

## Diagnosis Codes

Many diagnostic radiology services are payable only if the claim is submitted with one of a limited number of diagnosis codes that the payor has designated as appropriate for that service. This makes accurate diagnosis coding very important for correct reimbursement. It also means that there are compliance risks for radiology groups and imaging centers that do not follow correct diagnosis coding procedures.

All effective coding and compliance programs should include auditing and monitoring of diagnosis codes, particularly since these codes often determine medical necessity for purposes of reimbursement.

### Documentation of Diagnosis

The Balanced Budget Act (BBA 4317(b)) requires the referring physician to provide diagnostic information to the testing facility at the time the test is ordered. Good clinical history is essential both for patient care reasons and also for coding purposes. Imaging facilities should provide education to referring physicians who frequently fail to communicate appropriate clinical history.

With the move to electronic health records and computerized physician order entry systems, it is becoming more common to receive a request for a diagnostic study with only a numerical diagnosis code listed as the reason for the study. When the referring physician provides only the numerical code with no descriptive statement of the patient's diagnosis, the radiologist may not be able to determine the clinical diagnosis for which the patient is being referred and ensure the most appropriate imaging study is performed.

This problem is compounded if the patient's treating physician or treating physician's office staff selects an unspecified diagnosis code, an incorrect diagnosis code, or one not supported by the patient's medical record. As Medicare and other payors increase their audit focus on imaging and their ability to analyze claims data for patients across providers, the importance of having a specific and accurate detailed diagnostic statement increases.

According to the Fourth Quarter 2015 issue of *Coding Clinic*<sup>®</sup>, it is "not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement." The provider is responsible to "provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes." Some diagnosis codes include multiple conditions, and the code number in and of itself does not provide sufficient information about the patient's condition.

In addition, the ACR *Practice Parameter for Communication of Diagnostic Imaging Findings* states that the request for an imaging study should include "relevant clinical information, a working diagnosis, and/or pertinent clinical signs and symptoms." This information is essential in customizing the exam protocol and interpretive report.

In summary, an order containing only an ICD-10-CM code and no clarifying diagnostic statement does not meet regulatory requirements and clinical standards of care.

## Documentation Requirements

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### **Electronic Health Records**

With the implementation of electronic health record (EHR) systems, CMS and the OIG are becoming increasingly concerned with the use of templates to meet documentation requirements.

Many radiologists use macros and templates while dictating radiology reports. Therefore it is very important to consider possible ramifications for compliance as well as ease of use for radiologists when designing the macros and templates.

The objective of macros and templates is to outline important elements to be included in the diagnostic report, insert information documented by other members of the clinical team, or add standard clinical guidelines (mammography statistics). For example, if the Radiology Information System (RIS) requires the technologist to enter medication information during the examination process, it is appropriate to pull the medication information into the radiology report.

Default language should not be used to create the entire report. The radiologist must include patient specific observations and should not rely solely on standard statements for negative or normal studies. This is different than structured reporting used by some radiologists in creating mammography reports. For structured reports, the radiologist documents specific elements of the exam in the mammography tracking system which then creates a report using standard text for each element documented.

When building a template, be sure to include all of the recommended elements from the *ACR Practice Parameter for Communication of Diagnostic Imaging Findings*.

## Modifiers

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Guidance on modifier use is available in the CPT® manual, in *CPT® Assistant*, and in the National Correct Coding Initiative Policy Manual. Additionally, please see the National Correct Coding Initiative section of this *Navigator®* (page 66) for information about modifier 59 and the Advance Beneficiary Notice section (page 117) for information about ABN-related modifiers.

When reporting multiple modifiers on a single procedure code, modifiers that determine the payment should be sequenced first, followed by informational modifiers. For example, modifier 26 (Professional component) should be sequenced before modifier LT (Left side).

### Professional and Technical Components

The professional component of an imaging exam or other diagnostic test represents the physician's professional service, including the interpretation and report. The technical component, on the other hand, represents the facility resources needed to complete the exam, including the cost of imaging equipment, technologists, supplies, etc.

When a radiologist interprets imaging studies in the hospital setting, the code for the study must be submitted with modifier 26 (*Professional component*). This tells the payor that the radiologist provided only the interpretation and report, not the facility resources. For example, if a hospital outpatient undergoes a non-contrast MRI of the brain, the hospital will report code 70551 and the radiologist will report code 70551-26.

In some cases an IDTF or physician office will bill only for the technical component of an exam. In this case the imaging facility should apply modifier TC (*Technical component*) to the exam code. For example, a limited breast ultrasound exam is performed at an IDTF, and the radiologist bills separately for the interpretation. In this situation the IDTF would submit code 76642-TC and the radiologist would submit 76642-26.

Hospitals generally do not use modifier TC. Payors will automatically treat hospital claims as claims for the technical component, even though there is no modifier.

## Orders for Diagnostic Tests

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physician office or independent diagnostic testing facility (IDTF). The requirements for the hospital setting are discussed in a subsequent section.

Of note, The Protecting Access to Medicare Act of 2014 Section 218 mandates the use of appropriate use criteria (AUC) in the ordering of any advanced imaging exams for Medicare patients in all non-inpatient places of services, including the Emergency Room, effective January 1, 2017; however this implementation date has been delayed to January 1, 2018. (See the 2017 Medicare Physician Fee Schedule Final Rule.) Referring clinicians will be required to consult AUC utilizing a CMS approved Clinical Decision Support Mechanism (CDSM) but only the provider who does the imaging study will be denied payment if there is no decision support verification. The mandate leaves it up to the Medicare agency to set the rules for how the process for submitting claims with decision support verification is done and what guideline content is acceptable. Every advanced imaging order will have to have a standard way to address CDS. More information will be forthcoming on this monumental change occurring in the radiology industry.

### Required Elements for a Valid Order

All orders for diagnostic imaging studies should include the following elements, regardless of the payor:

- Specific Test to be Performed – The referring physician may request a test with specific views or protocols, such as “Chest x-ray PA and lat” or “MRI T-spine without contrast.” Alternatively, the referring physician may request a more general category of exam, such as “CT Abdomen & Pelvis” or “Ankle x-ray.” Both types of requests represent valid orders.
- Clinical Indications – The referring physician must supply the patient’s signs, symptoms, confirmed diagnosis, or other reason for ordering the exam. Orders received without any clinical indications or with “rule out” conditions do not provide enough information to determine whether the exam meets the payor’s coverage criteria.
- Referring Physician/Practitioner Name – The name of the referring physician or NPP can be in the header of the order, as on a prescription form, or typed under a signature, or handwritten. If multiple provider names are on the order it is acceptable for the name of the referring provider to be circled.
- Referring Physician/Practitioner Signature – If the referring provider name is not typed or hand printed anywhere on the order, the provider’s signature must be legible (see discussion on signature requirements for more detailed information).