

# Coding Denials in Radiology

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# Disclaimer

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# Agenda

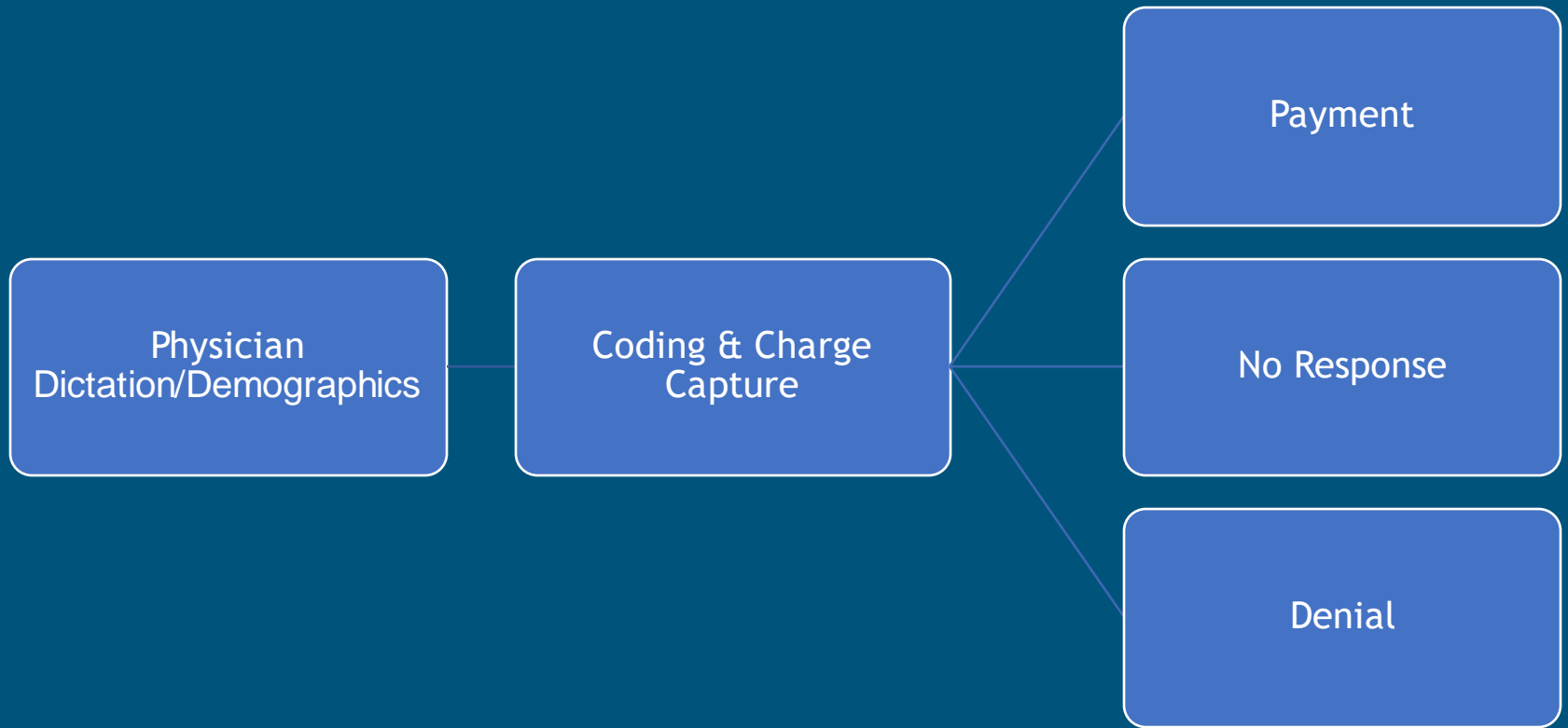
- Intro/Billing Basics
- Denial Categories
- Payor Policies & References
- Types of Coding Denials
- Strategic Improvement

# Resources

- AMA
- CMS



# RCM-Billing Basics



# Denial Categories

- Registration Related Denials
  - Cannot ID Patient
  - Other Payor Primary
  - No Coverage on DOS
  - No Precertification on File
- Patient Benefit Related Denials
  - Non-Covered Patient Responsibility
  - Non-Covered Provider Responsibility
- Coding
  - Duplicate/Frequency
  - Bundling
  - Non-covered Services/Medical Necessity



## Payor Policies & References

- Commercial/Private Insurance
- Not readily available
- Most generally will follow CMS guidelines
- Check websites



# CMS Policies & References

- Coverage-Billing & Coding Articles
- Medicare Physician Fee Schedule
- National Correct Coding Initiative
- Transmittals/Medicare Learning Network (MLN)



**CMS.gov**

# CMS Coverage

- <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>
- Billing & Coding Articles
  - LCD Transition
  - Medicare Administrative Contractor (MAC)
- National Coverage Determination (NCD)

# CMS Articles

**MCD**  
Medicare Coverage Database

[Search](#)

[Reports](#)

[Downloads](#)



## Welcome to the MCD Search

Start your search below

Enter keyword, code, or document ID

All States



### Notice Board

04/30/2021 Check out the Latest Site Updates

04/30/2021 **Alert:** Overall changes to MCD



### Beneficiary?

Are you a beneficiary and need help using the MCD?

Need more help? [Contact a MAC](#) for questions about claims and denials or call 1-800-MEDICARE for other questions.

Looking for health care providers and services? [Find a health care provider on medicare.gov](#)



### Public Comments

**Please Note:** There are currently no National Coverage Documents open for public comment.



#### Article Text:

This First Coast Billing and Coding Article for Local Coverage Determination (LCD) L33282 Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries provides billing and coding guidance for diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in the LCD, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Refer to the LCD for reasonable and necessary requirements and limitations.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in the LCD.

#### Coding Guidelines

At times, it may be necessary to evaluate the patient for both cardiac and noncardiac disease. Pending the assignment of a code that more precisely describes this service, protocols using cardiovascular CT angiography for the evaluation of acute chest pain in the emergency setting, where pulmonary and/or aortic vascular etiology are also a concern, must be coded with CPT code 71275 only.

Billing CPT code 71275 plus one of the following CPT codes (75571, 75572, 75573, or 75574) would attest to the fact that two completely separate procedures were performed in their entirety.

**Notice:** It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

#### Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

#### Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Compliance with the provisions in LCD L33282, Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries may be monitored and addressed through post payment data analysis and subsequent medical review audits.

#### Coding Information

##### CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

CODE	DESCRIPTION
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING

Group 2 Paragraph: N/A

Group 2 Codes:

CODE	DESCRIPTION
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC

# CMS Coverage

# Medicare Physician Fee Schedule

- MLN Guide:
  - <https://www.cms.gov/files/document/2020-physician-fee-schedule-guide.pdf>
- Lookup Tool:
  - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup>
- Updated Quarterly
- Pricing/RVU's
- Payment Policy Indicators by CPT
  - -PC/-TC
  - Global Periods
  - Multiple Procedure
  - Bilateral Procedure
  - Assistant/Co/Team Surgeon
  - Physician Supervision Level

# Medicare Physician Fee Schedule

## Search the Physician Fee Schedule

Data Updated: 01/20/2021

Use this search to view adjusted pricing amounts that reflect variations in pricing costs from area to area.

Select search parameters.

**Year**

2021

[See notes for selected year](#)

**Type of Information**

All

Select Healthcare Common Procedural Coding System (HCPCS) criteria.

**HCPCS Criteria**

Single HCPCS Code

**HCPCS Code**

**Modifier**

All Modifiers

Select Medicare Administrative Contractor (MAC) option.

**MAC Option**

All MACs

Search fees

# Medicare Physician Fee Schedule

2021

[See notes for selected year](#)

## Type of Information

Payment Policy Indicators

Select Healthcare Common Procedural Coding System (HCPCS) criteria.

## HCPCS Criteria

Single HCPCS Code

## HCPCS Code

71275

## Modifier

Global (Diagnostic Service) OR Physicians Professional Se

[Search fees](#)

[Reset search inputs](#)

## Search Results

Showing 1 - 1 of 1

	Global	Pre Op	Intra Op	Post Op	Mult Surg	Bilt Surg	Asst Surg	Co Surg	Team Surg	Phys Supv	Enc
	XXX	0.00	0.00	0.00	4	0	0	0	0	9	

[Download CSV](#)

[Copy link](#)

# NCCI Tools

- MLN Guide:
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf>
- Policy Manual:
  - <https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-policy-manual-medicare>
- Procedure to Procedure (PTP) Edits:
  - <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits>
- Medically Unlikely (MUE) Edits:
  - <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE>



# NCCI Policy Manual

- Uniform Payment Policies Across MACs
- Based on:
  - AMA/CPT Coding Conventions
  - CMS policies and edits
  - Medical Societies
  - Standard Practices
- Radiology-Chapter 9

- Medicare
- Medicaid/CHIP
- Medicare-Medicaid Coordination
- Private Insurance
- Innovation Center
- Regulations & Guidance
- Res D

Home > Medicare > National Correct Coding Initiative Edits > NCCI Policy Manual for Medicare

- National Correct Coding Initiative Edits**
- NCCI Policy Manual for Medicare
- [NCCI Policy Manual Archive](#)
- [Correspondence Language Manual Archive](#)
- [Medically Unlikely Edits](#)
- [Quarterly PTP and MUE Version Update Changes](#)
- [PTP Coding Edits](#)
- [Add-on Code Edits](#)
- [NCCI FAQs](#)

## NCCI Policy Manual for Medicare

- [Introduction \(PDF\)](#)
- [Chapter 1 \(PDF\)](#)
- [Chapter 2 \(PDF\)](#)
- [Chapter 3 \(PDF\)](#)
- [Chapter 4 \(PDF\)](#)
- [Chapter 5 \(PDF\)](#)
- [Chapter 6 \(PDF\)](#)
- [Chapter 7 \(PDF\)](#)
- [Chapter 8 \(PDF\)](#)
- [Chapter 9 \(PDF\)](#)
- [Chapter 10 \(PDF\)](#)
- [Chapter 11 \(PDF\)](#)
- [Chapter 12 \(PDF\)](#)
- [Chapter 13 \(PDF\)](#)

# NCCI Policy Manual

# NCCI Edits

- Procedure to Procedure (PTP) Edits
  - Hospital vs. Practitioner Files
  - Column 1/Column 2
- Medically Unlikely Edits (MUE)
- Add-on Code Edits (OCE)
- Released Quarterly
- Medicare/Medicaid files
- Denied service may not be billed to beneficiary

	A	B	C	D	E	F	G	H	I	J	K	L
1	CPT only copyright 2020 American Medical Association. All rights reserved.											
2	Column1/Column2 Edits											
3	Column 1	Column 2	*=in existence	Effective	Deletion	Modifier	PTP Edit Rationale					
4			prior to 1996	Date	Date	0=not allowed						
5					*=no data	1=allowed						
6						9=not applicable						
291419	71275	0558T		20200101	*	1	CPT Manual or CMS manual coding instructions					
291420	71275	36000		20020101	*	1	Standards of medical / surgical practice					
291421	71275	36005		20070101	*	1	Misuse of column two code with column one code					
291422	71275	36011		20020101	*	1	Standards of medical / surgical practice					
291423	71275	36406		20020101	*	1	Standards of medical / surgical practice					
291424	71275	36410		20020101	*	1	Standards of medical / surgical practice					
291425	71275	36591		20151001	*	0	CPT Manual or CMS manual coding instructions					
291426	71275	36592		20151001	*	0	CPT Manual or CMS manual coding instructions					
291427	71275	71250		20100101	*	1	Misuse of column two code with column one code					
291428	71275	71260		20100101	*	1	Misuse of column two code with column one code					
291429	71275	71270		20100101	*	1	Misuse of column two code with column one code					
291430	71275	71271		20210101	*	1	Misuse of column two code with column one code					
291431	71275	76000		20030101	*	1	Misuse of column two code with column one code					
291432	71275	76001		20091001	20181231	1	Misuse of column two code with column one code					
291433	71275	76003		20030101	20061231	1	Misuse of column two code with column one code					
291434	71275	76350		20060401	20101231	0	Standards of medical / surgical practice					
291435	71275	76375		20011001	20051231	0	Standards of medical / surgical practice					
291436	71275	76376		20060101	*	0	CPT Manual or CMS manual coding instructions					
291437	71275	76377		20060101	*	0	CPT Manual or CMS manual coding instructions					
291438	71275	76380		20091001	*	1	Misuse of column two code with column one code					
291439	71275	76942		20030101	*	1	Misuse of column two code with column one code					
291440	71275	76970		20170101	20201231	1	Misuse of column two code with column one code					
291441	71275	76986		20030101	20061231	1	Misuse of column two code with column one code					
291442	71275	76998		20070101	*	1	Misuse of column two code with column one code					
291443	71275	77001		20110101	*	1	Misuse of column two code with column one code					
291444	71275	77002		20070101	*	1	Misuse of column two code with column one code					
291445	71275	78803		20200101	*	1	Misuse of column two code with column one code					
291446	71275	78830		20200101	*	1	Misuse of column two code with column one code					
291447	71275	78831		20200101	*	1	Misuse of column two code with column one code					
291448	71275	78832		20200101	*	1	Misuse of column two code with column one code					
291449	71275	90760		20060101	20081231	1	Standards of medical / surgical practice					
291450	71275	90765		20060101	20081231	1	Standards of medical / surgical practice					

# P2P Edits

# Modifiers

- 25-Separate Unrelated E&M on Day of Procedure
- 50-Bilateral
- 76-Repeat Procedure Same Physician
- 77-Repeat Procedure Different Physician
- 59-Distinct Procedural Service
  - XE-Separate Encounter
  - XP-Separate Practitioner
  - XS-Separate Structure
  - XU-Unusual Non-Overlapping Service
- 58-Staged/Related Procedure During Post-Op Period
- 78-Unplanned Return for Related Procedure (Complication) During Post-Op Period
- 79-Unrelated Return During Post-Op Period

# TYPES OF CODING DENIALS

- Duplicate
- Frequency
- Bundling
  - NCCI
  - Global Period/IR
- Medical Necessity

# DUPLICATE DENIALS

Review the  
Report(s)

Separate  
Encounter/Same  
Physician=  
Modifier 76

Separate  
Encounter/Different  
Physician=  
Modifier 77

# FREQUENCY DENIALS

Review the  
Report(s)

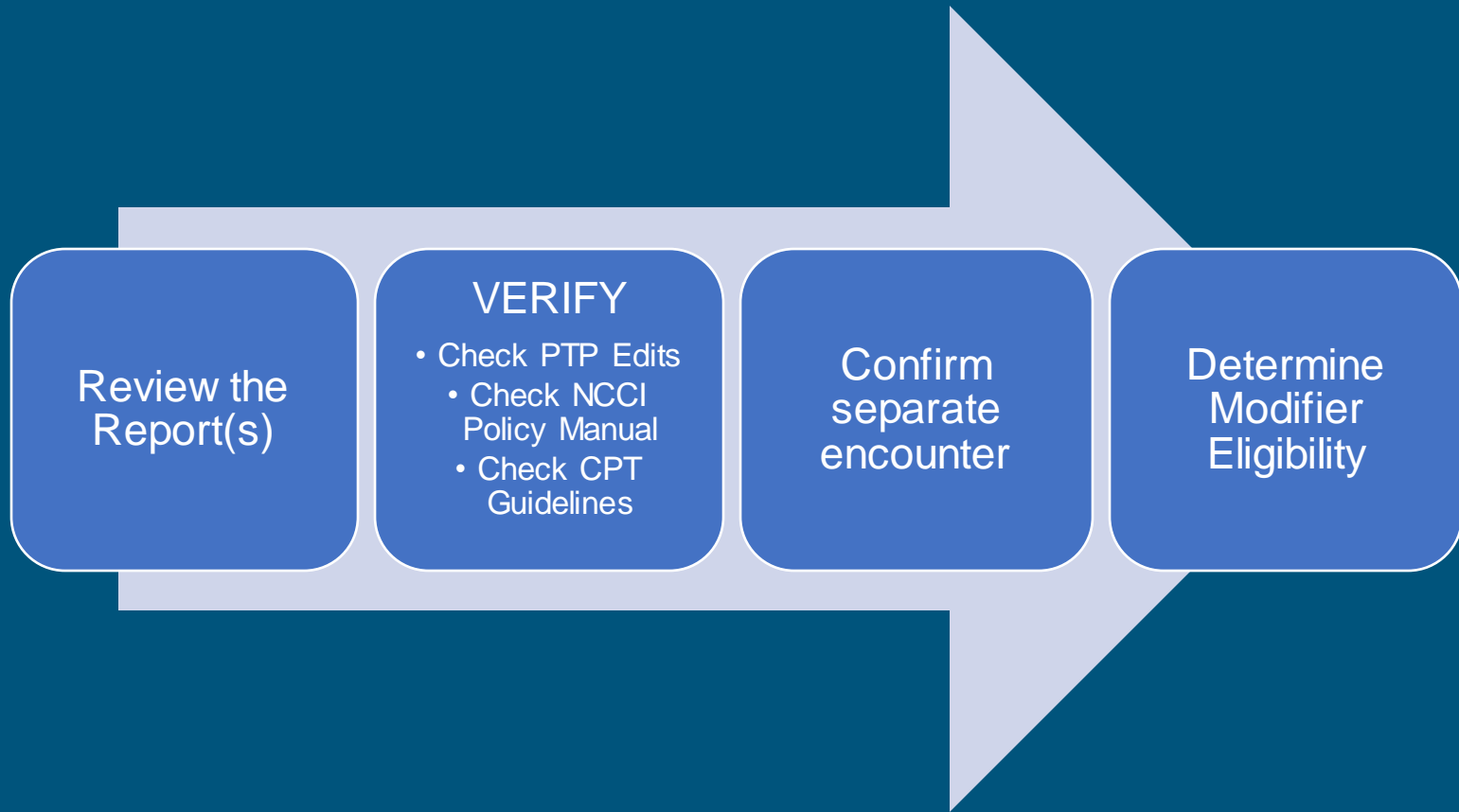
## VERIFY

- Check MUE Edits
- Check Coverage Limitations

Determine  
Appeal  
Eligibility



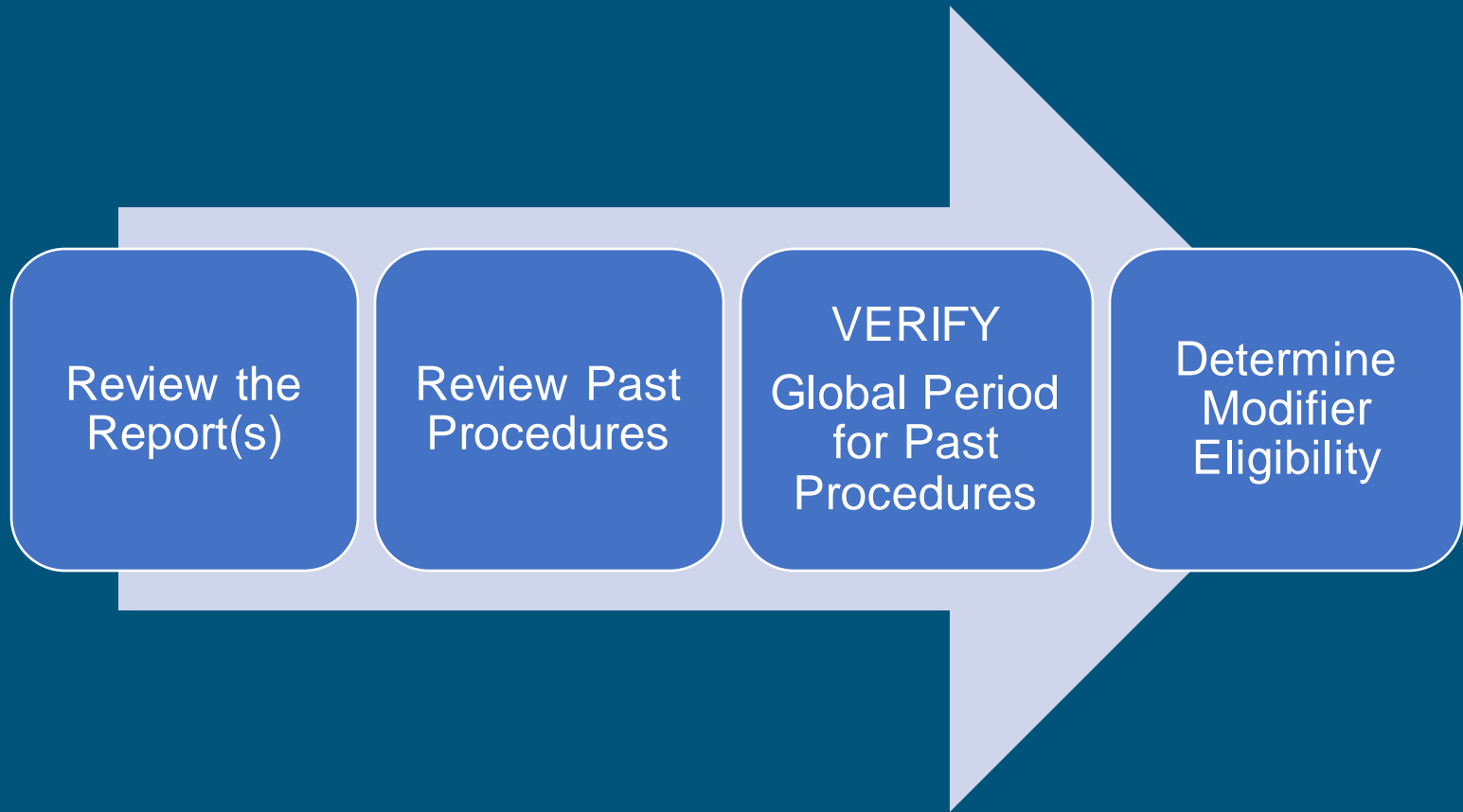
# BUNDLING DENIALS



# Understanding the Global Period

- Can be found in MPFS
- Routine Pre- and Post- Operative Care
- Global Days-0, 10, 90
  - XXX/YYY/ZZZ
- Billable Scenarios
  - Unrelated E&M service on day of procedure(-25)
  - Return to OR/Procedure Room during global period
    - Staged/Planned (-58)
    - Related but Unplanned-COMPLICATION (-78)
    - Unrelated (-79)

# BUNDLING DENIALS-GLOBAL PERIOD



# MEDICAL NECESSITY DENIALS

Review the Report

Check CMS Article/NCD Covered Diagnoses

Secondary Review of the Report and Order/Clinical History

Determine if Resubmission with new ICD-10 code is appropriate

# MEDICAL NECESSITY:

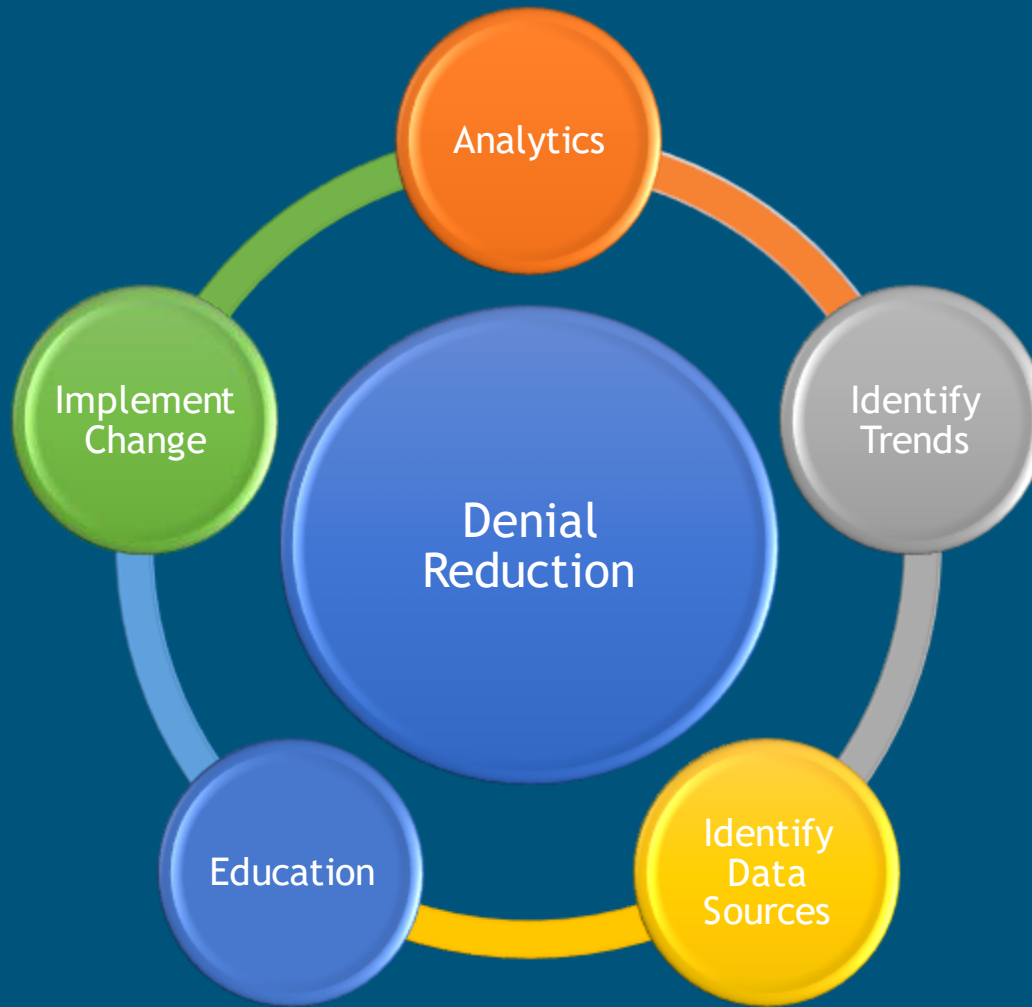
## *Common Studies At Risk*

- Lower Extremity Venous Duplex Studies
  - “R/O”, “Assess for” or “Possible” DVT
  - Swelling
- Carotid Duplex Studies
  - “R/O” carotid stenosis
- Modified Barium Swallows
  - Requires a Secondary Dx
- Pre-Op Chest X-rays
- Low Dose Lung Cancer Screening
  - Type of Smoking Not Documented
- DEXA Scans
  - “Osteopenia Unspecified”

# CHALLENGE: MEDICAL NECESSITY

- Pain Point-Clinical Indication/Reason for Exam
- Challenge to Radiology
- Strategic Improvement:
  - Analysis
  - Education
  - Facility/Referring Physician Feedback

# Strategies for Improvement



# Q&A





# Thank you!

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