04/25/06 Audioconference Questions and Answers

Radiology Orders for Diagnostic Testing: Appropriate documentation for proper reimbursement

 Ordering tests

Federal regulations guide test orders

Q: Where can we find the federal regulations regarding radiology orders in the hospital setting? My radiologist wants to see written documentation that states he can add procedures to the referring physician's orders if he deems them medically necessary.

A: Part of the Hospital Conditions of Participation 42 CFR 482.26 can be accessed at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr482_02.html, says Stacie L. Buck, RHIA, CCS-P, LHRM, Vice President of Southeast Radiology Management of Stuart, FL.

Radiologist or referring physician

Q: Should we allow our radiologists to order additional tests without an order from the attending physician?

A: “The short answer is yes—if the additional test is medically necessary,” Buck says.

And, adds Stacy Gregory, RCC, CPC, of Gregory Medical Consulting Services, in Tacoma, WA, it is only acceptable for a radiologist to order additional tests in the hospital setting under certain circumstances following guidelines as outlined in 482.26.

There is a distinct difference with hospital rules, says Buck. In the non-hospital setting you can only do this if one of the exceptions to the test order rules exist.

Hospitals should also address this scenario in their bylaws. If you can get an order from the referring physician do so, Buck says.

“Remember, protocols are not allowed. Medical necessity always prevails. And be sure everything is documented,” says Buck.
**Order errors**

**Q:** Can physician orders be changed (in the physician setting) by the radiologist if clearly wrong according to the patient's clinical signs and symptoms, (i.e.: clinical indications call for Computed Tomography Angiography (CTA) rather than Computed Tomography (CT))? Does the ordering physician have to be notified or issue another order?

**A:** Centers for Medicare & Medicaid Services’ (CMS) Ordering of Diagnostic Tests rule (Medicare Carriers Manual 15021, Transmittal 1725) provides for “clear error,” says Gregory.

The document states “the interpreting physician may modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that would be apparent to a reasonable layperson, such as the patient receiving the test, (e.g., x-ray of wrong foot ordered.)”

This scenario may also fall under the “test design” exception to the rules for ordering diagnostic tests, Gregory says.

“All specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).”

Diagnostic test supervision and ordering requirements for hospitals can be found in what is commonly known as 42 CFR, which is referenced above.

**Adequate orders in a hospital setting**

**Q:** Can a radiologist in a hospital-based radiology department order additional radiology procedures if the requested scan would not provide the medical information necessary to help the patient?

**A:** “Yes, this is [appropriate] in the hospital setting,” says Gregory.

The radiologist should always try to consult with the referring physician. But, in the interest of patient care, if additional/different procedures need to be performed, the radiologist may order and provide these services in the hospital setting “with a written order and medical necessity, of course,” she says.
Breast ultrasounds are an exception to that rule, warns Gregory. A radiologist cannot order a breast ultrasound on a patient presenting for a diagnostic mammogram. That order needs to come from the patient’s treating physician.

Q: For a mammography requiring further evaluation, should the referring physician provide a new order for ultrasound of the breast, or can the radiologist order the ultrasound based on findings? Does he need to write a new order or just dictate the need?

A: A radiologist can request a screening mammography be converted to a diagnostic mammography, but the radiologist cannot order the breast ultrasound, Gregory says. The order for the breast ultrasound must be generated by the referring physician.

Q: Who should be listed as the ordering physician if the radiologist appropriately adds procedures—the radiologist or the original referring physician?

A: The radiologist, says Gregory.

**Signature requirements**

Check state regulations for rules on abbreviated signatures

Q: Many referring office receptionists sign the doctor’s name themselves or sign the doctor’s name then put their own initials next to it. Do Medicare and other payers require the doctors official signature on the order?

A: All test orders need to be authenticated by the ordering physician or practitioner, says Buck.

Who else can sign

Q: Can we accept orders from physician assistants and nurse practitioners without a doctor co-signing them?

A: State law governs whether professionals other than doctors can order diagnostic tests, Buck says.

But most states allow it, she says. “In fact, off of the top of my head, I can’t think of one that does not allow these individuals to order tests.”
Sonograms and Ultrasounds

Ultrasound documentation requirements
Q: Where can we find ultrasound (US) documentation requirements in writing?


Bundling transabdominal with transvaginal scans
Q: Our ultrasound department routinely performs both transabdominal and transvaginal (endovaginal) exams together as part of protocol.

Sometimes the radiologist dictates transvaginal; other times he does not. If the report does not indicate that a transvaginal US was performed, I always question the ultrasound department to see if it was actually performed.

When I question this situation, they explain, “it is not required due to protocol.” Is it correct to be charging this way?

A: The radiologist definitely must document the performance of the transvaginal examination, as well as the reason for the exam, says Gregory.

It is common to perform both of these examinations in the same setting for a variety of reasons, but there must be clear, documented medical necessity for both studies, she says.

For example, if during a preliminary transabdominal pelvic ultrasound some components cannot be visualized (due to obstruction by bowel loops, gas, empty bladder, body habitus, etc.), the technologist may discuss the need for additional imaging with the radiologist. The radiologist can then request that a transvaginal examination to completely evaluate the pelvic contents.

This should not be routine practice or protocol. The transvaginal exam should only be performed on a medically necessary basis, Gregory says.

Have a physician order form on file designed to allow for both examinations. For example, “pelvic ultrasound (with transvaginal ultrasound if needed).”
Using S&I codes for interpretation only
Q: If gastrointestinal specialist at a gastrointestinal laboratory performs an endoscopic retrograde cholangiopancreatography (ERCP) and sends the images to a radiologist for interpretation, does the radiologist need to add modifier 52 since no supervision was performed? Or, since this is a technical charge, is it more appropriate to charge the entire supervision and intervention (S&I) without 52?

A: There is no need to apply the -52 modifier to the hospital’s technical charge when the radiologist performs only either supervision or interpretation (usually interpretation only), says Gregory.

The professional fee covers the physician’s S&I work, and is typically billed by the radiologist’s office. In this setting, a –52 modifier should be added to the S&I code if only either supervision or interpretation is performed.

However, in the hospital setting, you are billing for the technologist’s time and salary, equipment costs, use of resources (either human or material), etc., all of which are provided by the radiology department. Therefore, it is not necessary to limit the technical charge, she says.

Obstetrics ultrasound difficulties
Q: If a patient comes in for an obstetrics (OB) ultrasound at around 14-weeks gestation but visualization of all fetal anatomic survey is not possible, do we still charge 76801 first trimester charge?

Also, if the patient returns for a follow-up scan to visualize the survey better (i.e. four-chamber heart, cord insertion, etc.) do we charge 76816 even though no abnormality is suspected?

A: If the fetal anatomy (or any other required component of 76801) cannot entirely be visualized, clearly document that in the report, says Gregory.

If the report contains no mention of those elements you must revert to code 76815.

If the patient returns later for follow-up, code as 76816, she says.

Modifying sonogram orders
Q: If the physician ordered a “complete” obstetric sonogram but the patient is only 10 weeks along, do you need to contact the referring physician to request a new order for a first trimester scan?
A: The performance of a “complete” first trimester obstetric ultrasound as outlined in CPT meets
the physician's request for a “complete” examination, in this case, Gregory says.

Evaluate, or at least attempt to evaluate, the components required for a “complete” first trimester
obstetric US, and have the interpreting physician document each of component (or the lack of their
visualization) in the report. You should be able to code and bill 76801 without issue.

Additional measurements for fetal ultrasounds
Q: If we take any fetal measurement at all along with the heartbeat, placental location, position, and
fluid can we charge 76815?

A: Any OB ultrasound that fulfills less than the required elements for 76801/76805/76811—even if
missing only one element—should be coded as a “limited” study 76815, says Gregory.

“Limited” vs. “complete” ultrasound exams
Q: If the referring physician orders a “complete” exam but the radiologist does not report all the
required elements, should a “limited” code be reported even though the order says “complete” based
on the report?

When we enter a charge from our hospital’s chargemaster, the actual report may not be available. We
don’t know if all the elements for a “complete” exam were described in the report. Do you have any
suggestions as to how to handle this situation?

A: If the referring physician orders a “complete” exam but the radiologist does not report on all of
the required elements, a “limited” code should be reported regardless of the order.

“The documentation is the bottom line. Always remember, if it’s not documented, it wasn’t done,”
says Gregory.

In an audit, all of the required elements of an exam must be seen and documented to report a
“complete” code. Take the report back to the interpreting physician and request an addendum or
corrected report indicating the need for additional information, she says.
“You are correct,” adds Gregory, “that in most facilities, the charges come directly from the chargemaster without any review prior to the claim being released. Because of this, I highly recommend devoting a specific person to reviewing diagnostic imaging charges for your facility.”

Someone responsible for daily, concurrent review of radiology charges, as well as chargemaster maintenance, RIS functions, and a variety of other duties but dedicated to reviewing only radiology charges and documentation can prove valuable to the department, she says.

**Q:** When performing a biopsy, aspiration, or drainage procedure, we should not charge a “limited” diagnostic ultrasound in addition to the US guidance and procedure codes, correct?

**A:** Correct. “limited” sonography of the target area is included in the ultrasound guidance code, says Gregory.

**Documenting missing ovaries**

**Q:** On a pelvic ultrasound, if the uterus was removed but the patient still has ovaries, do we charge a “limited,” or charge a “complete” and note that the uterus has been removed? What if a patient and the doctor don’t know if the patient still has both ovaries?

**A:** If the physician tries to evaluate the ovaries (or other organs) but they are absent or unidentified, and the report includes these facts, code for a “complete” pelvic ultrasound. Make sure the radiologist met all the other requirements of a “complete” evaluation, says Gregory.

**Duplex evaluations**

**Q:** With regard to slide 44, the question asked what CPT code(s) should be assigned? We normally charge 76870 and 93976. Is this correct?

**A:** There is not enough documentation provided in this example to support coding both 76870 and 93976, Gregory says.

Quick look use of color flow Doppler simply to verify whether an anatomic structure is vascular should not be separately coded.
As indicated in the HCPro Inc. audioconference, in order to separately code for Duplex scanning, evaluation of blood flow (both arterial inflow and venous outflow) must be performed in addition to gray scale evaluation.

Documentation of an order from a physician for both examinations should be maintained, and medical necessity must be present.

In the hospital setting, the ordering physician may be the radiologist. An order from the referring physician is required in the freestanding (non-hospital) and IDTF settings, says Gregory.

**Q:** Can we use the “limited” vascular CPT code 93976 with a prostate ultrasound if we use color the same way it was used in the scrotum exam?

**A:** No, says Gregory. See requirements for reporting Duplex evaluations in addition to real-time ultrasound examinations.

**Documentation and coding for male pelvic ultrasounds**

**Q:** Should we always bill for a male pelvis scan when viewing the bladder during an ultrasound? That is our current procedure because our doctors want the prostate measured.

**A:** In order to code a “complete” male pelvic ultrasound (76856), the report must contain documentation of performance (or attempt at performance of) measurement and evaluation of the urinary bladder, prostate, and seminal vesicles, and any pelvic pathology.

If less than the above components are evaluated, then the exam should be coded as a “limited” study (76857).

If only the urinary bladder is evaluated, 76857 would also apply.

**Q:** Is it okay to bill for a post-void residual (PVR) with the male pelvis as a matter of policy?

**A:** Per National Correct Coding Initiative edits, 51798 (PVR) is included in the 76856. Therefore, no modifier is allowed on the 51798; only bill 76856, says Buck.
Q: Can a 76856 (male pelvis), 76770 (retroperitoneum), and 51798 (PVR) be coded at the same time when imaging renals, IVC, aorta, bladder, prostate, seminal vesicles and post void bladder?

A: In this case, 76856 and the 76770 can be billed together if both are ordered and performed, Buck says.

**Breast imaging**

Test design for CAD

Q: To bill for CAD use in review of a screening mammogram, should we have a specific order from the ordering physician or can we dictate in the report that we used the CAD system and code the addition?

A: This falls under the concept of test design, says Gregory. However, the patient should be notified and given the opportunity to “opt out” of the CAD if they do not desire the additional service (or if lack of coverage would result in the patient being billed). Refer to the specific instructions for Ordering of Diagnostic Tests.

Appropriate diagnosis for screening

Q: Is the diagnosis of “breast pain” appropriate for screening, or diagnostic, mammography?

A: The referring physician determines the appropriateness of a screening or diagnostic mammogram based on the symptoms of the patient, says Buck.

Typically a screening is most appropriate for an asymptomatic patient and a diagnostic would be appropriate for a patient experiencing breast pain.

Bill screening mammograms with the V76.12 or V76.11 for the primary diagnosis code. It will be denied if coded for breast pain, 611.72, she says.

Mammography reflex orders

Q: Our radiology department wants a new order form allowing a selection of follow ups after abnormal screening mammograms. Can a hospital setting radiology department utilize reflex orders? If so, does the diagnostic test need to be done the same day as the screening for the order to be valid?
A: Using a new order form for mammography patients as described is perfectly acceptable, says Buck.

Furthermore, “I highly recommend it,” she says. “This is something I have advised independent facilities to implement, too.”

The order can be as simple as providing check boxes for verbiage such as “ultrasound if indicated” or “ultrasound if mammogram abnormal.”

Buck says the tests do not have to be completed on the same day “obviously for the convenience of the patient it should be, but as far as I know this is not a must.”

Nuclear imaging

Here, there, elsewhere

Q: What CPT code should be used for a written report given on a MRI, CT or ultrasound exam performed elsewhere? Currently our hospital is not billing for the interpretation because the CPT code 76140 states “x-ray examination made elsewhere.”

A: When the physician provides an “over-read” or second opinion, use 76140 for a CT, MRI, or ultrasound exam, says Gregory.

Even though the code description states “x-ray,” she says, this CPT code applies to diagnostic imaging exams of any modality.

“Remember 76140 represents the work of the radiologist re-reading the original images. There is no technical component for this code,” Gregory says.

The radiologist’s office generally bills for the professional component. 76140 applies to the professional component only. If using 76140 in the hospital setting, verify that no dollar amount attached to this code exists in your chargemaster or fee schedule, she warns.

“I do not believe there is any reimbursement for this code in most cases (unless the patient is being billed directly),” says Gregory.
**Smile for the scan**

**Q:** We provide CT procedures of the teeth. Is 70486 the most accurate code for this?

**A:** “I know you don’t want to hear this,” says Buck, “but I recommend the unlisted code—76497 unlisted CT procedure (e.g., diagnostic, interventional).

“I agree,” says Gregory. “I would not use 70486 since it applies to a “complete” CT of the maxillofacial structures.”

Gregory suggests a case could be made for 70486 with a -52 modifier. She points to the ACR Practice Guideline for the Performance of CT of the Extracranial Head and Neck In Adults and Children (http://www.acr.org/s_acr/bin.asp?CID=542&DID=12202&DOC=FILE.PDF) which states:

“Computed tomography (CT) is a proven and useful modality for the evaluation of a variety of disorders involving the extracranial head and neck. CT should be performed only for a valid medical reason and . . . additional or specialized examinations may be required.”

**Whole body PET**

**Q:** We currently perform whole body positron emission tomography (PET) scans (skull to thigh) with fusion of outside CT. Should we code with 78812, 78812 and CT code with modifier 26, 78812 and reconstruction code 76376, unlisted code 78999, or none of these mentioned? Everyone seems to have a different opinion.

**A:** Bill the PET code and the 78999 for performance of the fusion, says Buck.

“Why bill with a -26 modifier if your facility performs the fusion?” she asks.

When fusing CT with PET bill 78999 for the fusion, she says.

“Getting that unlisted code paid can be a hassle,” Buck says. So, submit documentation with an explanation. Although Buck herself is not always successful receiving reimbursement “when it works, it works well, especially at 100% of the charge,” she says.
Do not bill the reconstruction codes 76376 or 76377 for the fusion, contrary to the opinion of many, Buck says.

“And don't forget to bill the fluorodeoxyglucose (FDG) if your facility provides the service and purchased the FDG,” Buck says. That FDG code is A9552.

**Q:** Since the PET registry is not in place yet, should we bill G0235 for PET scans for non-covered indications? Our local intermediary has no ICD-9 restrictions for PET scan, which makes this a grey area.

**A:** CMS says to use G0235 for non-covered indications for PET scans performed on, or after, January 28, 2005 (see http://www.cms.hhs.gov/transmittals/downloads/R527CP.pdf), says Buck.

Also, the American College of Radiology (ACR) and the American College of Radiology Imaging Network (ACRIN) officially launched the National Oncologic PET Registry (NOPR), to expand Medicare coverage of positron emission tomography (PET) scans, on Monday, May 8, 2006, Gregory says.

**Navigating pre-authorizations**

**Q:** More and more payers require pre-authorizations for certain radiology procedures. If, for example, the original ordering physician requests a nuclear medicine bone scan, and the radiologist adds an additional order for Single Photon Emission Computed Tomography (SPECT) images, how can we meet preauthorization requirements for both? What do we do?

**A:** Performance of SPECT images in addition to planar images would be considered part of the test design, says Gregory.

Consult with the insurance company and appeal on the back end of the claims procedure, if necessary, she suggests.

“In the interest of patient care, sometimes additional procedures need to be performed. Sometimes prior authorization cannot reasonably be obtained without directly impacting the care of the patient. This is an unfortunate conundrum caused by the ever-increasing involvement of the insurance payers in patient-care decision making,” Gregory says.
Appropriate orders

Q: If a referring physician orders a CT of the chest and the radiologist sees something medically necessary in the abdomen, can the radiologist order the CT of the abdomen based on his/her findings? Also, should there be a separate order by the radiologist for the CT of the abdomen or does the radiologist need to call the referring physician for the separate order?

A: Diagnostic test supervision and ordering requirements for hospitals can be found in “42 CFR.”

A separate order should be obtained from the referring doctor, says Gregory and Buck.

Contrasting orders

Q: If a referring physician orders a CT chest with contrast and, upon review of the diagnosis, the radiologist sees contrast is not indicated to achieve the desired result, does the ordering physician need to be contacted and a new order generated for the non-contrast exam?

A: The decision to perform an exam without, with, or without/with contrast falls under the concept of test design described in Section 15021 of the Medicare Carriers Manual as follows, says Gregory.

“Test design—Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).”

The test should be performed as the referring physician requested it in this case, says Gregory. In the hospital setting, the radiologist may elect not to use contrast if she or he believes it is not indicated. Nevertheless, this should be discussed with the referring physician to gain an understanding of why the exam was ordered with contrast in the first place.

In the physician independent facility settings, the radiologist cannot modify the exam at all without a new, written request from the referring physician, she says.

3D construction

Physician orders needed for 3D tests
Q: We supply tailor-made order forms to our referring physicians that state MRI’s and CT’s may include multiplanar reconstruction. Do you think this constitutes a legitimate order if 3D rendering or plain films are necessary?

A: The ACR recommends that physician orders be obtained for performance of 3D reconstructed images of tomographic modalities (CT, MRI, ultrasound, digital angiography), Gregory says. This applies to both the physician and hospital settings.

The work needed to create a 3D format image is not included in the concept of "test design," and should only be performed at the request of a physician, with a written, medically necessary physician order, and appropriate documentation, ACR says.

Q: What about adding 3D reconstructions when the radiologist sees that it is necessary?

A: ACR strongly encourages radiology practices to obtain an order from the referring physician based on the prior exponential rise in the use of 76375, and they have carried this recommendation over for new 2006 codes 76376 and 76377.

In the hospital setting, radiologists are able to generate their own orders, but the ACR strongly encourages them to justify medical necessity for the use of 3D rendering in a separate dictation, Buck says.

Billing for reconstructions

Q: Our current 64-slice CT allows us acquire images the axial plane. Coronal and sagittal reconstructions are done automatically by the CT software and the radiologists dictate that the studies were done in their report. Are we allowed to bill 76376?

A: Coronal, sagittal, multiplanar, and oblique reformats are considered 2D reconstructions and are not separately billable with the new codes, says Buck.

New codes 76376/76377 represent the following 3D renderings: shaded surface, volumetric rendering, quantitative analysis (segmental volumes and surgical planning), maximum intensity projections (MIP).
**Coding for heart images**

*Computed tomographic angiography*

**Q:** What has been your experience with reimbursement and the new temporary codes for CTA of the heart and coronaries? We have done several of these studies, and all but one of them have gone to review. Only a couple of them have paid and there seems to be no solid criteria for payment (i.e.: one paid with a non-specific chest pain ICD-9 and the same insurance company denied one on a patient with known coronary artery disease).

**A:** The majority of payers, private and Medicare alike, do not currently reimburse for coronary CT angiography (CCTA) or calcium scoring, says Gregory.

“These examinations are still considered investigational procedures by many payers, carriers, and fiscal intermediaries,” she says.

Title XVIII of the Social Security Act specifically prohibits reimbursement for investigational and/or experimental procedures unless they fall under independent developmental evaluation (IDE) or clinical trials policies and all requirements for coverage are met.

Without specific CMS guidance or instructions to the contrary, providers and other healthcare professionals should use Category III codes, by CPT definitions, for the purpose of tracking new and emerging technologies, Gregory says.

“In most cases, medical benefit for these services has not yet been defined or validated,” she says.

Furthermore, there is no guarantee of reimbursement, says Gregory.

There are exceptions specifically described in various CMS instructions (Change Requests, Manuals or Local Coverage Determinations), and individual considerations may be made by contractors, in which case the code may be billed and reimbursed according to their fee schedule.

Those payers/carriers who do cover CCTA have very specific policies, clinical indications, and criteria that must be met in order to reimburse for CCTA.
Join Gregory and Buck for a 90-minute live, HCPro audioconference *Cardiac Imaging: Compliant coding and documentation strategies* on Wednesday, July 12, 2006. Learn how to improve your facility’s reimbursement for diagnostic cardiac images ranging from MRI to ultrasound, CT to PET. For more information visit, http://www.hcmarketplace.com/prod.cfm?id=1044&CFID=5452179&CFTOKEN=55319749

**Other coding concerns**

**Q:** Is there a new code for abdominal aortic aneurysm (AAA) screening in males over a certain age with history of tobacco use?

**A:** Use ICD-9 code V81.2, special screening for other and unspecified cardiovascular conditions, says Gregory.

**Documenting and coding for multiple views**

**Q:** If a radiology technologist enters the procedure room multiple times during a lumbar laminectomy and takes a view of the lumbar spine, to assist the surgeon, and a radiologist dictates a report for each view (each encounter in the room), would the hospital use *Common Procedural Terminology* (CPT) code 72020 for each single view (maybe multiple times) or should we add all lumbar views together at the end of the laminectomy, despite the individual reports, and use 72100 or 72110?

**A:** For multiple operative views taken during the same session, but interpreted after the procedure, the American College of Radiology (ACR) says to use the lowest level “multiple” view procedure code associated with the anatomic area, reports Gregory.

“Therefore, CPT 72100 would be appropriate in the above scenario,” says Gregory.

If the radiologist, present during the surgery, provides “wet reads” at each image, then each film/interpretation would be coded separately using 72020 with a -76 modifier appended to each additional instance, Gregory says.

**Cancer coding**

**Q:** When cancer is documented in the clinical indication but not mentioned in the findings, can we/should we code the cancer just because it's given as a clinical indication or should there be a mention of it in the report?
A: Seek clarification on whether or not the cancer is still present and the patient is still being treated before assigning a cancer code, says Buck.

Understanding technical charges
Q: We have contracts with some entities that state "technical charge only" and the films are sent to these entities for interpretation. Are we violating the rule that the presentation stated "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)?" I know these are being interpreted on the other end (VA Hospital or Texas Department of Health) but we never see the report.

A: A report should be included in the patient medical record, says Buck, but the reference made in the HCPro audioconference referred to a recommendation from the ACR, not a CPT or payer guideline.

“Assuming that you bill for the technical component and you keep a copy of the test order at your facility, you may want to consider keeping a copy of the interpretations as well,” Buck suggests.

One large company did have similar arrangements where other sites provided the technical component but Buck says “we requested a copy of the interpretation for our records, mainly to ensure correct billing.”

Permanent records
Q: We recently converted to an all Picture Archiving and Communication System (PACS) department and are both film less and paperless. Should we scan the physician order to make it a permanent part of the patient’s radiology file?

A: The test order must be kept on file, says Buck, but how you maintain those files is up to the facility.

“You can store in paper or scan it,” she says. “Which ever is easier for you.”

Code from the report, not the header
Q: Can I code from the header or does it have to be specified in the body of the report?
A: “This is another area where there really is no black and white answer,” says Buck. However, “I caution against coding from the header of the report. Often the report header is automatically generated during the order entry process. Coding from the header can lead to both up-coding and under-coding.”

Providers commonly code x-ray exams based on the report header because radiologists do not specify the number and types of views. For most other exams, look to the body of the report to determine what to code.

“Keep in mind during a third-party audit the report is usually all there is to go on, therefore to avoid any issues I highly recommend coding only from the body of the report,” Buck says.

**Code or language description**

**Q:** Is an ICD-9 code only permitted on the order or must verbiage also be present? For example, “chest x-ray reason 786.2” or “chest x-ray reason cough.”

**A:** Either ICD-9 code or verbiage on the order are appropriate for diagnostic tests, says Gregory.

“However, the order needs to be easily understood and interpreted by any clinical staff who come in contact with it, so just an ICD-9 might not always be sufficient. I recommend having both an ICD-9 and a description of the reason for the exam on the order form. If that’s not possible, then just the verbiage would be the best choice,” she says.