Briefings on APCs

Properly document imaging even when it’s bundled into procedure codes

by Laura Evans, CPC

Pay close attention to new documentation and coding guidance for reporting radiological imaging in the 2019 CPT manual.

For example, a new paragraph titled “Imaging Guidance” in both the surgery and medicine guidelines advises that even when imaging guidance or supervision are included in a surgical procedure code, you must still follow the radiology documentation requirements in the CPT manual.

The new guidance is meant to help clarify imaging documentation for codes that include both a procedure and imaging guidance, explains **Melody W. Mulaik, CPC,** president of Coding Strategies Inc. in Powder Springs, Georgia. “Over the last few years, they’ve bundled imaging into a lot of codes,” she says. “We don’t have a lot of radiological supervision and interpretation codes left.”

What this means for imaging guidance documentation, according to coding experts is:

- Documentation should state that imaging was used and what type it was.
- It should also state that imaging confirms, for example, that the needle is in the correct position.
- You should save a static image of the localization in the patient’s medical record.

The new CPT guideline puts into writing what coding consultants have been saying for a long time, explains coding and compliance manager **Ruby O’Brochta-Woodward, CPC, CPMA**, Suburban Imaging/Suburban Radiology, Minneapolis-St. Paul, Minnesota. “In order to bill for guidance, there have to be images stored in the patient record as well as documentation of the use of guidance and the type of guidance,” she explains.

For example, says Mulaik, “Let’s say they do an ultrasound guided injection — they should document that ultrasound was used for needle localization and capture a static image of the needle placement.”

In addition, you may not use a code that describes imaging to report such non-imaging tracking methods as radar or electromagnetic signals, the AMA advises. However, you may report imaging codes for modalities including radiography, fluoroscopy, ultrasound, MRI, CT or nuclear imaging as appropriate, the guidance states.

Imaging report can be in physician note

New guidance added to the CPT radiology guidelines further clarifies what must be documented.

Under the heading, “Supervision and Interpretation, Imaging Guidance,” AMA advises that “imaging guidance is not separately reportable when it is included in the base service.”

That means it would not be appropriate to skirt the rules by separately reporting a diagnostic radiological exam with therapeutic injections such as arthrocentesis (codes 20600-20611) or epidural injections (62320-62323) that already include imaging.

As Mulaik notes, “By the time they’re going in to do an epidural injection, they should already have done all the diagnostic imaging needed” to confirm the condition they are treating.

Additional diagnostic imaging during treatment would not be warranted unless it addresses a separate problem.

The new guidance also spells out the required documentation elements for radiological supervision and interpretation (RS&I) codes, including:

(1) Image documentation in the patient’s permanent record and

(2) A procedure report or separate imaging report that includes written documentation of interpretive findings of information contained in the images and radiological supervision of the service.

Note that the AMA appears to clarify that the interpretive findings may be included in the procedure report, so you are not required to generate a separate RS&I report.

Mulaik suggests that you use the “black pen” test to make sure your imaging documentation is up to snuff: “If I cut out

three to four sentences describing the procedure, could the note support the imaging study?”

Guard against cloned notes

In a separate section of the radiology guidelines titled Written Report(s), “the AMA warns that imaging documentation “must contain anatomic information unique to the patient for which the imaging service is provided.”

That guidance is designed to prevent practices from setting up macros in their EHRs to parrot the same radiology report on every scan — a practice also known as cloned notes, explains Mulaik.

“They want to make sure a truly unique interpretation was done,” she says. “The danger with cloned notes is that with simple procedures like biopsies or even some injections, sometimes the notes look the same” from patient to patient.

Note that this guidance applies more to diagnostic imaging than to interventional procedures, Mulaik says.

Editor’s note: This article originally appeared on Part B News.