Hot Topics in Diagnostic Radiology

April 2019
Jennifer Bash, RHIA, CIRCC, CPC, RCC
Director of Coding Education
Agenda

• Introduction
• Common Coding Questions
• Common Coverage and Medical Necessity Issues
• Documentation Risk Areas
• Coding Changes/Trends
• Communication
Disclaimer

The information presented is based on the experience and interpretation of the presenters. Though all of the information has been carefully researched and checked for accuracy and completeness, ADVOCATE does not accept any responsibility or liability with regard to errors, omissions, misuse or misinterpretation.

CPT codes are trademark and copyright of the American Medical Association.
Resources

• AMA
• CMS
• National Correct Coding Initiative (NCCI)
• Ultrasound Coding User’s Guide
• ACR Radiology Coding Source
Common Coding Questions

- Hip & Pelvis X-Rays
- Scoliosis Studies
- Pelvic/OB Ultrasound
- Ultrasound with Duplex
- MRI Brain with IAC/Pituitary/Orbits
Hip & Pelvis X-Rays

- Unilateral vs. bilateral codes
- Based on total number of views
- Pelvis included “when performed”
- Separate encounters on same day
Scoliosis Studies

• Entire Thoracic/Lumbar spine views
• Codes are based on number of views
• Codes include skull, cervical and sacral spine if performed
• Separate spine radiographs
Typically, focal pathology in a particular region is not adequately evaluated on entire spine radiographs (CPT codes 72081-72084).

Total spine radiographs designed to evaluate the entire spine for alignment abnormalities (eg, scoliosis) differ substantially from and are not a substitute for regional spine radiographs, which are designed to evaluate focal abnormalities (eg, compression fractures, lesions, degenerative change). Therefore, while radiographs of the entire spine and separately performed radiographs of the regional spine both visualize the spine radiographically, each is optimized for different clinical indications.
Pelvic/OB Ultrasound

- OB or Non-OB?
- Nonviable pregnancy
- When to use the limited code
Ultrasound with Abdomen/Pelvis Duplex

- Requirements for Billing
  - Order
  - Medical Necessity
  - Diagnostic Findings
- Complete vs. Limited
- NCCI Edits
MRI Brain Combinations

- MRI Brain with Orbits
- MRI Brain with IAC
- MRI Brain with Pituitary
MRI of the Internal Auditory Canal (IAC)

There has been much discussion by insurance carriers at the local level about how to appropriately code for an MRI of the brain and an MRI of the internal auditory canal (IAC) if both studies are performed, and if a specific number of sequences needs to be performed before coding for both.

If a complete MRI of the brain study is performed in conjunction with a complete study of the IACs, it is appropriate to code for two MRI of the brain studies; a "–59" modifier* should be appended to the second MRI brain code to indicate that separate and distinct services were provided. On the other hand, if a complete MRI of the brain is done with just a few extra sequences focused on the IACs, the extra sequences would be considered part of the base study, and only one MRI of the brain study should be coded.

It would be difficult to set the reimbursement rate for a limited MRI study based on the number of additional sequences, because each patient study has its own protocol. The number of sequences needed to fully evaluate the patient's condition, injury or disease varies and is part of the original MRI study ordered.

Note that a radiology group rarely performs a full MR of the brain with a separate and distinct study of the IACs; therefore, the ACR does not see the need to develop a new CPT® code that describes MRI of the IACs. Instead, Medicare carriers and other third-party payers should allow radiologists to submit two MRI of the brain codes when it is medically necessary to perform separate and distinct studies and when appropriate documentation is provided.

*Or Appropriate X modifier or payer preferred modifier
Coverage & Medical Necessity Issues

- Medicare Coverage Database
- NCD/LCD/Private Payer Policies
- Frequency
- “Medical Necessity” Definition is Changing
- Utilization Reviews
- Bundling-NCCI
- ABN’s
Coverage & Medical Necessity Issues

Coverage & Medical Necessity Issues

- Pre-Operative Studies
- Duplex Studies
- PET
- Preventive Services
  - https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
Documentation Risk Areas

- Views
- OB Ultrasound
- Abdomen/Retroperitoneal Ultrasound
- Duplex
- CTA
Coding Changes & Trends

- Elastography
- Micro-Bubble Ultrasound
- Whole Breast Ultrasound
- Category III Codes
- Unlisted Codes
Elastography

- Definition
- 3 new codes for US elastography/1 new code for MR elastography
- Organ/Parenchyma vs. Lesion
- NCCI edits
- 91200-Non Imaging
Targeted Micro-Bubble Ultrasound

• Definition
• New codes 76978-76979
• Once per lesion
• 76979 can only be reported if a separate contrast injection is performed on each additional lesion.
• Injection code can’t be reported separately
Whole Breast Ultrasound

- Whole Breast US/Automated Breast US
  - Screening Study
  - Dense Breasts
- Coding
- Coverage
Category III & Unlisted Codes

• Category III Codes
  • New & Emerging Technology
  • Required to Report
  • Data Collection
• Unlisted Codes
• Reimbursement
Communication with Providers

• Back to Basics
  • W-W-W-W-W-H
• Language Barrier
• Have a Structured Plan & Process
Q&A
Thank you!

Jennifer Bash, RHIA, CIRCC, CPC, RCC
Director of Coding Education

ADVOCATE Radiology Billing
10567 Sawmill Parkway, Suite 100 | Powell, Ohio 43065
jennifer.bash@radadvocate.com | www.radadvocate.com