Improving Reimbursement with Accurate Radiology Documentation

- Webinar begins at 11:00 a.m. central time (no sound until then)
- Trouble connecting to audio? Click the audio button for options:

- Question? Please send a chat to the host.
- Today's presentation is informational only - no credit available.

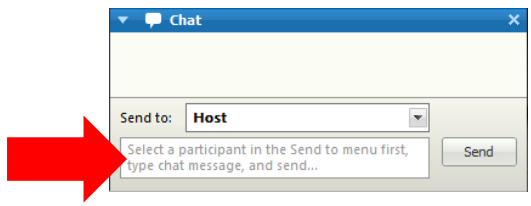
Wendi J. Krumm, RCC

November 19, 2015

Welcome

Use "Chat" to ask questions during the Webinar:

Ask questions in this space in the Chat panel on the right side of your screen.



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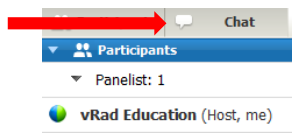


Save the date!

Fifth Annual
νRad Academic Conference in Las Vegas

Practical Radiology 2016:
Core Topics in Emergency Radiology

February 19-21, 2016

The Venetian Las Vegas

18 CME Credit is Available

FEATURED SPEAKERS

Jerry D. Dwek, MD
Specialist in Pediatric Radiology, Rady Children's Hospital in San Diego

H. Ric Harnsberger, MD
Professor of Radiology and R.C. Willey Chair of Neuroradiology, University of Utah

Stuart E. Mirvis, MD, FACR
Professor of Radiology, University of Maryland School of Medicine
Director, Emergency Radiology Section, Department of Radiology and Maryland Shock-Trauma Center

Benjamin W. Strong, MD
Chief Medical Officer, Virtual Radiologic

Ronald Zagoria, MD
Professor in Residence and Chief of the Abdominal Imaging Section, UCSF School of Medicine

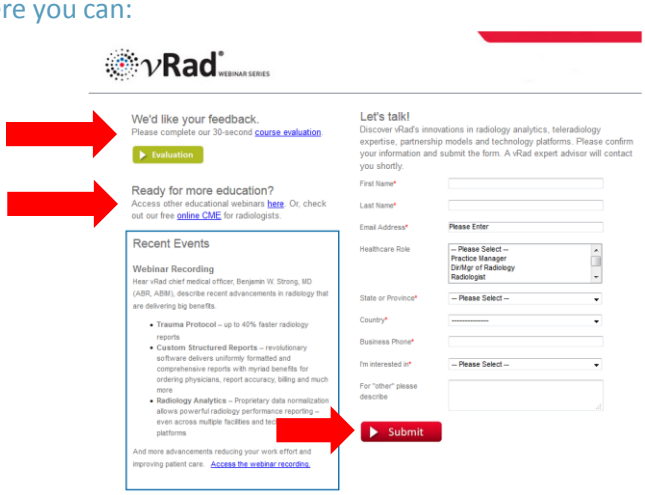
2015 Attendee Comments

"Great conference - educational and enjoyable."
"Really good speakers."
"One of the most useful meetings I have attended."

νRad EDUCATION

Welcome

After you leave the session, a web page will appear where you can:



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Improving Reimbursement with Accurate Radiology Documentation

Wendi J. Krumm, RCC
November 19, 2015

Disclaimer

- This presentation is designed to provide participants with reimbursement and coding related news, updates and guidance.
- The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted.
- The information, while accurate, to the best of our knowledge, at the time of production, may not be current at the time of use.
- Information is provided as general guidance only and is not a recommendation for a specific situation. Viewers should consult official sources (CMS, ACR, AMA) or a qualified attorney for specific legal guidance.
- Information provided is based on Medicare Part B billing guidelines and may or may not pertain to Medicare Part A billing. Viewers should consult their Part A – Medicare Administrative Contractor website for hospital billing guidelines.

Our Agenda

- Introductions
- Duplex US
- Abdomen US
- Pelvic US
- Retroperitoneal US
- Clinical Indications
- Questions

Document to Support Services and Minimize Risks

- ***EVERY*** portion of a radiology procedure must be clearly documented.
- A coder ***CAN NOT*** assume that services were included in a procedure if they are not clearly documented.
- The omitted portion(s) of the service or procedure will not be billed.
- Payers perform post-payment audits to assure compliant billing practices.
- The final radiology report must support the billed service.
- Documentation omissions result in lost revenue through suboptimal payments, procedure denials, or reimbursement take-backs.

Accurate and complete documentation of services, dictated by the radiologist, is critical to maximal reimbursement and compliance to CMS regulations.

The radiology report is a legal documentation of what was done.

Document Number of Views, Not Number of Images

CMS *NCCI Policy Manual,* Chapter 9, Section C:

1. If *imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are* repeated *during* the course of a *radiological* encounter due to substandard quality *or need for additional views*, only one unit of service for the *appropriate* code *may* be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service should be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a "minimum" number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service should be reported. However, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate.

Document the number and type of views in the final report.

It is inappropriate to bill based upon the number of films it takes to get readable images.

Examples:

- An infant imaged on one film is billed as an x-ray of the chest and an x-ray of the abdomen
  (previously known as a babygram)
- Multiple films may be needed to get a satisfactory image for interpretation (suboptimal)
- A large body habitus that can not be fully imaged on a single film
  (two images on an obese patient to obtain one view)

Duplex/Doppler Requirements
CPT Codes 93880-93998

Duplex Ultrasound Introduction

- **Duplex ultrasound combines Doppler and conventional ultrasound**
- **Duplex US allows the radiologist to see:**
  - The structure of blood vessels
  - How the blood is flowing through the vessels
  - Any obstruction in the vessels
- **Color Doppler:**
  - Produces a picture of the blood vessel
  - A computer converts the Doppler sounds into colors overlaid on the image
  - Provides information about the speed and direction of blood flow
- **Using spectral Doppler analysis[1]:**
  - Duplex scan images provide anatomic and hemodynamic information
  - Identifying the presence of any stenosis or plaque in the vessels

Documentation of the assessment of flow with color, recording a spectral waveform, and a report of the findings should all be present in the dictation.

[1] Spectral Doppler: The distribution of the amplitude (and sometimes phase) of the components of the wave as a function of frequency, and the set of frequencies, wavelengths, or related quantities involved in an ultrasonic pulse or electronic signal.

Definition from the 2006 *ACR Ultrasound Coding User's Guide*.

Coding and Documentation Tips: Duplex US

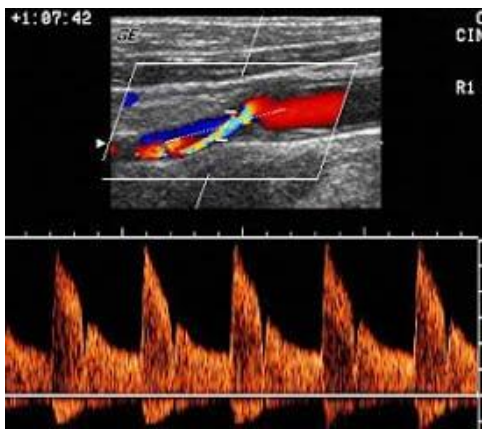
Dictations for Doppler or Duplex US scans
(evaluating both the **arterial inflow** and the **venous outflow**)

Specify **BOTH**:

1. Spectral Analysis or Waveform Analysis, or Peak Systolic Velocity (PSV)

AND

2. Color Flow or Doppler Color Flow



Suboptimal Dictation of Duplex Study

EXAM:
US Duplex Right Lower Extremity Veins.
CLINICAL HISTORY:
80 years old, male; Pain, swelling, R/O dvt
TECHNIQUE:
Real-time ultrasound scan of the veins of the right lower extremity with color Doppler flow, spectral waveform analysis and compression.
COMPARISON:
DX - XR RIGHT KNEE 4/27/2015 5:21:33 PM
*** FINDINGS:**
Deep veins: Unremarkable. No DVT in the common femoral, femoral or popliteal veins.
Superficial veins: Unremarkable. No thrombus in the visualized greater saphenous vein.
Soft tissues: No acute findings. No popliteal cyst.
IMPRESSION:
No deep venous thrombosis in the right lower extremity.

*** No impression provided on what was seen or gleaned from the color flow and spectral analysis.**

Accurate Documentation for a Duplex Study

EXAM:
US Duplex Left Upper Extremity Veins.
CLINICAL HISTORY:
90 years old, female; Left lower extremity swelling and pain
TECHNIQUE:
Real-time ultrasound scan of the veins of the left upper extremity with color Doppler flow, spectral waveform analysis and compression.
EXAM DATE/TIME:
Exam ordered 5/7/2015 11:20 PM
COMPARISON:
No relevant prior studies available.
FINDINGS:
There are normal grayscale & compressibility images of the left common femoral, femoral, popliteal and visualized calf veins. Incidental 28x13 mm Baker's cyst.
Deep Veins: All of the aforementioned vessels demonstrate normal respiratory variation patterns and augmentation patterns, with normal **spectral Doppler** venous wave forms. **Color flow** images demonstrate normal color flow in all of these vessels.
IMPRESSION:
No sonographic evidence of deep venous thrombosis.

Coding and Documentation Tips: Duplex US

Doppler/Duplex US studies dictations for the following areas MUST include verbiage that both color flow and waveform analysis were interpreted:

- Intracranial (93886-93893)
- Extracranial (93880-93882)
- Upper and lower extremities
  - Arterial (93922-93931)
  - Venous (93970-93971)
  - AV Fistula (93990)
- Visceral (93975-93979)
- Penile (93980-93981)

Ankle Brachial Indices (ABI)

- In 2012 the definition and utilization changed on Noninvasive Physiological Studies
- ABI is no longer a billable service when performed as a stand alone procedure
- The only billable radiology services for ABIs are 93922 or 93923 Noninvasive Vascular studies. These exams require performance and documentation of the ABI and one of the following:
  - Doppler waveforms,
  - Volume plethysmography, or
  - Transcutaneous oxygen measurements are required
- If an ABI is done during the same encounter as a duplex US, only the duplex US can be coded.

Noninvasive Physiologic Studies

93922 Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)

Required elements:

ABI pressures at the ankle and brachial arteries

PLUS one of the following:

- One to two levels Doppler recording and analysis of wave form
- One to two levels plethysmography (volume)
- One to two levels oxygen measurements (tension)

If upper and lower extremity arteries are studied in this fashion, report code 93922 twice with Modifier 59 added to the second procedure.

If 1-2 levels recorded on only one (1) extremity, report code 93922 with modifier 52.

Noninvasive Physiologic Studies

93923 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

Required elements:

ABI pressures at the ankle and brachial arteries

PLUS one of the following:

- Three (3) or more levels Doppler recording and analysis of wave form
- Three (3) or more levels plethysmography (volume)
- Three (3) or more levels transcutaneous oxygen measurements (tension)

If upper and lower extremity arteries are studied in this fashion, report code 93923 twice with Modifier 59 added to the second procedure.

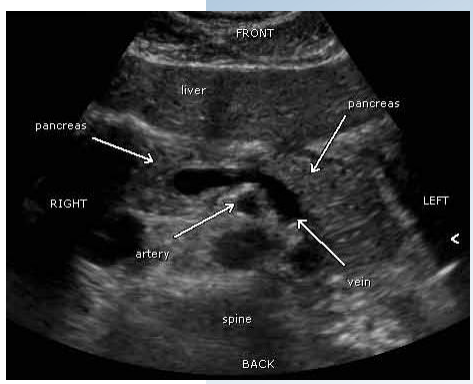
When only one (1) extremity is available for study, report code 93922 for a unilateral when 3 or more levels.

Abdominal Ultrasound Required Elements

CPT Codes 76700, 76705

Required Elements: Abdomen US

- ✓Liver
- ✓Gallbladder
- ✓Common Bile Duct (CBD)
- ✓Pancreas
- ✓Spleen
- ✓Right Kidney
- ✓Left Kidney
- ✓Upper Abdominal Aorta
- ✓Inferior Vena Cava (IVC)
- ✓Any Demonstrated Abnormalities in the Abdomen



Coding and Documentation Tips: Abdomen US

- **The elements most commonly missed on complete abdominal US reports:**
  - Aorta and/or Inferior vena cava (IVC)
  - Pancreas
  - Spleen
- **All elements must be listed or mentioned in the dictation: even if not visible:**
  - List and explain why each element was not visualized
  - "the spleen was surgically absent"
  - Do not use generic phrase, such as: "The study is limited by overlying bowel gas."
- **If a limited US is ordered and performed, specify "limited" in the dictated title and technique of the report**

Pelvic Ultrasound Required Elements

CPT Codes 76856, 76857, 76830

Required Elements

Non-OB Female Pelvic US

- Description AND Measurements of the Uterus and Adnexal Structures
- Measurements of the Endometrium
- Measurement of the Bladder (when applicable)
- Any Pelvic Pathology Imaged

Male Pelvic US

- Evaluation and Measurement (when applicable) of the Urinary Bladder
- Evaluation of the Prostate and Seminal Vesicles (to the extent they are visualized transabdominally)
- Any Pelvic Pathology Imaged

Coding and Documentation Tips: Pelvis US

- **The elements most commonly missed on a female pelvic US report:**
  - Bladder
  - Endometrial measurement

- **Dictation must mention each separate element/organ that could not be visualized and why (e.g., obscured by bowel gas or surgically absent).**

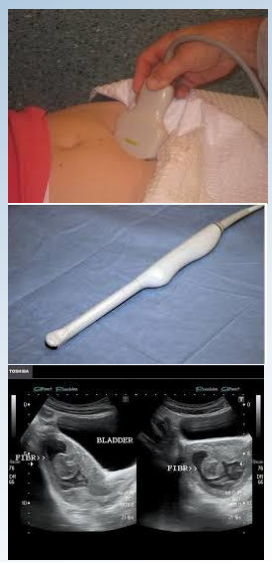
- **If a limited US is ordered and performed, specify this in the dictated title and the technique section of the report.**

Transabdominal or Transvaginal

Specify in the dictated title and the technique if the ultrasound approach was:

- Transabdominal
- Transvaginal
- Both Transabdominal and Transvaginal

Documentation must specify the reason that both approaches were utilized, and what diagnostic information was gleaned from each approach.



What is Missing From This Dictation?

EXAM: US Pelvis, Transvaginal and transabdominal. **EXAM DATE/TIME:** Exam ordered 8/17/2015 5:35 AM

CLINICAL HISTORY: 24 years old, female; Pelvic pain, previous ectopic with surgical tube resection and d&c. Now with increased pain

TECHNIQUE: Real-time transabdominal and transvaginal pelvic ultrasound (complete) with image documentation. Transvaginal imaging was used for better evaluation of the endometrium and adnexa.

COMPARISON: US Pelvic Non OB Complete W/Transvag 7/14/2015 5:36:44 PM

FINDINGS:
Endometrium: Endometrial thickness is 8 mm. There is moderate free fluid in the pelvis.
Uterus/cervix: Unremarkable. No myometrial mass.
Right ovary: Unremarkable. No mass. Normal blood flow.
Left ovary: Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.
Normal blood flow seen within the surrounding tissue.
Free fluid: No free fluid.
Other findings: Transvaginal images were performed for better anatomy visualization.

IMPRESSION:
Moderate free fluid. Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.

Optimal Dictation for a Complete Pelvic Ultrasound

EXAM: US Pelvis, Transvaginal and transabdominal. **EXAM DATE/TIME:** Exam ordered 8/17/2015 5:35 AM

CLINICAL HISTORY: 24 years old, female; Pelvic pain, previous ectopic with surgical tube resection and d&c. Now with increased pain

TECHNIQUE: Real-time transabdominal and transvaginal pelvic ultrasound (complete) with image documentation. Transvaginal imaging was used for better evaluation of the endometrium and adnexa.

COMPARISON: US Pelvic Non OB Complete W/Transvag 7/14/2015 5:36:44 PM

FINDINGS:
Endometrium: Endometrial thickness is 8 mm. There is moderate free fluid in the pelvis.
Uterus/cervix: Unremarkable. No myometrial mass.- measurement of the uterus
Right ovary: Unremarkable. No mass. Normal blood flow. – measurement of right ovary
Left ovary: Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm. – measurement of left ovary
Normal blood flow seen within the surrounding tissue.
Free fluid: No free fluid.
Other findings: Transvaginal images were performed for better anatomy visualization.

IMPRESSION:
Moderate free fluid. Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.

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Retroperitoneal Requirements

CPT Codes 76770, 76775

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Required Elements: Retroperitoneal US

With Urinary Tract Pathology:

- Bilateral Kidneys
- Bilateral Ureters
- Bladder

Without Urinary Tract Pathology:

- Bilateral Kidneys
- Abdominal Aorta
- Common Iliac Artery Origins
- Inferior Vena Cava (IVC)

Coding and Documentation Tips: Retroperitoneal US

- **Most commonly missed element on a retroperitoneal US with urinary tract pathology:**
  - Bladder measurement
- **Most commonly missed element on a retroperitoneal US without urinary tract pathology:**
  - Iliac artery origins
  - Inferior Vena Cava (IVC)
- **To support billing a complete study, the dictation must mention each element/organ, including those that could not be visualized and why**
- **If a limited US is ordered and performed, specify this in the dictated exam title and technique section of the report.**

Are all Required Elements Mentioned?

EXAM:
US Retroperitoneum Complete, Renal.
CLINICAL HISTORY:
62 years old, female; Reason for exam: 241. 0, nontoxic uninodular goiter; 593. 2, cyst of kidney aquired
TECHNIQUE:
Real-time ultrasound of the retroperitoneum (complete) with image documentation.
COMPARISON:
Lumbar spine CT from 3/5/15
FINDINGS:
The right kidney measures 10.4 cm. A mildly prominent right extrarenal pelvis is present.
The left kidney measures 9.8 cm. There is an 11 mm hypoechoic lesion within the interpolar region of the left kidney. No hydronephrosis, mass lesion, or calcification is seen. The urinary bladder is poorly distended but grossly unremarkable. Normal bilateral ureteral jets are seen. No significant postvoid residual volume is identified.
IMPRESSION:
1. 11 mm hypoechoic lesion in the left kidney which corresponds to the hyperdense lesion on the recent lumbar spine CT. This probably represents a hemorrhagic cyst.
2. No hydronephrosis

All Required Elements are Documented

EXAM:
US Retroperitoneum Complete, Renal.
CLINICAL HISTORY:
62 years old, female; Reason for exam: 241. 0, nontoxic uninodular goiter; 593. 2, cyst of kidney acquired
TECHNIQUE:
Real-time ultrasound of the retroperitoneum (complete) with image documentation.
COMPARISON:
Lumbar spine CT from 3/5/15
FINDINGS:
The right kidney measures 10.4 cm. A mildly prominent right extrarenal pelvis is present.
The left kidney measures 9.8 cm. There is an 11 mm hypoechoic lesion within the interpolar region of the left kidney. No hydronephrosis, mass lesion, or calcification is seen. The urinary bladder is poorly distended but grossly unremarkable. Normal bilateral ureteral jets are seen. No significant post-void residual volume is identified.
IMPRESSION:
1. 11 mm hypoechoic lesion in the left kidney which corresponds to the hyperdense lesion on the recent lumbar spine CT. This probably represents a hemorrhagic cyst.
2. No hydronephrosis

Retroperitoneal Without Renal Indication

EXAM:
US Retroperitoneum Complete, Aortic.
CLINICAL HISTORY:
81 years old, female; Abd pain stent graft for abd aortic aneurysm with substantial rt sided pain and edema , . Area of inflammation 7 CMS long and 3 CMS. w. Surg for stent placement was 1/22/15.
TECHNIQUE:
Real-time ultrasound of the retroperitoneum (complete) with image documentation.
COMPARISON:
US RETROPERITONEAL 11/5/2014 9:15:48 AM
FINDINGS: There are postsurgical changes related to reported aortic stent graft placement. No fluid is noted around the stent. The proximal, mid, and distal aspects of the aorta and bilateral common iliac arteries were imaged.
Along the postsurgical site overlying the RIGHT groin, there is a complex hypoechoic area measuring 4.6 x 2.0 cm. This may reflect a post procedural hematoma.
There is incidental fullness of the RIGHT renal collecting system, not well imaged.
IMPRESSION:
1. Postsurgical change related to aortic stent graft placement. No periaortic fluid noted.
2. Complex changes within the RIGHT groin, with a suspected 4.6 x 2.0 cm hematoma.
3. Mild fullness of the RIGHT renal collecting system.

Unbundling a Limited Pelvis and Limited Retroperitoneal US

It is NOT appropriate to order and separately dictate these exams. This is an example of unbundling:

- A report for bilateral kidneys only
- A report for the bladder (pre and/or post void residuals provided)

These two US examinations are the equivalent of one complete retroperitoneal US for the patient's with a urinary tract indication – 76770

•Do not bill these out as two different studies – ~~76775/76857~~

NOTE TO RADIOLOGISTS: please combine the orders if you see them come through separately

Unbundling a Retroperitoneal US with Urinary Tract Pathology

EXAM: US Retroperitoneum Complete, Renal.
CLINICAL HISTORY: 74 years old, female; Hematuria
TECHNIQUE:
Real-time ultrasound of the retroperitoneum (complete) with image documentation.
COMPARISON: None.
FINDINGS:
Right kidney: Unremarkable, measuring 9.2 x 4.8 x 5.8 cm. Mild increased echogenicity. No stones. No solid mass. No hydronephrosis. Small amount of ascites noted in the right quadrant.
Left kidney: Slightly decreased in size, measuring 8.8 x 5.6 x 6.6 cm. Mild increased echogenicity. No stones. No solid mass. No hydronephrosis.
Bladder: Not evaluated.
IMPRESSION:
1. Mild medical renal disease. No hydronephrosis. No renal calculi.
2. Small amount of ascites incidentally noted.

EXAM: US Bladder.
CLINICAL HISTORY: 74 years old, female; Hematuria
TECHNIQUE:
Real-time pelvic ultrasound of the bladder with image documentation.
COMPARISON: None
FINDINGS:
Prevoid volume measuring 292 mL and post void volume measuring 15 mL.
Bladder is unremarkable in contour without wall thickening. There is no intraluminal mass/hematoma. Foley catheter is in place.
IMPRESSION:
Unremarkable study, without significant postvoid residual.

Example of appropriate dictation for Complete Renal EXAM:

US Retroperitoneum Complete, Renal.
CLINICAL HISTORY:
11 years old, male; Signs and symptoms; Other: Uti; Additional info: Uti; ;
TECHNIQUE:
Real-time ultrasound of the retroperitoneum (complete) with image documentation.
COMPARISON:
No comparison study is provided.
FINDINGS:
Right kidney: Right kidney measures 9.1 x 3.2 x 4.5 cm. No renal mass, renal stone or hydronephrosis seen.
Left kidney: Left kidney measures 9.3 x 4.2 x 3.5 cm. No renal mass, renal stone or hydronephrosis seen.
Bladder: Urinary bladder incompletely distended but demonstrates no definite wall thickening or filling defect. Prevoid urinary bladder volume is 145 cc. Postvoid urinary bladder volume is 84 cc.
IMPRESSION:
1. No renal abnormality seen.
2. Other findings as described above and including some urinary retention which is of uncertain clinical significance. Clinical correlation is suggested.

Components of the Radiology Report

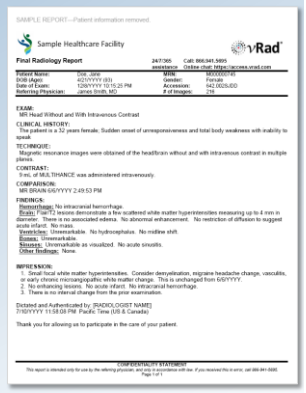
Demographic Header:

- Location where the study was performed
- Patient identifiers
  - Name
  - Date of birth or age
  - Gender
- Referring physician
- Date and time of the study

Clinical History or Reason for the Exam

Technique

- Views or additional imaging such as 3D reconstructions
- Materials if not recorded elsewhere
  - Contrast media or medications
  - Approach (e.g., abdominal or transvaginal)
  - Catheters
  - Other devises


SAMPLE REPORT—Patient information removed.

Sample Healthcare Facility

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Final Radiology Report

247/365 assistance: Call: 866.941.5695 Online chat: https://access.vrad.com

Patient Name: XXX, XXX — MRN: XXXXXXX-XX
DOB (Age): 4/21/YYYY (XX) — Gender: Female
Date of Exam: 12/XX/YYYY 10:15:25 PM — Accession: 042 0625-EID
Referring Physician: James Smith, MD — # of Images: 216

EXAM:
MR Head Without and With Intravenous Contrast

CLINICAL HISTORY:
The patient is a 32 years female. Sudden onset of unresponsiveness and total body weakness with inability to speak

TECHNIQUE:
Magnetic resonance images were obtained of the head/brain without and with intravenous contrast in multiple planes.

CONTRAST:
9 mL of MULTIHANCE was administered intravenously.

COMPARISON:
MR BRAIN 6/6/YYYY 2:49:53 PM

FINDINGS:
Hemorrhage: No intracranial hemorrhage.
Brain: FlairT2 lesions demonstrate a few scattered white matter hyperintensities measuring up to 4 mm in diameter. There is no associated edema. No abnormal enhancement. No restriction of diffusion to suggest acute infarct.
Ventricles: Unremarkable. No hydrocephalus. No midline shift.
Bones: Unremarkable.
Sinuses: Unremarkable as visualized. No acute sinusitis.
Other findings: None.

IMPRESSION:
1. Small focal white matter hyperintensities. Consider demyelination, migraine headache change, vasculitis, or early chronic microangiopathic white matter change. This is unchanged from 6/5/YYYY.
2. No enhancing lesions. No acute infarct. No intracranial hemorrhage.
3. There is no interval change from the prior examination.

Dictated and Authenticated by: [RADIOLOGIST NAME]
7/10/YYYY 11:58:08 PM Pacific Time (US & Canada)

Thank you for allowing us to participate in the care of your patient.

CONFIDENTIALITY STATEMENT
This report is intended only for use by the referring physician, and only in accordance with law. If you received this in error, call 866.941.5695.
Page 1 of 1

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Components of the Radiology Report

Findings or the Body of the report

- Observations about all the parts of the body seen in the exam
- Potential limitations or factors that compromised complete examination
- Comparison studies and reports
- Findings

Impression or Conclusion

- Restate any clinically relevant information in order of clinical importance
  - List primary finding or diagnosis first
  - Differential diagnosis: any abnormality you are trying to diagnose or consider
  - Incidental finding

The goal is to generate an accurate, concise, and clear radiology report

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Tips for Exam Titles

- Exam titles should have all elements for correct code assignment, including:
  - Modality (e.g., MR, ultrasound, CT, X-ray)
  - Anatomical site
  - Views
  - Whether contrast was used.
- Exams should be succinct—for example: upright, oblique, decubitus views of the abdomen, CT chest with and without contrast.
- Exam and clinical indication should be void of ambiguous, nonspecific, or unfamiliar terms or abbreviations.
- Avoid phrases without necessary descriptors, such as abdomen complete or abdomen series, or pulmonary embolism study.
- When separate studies are performed and documented in the same report:
  - Document with separate report header and findings
  - Do NOT copy and paste the same report for both studies

Tips for Quality Radiology Reports

- Recommendations for a follow-up exam or additional studies to provide the medical necessity of the additional exams.
- Comparison of prior studies, as appropriate.
- Capture clinical documentation for PQRS measures, such as:
  - Total fluoroscopy exposure time
  - Direct or indirect reference to measurement of distal internal carotid diameter
  - Prophylactic antibiotics and VTE preventive meds given for IR procedures
- Indication of any limitations in the study, such as poor image quality, poor imaging of specific elements, or poor patient prep.
- A summary of conversations with other health care providers.
- Any known significant patient reaction or complication.

Reason for Exam

Reason for Exam: Patient's Chief Complaint

1. Is "Deformity" a codeable diagnosis? NO

Provide additional clinical information:

- What was the anatomical location of the deformity
- Additional details about the type of deformity

2. Are the following codeable diagnoses? NO

- ***Fall***
- ***Trauma***
- ***MVA***

Provide additional clinical information:

- What injury did the patient sustain? Crushing injury; Gunshot wound
- Does the patient have any signs or symptoms, such as pain? Where is the pain located?
- Does the patient have a contusion, laceration, or abrasion?
- Is the patient conscious?
- Is there any other clinical history that might be pertinent to this exam?

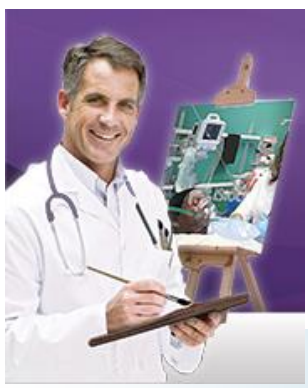
Reason for Exam: Chief Complaint

The following reasons for exam cannot be coded:

"Rule out"	*"Indicative of"*	*"Compatible with"*
"Suspected"	*"Suggestive of"*	*"Consistent with"*
"Probable"	*"Questionable"*	*"Comparable to"*

The following are acceptable reasons for exam:

- Chief complaint is principal symptom causing the patient to seek the radiology exam.
- Injury
  - Anatomical location (laterality)
  - Type of injury, e.g., contusion, swelling, laceration
- Known diseases or conditions
- Complications
- Clinical findings



"Paint the picture of the patient properly with words, so the coder can paint the same picture with codes."

Dr. Robert S. Gold, co-founder of DCBA

Rule Out Fracture of the Femur

MVA - Rule Out Fracture

Reason For Exam

Based on the patient's chief complaint and the medical record, please provide all pertinent indications for the radiologic exam(s). Please select all indications that apply from the lists below. Provide detailed information in the "OTHER" sections when none of the listed conditions apply to the patient's current history or where additional information is needed.

ICD-10-CM Code(s):

*Reason(s) for exam:
- ☐ Pain
- ☑ Injury or Trauma
- ☐ Signs and Symptoms
- ☐ Existing Condition or Disease
- ☐ Screening Exam or Abnormal Findings

*Describe the timing of this patient's encounter for their lower extremity injury:
- ◉ Initial encounter (evaluation and/or active treatment for injury)
- ○ Follow-up exam during the healing stage
- ○ Late effect from previous injury

*What type of injury has the patient sustained?
- ☐ Bite
- ☐ Contusion
- ☑ Crushing
- ☐ Dislocation
- ☐ Fracture, pathological
- ☐ Fracture, stress
- ☐ Fracture, traumatic injury
- ☐ Laceration
- ☐ Puncture
- ☐ Sprain or strain
- ☐ Wound
- ☐ Other

*Which part of the lower extremity was crushed?
- ☐ Ankle
- ☐ Calcaneus
- ☑ Femur
- ☐ Fibula
- ☐ Hip
- ☐ Metatarsal
- ☐ Patella or knee
- ☐ Tibia
- ☐ Toes
- ☐ Other

*Laterality of the crushed the femur:
- ○ Right
- ◉ Left
- ○ Bilateral

Capturing Pertinent Clinical History

*Laterality of the crushed the femur:
- ○ Right
- ◉ Left
- ○ Bilateral

Date of the injury: Today

*Was the injury the result of a vehicle accident?
- ◉ Yes
- ○ No
- ○ Unknown

What type of vehicle? Delivery Truck

*Was the injury work related?
- ◉ Yes
- ○ No
- ○ Unknown

Where did the injury take place? Highway head-on

*Is the patient pregnant?
- ○ Yes
- ○ No
- ◉ N/A
- ○ Unknown

*Any prior surgery in imaged area?
- ○ Yes
- ◉ No
- ○ Unknown

Pertinent patient history: Add history that is significant to the exam

"LT femur fracture at age 17."

Additional Exam Information: Information added here will transfer to the final report template.

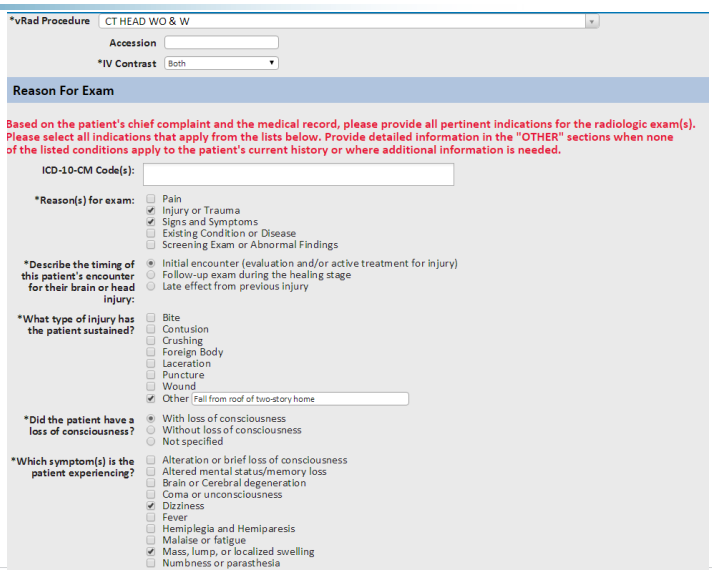
Do not repeat the information that was provided in the checked answers above.

Other Notes: Information added here will not transfer to the final report.

Pertinent Clinical Information:

- Chief Complaint:
  - The major health problem or concern
- Clinical findings:
  - From physical exam
  - Prior lab or x-ray findings
- Past medical history:
  - Concurrent conditions impacting the chief complaint
  - Past surgeries to the imaged area
- Inhibiting factors
  - Unconscious
  - Communication disorders
  - Physical inabilities

Fall: Possible Head Injury



*vRad Procedure: CT HEAD WO & W
Accession:
*IV Contrast: Both

Reason For Exam

Based on the patient's chief complaint and the medical record, please provide all pertinent indications for the radiologic exam(s). Please select all indications that apply from the lists below. Provide detailed information in the "OTHER" sections when none of the listed conditions apply to the patient's current history or where additional information is needed.

ICD-10-CM Code(s):

*Reason(s) for exam:
- [ ] Pain
- [x] Injury or Trauma
- [x] Signs and Symptoms
- [ ] Existing Condition or Disease
- [ ] Screening Exam or Abnormal Findings

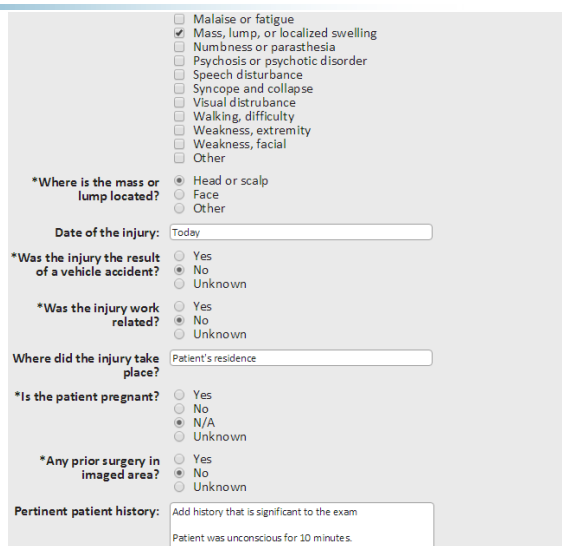
*Describe the timing of this patient's encounter for their brain or head injury:
- (•) Initial encounter (evaluation and/or active treatment for injury)
- ( ) Follow-up exam during the healing stage
- ( ) Late effect from previous injury

*What type of injury has the patient sustained?
- [ ] Bite
- [ ] Contusion
- [ ] Crushing
- [ ] Foreign Body
- [ ] Laceration
- [ ] Puncture
- [ ] Wound
- [x] Other: Fall from roof of two-story home

*Did the patient have a loss of consciousness?
- (•) With loss of consciousness
- ( ) Without loss of consciousness
- ( ) Not specified

*Which symptom(s) is the patient experiencing?
- [ ] Alteration or brief loss of consciousness
- [ ] Altered mental status/memory loss
- [ ] Brain or Cerebral degeneration
- [ ] Coma or unconsciousness
- [x] Dizziness
- [ ] Fever
- [ ] Hemiplegia and Hemiparesis
- [ ] Malaise or fatigue
- [x] Mass, lump, or localized swelling
- [ ] Numbness or parasthesia

Fall: Possible Head Injury



- [ ] Malaise or fatigue
- [x] Mass, lump, or localized swelling
- [ ] Numbness or parasthesia
- [ ] Psychosis or psychotic disorder
- [ ] Speech disturbance
- [ ] Syncope and collapse
- [ ] Visual distrubance
- [ ] Walking, difficulty
- [ ] Weakness, extremity
- [ ] Weakness, facial
- [ ] Other

*Where is the mass or lump located?
- (•) Head or scalp
- ( ) Face
- ( ) Other

Date of the injury: Today

*Was the injury the result of a vehicle accident?
- ( ) Yes
- (•) No
- ( ) Unknown

*Was the injury work related?
- ( ) Yes
- (•) No
- ( ) Unknown

Where did the injury take place: Patient's residence

*Is the patient pregnant?
- ( ) Yes
- ( ) No
- (•) N/A
- ( ) Unknown

*Any prior surgery in imaged area?
- ( ) Yes
- (•) No
- ( ) Unknown

Pertinent patient history: Add history that is significant to the exam

Patient was unconscious for 10 minutes.

Key Aspects to Document

Location:

- Anatomical site
- Localization: Distal, proximal, quadrant
- Laterality

Context:

- Type of condition, for example:
  - Traumatic, stress, or pathological fracture
- Temporal parameters (timing), for example:
  - Acute, chronic, acute on chronic, subacute, or recurrent
- Etiology of the condition
- Severity of the symptoms or condition
- Status or stage of disease

Associated or Concurrent Condition:

- Complications, manifestations, and comorbidities
- Contributing factors
- Pregnant (First day of the last menstrual period)
- Medical history pertinent to exam (personal /family)

Provide an complete and accurate story

Resources

- *ACR Practice Guideline for Communication of Diagnostic Imaging Findings*, Revised 2014
- *ACR Radiology Coding Source™, Radiology Coding Source Archive* January - February 2007 Noninvasive Vascular Diagnostic Studies
- *Clinical Examples in Radiology* (Winter 2006, Vol. 2, Issue 1)
- *Clinical Examples in Radiology,* Volume 3:7, Winter 2007
- *CPT® Assistant,* October, 2001
- *2006 ACR Ultrasound Coding User's Guide*
- *2015 AMA CPT® Manual, Professional Edition*

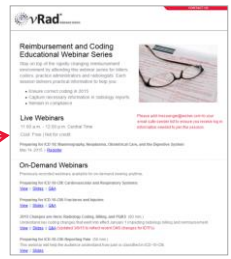
Thank You

Please submit questions using Chat.

Enter question here

Answers, with supporting resources, will be posted on the webinar series webpage:

http://webinars.vrad.com/reimbursement_series



vRad team members with specific scenarios or questions are encouraged to contact Sharon Roeder for further support.