Comprehensive Diagnostic Radiology Documentation Overview

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Importance of Clinical Indications

- Reason for exam is critical

- Lack of clinical indication leads to inaccurate, incomplete, or incorrect coding

- Payors will be less inclined to accept *unspecified* codes

- With the implementation of EHR/EMRs, the question is raised – *Why don’t you have the information?*
Diagnosis Coding Guidelines

Primary Diagnosis
- Relevant findings or
- If no relevant findings, signs/symptoms coded as primary or
- Screening Exams

Secondary Diagnosis
- Additional significant findings
- Incidental findings (never code as primary)

Cannot code
- “probable,” “suspected,” “r/o,” or other uncertain conditions
- “MVA” or “Fall” as an injury, only considered an accident

***It is important to document all the clinical information relevant to the exam. The coder will be able to determine the most relevant and appropriate diagnosis for that exam.
Obtaining Clinical Information

Ordering Physicians*
- Provide detailed information in the medical record proving medical necessity.
- Convey the appropriate diagnosis information for the medical necessity and coverage of the procedure.

*Best source of information

Scheduling/Registration
- Ask the correct questions to obtain the details (i.e. laterality, pain, patient history).
- History can be obtained from patient intake forms and/or patient’s family.

Technologist
- Direct patient contact to correct any errors or get more details for the reading physician.

Electronic Health Record
- EHR is the detailed record of the past and present medical history.
- Can be referenced by the physician and the details added to the radiology report.
Documentation Must Stand Alone

• Radiology reports are the source documents that support all coding for the professional component as well as the technical component.
• Each report must stand alone for documentation purposes.
• “No change from the previous report” leaves no findings to code.
• Can’t assume the exams are always performed a certain way.
• If a 3-view hand is “always” done and the report does not specify the number of views it must be coded as a 2-view study.
Plain Films

• State number of views
  – CPT defines codes based on number and/or type of views
  – The number of views is not necessarily the same as the number of *digital images or films*.
    ➢ It may be necessary to obtain more than one *image*, *radiograph* or *film* to capture a single view.
    ➢ For x-rays defined as “complete,” further documentation to the number or type of views is also required. Even if the code is described as “complete,” the code also states “minimum of ___ views” or requires a specific type of view be performed.

• Without this information, the coder must use the lowest valued code available for that procedure.
  – Example: A 2-view chest was performed but the report only read “Chest X-ray” and the body of the report includes only the findings of the procedure and not the number or type of views. This would force this procedure to be coded as a one-view study.
Plain Films

Requirements are sometimes different depending on the body area imaged.

• Abdominal X-Rays
  – Requires documentation of specific types of views performed, not just number of views

• Hip/Pelvis X-Rays
  – Coded based on number of views performed
  – The total number of views are calculated by adding the number of hip views plus the number of pelvis views
Contrast Procedures

• It is important with all CTs and MRIs to dictate the use of contrast.
  – The type of contrast is also important to mention (i.e., IV, oral, non-ionic, etc.)
  – IV, Intrathecal and Intra-articular injections are all coded as “with contrast” studies
    ➢ Post arthrogram and Post myelograms CTs and MRs are coded as “with contrast” studies even though the contrast was injected at a separate session.
  – Oral and rectal contrast are coded as “without contrast” studies
• 2D reconstructions not separately billable
• CTA exams should be documented specifically as a CTA study. 3D post-processing must be performed and documented in order to bill a CTA study.
3D Rendering

- 76376 – not requiring an independent workstation
- 76377 – requiring an independent workstation
  - Requires concurrent physician supervision of image post-processing, 3D manipulation of volumetric data set and image rendering
  - Terms for 3D post-processing
    - 3D
    - Maximum intensity projection (MIP)
    - Shaded surface rendering
    - Volume rendering
  - An order (non-hospital setting) and/or dictation of medical necessity (hospital setting) for 3D rendering is recommended by ACR
Combination Services

- Clearly document that each exam was performed
  - CT abdomen/pelvis and chest
  - US w/ duplex imaging
  - Multiple extremities
  - Transabdominal and transvaginal ultrasound

- Structure
  - In one paragraph with attention spent on each exam
  - In separate paragraphs
  - Each separated by own heading and body
  - If the documentation for one study was removed, what would be left to justify the other?

- Medical Necessity
  - Reason for each exam should be documented, especially for “additional services” such as duplex exams and transvaginal US
Low Dose CT (LDCT) Lung Cancer Screening

Patient eligibility
• Patient must:
  1. Be age 55-77 years of age
  2. Have no signs or symptoms of lung cancer
  3. Have a 30-pack years or greater history of tobacco smoking
  4. Be current smokers or have quit smoking within the last 15 years, AND
  5. Have a written order for LDCT from a qualified health professional following a lung cancer screening counseling that attests to shared decision-making having taken place before their first screening CT

Follow up studies
• Lung-RADS category 1 and 2:
  – Annual 12 month screening exam is the next management step
  – However, interim CTs are considered diagnostic
• Lung-RADS category 3 or 4:
  – 3 or 6 month follow up diagnostic study is recommended using LOW DOSE protocols
Low Dose CT (LDCT) Lung Cancer Screening

Documentation Requirements

• Screening
  – LDCT is only covered for asymptomatic patients
    ➢ No signs or symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood or unexplained significant weight loss.
  – Report should include patient’s smoking history as defined in the eligibility requirements (i.e., 30-pack year)
  – Include if the patient is a current smoker or has quit smoking, and if no longer smoking, for how long.

• Lung Nodule Follow-up Studies
  – If the patient is being followed for lung nodules, the documentation must state the following:
    ➢ Timeframe for follow-up (i.e., 3, 6 or 12 months)
    ➢ If the study is 12 months, it is still considered part of the patient’s screening program and all of the information required for a screening exam must still be documented (i.e., pack year smoking history, current vs. quit).
    ➢ If the study is 3 or 6 months (or anything less than 12 months), the study is considered a diagnostic study and the documentation must include that the patient is being followed for lung nodules.
Breast Imaging Studies

- Mammography
  - Screening vs. Diagnostic
    - Reason for exam
  - Unilateral vs. Bilateral
  - Analog vs. Digital
    - Coding distinction removed for codes in 2017
  - Computer-aided Detection (CAD)
    - CAD bundled into all mammography in 2017
- Tomosynthesis
- Ultrasound
  - Reason for exam (i.e., symptoms, abnormal mammography findings, screening, dense breasts, ABUS)
Nuclear Medicine

• Specific exam performed
• Specific anatomic area(s) imaged as some procedures are defined by limited, multiple, and whole body
• Radiopharmaceutical utilized
• SPECT vs. planar imaging
• Multiple day exams
  – Dictate into single report, if possible
Positron Emission Tomography (PET)

• PET vs. PET/CT
  – PET/CT codes should only be used when the PET and CT scans are performed on the same scanner.
  – If separate CT scan is performed for anatomic localization, the CT cannot be billed separately.
    ➢ Unlisted code can be used for fusion of the two modalities
  – If a diagnostic CT is separately ordered and dictated, it can be in addition to the PET.
    ➢ Dictation should state whether separate data set is used for diagnostic CT and anatomic localization or if the same data set was used for both.

• Body Area Imaged
  – Limited Area (one body section)
  – Skull base to mid-thigh
  – Whole body
PET Coverage - Medicare

- Medicare will cover a maximum of three FDG PET scans for subsequent treatment strategy after the initial anticancer therapy. A modifier is added to the code to identify the study as either an initial or subsequent scan.
- Coverage of any additional scans after the three is at the discretion of the Medicare contractor.
- This limit is per each type of cancer. So if the patient is treated for colon cancer and later develops lung cancer, the count starts again.
- A modifier must be added to indicate that the 4th and any subsequent PET scan is medically necessary and performed within the guidelines of the medical policy which includes:
  - PET is not covered for screening (surveillance).
  - Use of PET to monitor tumor response during the planned course of therapy (i.e., when no change in therapy is being contemplated) is not covered.
- A more detailed history of the patient is now necessary, including the patient’s cancer, treatments, and prior imaging studies.
  - How many prior PETs has the patient had for this cancer?
  - What is the specific reason for the current study?
    - Completed radiation?
    - Having current signs & symptoms?
    - Evaluation for mets?
    - Surveillance/routine follow up?
PET Case Example

Reason for Exam
PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST
Report
EXAM: PET TUMOR SKULL TO THIGH WITH CT
INDICATION: Breast cancer.
COMPARISON: Outside PET scan dated 11/15/2013.
TECHNIQUE: Sagittal, coronal and axial tomographic images were obtained from base of skull to proximal thighs 70 minutes after the intravenous injection of 11.36 mCi of F18 labeled FDG. Concordant, low-dose, uninfused CT images were also obtained for attenuation correction and for localization of nuclear findings. Blood Glucose: 101 mg/dL.

IMPRESSION:
Negative PET scan.

• Not enough information provided to add the KX modifier.
• Why was PET scan ordered? Is this for surveillance?
PET Case Example

Reason for Exam

ANAL CA

Report

EXAM: PET TUMOR SKULL TO THIGH WITH CT

INDICATION: 87-year-old female with anal cancer.

COMPARISON: None.

TECHNIQUE: Sagittal, coronal and axial tomographic images were obtained from base of skull to proximal thighs 77 minutes after the intravenous injection of 10.54 mCi of F18 labeled FDG. Concordant, low-dose, uninfused CT images were also obtained for attenuation correction and for localization of nuclear findings. Blood Glucose: 173 mg/dL.


IMPRESSION:

1. Hypermetabolic mass of the anus, consistent with patients primary neoplasm.
2. Left subpectoral mass versus volume imaging artifact of the left subclavian vein. Recommend diagnostic chest CT for further evaluation.

• Information supports that service is an initial scan.
Ultrasound Documentation Guidelines

• Complete Study
  – The documentation must contain a description of the elements that comprise a complete exam OR a reason that an element could not be visualized.

• Limited Study
  – If less than the required elements for a “complete” exam are reported, the “limited” code for that anatomic region must be used.
Breast Ultrasound

• Codes are unilateral in nature.
• Complete vs. limited concept applies.
• Complete
  – Includes all four quadrants of the breast and the retroareolar region, as well as an exam of the axilla, if performed.
  – All elements must be documented.
• Limited
  – Is limited to the assessment of one or more, but not all of the elements for a complete, including an exam of the axilla, if performed.
• Case Studies per the AMA publication *2015 CPT Changes: An Insider’s View*
  – Complete – diffuse breast pain
  – Limited – palpable lump
Abdominal/Retroperitoneal US

• Complete abdominal ultrasound
  – Liver
  – Gallbladder
  – Common bile duct
  – Pancreas
  – Spleen
  – Kidneys
  – Upper Abdominal Aorta
  – Inferior Vena Cava
• Complete retroperitoneal ultrasound
  – Kidneys
  – Abdominal Aorta
  – Common iliac artery origins
  – Inferior Vena Cava
  – Alternatively, if clinical history indicates urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound.
OB Pelvic Ultrasound

• <14 weeks gestation
  – Determination of number of gestation sacs and fetuses
  – Gestational sac or fetal measurements
    • i.e. Gestational sac measurements, fetal pole, CRL
  – Survey of visible fetal and placental anatomic structure
    • i.e. The presence or absence of subchorionic hemorrhage would be counted as documentation of placenta
  – Qualitative assessment of amniotic fluid volume or gestational sac shape
  – Exam of maternal uterus and adnexa
  – Alternately, if there is a positive pregnancy test, but imaging shows there is no IUP, the following supports a complete study.
    ➢ If the maternal uterus/adnexa are documented along with a statement that a gestational sac, yolk sac or fetal pole could not be visualized.
OB Pelvic Ultrasound

• >14 weeks gestation
  – Determination of number of fetuses and amniotic/chorionic sacs
  – Measurements appropriate for gestational age
    • i.e. Biparietal Diameter, Head Circumference, Abdominal Circumference and Femur Length
  – Survey of intracranial, spinal, and abdominal anatomy
  – 4-chambered heart
  – Umbilical cord insertion site
  – Placenta location and amniotic fluid assessment
    • Amniotic fluid can be stated as qualitative or quantitative
  – Exam of maternal adnexa, when visible
Non-OB Pelvic Ultrasound

• Female
  – Description and measurements of the uterus and adnexal structures
  – Measurement of the endometrium
  – Measurement of the bladder (when applicable)
  – Description of any pelvic pathology
  – *When performing a transabdominal and transvaginal technique during the same session, the documentation should include the reason for the additional study*
    ➢ i.e., for better visualization of the ovaries or adnexa

• Male
  – Evaluation and measurements of bladder (when applicable)
  – Evaluation of the prostate and seminal vesicles (to the extent they are visualized transabdominally)
  – Description of any pelvic pathology
Duplex US Documentation Guidelines

• Duplex Clarification
  – Per CPT, Duplex must include:
    ➢ Spectral Doppler
    ➢ Color Doppler

• CPT states:
  – The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical exam of the vascular system and is not separately reported.
  – Evaluation of vascular structures using both color and spectral Doppler is separately reportable. However, color Doppler alone is not separately reportable.
Ultrasound with Duplex Imaging

• NCCI edits
  – Must add a modifier to show separate, distinct, medically necessary procedure
    ➢ Modifier usage is highly scrutinized by payers
    ➢ Documentation must clearly show the justification for the separate procedure with the modifier

• Documentation Requirements
  – Color flow and Spectral Doppler stated in technique
    ➢ If study is not documented as “duplex” or if these elements are not documented, a duplex study cannot be reported.
  – Arterial inflow and/or venous outflow
    ➢ This will define the procedure as complete vs limited.
    ➢ If only one element is documented, a limited procedure must be reported.
  – Both the technique and the findings must support that a duplex procedure was performed.
Medical Necessity for Duplex with US

• Per ACR and AMA:
  – “Should not be done routinely but only when medically necessary based on clinical presentation and to answer a specific clinical question.”
  – “Medical necessity should be documented through an explicit physician order for the duplex study or a detailed explanation by the radiologist.”
    ➢ Clinical Examples in Radiology, Summer 2009
  – Clearly document the reason that the Duplex was necessary
    ➢ Rule out torsion
    ➢ Evaluate pts with chronic liver disease to rule out varices, portal hypertension, or portal vein thrombosis, etc.
    ➢ Evaluate post liver transplant pts or for potential donors
    ➢ Evaluate kidneys for renovascular hypertension or possible renal artery stenosis
Noninvasive Physiologic Studies

• Ankle/Brachial indices (ABIs) must be performed at the following levels:
  – Distal Posterior Tibial (PTA)
  – Anterior Tibial (ATA) **OR** Dorsalis Pedis (DPA)

• One of the following testing options must be performed:
  – Bidirectional Doppler waveform recording and analysis
  – Volume plethysmography
  – Transcutaneous oxygen tension measurements

• Code choices are defined by “Limited” or “Complete” study:
  – **Limited study**: testing is performed on **1-2** levels
  – **Complete study**: testing performed on **3 or more** levels
Vascular Interventional Procedures

• Vascular Angiography Procedures
  – Initial puncture and final placement of catheter
  – Imaging services provided
    ➢ Cervical and/or cerebral studies
    ➢ Diagnostic or roadmapping
  – Prior imaging, if relevant and available

• Diagnostic Angiography vs Roadmapping
  – Diagnostic angiography codes should NOT be billed with interventional procedures for:
    ➢ Guiding shots, localization injections, roadmapping, and/or fluoroscopic guidance for the intervention
    ➢ Vessel measurement
    ➢ Post angioplasty or stent angiography
  – This work is captured in the S&I code for the intervention or the “bundled” surgical code
Diagnostic Imaging vs Roadmapping

Per CPT:
• Diagnostic angiography/venography performed at the time of an interventional procedure is separately reportable if:
  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed and the decision to intervene is based on the diagnostic study
  OR
  2. A prior study is available, but as documented in the medical record:
     a) The patient’s condition with respect to the clinical indication has changed since the prior study, OR
     b) There is inadequate visualization of the anatomy and/or pathology, OR
     c) There is a clinical change during the procedure that requires new evaluation outside the target area of intervention
Central Venous Access/Catheters

• Key coding concepts:
  – Guidance
    - fluoroscopy, ultrasound, or both
  – Approach
    - Central vs peripheral
    - Vessel accessed
  – Final catheter placement
    - Rt heart, vena cava, subclavian, axillary (midline)
  – Procedure performed
    - Insertion, repair, replacement (partial vs complete), or removal
  – How was it done?
    - Non-tunneled, tunneled, port or pump
Central Venous Access - Imaging

- Fluoroscopic guidance
- Per CPT code definition, the report should include *radiographic* documentation of final catheter position.
- In order to report this code, there should be a discussion of the use of fluoroscopy to guide the catheter through the vessels.
- Code 77001 includes guidance for:
  - Vascular access
  - Catheter manipulation
  - Any necessary contrast injections through access site or catheter
  - Related venography radiologic supervision and interpretation
  - Radiographic documentation of final catheter position
Central Venous Access - Imaging

• Ultrasound Guidance
  – 76937 Ultrasound guidance for vascular access
  – This service requires
    ➢ Ultrasound evaluation of potential access sites
    ➢ Documentation of selected vessel patency
    ➢ Real-time ultrasound visualization of vascular needle entry
    ➢ Permanent recording and reporting

• Can be reported for any type of vessel access; however, some payers only reimburse when performed with CVA procedures.
Central Venous Access – Imaging Examples

• Sample dictations:

*Realtime ultrasound was used to evaluate the veins of the upper right arm. ___ vein was patent and was accessed using ultrasound. A permanent image was obtained.*

OR

*The central veins were evaluated by US and images were recorded. The ___ vein was patent and subsequently accessed using US guidance.*
Non Vascular Intervention

• Genitourinary
  – Nephrostomy tube vs internal/external drain
  – Neprhoureteral stent

• Gastrointestinal
  – Clearly document the device location
    ➢ Gastrostomy
    ➢ Jejunostomy

• Biliary
  – Internal vs internal and external drain
Non Vascular Intervention

• Biopsies
  – Area biopsied
  – Core or Aspiration
  – Guidance Used
  – If both a core and aspiration are medically necessary (one sample is inadequate thus requiring the other), both may be reported if inadequacy of one sample is documented

• Drainage and Aspiration
  – Is it a catheter drainage or needle aspiration procedure?
  – Document specifically where the abscess/fluid collection is located
    ➢ Peritoneal
    ➢ Subphrenic or subdiaphragmatic
    ➢ Retroperitoneal
    ➢ Abdominal or chest wall
    ➢ Subcutaneous
Non Vascular Intervention

• Arthrogram vs Therapeutic Joint injection
  – Diagnostic radiographic arthrography vs CT/MR arthrogram
    ➢ Contrast injection for localization purposes, to administer medication, should not be reported as a diagnostic study

• Myelogram
  – Diagnostic imaging vs fluoro guided contrast injection
Moderate Sedation

• Requires the presence of independent trained observer to assist in monitoring

• Documentation must specify the level of consciousness achieved by the patient as “moderate” or “conscious”
  – Does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

• The specific drugs provided should be documented if performed in a global imaging center location.
Moderate Sedation

• Sedation is reported based on physician intra-service (face-to-face) time
  – From the time sedation is given until physician leaves the patient

• Time
  – Time is used to report moderate sedation in increments of 15 minutes
  – Under 10 minutes is not reported

• Time must be documented for appropriate code assignment and reimbursement
Moderate Sedation - Examples

• Sample dictations:

“__ mg Versed and __ mcg Fentanyl IV was used for moderate sedation monitored under my direction. Total intraservice time of sedation was __ minutes. The patient’s vital signs were monitored throughout the procedure and recorded in the patient’s medical record by the nurse.”

OR

“Moderate sedation was provided. Pulse oximetry and continuous cardiac monitoring by the nurse was performed throughout the exam. Intraservice time was __ minutes.”
Multiple Physicians

• If more than one physician is involved, the documentation should tell which physician performed which service.

  – ERCP and intraoperative cholangiograms – if only interpreting films, state that the “films are submitted for interpretation” so the appropriate modifier can be applied.
  – AAA stent graft performed with vascular surgeon.
Thank you for your time. Please contact me if you have any questions.

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