Radiology Views™ Newsletter – August 2009

Dictating the Number of Views

The description or number of views MUST be documented in the radiology exam report for accurate coding and reimbursement. If the description or number of views is not clearly documented, reimbursement will be affected.

- ✓ **CPT:** The AMA's CPT Manual sets the standard for procedure description and CPT coding. CPT codes are assigned by PRC staff based on the radiology exam documentation provided by the radiologist. Insurance companies reimburse radiology practices based on the CPT codes that are assigned and billed. Many diagnostic radiology exams may contain more than one CPT code depending on the number of views performed and documented.

- ✓ **CPT Examples:** Some examples of multiple CPT codes are:

  1. Cervical Spine – 72040 two or three views, 72050 minimum of four views and 72052 complete including oblique and flexion and/or extension studies.
  2. Hand – 73120 two views and 73130 minimum of three views.
  3. Knee – 73560 one or two views, 73562 three views, 73564 complete four or more views.

- ✓ **Reimbursement:** Intuitively, the higher the number of views performed and documented, the higher the reimbursement is by exam. If an exam is under documented, reimbursement will be reduced.

- ✓ **Ideal Dictation:** Ideally, proper documentation should include the actual views that were performed. There has been a debate for many years regarding some "views" that are performed. For example, is the spot lateral lumbar spine a separate view or is it included with the lateral? It is recommended that the "description" of views be stated in the diagnostic report, such as AP, Lateral, Oblique; however, at a minimum, the "number" of views must be documented in the report, such as 1 view, 3 views, 6 views, etc.

If you have any questions on this or other documentation and coding topics, please call or email Don Clark, RCC, at 330.564.2608 or dclark@prcmedical.com.

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