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Documentation Standards: Radiology Reports

When reporting both the technical component and the professional component of a radiology service to a patient's insurance carrier, you are being paid for taking the film, and for providing a formal interpretation. This applies to all radiology services, including ultrasounds.

The ACR (American College of Radiology) suggests that the formal report include the following components:

Format:

- The report should be typed.
- The report should be signed by the interpreting provider. If the report is signed by hand, then the interpreting physician's name and credentials should also be typed on the report, so that it is legible.

Identification:

- Name of the patient and at least two other patient identifiers, (i.e., birth date and patient identification number) For greater protection from identify theft, don't use the patient's social security number as an identifier.
- Name of referring physician, if appropriate.
- Name or type of examination performed.
- Date of service.
(This should be the date the x-ray occurred. If the interpretation date is different, this should also be noted.)
- Name and credentials (i.e., MD) of the interpreting physician.
- Indication for the service (i.e., "suspected fracture")

Report:

- Document the procedure and materials
- Document the findings
- List any limitations (i.e., body habitus, poor prep, pain interfering with positioning, etc.)
- Clinical issues, if any
- Comparative data if indicated
- Diagnosis
 - Provide a prescribing diagnosis when possible
 - Provide a differential diagnosis when appropriate
- Recommendations for follow-up or additional films as appropriate

The formal report should also be stored in the patient's chart.

Films should be filed in accordance with your patient identification system (i.e., alphabetic, numeric, alpha-numeric, etc). The formal report should also be included in the film jacket and readily available with the films themselves.

E/M Coding: Medical Decision Making

Editors Note: This is a continuation of our series to cover the key components of E/M coding.

The third key component to coding evaluation and management services is medical decision making. CPT defines four defined levels of medical decision making: straightforward, low complexity, moderate complexity, high complexity.

The medical decision making component has two internal algorithms. The basic elements are: 1) number of diagnosis/treatment options, 2) data complexity, 3) level of risk. The level of medical decision making is based on the "score" in two of three of the elements. For example, if there are three points in the "Dx/Tx" section, and three points in the "Risk" section, then this is equal to moderate complexity decision making.

The "Risk" section also has its own algorithm. "Risk" has three tables: 1) Presenting Problem, Diagnostic Procedure Ordered, Management Option Selected. The level of "Risk" is based on the highest score in any one column.

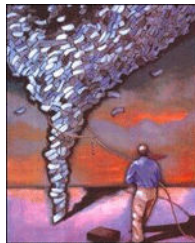
Once the level of decision making is determined, it is applied to the other two key components to determine the overall level of the code.

The levels of decision making are described in CPT. The algorithms that assign points for each element are most commonly attributed to a matrix developed by the Marshfield Clinic in the 1990's that is widely used by nearly all coders, auditors, and payers. This matrix was patterned after an original matrix and publication from Medicare in 1995.

Some Tips for Following the Decision Making Matrix

- In the "Dx/Tx" column, 3 points are assigned for a "new problem to examiner, no additional work-up planned". If the patient presents with an exacerbated chronic problem that your partner has addressed, this would be an established problem to your partner. But if you are covering for your partner, and have not addressed it before, the problem is new to you. Your documentation must support this fact.
- In "data complexity" additional credit is given when "obtaining history from someone other than the patient". When this occurs, be sure to document this fact and the information they are contributing. This may apply to family members, caregivers, and/or interpreters. (When the patient is a child, the "extra credit is generally not given unless both the child and the caregiver are providing history.)
- Also in "data complexity", extra credit is given for "independent visualization of image, tracing, or specimen". If you base your treatment plan based on your analysis of films rather than a radiology report of the films, this counts, so long as it is clear in the documentation that you've reviewed actual films.
- Other common tests that providers often "independently visualize" include EKG's and wet mounts or KOH preps.
- "Risk" is based on risk to the patient at that point in time. The "Risk" column assigns an "acute or chronic illnesses or injuries that may pose a threat to life or bodily function". Certainly diabetes is a condition that can cause a threat to life and bodily function. But if the patient is currently stable, the patient is not considered at high risk.

Industry News



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