Uncovering Coding & Billing Concerns in Diagnostic Radiology

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NHCAA
National Health Care Anti-Fraud Association

Goal of today's session is to help with the identification of abuse.

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No Definitive List of Fraudulent Conduct

- Up-coding (aka, “under-documenting”)
- “Incident to” violations
- Billed services not provided
- Services not medically necessary
- Unqualified or unlicensed providers
- Inappropriate supervision of services

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Agenda

- Ordering Guidelines
- Payment Reductions & Scheduling
- Supervision Requirements
- Other Areas of Concern

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Ordering Rules for Diagnostic Tests

Medicare

- In the NON-HOSPITAL setting, all diagnostic tests must be ordered by the physician or non-physician practitioner who is treating the patient.
- The testing facility may not change the treating physician's order.
- The testing facility may not add a test to the treating physician's order.

Non-Medicare

- Pre-certification Required?
  - Specific code (exam) approved?
  - Range of codes approved to take into account technique?
  - Does it matter which diagnosis code is submitted?

Conditional Orders

- The treating physician may request an additional test based on the results of the first test.
- This cannot be a standing order ("Do an ultrasound on Dr. Smith's patients whenever mammo is abnormal").
  - Order must be written to apply to a specific patient.
- The result which triggers the second test must be determined by the treating physician.

The exception to the rule

- An additional test can be performed without a new order if ALL of the following conditions are met:
  - The results of the ordered test are abnormal.
  - An additional test is medically necessary.
  - The ordering physician can't be reached.
  - A delay in testing would adversely affect the patient's care.
  - The radiologist documents why the additional test was done.
  - Results of the additional test are communicated to the ordering physician.

Exception, cont.

- The center must make an effort to get a revised order from the referring physician.
  - Document the attempts to reach the referring physician.
- Radiologist must document the clinical rationale—why the additional test was necessary, and that delay would have adverse effect on patient.

Exception, cont.

- If the testing facility is able to determine prior to performing the exam that it will probably not yield the information the referring physician is looking for, an amended order should be requested at that point (before any testing is performed).

The “other” exception

- If the order doesn’t specify the test design parameters (for example, whether contrast is to be used), the parameters may be determined by the radiologist.
- If the order does specify the test design parameters, the order must be followed unless an amended order is obtained.
- Testing facility may correct errors in the order that would be obvious even to a layperson (for example, order specifies wrong body part).

Test design

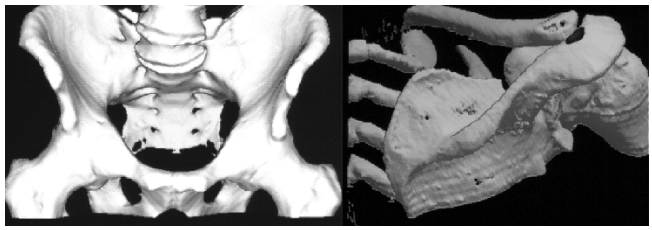
- What constitutes a test design parameter?
  - Number of views (two-view knee vs three-view knee vs complete knee exam)
  - Use of contrast
    - CT without contrast vs CT with contrast
    - MRI with contrast vs MRI without and with
  - Dual contrast upper GI vs regular upper GI
  - Upper GI with KUB vs upper GI without KUB

Test design, cont.

- Complete vs limited abdominal or retroperitoneal ultrasound
- Complete OB ultrasound vs limited
- SPECT vs planar tumor localization
- Whole body bone scan vs multiple-area scan
- Gaseous pulmonary ventilation scan vs aerosol pulmonary ventilation scan

3-D Rendering

- 3-D rendering of acquired images
- Test Design?
- Major issue in Florida imaging center case
- ACR recommends order



Issues to Examine..

- Are orders being kept for 7 years?
- Does the order match the performed (documented) exam?
- Are amended orders being obtained as appropriate?

Biggest Problems - Protocols

- CT Abdomen– CT Pelvis
- Transvaginal US/Transabdominal US
- Breast US following + Diagnostic Mammo

Biggest Problems - Protocols

- Doppler with Duplex (US)
- 3-D Rendering

Key Areas of Concern

- Referring physicians “forced” to only order certain exams when clinically a range is appropriate.
  - E.g., only CT Abdomen + Pelvis versus each option separately.
- Leading order forms that only offer a limited choice of procedures.

Key Areas of Concern

- Specialists who order exams on every patient (they own equipment):
  - Cardiologist ordering annual Nuclear Medicine exams (medical necessity?)

Payment Reductions and Scheduling

Current Reimbursement

- Medicare takes 50% multiple procedure reduction on the technical component for certain CT, CTA, MR, MRA and ultrasound services
- Medicare also caps reimbursement for certain imaging services at the OP OPPS rate
- Many private payors following the same or similar model.

Payment Reduction

- Technical component of non-hospital entities ONLY
- Discussion of Professional component for 2012
- Highest procedure paid at 100% of allowable – add'l procedures will be reduced by 50%

Payment Reduction

- Only TC of subsequent exams during the same encounter is reduced
- Does not apply to separate sessions.
- Single session = "*One encounter where a patient could receive one or more radiological studies."*
- Use modifier 59 for separate sessions on the same day BUT

Payment Reduction

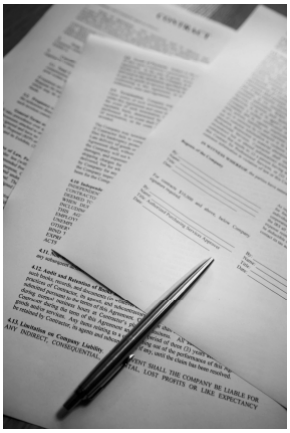
CMS states

"Use of modifier where not medically necessary in order to bypass the payment reduction constitutes fraud."

What to look for…

- Patients frequently receiving services on multiple days versus all on one day.
- Use of modifier 59 where no bundling edits exist to bypass payment reduction.
- Facilities with small amounts of payment reductions.

Advance Beneficiary Notices



ABN

- Private payors may use something similar
- Provider must indicate the estimated cost of each service covered by the ABN
- Patient has 3 options:
  - Will have service – bill Medicare
  - Will have service – do not bill Medicare
  - Will not have service

ABN requirements

- Patient may not be coerced into signing an ABN.
  - Situations that may be considered coercive:
    - Asking patient to sign during a medical emergency
    - Asking patient to sign after being prepared for the procedure--for example, after disrobing and being placed on the examining table
- Patient must be able to understand the ABN. Do not ask patient to sign if:
  - Patient is demented, confused, or legally incompetent
  - Patient does not speak English or is illiterate
  - Patient is blind
- Patient's representative may sign for him/her.

Billing with ABN

- Service must be billed to Medicare in accordance with the patient's wishes.
- CMS-1500
  - Appropriate modifiers must be submitted

What to look for…

- Updated ABN form?
- All patients being asked to sign ABN?
- Are patients given a copy of the ABN?
- Does the facility maintain a copy of the ABN?
- Are modifiers being appended to the procedure code when initially submitted?

Documentation of Radiology Services

Documentation

- Radiology report should include the following:
  - Clinical history (from requisition and--if applicable--from patient)
  - Title of exam
  - Technique (contrast use, position, number/type of views, etc.)
  - Radiologist's findings
  - Radiologist's diagnostic impression
- In a brief report, the impression can be included with the findings

The Radiology Report

- A report must be completed for *each* radiological examination.
- Multiple radiological exams on the same patient may be listed on the same report, but should have separate paragraphs, or be otherwise separately identifiable.

Documentation, cont.

- Ideally exams that are separately billed should be reported under separate headings (for example, CT abdomen and CT thorax).
  - This helps support the separate nature of the services when payors attempt to bundle them.
- Report should be authenticated by the interpreting physician

Physician Signature

- Physicians must sign their own reports!
- This is still a problem in many facilities….
  - Vacation
  - Covering multiple facilities/hospitals
  - Incorrect use of Non-physician practitioners

What to look for….

- Interpreting and Signing Physician not the same.
- Physician reports not signed by anyone.
- Excessive volume for one physician
  - Signing for another?
  - Billing a non-credentialed physician under another's name?
  - Incorrect use of physician extenders?

Mammography Report

- Title of procedure: Screening or Diagnostic
  - Based on *order* by attending physician
  - Perform screening and diagnostic on the same day if:
    - Screening mammogram ordered and performed
    - Clinical findings documented & decision to perform additional views
    - Impression documented after additional views
- Number and type of views
- Patient symptoms/complaints for diagnostic

Typical audit findings

- Reports do not include clinical history
- Reports do not indicate number of views for skeletal exams
- Reports do not indicate contrast use
- Findings may be inadequately described
- Note— ultrasound criteria for documentation of complete abdominal (76700) exam is problematic

Physician Supervision of Diagnostic Tests

Medicare requirements

- Medicare has established specific supervision requirements for diagnostic tests regardless of site of service (hospital, office, IDTF, imaging center, etc.)
- Medicare recognizes three levels of supervision:
  - General
  - Direct
  - Personal
- Most payors follow these guidelines as well.

Hospital Outpatient Setting

- 2010 OPPS Final Rule
- "All hospital OP diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS Relative Value File."

Medicare requirements

- Guidelines can be found at:

http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

Column Title:

Physician Supervision of Diagnostic Procedures

General supervision

- For general supervision, the physician's presence during the procedure is not required.
- The training of the non-physician personnel who actually perform the procedure, and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
- Examples:
  - Chest x-ray
  - Abdominal ultrasound
  - CT abdomen without contrast
  - MRI of the brain without contrast

Direct supervision

- For direct supervision, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.
  - Physician does not have to be present in the room when the procedure is performed.
- Examples:
  - MRI of the brain with contrast
  - CT of the abdomen with contrast
  - Intravenous pyelogram

Direct Supervision

- For example, the MPFS RVU files indicates that a head CT w/contrast (70460) requires “direct” supervision.
- Direct supervision applies whether
  - Hospital OP Department
  - Hospital-owned imaging center (PBD)
  - Physician office under arrangements with the hospital (facility bills hospital for exams it performed on hospital patients)
  - IDTF/Physician office

Hospital Outpatient Setting

- CMS criteria for Direct Supervision
  - When hospital or in an on-campus PBD, supervising physician "must be present on the same campus" (anywhere)
  - When performed in an off-campus PBD, supervising physician "must be present in the off-campus PBD"
  - Under arrangements – "present in the office suite"

Immediately Available

Noridian Medicare:

- "There are no Medicare laws or regulations that define the term 'office suite.' The key factor in 'incident to' billing is the physician's availability to the practitioner performing the service. Noridian uses a general rule that 'immediately available' means the supervising physician is able to provide assistance and direction in five minutes or less. The supervising physician must be within the same entity to be considered immediately available. For example, if the patient is being seen in the clinic and the supervising physician is located in the adjoining hospital, the physician is not considered to be in the 'office suite.'"

Hospital Outpatient Setting

- In addition:
  - The physician must be “immediately available to furnish assistance and direction throughout the performance of the procedure.”
  - Not performing another procedure that cannot be interrupted
  - Not so physically far away that he or she could not provide timely assistance

Hospital Outpatient Setting

- Nonphysician practitioners may not supervise diagnostic tests provided to hospital outpatients.
- Required supervision can be provided only by a physician (MD or DO).
- CMS believes “it is reasonable for the physician that supervises the provision of the services to be knowledgeable about *those* tests.”

Personal supervision

- For personal supervision, the physician must be in attendance in the room during the performance of the procedure.
- Examples:
  - Upper GI (74240)
  - Retrograde urography (74420)
- Personal supervision should be documented in the radiology report – this occurs by the physician indicating what s/he did.

What to look for…

- No documentation of personal supervision
- No documentation of physician presence for direct supervision
- Worst case scenario: Use of non-physician personnel for supervision (e.g., paramedic)

What we should see…

- Documentation of direct supervision in radiology report or by means of physician coverage logs
- Trained scheduling personnel and Technologists who understand regarding supervision requirements
- If possible, supervision levels should be incorporated into the imaging center's scheduling system

Other Issues

Other Issues

- Diagnosis Coding/Medical Necessity
  - High utilization of a small number of codes
    - Abdominal Pain
    - Chest Pain
    - Headache
    - Confusion
    - Neoplasms
    - Etc.

Other Issues

- Use of Modifiers
  - In the imaging center setting modifier use is generally limited to:
    - - 26 (Physician Component)
    - - TC (Technical Component)
    - - 50 (Bilateral Procedure)
    - - LT/RT (Laterality)
  - Modifier 59 should not have a high frequency in an imaging center or physician office setting.

Examples of appropriate use of -59

- Bilateral imaging with differing sets of images
  - 2 views of the LT knee and 3 views of the RT knee (73560-59, 73562)
- Core breast biopsies on separate lesions (non-Medicare)
  - 19102, 19102-59, 76942, 76942-59

Examples of potentially inappropriate use of -59

- Transvaginal/Transabdominal US
  - 76830 + 76856
  - Usually individual payor edit vs CCI
- CT and CTA on the same dates of service
  - Both are separately ordered for different medical conditions – rare occurrence.

Questions?

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This Concludes Today's Session

Thank You!

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