Radiology Billing, Other Coding Under Scrutiny

BY SARAH PRESSMAN LOVINGER
Contributing Writer

CHICAGO — The Office of Inspector General will be looking more carefully at how all practices bill for radiology services. This issue is particularly important for rheumatology practices that provide in-office radiology services, Mark Painter said at a meeting of the American College of Rheumatology.

"Billing for radiology services has gone up significantly. OIG will be very carefully looking at your imaging services," he said. "If you did not have an imaging machine, and now you do, that's going to be a flag." He advises thoroughly documenting medical necessity in the chart for all imaging services they provide.

Mastering CPT coding guidelines can improve practice management. "You have to understand what the payers are doing," said Mr. Painter, a medical coding and reimbursement consultant in Denver.

The federal government did not make a lot of changes in current procedural terminology coding this year because the coding is budget neutral, and those involved in making decisions about CPT codes are careful about adding new codes, Mr. Painter said. However, there have been changes in policy that are important to physicians, he said.

Mr. Painter said another concern for rheumatologists is the Tax Relief and Health Care Act of 2006. Although this program averted a 5% payout on the conversion factor, it is only temporary. The act did not put any policies in place that extend beyond 2007.

Rheumatologists should also be aware of recovery audit contractors, independent contractors who report to insurance companies about billing companies. Currently, only Florida, California, and New York permit these "bounty hunters" to peruse bills obtained from insurance carriers and to zero in on questionable billing.

"They are out looking for low-hanging fruit," Mr. Painter noted about these contractors. "The place where rheumatology is most vulnerable is infusions." He advised physicians to document what they are billing for and, when using infusions, to provide the lot numbers of the medications.

Congress also passed the multiple imaging reduction policy, a change in the final rule that was supposed to be phased in over a 3-year period, but is now frozen at a 25% reduction rate. Under this policy, Medicare reimburses 100% of the first radiology service, but reduces payment for the technical component of the second service by 25% on the same day. Though this act applies to both hospital and in-office imaging, rheumatologists with an in-office radiology service could see losses.

Mr. Painter also discussed pay-for-performance updates. He said that Congress and the Centers for Medicare and Medicaid Services (CMS) are very interested in moving payments toward evidence-based medicine.

Although CMS opened up pay for performance to the general medical community in 2006, little voluntary reporting took place. To improve this, the CMS is offering a 1.5% bonus to physicians who report on their Medicare patients. A 6-month trial program began July 1. Physicians who report on at least 80% of total visits qualify for the bonus.

The future of this program will depend on ongoing budgets. Congress has not yet set aside funding for 2008.

Both pay for performance and the Physician Quality Reporting Initiative rely on adequate data collection, said Mr. Painter. He said practices must move toward electronic health records to improve data collection for these initiatives. "Data are driving this," he said. ■

Crackdown on Fraudulent Medicare Billing Scheme Leads to 38 Arrests

A multiagency "strike force" targeting fraudulent Medicare billing related to infusion therapy and durable medical equipment recently made 38 arrests.

The arrests, all in south Florida, mark the first phase of operations for the team of federal, state, and local officials. The team began its investigations in March using real-time analysis of billing data from Medicare and claims data from the Health Care Information System. In May, the departments of Justice and Health and Human Services jointly announced the team had obtained indictments of individuals and health care companies alleged to have collectively billed the Medicare program for more than $142 million. Charges include conspiracy to defraud the Medicare program, criminal false claims, and violations of the antikickback statutes.

The antifraud efforts drew praise from Senate Finance Committee Chairman Max Baucus (D-Mont.).

"Federal health dollars are just too scarce to lose to fraud and abuse in Medicare," he said in a statement. "I'm glad to see the Justice Department taking this new, more aggressive stance against scams that endanger Medicare patients and that rob all taxpayers who contribute to America's health care programs."

Sen. Baucus recently expressed concern about reports of durable medical equipment fraud in South Florida. In one instance, the Health and Human Services inspector general found many device suppliers were not at their advertised addresses but were billing Medicare for millions of dollars in reimbursement.

—Mary Ellen Schneider

CMS Proposes to Streamline the Part D, Medicare Advantage Plans

BY MARY ELLEN SCHNEIDER
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Officials at the Centers for Medicare and Medicaid Services are proposing changes to the Medicare Part D prescription drug plans and Medicare Advantage plans in an effort to strengthen oversight of the programs.

The proposal includes mandatory self-reporting aimed at curbing potential fraud and misconduct by plans. The CMS proposal also includes changes to streamline the process of intermediate sanctions and contract determinations. In addition, the proposal clarifies the process for imposing civil money penalties.

"While the majority of Medicare Advantage and Medicare Prescription Drug Plans that offer important benefits to beneficiaries are conducting themselves professionally, it is important for CMS to be able to take swift action to safeguard beneficiaries from unlawful or questionable business practices," Leslie Norwalk, acting CMS administrator, said in a statement.

But the Bush administration is falling short in policing the marketing practices of Medicare Advantage plans, according to Robert M. Hayes, president of the Medicare Rights Center. Mr. Hayes has called on Congress to establish clear safeguards against "abusive and deceptive" marketing practices and to give state governments the power to enforce those standards. He also called on Congress to establish minimum benefit standards and standardize benefit packages to allow for better consumer comparison of plans.

Officials at the American Medical Association are also reporting problems with Medicare Advantage plans. An online survey of more than 2,200 AMA member physicians conducted in March found that patients had difficulty understanding how the Medicare Advantage plans work or have experienced coverage denials for services that were typically covered under traditional Medicare plans.

For example, about 84% of physicians with patients in Medicare Advantage managed care plans said their patients had difficulty understanding how the plan works. About 80% of physicians with patients in Medicare Advantage private fee-for-service plans also reported confusion among their patients. More than half of physicians reported excessive hold times and documentation requested by payers with both types of Medicare Advantage plans.

CMS is accepting comments on the proposal through July 24. ■

Coding Modifiers May Be Needed In Pay-for-Performance Reports

Physicians who participate in Medicare's pay-for-reporting program do not have to satisfy quality indicators to receive a bonus. But in some cases, they will need to cite why they did not follow evidence-based guidelines.

Under the Physician Quality Reporting Initiative (PQRI) that began July 1, reporting for certain measures will include adding a coding modifier explaining why a service was not performed. For example, the service may not have been provided because it was not medically indicated or the patient declined.

The PQRI is a voluntary program that lets physicians earn a bonus payment of up to 1.5% of total allowed Medicare charges for reporting on certain quality measures. The program will run from July 1 through the end of the year. CMS officials have selected 74 quality measures, and physicians are expected to report on between one and three, depending on how many apply to their patient populations.

When reporting on measures, physicians must include a CPT-II code or G-code. Some measures may also require that physicians add a modifier to the CPT II code if the service was not provided. These modifiers are not used when reporting G codes. The CPT-II modifiers include performance measure exclusion modifiers and a performance measure reporting modifier. For example:

► Modifier -1P is shows the service was not indicated or is contraindicated.

► Modifier -2P is used to indicate that the service was not provided for patient reasons, such as the patient declining or religious objections.

► Modifier -3P is used to indicate that the service was not provided for systems reasons such as insurance coverage limitations or a lack of resources to provide the service.

► Modifier -8P is a performance measure reporting modifier and indicates that the action was not performed and the reason has not been specified.

Specific instructions on when to use a modifier in the 2007 PQRI Specifications Document are available online at www.cms.hhs.gov/pqri. CMS officials also plan to issue a detailed handbook on how to implement PQRI measures in clinical practice, which will include when to use CPT-II modifiers.

—Mary Ellen Schneider