferior vena cava

The radiologist's report must document and interpret all of these areas, including any demonstrated abdominal abnormality, in order for the exam to be billed as complete. If one of the listed elements cannot be imaged, for example due to its surgical removal or because it is obscured, then the exam will still be considered to be complete if the report includes a description of the reason it is not visualized.

Similarly, the guideline for a complete exam of the retroperitoneum includes imaging and documentation of all of the following:

- Kidneys
- Abdominal aorta
- Common iliac artery origins
- Inferior vena cava

Note that if the clinical history suggests urinary tract pathology, then a complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound.

In either case, including fewer than the full complement of required elements in the documentation of a "complete" exam will cause it to be billed as a "limited" exam resulting in 22-27 percent lower reimbursement for the professional component and up to 49 percent lower global reimbursement from Medicare.

When there is medical necessity and an updated order is obtained from the referring physician, duplex Doppler evaluation of blood flow characteristics might also accompany these abdominal exams. It would be separately and additionally billable provided there is adequate documentation, as previously described.

Improvement of documentation deficiencies

Radiologists have a lot to think about as they analyze images and report their findings. Remembering all of the elements of documentation for every type of exam is a daunting task, especially for those encountered less frequently. The history and training of radiologists has mostly included the use of free-text prose reporting, with the Breast Imaging Reporting and Data System (BI-RADS®) being a notable exception, but there is a gradual trend toward the idea of more structured reporting systems. While such systems are generally put forth as a way to promote higher quality reporting and improved patient

outcomes, they also can help ensure complete documentation that will result in improved reimbursement.

The authors of a 2012 study³ opined that documentation deficiencies contribute to substantial losses in legitimate professional revenue. In their report that analyzed the completeness of documentation in abdominal ultrasound exams, Dr. Richard Duszak, Jr. and his colleagues wrote, "In addition to increased physician training, structured reporting tools may help practices improve the overall quality of their radiology reports."

Fully integrated structured reporting systems are not gaining acceptance quickly, but one aspect of them—the use of templates—can greatly improve documentation compliance. Templates can be built within current speech-to-text systems to prompt radiologists for the essential elements of the more complex or infrequent exams.

Conclusion

With so much complexity confronting radiology practices today, it pays to put in place documentation procedures that properly support the coding submitted to payors. When the radiology report fails to include all of the required elements, reimbursement will either be reduced or denied. Getting it right is a team effort that starts with radiologists being aware of these requirements and reminded on an ongoing basis to fully report them in all cases. Templates can be utilized as an aid to prompt radiologists to include the essential reporting elements necessary to ensure reimbursement that matches the exams ordered and performed.

REFERENCES:

1. ICD stands for International Classification of Diseases, the system owned and copyrighted by the World Health Organization that is used to report diagnoses when submitting claims for reimbursement of physician services, among many other purposes. ICD-10 is the 10th edition of this coding system.
2. http://www.rbma.org/CPT_Codes/
3. Duszak R, Nossal M, Schofield L, Picus D. Physician Documentation Deficiencies in Abdominal Ultrasound Reports: Frequency, Characteristics, and Financial Impact. *Journal of the American College of Radiology*, June 2012, Vol. 9:6, pp. 403-408.



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