Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

CPT® five digit codes, nomenclature, and other data are copyright 2006 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or service(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.
Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

Ms. Buck has served in several different roles during her 14-year career in health information management including as a medical records coordinator, medical coder, a revenue analyst, an internal auditor, corporate compliance officer, and consultant. She is currently Vice President and Managing Partner of Southeast Radiology Management in Stuart, Florida.

She is on the editorial advisory board for the HCPro newsletters Mammography Regulation Report, Radiology Administrator’s Compliance Insider, Health Care Auditing Strategies and she is a frequent contributor to Strategies for Health Care Compliance and to Compliance Monitor Q & A’s Ask the Expert. In addition, she is the author of the recently released Radiology Technologist’s Coding Compliance Handbook and is a Contributing Editor for The Radiology Manager’s Handbook: Tools & Best Practices for Business Success. Stacie also is an audioconference presenter for HCPro, the Coding Institute and the American Health Information Management Association (AHIMA).

An adjunct instructor and advisory board member for the health information management program at Indian River Community College in Florida, Stacie also serves in the AHIMA Mentoring program. Recently she was the recipient of several awards including the 2005 AHIMA Rising Star Award, FHIMA Outstanding Professional Award & FHIMA Literary Award.

Stacie is a current member of the American Health Information Management Association (AHIMA), the Florida Health Information Management Association (FHIMA) and the Suncoast Health Information Management Association (SHIMA). She serves on the AHIMA Physician Practice Council and is President of the Florida Health Information Management Association.

Stacie graduated Magna Cum Laude from Florida International University with a Bachelor of Science degree in Health Information Management after earning an Associate of Arts degree in Business Administration.
# Table of Contents

Disclaimer .......................................................................................................................... i
Faculty ................................................................................................................................ ii
Objectives ......................................................................................................................... 1
CPT Guidelines.................................................................................................................. 1
Supervision and Interpretation ......................................................................................... 2
CMS Guidelines ............................................................................................................... 3
Contrast Materials ............................................................................................................. 3
Coding and Documentation .............................................................................................. 4

## Report Documentation
- Screening Mammography ............................................................................................. 5
- Diagnostic Mammography ............................................................................................. 6
- Diagnostic vs. Screening Mammography ....................................................................... 6

## High Risk V codes
- OB – 76815 .................................................................................................................. 20
- OB vs. Abdominal ......................................................................................................... 20
- OB – 76816 .................................................................................................................. 21
- Ultrasound Guidance ................................................................................................... 21
- US w/US Guidance ....................................................................................................... 22
- US Guidance – Vascular Access .................................................................................. 23
- Duplex Scans ................................................................................................................. 23
- Coding Guidelines ......................................................................................................... 25

## US Documentation Guidelines
- CPT ................................................................................................................................. 14
- Abdomen ......................................................................................................................... 15
- Retroperitoneum ............................................................................................................. 16
- Abdominal and Retroperitoneal ..................................................................................... 17
- Pelvic vs. Retroperitoneal .............................................................................................. 17
- Transabdominal .............................................................................................................. 18
- Transabdominal vsTransvaginal .................................................................................. 18
- OB vs. Pelvic .................................................................................................................. 19
- OB vs. Abdominal ......................................................................................................... 20
- OB – 76815 .................................................................................................................. 20
- OB – 76816 .................................................................................................................. 21
- Diagnostic vs. Screening Mammography .................................................................... 6
- Diagnostic Mammography ........................................................................................... 6

## Code Signs/Symptoms
- No Reason for Test ....................................................................................................... 27
- Coding Guidelines ......................................................................................................... 25

## Common Radiology Modifiers
- “Pecking” Order for Dx Coding ..................................................................................... 28
- -26 and -TC ................................................................................................................... 29
- -50 and -52 .................................................................................................................... 30
- -53 ................................................................................................................................. 31
- -50 ................................................................................................................................. 32
- -76 and -77 ................................................................................................................... 33
- -GG, -GA, -GY and -CZ ............................................................................................... 34

## Florida Whistleblower Case
- Why the Confusion ....................................................................................................... 36

## 42 CFR 410.32
- 42 CFR 410.32 ............................................................................................................. 38

## Common Questions
- Common Questions ......................................................................................................... 40
# Table of Contents

Test Orders in the Hospital Setting .................................................................................43  
ACR Guidelines for Communication .................................................................................43  
References and Resources .............................................................................................44  
Audience Questions  
Appendix ..................................................................................................................48  
   CE Certificate Instructions
Objectives

- Review ICD-9-CM Diagnostic and CPT coding guidelines for radiology services including X-Ray, Ultrasound, CT, MRI, PET, Nuclear Medicine, and Mammography.
- Discuss modifier usage, contrast media, supervision and interpretation.
- Review documentation requirements for accurate code assignment and for Medical Necessity/ABN.

CPT Guidelines

- CPT-Specific Guidelines
  - Carefully review the guidelines at the beginning of each section in CPT
  - Know and adhere to the subsection- and code-specific guidelines and documentation requirements.
  - Utilize CPT Assistant references when available/applicable.
  - Clinical Examples in Radiology - AMA/ACR
CPT Guidelines

- Written report, signed by the interpreting physician should be considered an integral part of a radiologic procedure or interpretation.
- When a procedure is performed by 2 physicians, the radiologic portion of the procedure is designated as “RS&I”
  - If physician performs both procedure and RS&I use surgical codes in addition.

Supervision and Interpretation

- Radiological supervision and interpretation (RS&I) codes require just that - both supervision and interpretation by the radiologist
- If either supervision or interpretation is not performed, append a modifier - 52 to the RS&I code
CMS Guidelines - NCD and LCD

- Although the Medicare Manuals may not specifically address elements required for a report, don’t forget there may be specific NCD or LCD documentation requirements!
- Locate and review all applicable coverage determinations.

Contrast Materials

- “With contrast" refers to contrast administered:
  - Intravascularly
  - Intra-articularly
  - Intrathecally
**Contrast Materials**

- Injection of IV contrast is part of the "with contrast" - CT, CTA, MRI, and MRA procedures.
  - For intra-articular injection, use the appropriate joint injection code.
  - For spine examinations "with contrast" - intrathecal or intravascular injection.
    - For intrathecal injection, use also 61055 or 62284.
- Oral and/or rectal contrast administration alone does not qualify as a study "with contrast."

**Contrast Coding and Documentation**

- Route of administration
- Type
- Concentration
- Amount

- Injecting the material is “bundled”, however the appropriate HCPCS code should be assigned for the contrast.
Report Documentation

- Number and types of views
- Amount, type and route for contrast
- Separate interpretations for each exam performed
- Don’t forget to check your LCDs!
  - Medical necessity
  - Documentation requirements

Screening Mammography

- 77057
  - Performed on asymptomatic females that have not manifested any clinical signs, symptoms, or physical findings of breast cancer.
  - CC & MLO views are obtained of each breast.
**Diagnostic Mammography**

- **77055 & 77056**
  - Also called problem-solving mammography or consultative mammography
  - Performed because there is a reasonable suspicion that an abnormality may exist
    - Clinical signs, symptoms, or physical findings suggestive of breast cancer
    - An abnormal or questionable screening mammogram
    - A personal history of breast cancer
    - A personal history of biopsy-proven benign breast disease.
    - A woman is asymptomatic, but based on her history and other factors the physician feels diagnostic is appropriate
  - Additional views performed

---

**Diagnostic vs. Screening Mammogram**

- **Implants**
  - **ACR**: Asymptomatic, diagnostic; Symptomatic, diagnostic
  - **CMS**: Asymptomatic, screening; Symptomatic, diagnostic
- **History of biopsy-proven benign disease**
  - **ACR**: Diagnostic
  - **CMS**: Diagnostic or screening as determined by referring physician
- **History of mastectomy**
  - **ACR**: Diagnostic (life-long)
  - **CMS**: May revert to a screening as determined by the referring physician
V76.11 vs. V76.12

- What constitutes “high risk”?
- CMS considers the following patients to be high risk:
  - Has a personal history of breast cancer (V10.3)
  - Has family history of breast cancer (V16.3)
    - Mother
    - Sister
    - Daughter
  - Had her first baby after age 30 (V15.89)
  - Has never had a baby (V15.89)
- Assign V76.11 as primary, above as secondary

3D Rendering - 76376/76377

- 76376
  - 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation

- 76377
  - 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post-processing on an independent workstation
3D Rendering - 76376/76377

- 76375 Deleted for 2006
- 2D no longer separately billable
  - Coronal
  - Sagittal
  - Multiplanar
  - Oblique reformats
- from 2D axial images

Clinical Examples in Radiology, Volume 2, Issue 1: Winter 2006

- New codes represent complex renderings:
  - Shaded surface
  - Volumetric rendering
  - Quantitative analysis (segmental volumes and surgical planning)
  - Maximum Intensity Projections (MIP)
- Performed on scanner or independent workstation
- Should not be reported in conjunction with CTA, MRA, PET, CT colonography, nuclear medicine codes or the Category III cardiac CT/CTA codes.
3D Rendering - 76376/ 76377

Required documentation

• Test order
  • Do I need an order from the referring doctor to bill for 3D rendering?

• Radiology Report
  • Must the radiology report state “3D images acquired” or “3D images acquired on independent workstation”?

Clinical Examples in Radiology, Volume 2, Issue 1: Winter 2006
ACR Coding Source, November/December 2005

What does “concurrent supervision” mean?

• Active participation in and monitoring of process
  • Design of anatomic region
  • Determination of tissue types and structures to be displayed
  • Determination of the images or cine loops to be archived
  • Monitoring and adjustment of 3D work product
**PET 78811 - 78813**

- Radiopharmaceutical injected
- Acquisition and reconstruction of PET data in multiple planes
- Physician reviews the study for adequacy and determines if additional acquisitions are needed
- Images are interpreted by physician and compared with any prior imaging studies
- Quantification of an abnormality is made by the calculation of the SUV when clinically indicated

**PET/CT 78814-78816**

- Radiopharmaceutical injected
- Acquisition of CT data and reconstruction of PET data in multiple planes
- Using a computer workstation, the physician overlays PET and CT images to create images for anatomic correlation
- Physician reviews 3 sets of images
  - PET Scans
  - CT anatomical localization data
  - Combined - images superimposed
- Images are interpreted by physician and compared with any prior imaging studies
- Quantification of an abnormality is made by the calculation of the SUV when clinically indicated
PET and PET/CT

- 78814 - 78816 reported once per imaging session
- The PET/CT codes designate that the CT portion of the procedure is for attenuation correction and anatomical localization.
- CT other than that for attenuation correction and anatomical localization (diagnostic CT) is reported using the appropriate site specific CT code with modifier -59
- Sites are able to bill a diagnostic CT procedure when it is separately ordered and medically necessary with a PET/CT scan
- If billing separately for FDG HCPCS code A9552

PET and PET/CT

- We have a PET/CT Integrated System and the referring physician’s initial order states PET study. Can we perform and bill a PET/CT?
- A referring physician has ordered a diagnostic CT and a PET/CT for anatomic localization on the same day. Our current PET/CT integrated system is capable of performing diagnostic CTs. How are these studies coded?

SNM Comments/Guidelines for PET/CT with Integrated Systems, July 2005
PET and PET/CT

- We have a PET/CT Integrated System. A referring physician has ordered a diagnostic CT and a PET/CT for anatomic localization on the same day. Our current PET/CT integrated system is capable of performing diagnostic CTs. How are these studies coded?

- If a PET/CT and a diagnostic CT are performed on the same day, how are these studies coded?

SNM Comments/Guidelines for PET/CT with Integrated Systems, July 2005

PET and PET/CT

- Who can make the determination that a PET/CT and a diagnostic CT are required?

- We have a PET only system, but we acquire a CT for fusion following the PET scan. Can we use the PET/CT CPT codes 78814-78816?

SNM Comments/Guidelines for PET/CT with Integrated Systems, July 2005
Source: ACR Coding Source, July/Aug 2005
**PET and PET/CT**

- We are fusing PET scans with both CT and MRI studies NOT acquired concurrently with integrated systems, how do we code for these studies including the fused images?

SNM Comments/Guidelines for PET/CT with Integrated Systems, July 2005

---

- Can I report 3D rendering in addition to a PET and PET/CT for anatomic localization procedure if the report documents this was completed?

- Do I code and bill separately using CPT or HCPCS Level II codes for the PET radiopharmaceuticals?

SNM Comments/Guidelines for PET/CT with Integrated Systems, July 2005
- Permanently recorded images with measurements, when such measurements are clinically indicated.
- A final, written report
- Complete vs. limited
  - To code complete – a description of elements or the reason an element could not be visualized (e.g., obscured by bowel gas, surgically absent etc.).
  - If less than the required elements for a "complete" exam are reported (e.g., limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic region should be used once per patient exam session.

- Doppler evaluation of vascular structures is separately reportable (other than color flow used only for anatomic structure identification). 93875-93990
- Ultrasound guidance
  - permanently recorded images of the site to be localized
  - documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.
- Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.
For those anatomic regions that have "complete" and "limited" ultrasound codes, note the elements that comprise a "complete" exam. The report should contain a description of these elements or the reason that an element could not be visualized (e.g., obscured by bowel gas, surgically absent etc.).

If less than the required elements for a "complete" exam are reported (e.g., limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic region should be used once per patient exam session. A "limited" exam of an anatomic region should not be reported for the same exam session as a "complete" exam of that same region.

**US Documentation Guidelines - CPT**

- Liver
- Gall bladder
- Common bile duct
- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta
- Inferior vena cava
Limited US - Abdomen

- If an US is performed on 2 quadrants (LLQ & RLQ) is it appropriate to bill 76705 twice?

AMA CPT Assistant, April 2003

Retroperitoneum Complete

- Kidneys
- Abdominal aorta
- Common iliac artery origins
- Inferior vena cava,
- If clinical history suggests urinary tract pathology include
  - Kidneys
  - Urinary bladder
Both abdominal US and retroperitoneal US include kidneys
• Can both be reported?

ACR Coding Source, July/August 2005

Pelvic vs. Retroperitoneal

What code should be reported for:
• Kidneys and urinary bladder?
• Kidneys only?
• Bladder only?

ACR Coding Source July/August 2005
CPT Guidelines
Transabdominal US - 76856

- Includes the complete evaluation of the female pelvic anatomy.
  - description and measurements of the uterus and adnexal structures,
  - measurement of the endometrium,
  - measurement of the bladder (when applicable),
  - a description of any pelvic pathology (eg, ovarian cysts, uterine leiomyomata, free pelvic fluid).
- Applicable to a complete evaluation of the male pelvis.
  - evaluation and measurement (when applicable) of the urinary bladder
  - evaluation of the prostate and seminal vesicles to the extent that they are visualized transabdominally
  - any pelvic pathology (eg, bladder tumor, enlarged prostate, free pelvic fluid, pelvic abscess).

Transabdominal and Transvaginal US

- If order states Pelvic US, and both transabdominal and transvaginal are performed can both be coded?
  - If a T/A US does not yield an adequate examination (i.e. ovaries and adnexa not visualized due to superimposed distended gas-filled loops of bowel) a T/V exam is medically necessary to fully evaluate the ovaries and adnexa
    - Code the T/V study (76830) in addition to the T/A study
**OB vs. Pelvic US**

- Patient presents with an established diagnosis of pregnancy and signs and symptoms that could be pregnancy related
  - Report the OB US code (76801-76815)
- Outcome that patient is not pregnant or has an US diagnosis that might not be related to pregnancy (eg, acute appendicitis, torsed ovary, necrotic fibroid).
  - Report the OB US code (76801-76815)

*AMA CPT Assistant, October 2001*

---

**OB vs. Pelvic US**

- Patient presents without an established diagnosis of pregnancy presents with gynecological problems necessitating ultrasound evaluation (eg, dysmenorrhea, oligomenorrhea, menstrual irregularity, pelvic pain)
  - Report code 76856 or 76857.
  - Use of these codes whether or not the outcome of the US is the diagnosis of pregnancy or a complication related to a pregnancy.

*AMA CPT Assistant, October 2001*
**OB and Abdominal US**

- Decision to order and perform an abdominal US is based on indications independent of the state of the patient's pregnancy status, even if the abdominal complication of a pregnancy is suspected (e.g., pyelonephritis secondary to ureteral obstruction by a pregnancy or suspected cholecystitis in a pregnant patient with right upper quadrant pain).

- The abdominal ultrasound codes 76700, 76705 should be reported for an ultrasound of the abdomen when signs and symptoms indicate the necessity of an abdominal ultrasound procedure.

  *AMA CPT Assistant, October 2001*

**OB - 76815**

- Use 76815 for a quick look of one or more of elements in code

- Code 76815 per exam, not fetus
  - Modifier not appropriate for multiple fetuses

  *AMA CPT Assistant, March 2003*
OB - 76816

- Reassessment of fetal size and interval growth
- Re-evaluate anatomic abnormalities on a previous US
- Code once per fetus
- Append modifier -59 for each additional fetus

*AMA CPT Assistant,* March 2003, Nov 2003

Ultrasound Guidance

- CPT 2005 clearly states that permanent images of the target area are required when imaging guidance is utilized.
- Limited sonography of the target area is included in imaging guidance codes.

*ACR Coding Source, Sept/Oct 2005*
Ultrasound Guidance

- **Is the radiologist required to state in the report “permanent images are stored?”**
  - Radiologist is required to dictate a statement about the localization process, eg, ultrasound guidance was used for needle placement, NOT that permanent images are stored.
  - “Permanent images” should be retrievable in the event of a practice audit.

  *ACR Coding Source, January/February 2005*

US w/ US Guidance

- Patient presents with an order for an US-guided thoracentesis or paracentesis and the technologist performs a limited US to evaluate how much fluid (if any) is present and in which location.
  - **Is it appropriate to charge a limited diagnostic US in addition to the guidance and procedure code?**

  *ACR Coding Source, September/October 2005*
US Guidance - Vascular Access

- CPT code 76937 specifically lists the requirements for using this code:
  - ultrasound evaluation of the potential access sites
  - documentation of selected vessel patency
  - concurrent real-time ultrasound visualization of vascular needle entry
  - permanent recording and reporting.

Duplex Scans

- Combines Doppler and conventional ultrasound
  - Conventional US: view structure of blood vessels
  - Doppler US: view movement and speed of blood through the vessels
- Duplex ultrasound produces images that can be color coded to show physicians where blood flow is blocked
US and Duplex - To Code or Not to Code?

- Doppler studies should **NOT** be routinely performed and billed in conjunction with US
- When it is **medically necessary** to perform a vascular study in conjunction with ultrasound of an organ, it is appropriate to report the vascular study separately, however,
  - to code a duplex study, true vascular analysis needs to be performed
  - duplex should not be coded when color is just turned on to determine if a structure is vascular

Ultrasound and Duplex

- NCCI edits allow -59 modifier
- Edits designed to prevent inappropriate use of the noninvasive Doppler imaging codes
  - when Doppler is performed with a real-time US study for anatomical structure identification
  - where an evaluation of blood flow is performed for a valid medical reason in addition to gray scale evaluation, billing of both CPT codes is justified.

*ACR Coding Source, Nov/ Dec 2005*
US and Duplex - Orders

- Documentation of an order from a physician for both examinations should be maintained.
  - In the hospital setting, the ordering physician may be the radiologist.
  - An order from the referring physician is required in the freestanding (nonhospital) and IDTF setting.

ACR Coding Source, Nov/Dec 2005

Coding Guidelines

- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition, or problem. Do not code a suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity.
- Code chronic conditions when they apply to the patient’s treatment and code all documented conditions that affect treatment.
- Do not code conditions that no longer exist.
Coding Guidelines

- Use the following guidelines to assign the primary diagnosis code
  - Code a diagnosis confirmed by test results
  - Code signs/symptoms when findings are normal or when the findings are uncertain (i.e. probable, suspected, questionable)
  - Do not code incidental findings or unrelated co-existing conditions
  - For screening tests (those performed in the absence of signs/symptoms) assign the appropriate V code (findings are coded as secondary)

Signs/symptoms or a diagnosis?

- Section 4317(b) of the Balanced Budget Act (BBA), requires referring physicians to provide this diagnostic information to the testing entity at the time the test is ordered. If the referring physician indicates a “rule out,” he/she must also include signs/symptoms prompting the exam for the “rule out” condition.
No Reason for Test?

- If the referring physician is unavailable to provide information, it is appropriate to obtain the information directly from the patient or the patient’s medical record if it is available.

- However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

Code Signs/Symptoms

- Test performed and the results are back but the physician has not yet reviewed them to make a diagnosis, or there is no interpretation.

- No report of the physician interpretation at the time of billing, code what is known at the time of billing.
**Coding FAQs**

- Can I code from the header of the radiology report?
  - Must the body of the report support the exam stated in the header?

- If a radiologist uses the phrase “consistent with” in his report can I code the condition as a definitive diagnosis?
  - Coding Clinic, 3rd Quarter 2005

---

**“Pecking” Order for Dx Coding**

- Radiology Report
  - Findings
  - Indications
- Test orders
Common Radiology Modifiers

-26
-50
-52
-53
-59
-76
-77
-GG
-GA, GY, GZ
-TC

-26 Modifier and -TC Modifier

- Professional Component (interpretation) - Modifier -26
  - Physician work
  - Practice expenses
  - Malpractice expenses

- Technical Component - Modifier -TC
  - Technologist services
  - Equipment
  - Supplies
  - Overhead associated with service
-50 Modifier

- Bilateral Procedure
- Unless otherwise indicated in the CPT descriptor or MPFSDB, bilateral procedures that are performed during the same operative session should be identified by appending modifier -50 to the appropriate five-digit code.
- Do not add modifier -50 to CPTs that are inherently bilateral (e.g. 76645).

-52 Modifier

- Reduced Services
- Procedures for which services performed are significantly less than usually required
- Some codes have no code for less than two views.
  - When only one view is performed and there is no code for the single view, the -52 modifier would be used.
-52 Modifier

• Reduced Services
  • For hospital outpatient reporting of a procedure/service that is partially reduced or cancelled due to extenuating circumstances or those that threaten the patient’s well-being (prior to or after the administration of anesthesia), see modifiers -73 and -74.

-53 Modifier

• Discontinued Procedure
  • Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure
  • Extenuating circumstances
  • Patient’s well being is threatened
  • Examples:
    • SBB attempted but calcifications are too small to be biopsied
    • Patient elects to terminate procedure in office or clinic setting after local anesthesia has been administered and the procedure has been started
-53 Modifier

- Discontinued Procedure
  - Do not use modifier -53 to report elective cancellation of a procedure prior to anesthesia and/or surgical prep in the operative suite.
  - For outpatient hospital or ASC reporting of a procedure/service that is partially reduced or cancelled due to extenuating circumstances or those that threaten the patient’s well being (prior to or after the administration of anesthesia), see modifiers 73 and 74.

-59 Modifier

- Separate session/encounter
- Different site, organ system
- Separate excision/incision
- Separate lesions
- Treatment of separate injuries
**-76 Modifier**

- Repeat Procedure by Same Physician
- A procedure or service was repeated subsequent to the original procedure or service.
  - Example: A 2-view chest x-ray is read by Dr. Jones at 0600 hours. A second 2-view chest x-ray performed at 1000 hours is also read by Dr. Jones. The second 71020 should have a modifier -76 appended.

**-77 Modifier**

- Repeat Procedure by Another Physician
- A basic procedure or service performed by another physician had to be repeated.
  - Example: A 2-view chest x-ray is read by Dr. Jones at 0600 hours. A second 2-view chest x-ray performed at 1000 hours; this study is read by Dr. Smith. The second 71020 should have a modifier -77 appended.
**-GG Modifier**

- Performance and payment of a screening mammography and diagnostic mammography on same patient same day.
- Attach to Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test; contractors will pay both the screening and diagnostic mammography tests.
- This modifier is for tracking purposes only.

**-GA, -GY, -GZ Modifiers**

- GA: Waiver of Liability [ABN] on file
  - For services not considered reasonable and necessary by Medicare for which payment is expected to be denied, an ABN should be obtained.
  - The physician/provicer should use the GA modifier on the claim to indicate that an ABN has been obtained and is on file for the service.
-GA, -GY, -GZ Modifiers

**GY: Service is statutorily non-covered**
- “A service denied as statutorily non-covered is denied as such based on the Social Security Act, Title 18 (SSA), which specifically indicates or states the service is limited in coverage or excluded from coverage, or because the circumstances under which it was rendered cause it to be non-covered.”
- Modifier GA and GZ should never be filed in conjunction with modifier GY.

-GA, -GY, -GZ Modifiers

**GZ: Service deemed not medically necessary**
- A service that is denied as not medically necessary is normally a covered service, but is being denied for medical necessity, such as the diagnosis does not support the need for the service.
- These situations, an acceptable denial of medical necessity, should never be filed with modifier GY.
-GA, -GY, -GZ Modifiers

- GZ: Service deemed not medically necessary
  - If an ABN is not obtained prior to a service being rendered and you believe the item or service could be denied as not medically necessary, the item or service can be filed with modifier GZ.
  - Modifier GA and GZ should never be filed in conjunction with modifier GY.

---

Florida Whistleblower Case
ACR Coding Source, July/Aug 2004

June 23, 2004 – DOJ announced that Radiology Regional Center, PA, (FL) had agreed to pay $2.5 million to settle charges that it filed false Medicare claims.

The suit alleged that the group billed for numerous studies that treating physicians did not order or otherwise were not reimbursable.

- Retroperitoneal ultrasound procedures (76770)
- Noninvasive physiologic studies of the extracranial arteries and extremity veins performed in conjunction with duplex scans of the same arteries and veins (93875/93880, 93965/93970, 93965/93971)
- Magnetic resonance imaging (MRI) of the orbit, face and neck
- Reconstruction imaging (76375)
- Mammograms that the DOJ alleged did not qualify as diagnostic and should have been billed as screening mammograms

---
Lessons from the Florida Case

ACR Coding Source, July/Aug 2004

- Ordering of Diagnostic Tests - practices must know what rules apply to each place of service (i.e., hospital vs. freestanding vs. office setting).
- Reinforces the need for radiologists to communicate with referring physicians and to document their efforts to obtain adequate orders and clinical indications when necessary for a requested study—even if the referring physician or office fails to provide such vital information.
- Shows the value of a useful compliance plan that follows the OIG model guidance for physician practices.

Why the confusion?

- Different rules for different settings
  - Hospital
  - Provider Based
  - IDTF
**42 CFR 482.26**

- Radiology services must be provided only on the order of practitioners with clinical privileges, or consistent with state law, or other practitioners authorized by the medical staff and governing body to order the services.

**42 CFR 410.32**

- All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

- Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary
42 CFR 410.32

- Mammography exception. A physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary.

42 CFR 410.33 - IDTFs

- All procedures performed by the IDTF must be specifically ordered in writing by the physician who is treating the beneficiary.

- The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF’s supervising physician is in fact the beneficiary’s treating physician.

- IDTF may not add any procedures based on internal protocols without a written order from the treating physician.
Common Questions

- **Does the referring physician need to include signs/symptoms or a diagnosis?**
- **What constitutes an order?**
- **Can a testing facility modify an order?**
- **Can a testing facility perform additional tests if necessary?**
- **Are there any exceptions to the rules?**

**Does the referring physician need to include signs/symptoms or a diagnosis?**

- Section 4317(b) of the Balanced Budget Act (BBA), requires referring physicians to provide this diagnostic information to the testing entity at the time the test is ordered. If the referring physician indicates a “rule out”, he/she must also include signs/symptoms prompting the exam for the “rule out” condition.
What constitutes an order?

- An "order" is a communication from the treating (referring) physician/practitioner requesting that a diagnostic test be performed for a beneficiary.
  - Written document
  - Telephone call
  - Email
- May be conditional

Can a testing facility modify a test order or perform additional tests?

- The treating (referring) physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient.
- A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order.
- This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.
Can a testing facility modify a test order or perform additional tests?

- Depending upon the site of service (hospital vs. non-hospital)
  - Medicare's Ordering of Diagnostic Tests Rule
    (Medicare Carrier Manual, 15021, Transmittal 1725)

ACR Coding Source, Sept/Oct 2005

Are there any exceptions?

- YES!
  - 5 criteria for additional tests must be met
    - Test originally ordered is performed
    - Based on result additional diagnostic test is necessary
    - Delaying performance of test would have adverse effect
    - Result communicated to referring physician and used in treatment of patient
    - Interpreting physician documents why additional testing is done

  - Test design
  - Clear error
  - Patient condition
Test Orders in the Hospital Setting

- Considerations
  - Just because something is permitted under regulation doesn’t mean it is a sound business practice!
    - Compliance
    - “Protocols”
    - Medical Necessity
    - Preauthorization

ACR Guidelines for Communication

- “Effective communication is a critical component of diagnostic imaging. Quality patient care can only be achieved when study results are conveyed in a timely fashion to those ultimately responsible for treatment decisions.”
- “An official interpretation (final report) shall be generated and archived following any examination, procedure, or officially requested consultation regardless of the site of performance (hospital, imaging center, physician office, mobile unit, etc.)”
ACR Guidelines for Communication

- Demographics
- Clinical indications
- Description of procedures
- Materials
- Findings
- Limitations
- Clinical issues
- Comparative data
- Impression

References/Resources

- Coding for Mammography Services, JAHIMA, July/August 2007
- Medicare Claims Processing Manual - Chapter 13 and Chapter 23
- PET and PET/CT FAQs - Society of Nuclear Medicine
- Modifier -59 Decision Tree
- Clearing Up the Confusion - 76376 & 76377
Audience Questions

Audio Seminar Discussion

Following today’s live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) – icon on top right
AHIMA Member ID number and password required – for members only

Join the Radiology Coding and Compliance Community
from your Personal Page then under Community Discussions, choose the Radiology Coding Forum
You will be able to:
• Discuss seminar topics
• Network with other AHIMA members
• Enhance your learning experience
AHIMA Audio Seminars

Visit our Web site http://campus.AHIMA.org for information on the 2007 seminar schedule. While online, you can also register for seminars or order CDs and pre-recorded Webcasts of past seminars.

Upcoming Audio Seminars

ICD-9-CM Coding for Obstetrics
Faculty: Barry Jarnagin, MD and Judy Richardson, MSA, RN, CCS-P
• August 16, 2007
Thank you for joining us today!

Remember – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:


Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate.

Certificates will be awarded for AHIMA and ANCC Continuing Education Credit.
Appendix

CE Certificate Instructions
To receive your

**CE Certificate**

Please go to the AHIMA Web site


click on

“Complete Online Evaluation”

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

*Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.*