Webinar Q&A

Improving Reimbursement with Accurate Radiology Documentation

The following questions were submitted following the webinar listed above:

Can an outpatient radiology facility ever code for an initial encounter?

The reference of an initial encounter in this presentation is not directed to the coding and billing of the service rendered (CPT® code). ICD-10-CM or the diagnostic code set, requires a 7th character extension for injuries and trauma which identifies the episode of care: initial, subsequent, and sequela encounter. The initial episode of care for an injury is defined as any encounter that occurs while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

The AAPC website has a concise, short article on coding the episode of care for ICD-10-CM. Link here to read more.

When a complete pelvic ultrasound is ordered, can we bill for both the transabdominal and transvaginal views as long as report states what information was gleaned from both approaches? More specifically, do we have to have an order that explicitly states "transabdominal pelvic ultrasound & transvaginal pelvic ultrasound"? Or does an order that states "pelvic complete" suffice?

It is appropriate to report a transvaginal US of the pelvis (CPT code 76830) in combination with other pelvic sonogram codes (same patient, same day) if ordered and supported by medical necessity. A hospital protocol to complete a transvaginal on every non-OB pelvic US does not demonstrate medical necessity. A transvaginal probe is often used in studies to assess fetal viability, vaginal bleeding, ectopic pregnancies, and fertility studies.

The CMS *Medicare Benefit Policy Manual,* Chapter 15, Section 80.6) outlines the requirements for an order to support the diagnostic tests rendered to a Medicare beneficiary. CMS indicates that an order from a referring physician may conditionally request an additional diagnostic test for a patient if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician (e.g., if test X is negative, then perform test Y).

When performing a transabdominal and transvaginal exam, the report should clearly state the indication for performing the second examination, for example, for better assessment of the endometrium and/or adnexa. Often the initial ultrasound results may lead to performing the transvaginal exam. It is then important that the finding of the initial ultrasound should document the suspected condition or the failure of the initial ultrasound to diagnose or confirm suspicions.

The *ACR Radiology Coding Source*™, July-August 2009 provides clear direction for part of your question.

Is the initial encounter the first visit with the referring physician?

In ICD-10-CM the initial visit is identified as the timeframe in which the patient is receiving active treatment. This could include:

- Emergency room treatment
- Initial radiologic exam
- Surgical treatment
- Evaluation (new or different diagnosis) and treatment by a new physician

Example of an initial episode of care:
A patient is seen in the emergency department for a head injury. The ED physician orders a CT scan that is read by a radiologist. A consultation is requested and completed by a neurologist. The 7th character extension for an initial visit is used by all three of these physicians.