

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the Affordable Care Act (section 6401a). Do NOT send in revalidated enrollment forms until you are notified to do so by your Medicare Administrative Contractor. You will receive a notice to revalidate between now and March 2013. For more information about provider revalidation, review MLN Matters® Special Edition Article SE1126, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf> on the Centers for Medicare & Medicaid Services website.

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Medicare Payments for Diagnostic Radiology Services in Emergency Departments

Note: This article was updated on July 31, 2012 to reflect current Web addresses. All other content remains the same.

Provider Types Affected

Providers and other practitioners billing Medicare Administrative Contractors (MACs) or Medicare Carriers for diagnostic radiology services in Emergency Departments are affected by this article. No new policies are contained in this article.

What You Need to Know

This article highlights the April 2011 report from the Office of Inspector General (OIG) entitled "Medicare Payments for Diagnostic Radiology Services in Emergency Departments" along with the Medicare policy regarding the coverage of radiology services.

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Specifically, the article summarizes the study's objectives which were:

- 1) To determine the extent Medicare allowed claims for interpretation and reports of diagnostic radiology services focusing on Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and X-ray services performed in hospital outpatient emergency departments met Medicare documentation requirements;
- 2) To determine if the X-ray services were performed before beneficiaries left the hospital outpatient emergency departments; and
- 3) To determine if X-ray services followed suggested documentation practice guidelines promoted by the American College of Radiology.

Background

Providers have a vital role when completing the documentation to support claims for payment for Diagnostic Radiology Services. The key elements of the medical record documentation should include (1) physicians' orders to support diagnostic radiology services performed and (2) complete interpretation and reports.

The study completed by the OIG included two populations from 2008 claims datasets, i.e., a sample of 220 CT and MRI claims and a sample of 220 X-ray claims. The standards the OIG used during the audit to determine incorrect claims from the sample were as follows:

- 1) Documentation did not support that services were performed;
- 2) Physicians' orders were not present; and
- 3) All interpretation and reports showed the services were performed during beneficiaries' diagnoses and treatments in the hospital outpatient Emergency Departments.

The OIG used the American College of Radiology's suggested documentation practice guidelines as a guidance document during the review.

OIG Findings

The study found that in 2008:

1. 19 percent of CTs and billed MRIs and 14 percent of billed X-rays in hospital outpatient emergency departments were not in compliance with Medicare requirements because of insufficient documentation.
2. Medicare paid for interpretation and reports performed for 16 percent of X-rays and 12 percent of CTs and MRIs after beneficiaries left hospital outpatient emergency departments and that Centers for Medicare & Medicaid Services (CMS) offers inconsistent payment guidance on the timing for interpretation.

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3. 71 percent of X-rays and 69 percent of CTs and MRIs in hospital outpatient emergency departments did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology.

CMS concurred with the first and third findings above. However, with regard to the second recommendation, CMS indicated that it does not believe that a single billed interpretation must, in all cases, exist with the beneficiary's diagnosis and treatment to contribute to that diagnosis and treatment. A uniform policy requiring that interpretation and reports be contemporaneous with, or, if not contemporaneous, demonstrably contribute to the beneficiary's diagnosis and treatment could reduce unexplained complexity in what is already a complicated billing system for medical diagnostics.

The Key Points section below reviews Medicare policy for coverage of diagnostic radiology services in emergency departments and includes a link to the suggested practice guidelines from the American College of Radiology.

Key Points

- The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See CFR 415.120 (a) at <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec415-120.pdf> on the Internet.)
- Medicare Carriers and MACs generally distinguish between an "interpretation and report" of an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.
- Medicare Carriers and MACs pay for only one interpretation of an EKG or X-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or changed diagnosis resulting from a second interpretation of the results of the procedure.
- When Medicare Carriers or MACs receive multiple claims for the same interpretation, they must generally pay for the first bill received. They must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.

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- The physician specialty isn't a primary factor during the claims decision process/cycle.

Additional Information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

You can find the entire OIG report on "Medicare Payments for Diagnostic Radiology Services in Emergency Departments" at <http://oig.hhs.gov/oei/reports/oei-07-09-00450.pdf> on the OIG website.

CMS Manual References: "Medicare Claims Processing Manual" (Internet-only manual), Chapter 13 <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf> on the CMS website.

The Practice Guidelines and Technical Standards from the American College of Radiology can be located at <http://www.acr.org/Quality-Safety/Standards-Guidelines> on the Internet.

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