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BCN Provider *News*

Clinical editing billing tips

Office and ER documentation of radiology reports

While "wet read" is an outdated term, it is still used in many cases to indicate an immediate or urgent review of an X-ray film. Due to advances in technology, films are no longer "wet" immediately after processing, but the term has remained. Blue Care Network has indicated that we won't accept or reimburse for quick or wet reads. We've been asked what documentation we require for reimbursement, especially when X-rays are done in the emergency room or office and the reads are done by the attending physician.

First, we'll only pay for one read on an X-ray. If there is a quick or "wet read" done and it's then sent to a radiologist, the radiologist should be the provider submitting the claim for the read. If we receive two claims, the first one we receive will be paid. On appeal, the documentation will support who did the actual read and money could be taken back if we paid for a wet read.

Second, if you are doing a read in the office or emergency room, there are components that need to be documented. Ideally, we 'd like to see a separate radiology report with the noted components. If this isn't possible, the imaging report must be clearly identified. A mention in the office or ER note isn't acceptable.

Components that need to be in the X-ray or imaging report include:

- Patient name
- Referring or ordering physician
- Name of radiology examination
- Date and time the radiology procedure was performed, as well as date and time of dictation/reporting
- Clinical information, including diagnoses and indications for radiological examination
- Findings described using appropriate medical terminology, including any limitations or clinical issues that could affect or influence the study results
- An impression should be documented, indicating a conclusion or diagnosis
- Signature of physician performing the read and completing the report

This isn't meant to be an all-inclusive list. Other information should be added as necessary for the report to provide a clear and accurate summary of the X-ray results.

Additionally, you can only bill for interpretation and report of radiological services in which a permanent film or imaging record is maintained. In instances where the physician may be performing the exam (for example, an ultrasound), it's important to document that a permanent image has been recorded along with measurements. If there's no permanent image or a complete written report, you can't bill for the interpretation and report on that study.

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Clinical editing billing tips *Cont.*

Modifier 59 review

Modifier 59 can be used to report a distinct procedural service, one that wouldn't typically be performed on the same date or at the same session, especially by the same provider or physician. It may be reported alone or in conjunction with other modifiers, such as anatomical or pricing modifiers. In either situation the modifier 59 should be used only when identifying a distinct procedural service.

Guidelines for modifier 59 usage indicate that the service was performed in, either:

- A different
  - Session or patient encounter
  - Procedure or surgery
  - Site or organ system
- A separate
  - Incision/excision
  - Lesion
  - Injury (or area of injury in extensive injuries)

While BCN recognizes modifier 59 as valid, we don't allow the modifier to override all edits automatically that are permitted in the National Correct Coding Initiative Manual. We maintain a list of codes for which modifier 59 will override appropriate edits. Modifier 59 and other modifiers should not be reported to bypass edits unless the criteria for the use of the modifier is met and documented in the patient's medical record.

When reporting modifier 59 on a primary code, it may be appropriate and necessary to report modifier 59 on the add-on codes if those are reported on the claim. (The list is available in the Claims Chapter of the *BCN Provider Manual*.) Again, the modifier should only be reported when the documentation supports it.

Note: The Medicare Learning Network publishes a comprehensive article on the correct use of modifier 59: **MLN Matters Number: SE0715**.