Coding & Compliance Concerns for Radiology: An Auditor's Perspective

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Executive Summary

Radiology tends to be one of the more complex coding and compliance areas. It differs from many specialties in that there is a professional component and a technical component that is billed, as well as coverage issues. This article discusses auditing of key coding and compliance concerns unique to diagnostic radiology services (MR, CT, ultrasounds, etc.) These concerns include radiologist documentation, referring physician orders for diagnostic services, Advance Beneficiary Notices (ABNs) for Medicare patients, diagnosis code assignment and bundling concerns that affect the assignment of procedure codes.

Current Environment

Medicare and other third party payors are continuing to increase their review of both facility and physician radiology services. Radiology services that do not meet payor-specified medical necessity guidelines are not paid and the radiologists and their facilities are many times left with no option but writing off receivables. In addition to medical necessity, physician documentation remains a key area of concern. The procedure and diagnosis codes submitted for payment must be supported in the patient's medical record. For radiology services, the dictated radiology report should be the beginning and the end of the audit trail.

With the implementation of the new Medicare Administrative Contractors (MACs) there is now the ability to match hospital and physician claim data which is of great concern for outpatient radiology services. What will happen when the claims of the hospital and the radiologist do not match? How will the contractor respond? Which one is correct? The physician? The hospital? Maybe neither. While some would argue that physician coding has the greater chance of being correct since the codes are usually assigned by reviewing the dictated report, an across-the-board assumption of accuracy cannot be substantiated. Given the continued focus on healthcare fraud and errors, MACs are a logical tool that the government can employ to identify new areas of audit focus.

Documentation

Regardless of the medical specialty, the physician's documentation is the most critical component of an audit. For diagnostic radiology services, the radiologist should dictate a separate report for each exam. If the radiologist chooses to include two or more exams in the same report, each exam should be represented by a separate paragraph. There must be clear and distinct documentation to support each exam for which reimbursement is sought. If you highlighted all of the documentation related to one exam, what is left to defend the coding/billing of the additional exam? There are many situations where the technique is best described in one paragraph, such as with CT abdomen and pelvis; however, the findings of the two exams should be separated into distinct paragraphs.

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When an audit is conducted to evaluate correct procedure and diagnosis code assignment, the radiology report is the central document to use. The order for service is also important and is generally included in an audit for Independent Diagnostic Testing Facilities (IDTFs), physician offices, and outpatient hospital services. The radiology report should clearly indicate what type of procedure was performed on the patient and any modifying factors related to the study, such as the number and type of views, or the use of IV contrast. Documentation standards have been set forth by the American College of Radiology. Their listing of report elements has been augmented by our experience to include key compliance/coding considerations.

All diagnostic radiology reports should contain the following elements (as applicable):

- Name of the patient & identifier
- Name of the referring physician
- Date and time of the radiology exam (especially important for inpatients)
- Comparative data, if available
- Signature of radiologist
- Patient clinical history
  - Chronic conditions, previously established diagnoses, signs, symptoms, reason for exam

- If the test is a follow-up and to what condition

- Pertinent positive and negative findings
- Impression and diagnosis, if known
- Name or type of examination (technique)
- Indication of whether the exam is limited, includes multiple areas, complete or whole body, unilateral or bilateral
- Number and type of views taken
- Detailed description of imaging performed and interpreted
- Type and amount of contrast media or radionuclide
- With or without KUB (kidneys, ureters, bladder), if applicable
- With or without duplex scan (ultrasound studies)
- Single or multiple determination (nuclear medicine)
- Qualitative or quantitative (nuclear medicine)
- 3-D Rendering
- Limitations (poor film, special patient prep)
- Recommendations for additional studies

Orders

When considering orders and their requirements it is important to create two categories: Medicare and non-Medicare (commercial). From a compliance perspective the biggest concern is associated with Medicare versus the commercial payors. Most commercial payors require that diagnostic exams such as CT, MRI, PET, etc. be pre-approved prior to their performance. If the payor refuses to approve the exam no payment will be provided to either the facility or the radiologist regardless of the medical finding(s).

Medicare does not have "pre-certification" like the commercial payors. Instead, we, the healthcare community, perform pre-certification by reviewing the National and Local Coverage Determinations (NCD/LCD) and issuing Advance Beneficiary Notices (ABNs), as appropriate. (The use of ABNs will be discussed later.) Medicare has therefore issued very specific guidelines regarding orders and the circumstances that allow for the "modification" of orders. It is important, again, to remember that individual Medicare carrier/fiscal intermediary guidelines prevail.

Effective January 1, 1997, diagnostic testing, including diagnostic x-rays, became covered by Medicare only when ordered by the physician who treats the patient. This restriction does not apply to diagnostic tests furnished in hospitals. Two separate provisions govern hospital diagnostic studies, and in those regulations there is no statement restricting ordering authority to treating physicians. *However*, many Medicare contractors have taken the position that only treating physicians, even in hospitals, may order diagnostic x-ray tests. It is extremely important that you obtain specific guidance for your payor to ensure compliance.

The Medicare guidelines state that the treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.

> The ABN *must* include an estimate of the cost.

When the radiologist at a testing facility determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal and that a different diagnostic test should be performed (e.g. an MRI should be performed instead of a CT scan because of the clinical indication), the radiologist/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received. Similarly, if the result of an ordered diagnostic test is normal and the radiologist believes that another diagnostic test should be performed (e.g. a renal sonogram was normal and based on the clinical information, the radiologist believes an MRI will reveal the diagnosis), an order from the treating physician must be received prior to performing the unordered diagnostic test.

There are a few exceptions to these rules. Prior to conducting an audit that encompasses the order for service it is recommended that you read the Medicare Benefit Policy Manual, Chapter 15, Section 80.6 (Requirements for Ordering and Following Orders for Diagnostic Tests).

Advance Beneficiary Notices

In addition to reviewing the order for a service, it is important to ensure that a facility is correctly utilizing Advance Beneficiary Notices (ABNs). In order to bill a Medicare beneficiary for a service that has been deemed "not medically necessary" by Medicare, the patient must be properly informed prior to the service being rendered. A written notice, referred to as an ABN must be provided to a

Medicare beneficiary before services are furnished when the provider believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary. The ABN must identify the service or item for which the denial is expected and clearly state the reason a Medicare denial is expected. The ABN *must* include an estimate of the cost. Since each ABN is procedure and date specific, the patient should never sign a blank ABN. The patient should be given a copy of the signed ABN. If the organization does not currently utilize ABNs, Medicare patients may never be billed for services not paid due to medical necessity. If ABNs are utilized, it is important that the appropriate guidelines be followed. The most common medical necessity guidelines for diagnostic radiology include MRAs and PET scans and screening mammograms (due to frequency limitations). Additional information can be found at www.cms.hhs.gov/medicare/bni.

Diagnosis Code Assignment

Audits of diagnostic radiology services usually identify more errors in the assignment of diagnosis codes than in the assignment of procedure codes. The Centers for Medicare & Medicaid Services' (CMS) guidelines for ICD-9-CM coding for diagnostic procedures are found in the Medicare Claims Processing Manual, Chapter 23. All radiology practices are required to follow these guidelines, so it is important that you review the information in full prior to auditing radiology charts.

> *Auditors should evaluate whether modifiers have been properly applied.*

In summary, the guidelines state that all diagnostic tests should be coded with definitive findings (if applicable) and then signs and/or symptoms (if necessary), information can be obtained from the patient if the referring physician is unavailable (but any information should be verified), incidental findings should only be coded as secondary diagnoses, unrelated and co-existing conditions may be reported as additional diagnoses, a screening exam is always a screening exam with any findings as secondary diagnoses and the longstanding *ICD-9-CM Official Guidelines for Coding and Reporting* should be followed.

Unbundling

Finally, auditors should evaluate whether modifiers have been properly applied and whether incorrect "unbundling" has occurred. Unbundling is defined as the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code. There are two (2) types of unbundling: 1) unintentional, resulting from a misunderstanding of coding, and 2) intentional, when an entity manipulates coding in order to maximize payment. Following are some examples of unbundling:

- Coding component parts of a procedure with separate CPT® codes
- Reporting separate codes for related services when the code for the primary procedure includes all related services
- Coding a unilateral service twice instead of coding the one bilateral code
- Downcoding a service in order to use an additional code when one higher-level, more comprehensive code is appropriate
- Separating a surgical approach from the major surgical service

Not all payors utilize the National Correct Coding Policy developed for Medicare. Many third party commercial payors utilize ClaimCheck or other rebundling software. As a result, services that may be considered separately payable by some payors could be "bundled" by other payors.

Unbundling issues frequently appear in radiology in the following National Correct Coding Policy (NCCP) directives:

- Due to patient variations, studies that require contrast do not have an established number of radiographs to be obtained. Therefore, all radiographs necessary to complete the study are included in the descriptor of the CPT® code.
- Unless specifically noted, fluoroscopy required to complete a radiology procedure and obtain the necessary permanent radiographic record is included in the major procedure performed.
- "Scout" films obtained prior to imaging studies with contrast or delayed images are considered to be included in the basic procedure.
- The injection of radionuclide is considered part of the nuclear medicine procedure.
- Bone age studies require a series of radiographs; billing separately for bone age studies and individual radiographs obtained in the course of the bone age study is inappropriate.
- Contrast administered orally or rectally is included as part of the procedure and no administration service is reported.
- Contrast administered parenterally, whether the timing of the injection has to correlate with the procedure or not (IVP, CT, etc.), the administration and injection are included in the contrast studies.

Summary

This article has highlighted the major items that should be evaluated in a diagnostic radiology audit. Within each sub-specialty (CT, MR, etc.) there are other more detailed considerations to evaluate. It is important that you prepare a checklist of key items to review to ensure a successful and productive audit. The checklist should incorporate the key items covered in this article that pertain to the specific modalities under audit. **NP**

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