APS Update
RADIOLOGY NEWSLETTER
Volume 7 September 2010 Issue 8

Abdomen and Retroperitoneum Ultrasounds

Is a particular imaging study a limited or complete procedure? There are four ultrasound codes that can be challenging. Choosing an incorrect code could have an impact on reimbursement. The four codes are:

* 76700 - Ultrasound, abdominal, real time with image documentation; complete
  * 76705 - ....limited (eg, single organ, quadrant, follow-up)
* 76770 - Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
  * 76775 - ....limited

Per CPT, “A complete ultrasound examination of the abdomen (76700) consists of real time scans of the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava including any demonstrated abdominal abnormality.”

Per CPT, “A complete ultrasound examination of the retroperitoneum (76770) consists of real time scans of the kidneys, abdominal aorta, common iliac artery origins, and inferior vena cava, including any demonstrated retroperitoneal abnormality.” Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound.

The documentation for diagnostic ultrasounds for a “complete” exam should contain a description of all required elements or explain as to why they could not be visualized. If the exam entails anything less than the above mentioned regions or does not explain why they could not be visualized, the corresponding limited ultrasound code would be reported. A “limited” study includes only a single quadrant or a single diagnostic issue.

This is why documentation is very important for these studies. If the documentation does not meet CPT guidelines for a retroperitoneal ultrasound (76770) by leaving out a comment on one or two of the required elements it means reporting 76775 for the limited. If billing globally this can be $20 less in reimbursement. A checklist may be one way to be sure all areas are covered for each ultrasound.

PECOS

Those of you who were keeping track noticed that a new claim submission guideline went into place on July 6, 2010. Providers are now required to submit PECOS numbers for referring/ordering physicians. Originally, PECOS enrollment was required only for ordering DME and related services. As in all such programs, however, the requirement to participate in PECOS (the Provider Enrollment Chain Ownership System, not a Wild West movie) has grown and mutated over time.

The first version of PECOS was only for ordering DME and was to be completed by January 4, 2010. Never fear, a delay until April 5, 2010 was forthcoming and then another delay until January 3, 2011 to accommodate the addition of the referring doctor’s PECOS number for all referred/ordered diagnostic tests.

With a great deal of grumbling, most doctors began the process of obtaining their PECOS numbers at that point. This really wouldn’t be worth an article except for one small bump in the road. The health reform legislation included a minor adjustment to the effective date of the PECOS number denial process: *July 6, 2010*. This broke all the rules as deadline changes almost always move later not earlier. As those experienced with such projects expected, the PECOS system could not handle the increased number of applicants and, as a result, the denial of claims due to missing PECOS numbers did not begin in July and is indefinitely delayed (the AMA asked for the old date of January 3, 2011).

In any event, APS has gone out to the PECOS system and obtained referring physician information for all of our client practices to ensure that, once the indefinite hold on denials for missing PECOS information is removed, client claims will be paid.

2010 EDUCATION CALENDAR

Hope to see you there!

Nov 28-Dec 3: Chicago, IL
RSNA

Non-Selective/Selective Catheterization

In Interventional Radiology there are two types of catheterization that can be performed. One type is a **non-selective** catheterization, when the catheter does not go beyond the vessel that was punctured into a smaller vessel or if the catheter is only moved into the aorta or vena cava. The most frequent non-selective **arterial** catheterization codes are:

* 36200 - Introduction of catheter; aorta
* 36140 - Introduction of intracatheter; extremity artery

The procedure codes for non-selective **venous** catheter placements are:

* 36005 - Injection procedure for extremity venography
* 36010 - Introduction of catheter, superior or inferior vena cava

The other type of catheterization is **selective.** To report a selective code, the catheter is moved outside the vessel that was punctured into a smaller branch vessel or is moved beyond the main trunk of either system. There are selective catheter codes for both the arterial and venous vessels. For the **arterial** vessels they are:

* 36215-36218 - Catheter placement above the diaphragm in the head, neck, arms and thorax.
* 36245-36248 - Catheter placement in the abdomen, pelvic and legs

There is one set of procedure codes for selective venous catheter placement:

* 36011-36012 - Catheter placement venous; any location

(FYI-There is no third order code and 36012 can be assigned as many times as needed)

Documentation is key for not only assigning the correct catheter placement codes but for assigning all codes for that study. Documentation should include clinical information to support medical necessity, the access site(s), route of catheter(s) with ending position of catheter tip, injection sites for imaging, anatomy imaged with documented interpretation of exact location, percentage of stenosis or any occlusions, site of type of interventions if performed, any complications and clinical findings. Providing key documentation is important for accurate coding and compliance.

ICD-9 Coding Update

Choosing the correct ICD-9 code can sometimes be a difficult task. Failing to assign the correct ICD-9 code may sometimes be reason for denials. Here are some guidelines to follow that may help in choosing the appropriate ICD-9 code to avoid unwanted denials.

1. Code to the highest level of certainty – This would be reporting the final diagnosis when one is provided. If the physician can't determine a definitive diagnosis or the specimen is "normal," report the patient's signs or symptoms to support medical necessity.
2. Be as specific as possible – The code assigned should be the most precise code for the service. If a fourth or fifth digit is required, this needs to be assigned for a complete diagnosis.
3. Never use "rule out," "suspect," "probable," etc. This is assigning the patient an unconfirmed diagnosis.
4. Assign "V" codes when applicable. This provides additional clinical information to the carrier. Most "V" codes are secondary codes but on occasion a "V" code is primary. For example, an elective sterilization.

October will be here before you know it, which means it will be time for the annual update for ICD-9-CM codes. For 2011 there are more than 130 proposed new codes along with the revised and deleted diagnosis codes. These changes become effective October 1, 2010. Remember, there is no longer a grace period to implement these new and changed ICD-9 codes. If using an incorrect diagnosis code after October 1st it will likely result in a denial. Revisions typically include expanded ICD-9 codes for some common conditions by adding an additional digit and deleting some codes you may know from memory. To ensure current, accurate diagnosis coding, make sure you consult the 2011 ICD-9 manual.

For those who are beginning to consider the impact of switching to the ICD-10 codes in October, 2013 please realize that the time is rapidly passing by. At APS we have completed the programming necessary to accommodate the new ICD-10 codes. Since previous conversions of billing data and formats have been accompanied by widespread confusion amongst payers about the date to convert and the types of billing supported by their systems, APS has developed the ability to work with either ICD-9 or ICD-10 codes as necessary. If we receive ICD-9 codes and the payer requires ICD-10 codes to be submitted we have the crosswalk to convert the 9s into 10s. Similarly, if a practice site has converted to ICD-10 but the payer cannot yet accommodate the new codes we can backstep the process to submit with ICD-9 codes.

While we are ready to ensure that our clients do not incur substantial cash flow difficulties as a result of the ICD-9/10 conversion process we cannot guarantee that all payers will be as diligent about ensuring that their processes can meet the deadlines that are fast approaching.