UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH
DEPARTMENT OF RADIOLOGY

Coding & Documentation

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Agenda

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2. Charges Write Off Form
3. Radiology Dictations
4. Teaching Physician Presence during Procedures
5. Professional coders contact information
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   - Equivocal language
   - Duplex scans
   - Complete and limited ultrasound scans.
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Compliance Reminder

Do not dictate a report for any radiologic examination that occurred before your start date (7/1/2022).

You are not credentialed for any date of service prior to that date.

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CHARGES WRITE OFF FORM

(This form is obsolete. If you need to write off a charge due to one of the reasons below see the technician so that the appropriate modifier, ERR, can be added to the charge session.)

Patient Name _____ **MR#** _____
Type of Exam _____ **Date/Time of Exam**_____

Select all that apply:

[__] Only scout images obtained _____
[__] Incomplete imaging (no diagnostic info) _____
[__] Incomplete imaging (some diagnostic info) _____
[__] Contrast administered: Yes or No (circle one)
[__] Patient refusal
[__] Incorrect study performed
[__] Incorrect study ordered
[__] Other - Describe what took place:

_____

Professional charges only:

[__] no charge
[__] Limited charge (52 modifier)
[__] full charge

(*Must obtain all signatures before handing in*)

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RADIOLOGY DICTATIONS--STANDARD FORMAT

* Must be included in every report.

*1. In the title of the exam, identify the specific procedure(s) the number of views performed (or specific views), and the use of contrast (if applicable). Example: AP, lateral and oblique views of the right knee.

a. For interventional, specify each selective catheterization separately (if applicable), or specify selective vs. super-selective (i.e., 1st vs. 2nd order branches, et..) (e.g., visceral arteriogram with selective celiac arteriography (1st order branch) and superior mesenteric arteriography (1st order branch).

b. For procedures performed by non-radiology services, specify whether guidance/over-read was performed (e.g., "intraoperative fluoroscopic guidance provided to Liver Transplant Service" or "ultrasound guidance provided to OB/GYN Service for uterine cyst aspiration").

c. For Outside Films (OSFs), dictate the specific studies that are being over-read (e.g., "CT Chest with contrast"). Specify types of images (reformats, etc.) Also include whether contrast was used and the facility where the study originated.

*2. Comparison: Provide exam date and time of previous study used as comparisons for current study.

*3. Indication: Provide all relevant clinical signs and symptoms relating to the requested x-ray, history, known diagnoses related to procedure ordered (e.g., "right foot ischemia S/P right femoral-popliteal bypass graft in 2016"). Include any important changes that have occurred since the order was placed.

*4. Moderate (conscious) sedation:

- Face-to-face time
- Time (minutes) spent
- Trainee can include the statement below in the draft report

Beginning with the administration of the sedating agent, I spent *** minutes of continuous face-to-face time with the patient for moderate sedation.

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RADIOLOGY DICTATIONS--STANDARD FORMAT (Continued)

Must be included in every report.

5. Approach/Guidance: List approach (e.g., right common femoral artery antegrade puncture), or type of guidance used (e.g., CT, US, fluoroscopy), if applicable.

6 . Procedure: briefly describe the technical aspects of the procedure.

a. For interventional, indicate each vessel that was accessed and what procedures/radiographs were performed in the vessels (e.g., Following informed consent, the right groin was sterilely prepped and draped in the usual fashion. Following routine local anesthesia, a 6 Fr. Pigtail catheter was placed into the thoracic aorta using standard angiographic technique. Biplane cut-film angiography and bilateral oblique digital subtraction angiography were performed. The patient tolerated the procedure well and was transferred to the ward in stable condition.)

b. For procedures performed by non-radiology services, indicate that Radiology performed guidance/over-read and name the service that performed the procedure.

7. Duration of Procedure: (e.g., "less than one hour", "one to two hours"), if applicable.

8. Complications: List all or "none".

*9. Findings: List 1.
2.

*10. Impression: Brief synopsis.

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RADIOLOGY DICTATIONS--ADDITIONAL GUIDELINES

1. Based on updated Current Procedural Terminology (CPT) guidelines, dictating the number of views is sufficient except for certain CPT codes (e.g., lumbar spine flex/ex) where description of specific views are required.

2. For an O.R. series of films (e.g., multiple chest, abdomen or spine radiographs within a short period of time during surgery), list each end time in your title, and dictate separate paragraphs for each set of films.

3. For CT or MRI scans, it is important to document if the procedures are with, without, or with and without contrast--dictate this information into your title.

Example: "MRI OF THE HEAD WITHOUT CONTRAST"

4. Normally, separate body parts have totally separate reports. However, there are a few exceptions---where the MD may order (e.g. hand and fingers, hand and wrist) and all the views can be obtained on the same film(s). Indicate in the title x-rays that include more than one bone area—dictate separate paragraphs.

Example: "AP & LATERAL VIEWS OF THE HAND WITH WRIST INCLUDED"

Avoid titles such as "Two views of the hand and wrist". It is unclear if two separate charges should be made or if the wrist is included in the hand films.

5. For ultrasound, if a Doppler exam is performed in addition to the scan, please dictate the Doppler in the title.

Example: "ULTRASOUND OF THE LOWER EXTREMITY AND DOPPLER OF THE LOWER EXTREMITY"

6. Outside Films: It is important to dictate the specific type(s) of study(ies) being read. Include whether contrast was used in the study.

7. Other special procedures--you will be instructed on dictation requirements for special procedures in areas in which you may rotate.

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Date: July 2022
To: All New Faculty, Fellows and Residents
From: Robert Bour, M.D., Medical Director, Coding and Compliance
Subject: Teaching Physician Presence During Procedures Involving Residents/Fellows

In 1996-97, Medicare established requirements for teaching physician presence during procedures that involve residents and accredited fellows in-training for a procedure. For studies that require the presence of the teaching physician (see the attached list), and for which the faculty will be billing professional charges, the teaching physician MUST BE:

PRESENT FOR THE ENTIRE PROCEDURE or,

PRESENT FOR THE "KEY PORTION(S)" OF THE PROCEDURE

Current UW Health guideline and based on updated Medicare rules is that the teaching physician must be present for the entire portion of minor procedures, defined as lasting less than 5 minutes. For major procedures, the teaching physician must be present for key portions, which are defined by the teaching physician.

For cases in which the key portion rule is applied the teaching physician must be "immediately available" during the non-key portion in the event he/she needs to be called back into the procedure. "Immediately available" means that the teaching physician must be physically accessible to respond to the patient's urgent change in medical condition during the procedure.

Note that imaging examinations such as radiographs, CT, ultrasound, MRI, or Nuclear Medicine (except those listed on the attached *"Procedure that Require Teaching MD Presence"* document), PET studies and upper and lower GI barium studies do not require teaching physician presence during the performance of the study.

A nurse practitioner cannot be the supervisor of a resident or fellow in-training for this regulation.

Documentation is critical to regulatory compliance. Per UW Health policy, if present for the entire procedure, the resident or fellow can document this presence such as:

"Dr. _____ was present for the entire procedure."

However, if present only for key portions, this must be reflected in the teaching physician's personal documentation, most commonly accomplished with an attestation below the resident/fellow dictation such as:

"Dr. _____ was present during the key portion(s) of the procedure."

The teaching physician is responsible for accurate documentation of his/her role during the procedure if the resident does not correctly dictate that role. We cannot bill for a procedure for which the teaching physician was not present during the entire, or key portion(s) of a, procedure. Medicare considers failure to accurately define the teaching physician's role as fraud and abuse and violators face significant fines and possible imprisonment.

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PROCEDURES THAT REQUIRE TEACHING MD PRESENCE DURING THE ENTIRE PROCEDURE or KEY PORTION(S) OF THE PROCEDURE

Angio- and Neuro-Interventional
ALL procedures, including during local anesthesia, insertion of catheter, injection of contrast, any interventional procedure(s), and through the radiologic imaging portion(s).

Biopsies/Aspirations/Abscess Drainages
Performance and/or guidance for all biopsies, FNAs and abscess drainages (such as for renal/liver tx, all cysts, thyroid, breast, pelvic, bone, abscesses, specimen collection). This applies even if another clinical service performs the biopsy and radiology provides the guidance.

Ultrasound and CT
Ultrasound- or CT-guided thoracentesis/paracentesis
Ultrasound- or CT-guided biopsies/aspirations/drainages/injections
Ultrasound- or CT-guided thrombin injections

Fluoroscopy
Presence required if only fluoroscopy is provided (CPT code 76000 requires physician time. E.g., "sniff test")
Fluoroscopic guidance (e.g., lumbar puncture, arthrocentesis, etc.)

Head and Neck
Laryngogram or Sialogram

Gastrointestinal
Proteinogram, herniogram, appendixogram
GI tube placement (e.g., NG, Dobhoff, G-tube)
Enteroclysis tube placement
Removal of foreign body in the esophagus with a balloon catheter
Repositioning of tube
Cholangiogram and/or pancreatogram (T-tube or cholecystostomy check), includes injection
Sinogram, fistulogram, tube check (drainage, abscess, pancreatic)
Abdominal/liver tumor ablation
ERCP
Other "procedures"

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Genitourinary
Antegrade pyelogram, nephrostogram, loopogram, pouchogram, stent/tube check
Aspiration of the bladder
Cystogram or voiding cystourethrogram
Urethrocystogram
Vasogram
Corpora cavernosogram
Retrograde ureterogram or stentogram
Hysterosalpingogram
Hysterosonogram

Mammography
Breast cyst(s) aspiration with ultrasound
Fine needle breast aspiration
Injection procedure(s) for ductogram or galactogram
Breast biopsies
Placement of breast localization wire(s)
Stereotactic localization guidance

Musculoskeletal
Bone tumor ablation
Diskograms
Epidurals
Injections
Myelograms
Nerve blocks
Vertebroplasty

Other
Introduction of needle or catheter, vein

Nuclear Medicine
Radiopharmaceutical therapy, hyperthyroidism; initial, including evaluation or subsequent each therapy
Radiopharmaceutical therapy, thyroid suppression, inc. patient evaluation
Radiopharmaceutical ablation of gland for thyroid carcinoma
Radiopharmaceutical therapy, blood dyscrasias, each treatment
Intra-articular radiopharmaceutical therapy

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Coding Staff Located at:

Working remotely.

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Report Correction Requests (Send backs)

Re: Name: , MRN: , DOS: , Accession#: , Resident:

[_x_] A statement that the staff MD was present for entire procedure.

[___] A statement that the staff MD was present for full S & I portion of procedure, (e.g., ERCP, hysterosalpingogram, radiologic guidance for biopsies, etc.).

[___] A statement that the staff MD was present for key portion of the procedure.

[___] The procedure the techs barcoded () does not match what is dictated in the "Findings" section ().

[___]

Please select the necessary action below; then forward form/report via e-mail to indicated person.

[___] I will dictate the addendum in PowerScribe. Forward to _@uwhealth.org

[___] The staff MD was not present for the required entire procedure--no charge. Forward to

[___] The staff MD was not present for the required key portion of the procedure but did the interpretation--bill only for interpretation. Forward to _@uwhealth.org

[___] Another clinical service performed the procedure --bill only for interpretation. Forward to _

[___] The barcode is incorrect and needs to be changed. Forward to RSewell@uwhealth.org

[___]

If this was sent to a Resident/Fellow working with a Faculty member, any changes made by the Resident/Fellow will subsequently go to the Faculty member as an "Addendum" for their final editing and signature.

We understand this may be an inconvenience, but CMS (Medicare) requires an appropriate statement indicating teaching MD's level of participation and accurate procedural information.

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Report Correction Request (Send back) Pitfalls

- Coding staff send approximately 150 reports a month back to tech managers/providers
- The send back process is cumbersome (for coders, tech managers and providers) involving a lot of copying and pasting
- Done through e-mail so there's a risk of forgetting about the request
- If a send back is not addressed the coder cannot code or bill for the service.

Common reasons for sending a report back:

1. Provider did not dictate a presence statement
2. Barcode (code entered with order) does not match the dictation
3. CTA report lacks 3D reconstruction/MIPs documentation.

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The American College of Radiology, with more than 30,000 members, is the principal organization of radiologists, radiation oncologists, and clinical medical physicists in the United States. The College is a nonprofit professional society whose primary purposes are to advance the science of radiology, improve radiologic services to the patient, study the socioeconomic aspects of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and persons practicing in allied professional fields.

The American College of Radiology will periodically define new practice parameters and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice parameters and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

Each practice parameter and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review and approval. The practice parameters and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice parameter and technical standard by those entities not providing these services is not authorized.

Revised 2020 (Resolution 37)*

ACR PRACTICE PARAMETER FOR COMMUNICATION OF DIAGNOSTIC IMAGING FINDINGS

PREAMBLE

*full 9-page article included in binder.

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3M CodeRyte

Computer Assisted Coding (CAC)

- Uses Natural Language Processing (NLP) technology to assign ICD (diagnosis) codes and CPT (procedure) codes
- Coders have been using in the Radiology Department since 2007
- Correct-to-bill feature allows for certain studies to go straight to billing without coder review
- Includes coder tools such as local coverage determination (LCD) policies and procedure-to-procedure (PTP) edits.

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Documentation

Needed procedure does not match the order

Issue:	Service provided by radiology staff differs slightly from procedure as ordered.
Example:	Referring provider orders CT of the abdomen without contrast; radiology staff determines contrast is needed.
Compliance:	Claim must correlate precisely to ordered procedure(s) if service is rendered at a freestanding facility (for example, One S. Park).
Recommendation:	Order changes are allowed in a hospital setting. In a freestanding facility, the ordering provider would need to revise the order before performing the procedure.

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Documentation

"Rule out", vague, or absent clinical indications

Issue:	Ordering provider refers to possible conditions/causes, not signs/symptoms.
Example:	Referring provider orders MRI to "rule out" or "check for" ankle fracture. Impression is negative for fracture.
Compliance:	Can not assign an ICD code for a probable condition unless it is confirmed in the radiology report.
Recommendation:	Encourage referring providers to order studies based on signs and symptoms, **NOT** possible diagnoses.

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Documentation

Equivocal language

Issue:	Radiologists often use phrases such as "consistent with", "suggestive of" and "compatible with." These phrases imply a lack of certainty.
Example:	Radiologist interprets findings on an x-ray as "consistent with" pneumonia; study cannot be coded for pneumonia.
Compliance:	These phrases CAN and SHOULD be used if the radiologist is NOT CERTAIN of the diagnosis, but the coder cannot assign an ICD code for the diagnosis.
Recommendation:	Use equivocal language only when the diagnosis is uncertain.

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Documentation

Duplex scans

CodeRyte engine looks for language evidence of spectral analysis and color flow imaging for duplex studies.

Duplex reports must contain language to support:

- Spectral Doppler: spectral, wave (includes wave form), flow velocity, resistive index, RI, pulse(d)
- Color Flow Doppler: color, gray scale

American College of Radiology (ACR) article "Noninvasive Vascular Diagnostic Studies (Jan – Feb 2007 Radiology Coding Source).

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Documentation

Complete and limited ultrasound scans

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).

Example: a complete abdominal ultrasound (76700) would consist of real time scans of the:

- Liver
- Gallbladder
- Common bile duct
- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta
- Inferior vena cava

Including any demonstrated abdominal abnormality. If the gallbladder was surgically absent, that fact should be mentioned in order to meet the documentation requirements of a complete study.

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GC Modifier

What is a modifier?

Modifiers are added to CPT codes (used to describe procedures) to provide further information, e.g.:

- RT/LT modifiers provide laterality information
- 26 tells the payer that we are billing for the interpretation
- GC indicates that the service has been performed in part by a resident under the direction of a teaching physician (Medicare only).

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Questions?

THANK YOU!

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