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OIG: Putting the Spotlight on Radiology Services in 2007

Due to the increased utilization of imaging services over the past several years, imaging services are now being added to the OIG's "hit list". Here are some items on the OIG Work Plan that radiology providers should be aware of:

Advanced Imaging Services in Physician Offices

This review will examine the appropriateness of imaging services provided in physician offices. From 1999 to 2005, utilization of advanced imaging services, such as MRI, PET, and CT scans, has grown on average by 20 percent per year. In 2005 Medicare allowed charges of over \$7 billion for these services. This review will examine the nature of the growth of these services over this period including examination of billing patterns in certain geographic areas and practice settings.



TIP: Examine your utilization and ensure that exams ordered and performed are medically necessary.

Inappropriate Payments for Interpretation of Diagnostic X-rays in Hospital Emergency Departments

We will determine the extent of inappropriate payments for the interpretation of diagnostic x-rays performed in emergency departments. In 2004, more than 2.5 million diagnostic x-rays were performed in Medicare-certified hospitals with emergency departments. According to the Medicare Claims Processing Manual, contractors are to pay for only one interpretation of an x-ray procedure furnished to an emergency department patient. They pay for a second interpretation, identified through the use of modifier 77, only under unusual circumstances, for instance when the physician performing the initial interpretation believes a specialist is necessary. Documentation must be present to support the second claim. We will determine whether the services were medically necessary and if the tests were interpreted contemporaneously with the patient's treatment.



TIP: Perform an audit of claims for the radiology services performed in the Emergency Department to ensure complete documentation and appropriate coding and reimbursement. Consult the Medicare Claims Processing Manual, Radiology Services, Chapter 13, Section 100.1 for instruction on when it is appropriate to bill for a second interpretation. <http://www.cms.hhs.gov/manuals/downloads/clm104c13.pdf>

Imaging and Laboratory Services in Nursing Homes

We will determine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. Medicare pays more than \$200 million a year for imaging and laboratory services. We will review a sample of services and examine utilization patterns in nursing facilities.



TIP: Examine your utilization and ensure that exams ordered and performed are medically necessary.

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Cardiography and Echocardiography Services

We will review Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and the technical components of the services. Like many physician services, cardiography and echocardiography include both technical and professional components. When a physician performs the interpretation separately, the modifier 26 should be used to bill Medicare.



TIP: Review the guidelines for use of the -26 and -TC modifiers and identify those codes that you bill for that have a technical component and professional component and ensure that modifiers are being assigned appropriately. Don't forget to review the billing for those procedures that are performed by another entity and interpreted by your practice. Consult your Medicare carrier for additional guidance regarding appropriate use of modifiers and place of service considerations.

Billing Service Companies

We will identify and review the relationships between billing companies and the physicians and other Medicare providers who use their services. We will identify the types of arrangements that physicians and other Medicare providers have with billing services and determine the impact of these arrangements on physicians' billings.



TIP: Review your contract with your billing company. Pay particular attention to contracts with percentage fee arrangements and be sure there is no incentive to "upcode". Many states do not allow billing companies to be paid on percentage basis for Medicaid claims. If your state prohibits this practice, "carve out" these claims and set a flat rate for submission of Medicaid claims. Review the Compliance Guidance for Third Party Billing Companies to determine if appropriate policies and procedures are in place. The compliance guidance published by the OIG may be viewed at <http://www.oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf>

To view the entire OIG Work Plan go to: <http://www.oig.hhs.gov/publications/workplan.html#1>

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