REVENUE CYCLE CODING STRATEGIES®

Navigator® for Diagnostic Radiology Billing Compliance 2022 Edition

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1 Fraud, Abuse, and Waste

Fraud is an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true and makes knowing that the deception could result in some unauthorized benefit to him/her or some other person. The most frequent type of fraud arises from a false statement or misrepresentation that contributes to entitlement or payment under the Medicare program.

Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided.
- Deliberately submitting duplicate bills.
- Billing non-covered services as if they were covered services.
- Misrepresenting the services rendered or the patient's diagnosis in order to justify the services or equipment furnished.
- Altering a claim form to obtain a higher payment.
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- Employing an individual who has been excluded from the Medicare program, and billing Medicare for services provided by the excluded individual.

The Federal Bureau of Investigation (FBI) is the primary investigative agency in the fight against health care fraud and has jurisdiction over both federal and private insurance programs. Most insurance companies have an internal Special Investigations Unit that works closely with the FBI on fraud issues. Health care fraud investigations are among the highest priority investigations with the FBI, ranking behind public corruption and corporate fraud. For more information, see:

https://www.fbi.gov/investigate/white-collar-crime/health-care-fraud

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Examples of abuse include:

- Unbundled charges
- Excessive charges
- Medically unnecessary services
- Improper billing practices

Although these practices may initially be considered as abuse, under certain circumstances they may rise to the level of fraud.

The Office of Inspector General (OIG)

The Office of Inspector General (OIG) is a branch of the Department of Health and Human Services (HHS). Its mission is to protect the integrity of HHS programs, as well as the health and welfare of the programs' beneficiaries. The OIG's duties are carried out through audits, investigations, inspections and other mission-related functions performed by OIG components, including the OIG Office of Audit Services and Office of Evaluation and Inspections.

The OIG Work Plan is a list of projects the OIG is currently working on or plans to begin in the near future. It includes projects in each of the major HHS agencies and administrations, such as the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention, and the Administration on Aging.

In the past the OIG published the Work Plan once a year, but beginning in June 2017, the Work Plan is web-based and is updated on a monthly basis. The OIG website allows users to browse or search the Work Plan projects:

https://oig.hhs.gov/reports-and-publications/workplan/index.asp

For example, the workplan includes as current projects the following:

Review of Medicare Facet Joint Procedures
Facet joint injections are an interventional technique used to diagnose or treat back pain. Several previous reviews found significant billing errors in this area, including a prior OIG review. We will review whether payments made by Medicare for facet joint procedures billed by physicians complied with Federal requirements (Social Security Act, § 1833(e), 42 CFR § 424.32(a)(1), and 42 CFR §414.40).

Accuracy of Place-of-Service Codes on Claims for Medicare Part B Physician Services When Beneficiaries Are Inpatients Under Part A
Generally, Medicare makes payments under Part B for physician services and payments under Part A for the costs of inpatient stays at inpatient facilities such as skilled nursing facilities (SNFs) and hospitals. While Medicare pays both SNFs and hospitals through prospective payment systems for the costs of inpatient stays, physician services provided to SNF and hospital inpatients are paid according to the Medicare Physician Fee Schedule. The amount Medicare pays physician service providers (such as physicians, podiatrists, and nurse practitioners, referred to collectively as "physicians") can vary based on where the service is provided (such as a SNF, hospital, or physician's office). Physician services can include medical and surgical procedures, office visits, and medical consultations…The physical setting where a physician performs a service does not always determine the appropriate place-of-service code. For example, when a beneficiary is a registered inpatient at a hospital or SNF, physician services should always be coded with a facility place-of-service code and paid at the facility rate. This is irrespective of the setting where the patient actually receives the face-to-face encounter. Our preliminary data analysis indicates that during 2018 and 2019, Medicare may have paid a significant number of Part B physician service claim lines at the nonfacility rate when the beneficiary was a Part A inpatient at either a hospital or SNF. We will determine whether Medicare appropriately paid claims for Part B physician services based on the correct place-of-service code when a beneficiary was an inpatient at a SNF or hospital.

In addition to the Work Plan, the Office of Evaluation and Inspections (OEI) performs national evaluations of HHS programs from a broad, issue-based perspective to provide recommendations on preventing fraud, waste, or abuse. On the next page are brief summaries of several OEI reports related to radiology issues.

Diagnostic Radiology Services in Emergency Departments

In April 2011, the OIG published an audit report (OEI; 07-09-00450) concerning interpretations of imaging exams on emergency department patients. Findings included:

- 19% of the MRI and CT claims and 14% of the x-ray claims had insufficient documentation including lack of a physician order for the exam and lack of documentation to support that an interpretation and report had been performed.
- 12% of MRI and CT studies and 16% of x-ray studies were not read until after the patient left the emergency department. CMS states that payments are to be made for interpretations performed "at the same time" as the diagnosis and treatment of the patient in the ER. The OIG believes interpretations rendered after the patient is no longer in the ER cannot be considered "at the same time" as the diagnosis and treatment of the patient and therefore should not be payable.
- Reports for 69% of the CTs and MRI and 71% of the x-rays did not follow one or more of the ACR suggested practice guidelines. The OIG believes documentation standards are essential to determining if diagnostic radiology services contributed to the patient's diagnosis and treatment.

2 Coding Compliance Program

Coding involves more than just the organization's coders. In the Final Rule on the adoption of ICD-10 (*Federal Register*, January 16, 2009, page 3346), CMS stated:

> "Coding is the assignment of a code to a specific clinical condition or procedure; the mechanism used to do this, whether electronic or manual may differ, but codes are still assigned."

This means every individual who captures a charge in an electronic medical record, checks a code on a fee slip or uses coding references to report a procedure or diagnosis code on an insurance claim is "coding." This includes clinicians who are involved in charge capture, even though they may not recognize what they are doing as coding.

An effective coding compliance program requires a sincere commitment to promoting a culture of ethical conduct and compliance with the law. It is backed up by ongoing management to prevent, detect and correct coding and billing inaccuracies. The compliance program must exercise due diligence, which means it is not just a paper document. Compliance is about the conduct of individuals, not about "checking the boxes" in a model plan or generating attractive policies or educational materials.

Coding and billing compliance is often pointed to as the most important area of compliance for the medical practice or hospital because of the frequency of unintentional violations. The complicated rules issued by government agencies make it imperative that healthcare providers invest a considerable amount of time, resources and systems to ensure appropriate billing and accurate code assignment.

When properly implemented, compliance plans can not only minimize risk exposure but also strengthen operational efficiencies and economics by reducing denial rates and error correction, improving medical record documentation, fostering better communication between billing and clinical staff and increasing claims processing efficiency.

Physician Practice vs Hospital

The code assignment process in a hospital is different from that in a radiology practice, and these differences should be taken into account when setting up a coding compliance program.

In the physician practice codes are usually assigned directly from the radiology report. Coding may be performed by employees of the practice or may be outsourced to a billing company. Also, coding may be performed manually or via computer-assisted coding (CAC), in which natural language processing software analyzes the report and determines what procedure and diagnosis codes it supports. There is, in most cases, good communication between the staff who are responsible for coding and those who are responsible for billing, so that coding staff are likely to be aware of problems with denials. However, coding errors can and do occur and may be related to lack of coder training, inadequate documentation by the radiologist, or unauthorized changes to codes and modifiers by billing staff.

In the hospital radiology department, technologists or other staff enter charges for services and supplies, and the Charge Description Master (CDM) crosswalks these charge codes to CPT® and HCPCS Level II procedure codes that appear on the outpatient claim. The charges are usually entered before the radiology report is completed, and the procedure codes generated by the CDM may not be checked against the documentation in the radiology report on a regular basis. There