

## Proper X-Ray Documentation

The documentation issue has been raised again, by the Inspector General for the Department of Health and Human Service. To choose the proper code, all the views must be documented to report the most comprehensive code. Documentation should include the planes, positions and number and type of views.

instruction originally published in a 2002 Medicare Part B newsletter.

It is essential that coders and auditors of medical records are able to accurately understand the nature of the physician work performed during a service reported to Medicare using CPT or HCPCS codes. In the case of

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For that reason, we will restate the

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## Identifying Views

To include all views at or above “minimum” number of views, it is helpful for the coder to know the definitions to assist in analyzing the reports.

- **Apical-chest** including apex of the lung to minimize the rib image overlapping a lung lesion
- **Anteroposterior (AP)**- front to back
- **Bucky**- film placed in a device the eliminates secondary radiation
- **Decubitus (DEC)** – lying on side
- **Odontoid** – open-mouth cervical spine to view and identify joint space C1
- **Oblique** – angled view
- **RAO** (right anterior oblique)—right front
- **RPO** (right posterior oblique)—right rear
- **LAO** (left anterior oblique)—left front
- **LPO** (left posterior oblique)—left rear
- **Posteroanterior (PA)**—back to front
- **Swimmers**—thoracic x-ray with one or both arms over head
- **Stereo**—two views of a structure, one at 90 degrees to the film and second with tube angled 12-15 degrees toward the head. ■

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interpretations of diagnostic imaging, this is especially important because Medicare (except in unusual circumstances per IOM Pub. 100-04, Chapter 13, Section 100.1) must make payment for only one interpretation per study reported with either the separate "S&I" code, the global procedure CPT code or a CPT code with modifier -26, although numerous physicians might view, review and otherwise interpret images of a single procedure.

Interpretations of diagnostic imaging procedures reported separately for Medicare payment must include, either as a separate document or within the main body of the patient's record, the following minimum information:

- Patient's name and other appropriate identifier (date of birth, Social Security number, record number, etc.).
- Referring physician name
- Name or type of imaging procedure performed
- Date and time imaging procedure was performed
- Name of interpreting physician
- Date and time interpretation was performed
- Body of the report including:
  - Procedures and materials

- Findings
- Limitations
- Complications
- Clinical issues
- Comparisons, when indicated and available
- Clinical impression and diagnosis, including differential diagnosis when appropriate
- Legible signature (holographic or electronic)

Records containing only documentation of diagnostic impressions, such as "Chest X-ray normal," "Chest X-ray shows CHF," and even more cryptic notations such as "CXR reviewed," are insufficient to support Medicare payment and must not be reported to Medicare as separately reported diagnostic imaging or interpretation.

Finally, interpretations reported to Medicare for payment must be available to the treating physician in a timely fashion. Reports must be contemporaneous with the care of the patient. Interpretations performed for quality control reasons or performed/reported so long after the procedure as to prevent their use in clinical decision-making must not be billed to Medicare. ■

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## New Medicare Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare Physician Fee Schedule (MPFS). As you are aware, the Temporary Extension Act of 2010, enacted on March 2, 2010, extended the zero percent (0%) update to the 2010 MPFS through March 31, 2010. CMS believes Con-

gress is working to avert the negative update that will take effect April 1. CMS has instructed its contractors to hold claims containing services paid under the MPF for the first 10 business days of April. This hold will only affect claims with dates of service April 1, 2010, and forward. **The hold should have minimum impact on provider cash flow because, under the current law, clean electronic claims are not paid any sooner than 14 calendar days (29 for paper claims) after the date of receipt.** ■