REVENUE CYCLE CODING STRATEGIES®

Navigator® for Radiation Oncology 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

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 OIG has conducted a couple of radiation oncology related reviews in the last several years. The primary ones were the review of IMRT services provided in the hospital setting with a published report in August 2018, two reviews specific to the MACs of Novitas and National Government Services (NGS) related to IMRT services, and before most recently a review of 3-D planning services to identify potential savings.

The initial review conducted by the OIG pertained to the Intensity Modulated Radiation Therapy (IMRT) planning process in hospitals and a report was released in August 2018. This was immediately followed by the review of two MACs, Novitas and NGS, related to overpayment of services. Due to the recommendations in the reports, there were many changes to edits and billing guidelines related to IMRT services by CMS. This also led to the most recent review by the OIG to evaluate the risk and reimbursement of 3-D planning services. The following reviews the premise of the OIG IMRT review of hospitals and a high-level summary of findings.

> **"Intensity-Modulated Radiation Therapy (Report Number W-00-16-35733; various reviews)** Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements."

The OIG submitted the report to CMS on the findings of this review. Per the report, the OIG stated CMS paid hospitals millions of dollars for IMRT planning services, which could have been saved if guidelines were followed. The following are the findings per the OIG report:

> "Payments for outpatient intensity-modulated radiation therapy (IMRT) planning services did not comply with Medicare billing requirements. Specifically, for all 100 line items in our sample, the hospitals separately billed for complex simulations when they were performed as part of IMRT planning. The overpayments primarily occurred because the hospitals appeared to be unfamiliar with or misinterpreted the Centers for Medicare & Medicaid Services (CMS) guidance. In addition, the claim processing edits did not prevent the overpayments because the edits applied only to services billed on the same date of service as the billing of the procedure code for the bundled payment, and the services in our sample were billed on a different date of service. (Medicare makes a bundled payment to hospitals to cover a range of IMRT planning services that may be performed to develop an IMRT treatment plan.) On the basis of our sample results, we estimated that Medicare overpaid hospitals nation-wide as much as $21.5 million for complex simulations billed during our audit period (for calendar years (CYs) 2013 through 2015). In addition, we identified $4.2 million in potential overpayments for other IMRT planning services that were not included in our sample. In total, Medicare overpaid hospitals as much as $25.8 million during our audit period.
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> For IMRT planning services billed in the 2 years after our audit period (for CYs 2016 and 2017), we identified an additional $3.7 million in potential overpayments for complex simulations and $1.7 million for other IMRT planning services. In total, Medicare overpaid hospitals as much as $5.4 million after our audit period.
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> We recommended that CMS (1) implement an edit to prevent improper payments for IMRT planning services that are billed before (e.g., up to 14 days before) the procedure code for the bundled payment for IMRT planning is billed, which could have saved as much as $25.8 million during our audit period and as much as $5.4 million in the 2 years after our audit period, and (2) work with the

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 are 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 physician or freestanding practice, and these differences should be taken into account when setting up a coding compliance program.

In the physician or freestanding practice, codes are commonly assigned by the physician and technical staff, such as radiation therapists, dosimetrists, physicists and nurses. There is in most cases good communication between the staff who are responsible for coding and those who are responsible for billing, so those staff members performing coding duties are more likely to be aware of problems with denials. However, coding errors can and do occur and may be related to lack of coder training, lacking education on appropriate coding guidelines, inadequate documentation, or unauthorized changes to codes and modifiers by billing staff.

In the hospital radiation oncology department, clinical staff members and physicians are responsible to capture charges within the radiation oncology electronic medical record, similar to the process within a physician or freestanding practice. These charges are then transmitted to the hospital billing system via interface or manual data entry. Once in the hospital billing system, the codes are further evaluated prior to claim submission. This process may include ICD-10-CM coding for the patient account or review of CPT® and HCPCS coding for coding edits and required modifiers. Similar to the process performed in physician or freestanding practices, errors can occur in the transmission between the two systems, incorrect code capture by the clinical staff, lacking education specific to radiation oncology coding guidelines or lacking access