

THREE RADIOLOGY CODING AND BILLING MISTAKES TO AVOID



Everyone knows that billing and coding are challenging tasks due to the complexity of regulations and rules, plus the numerous staff and departments involved. This means that mistakes can occur at myriad points throughout “front-end” and “back-end” processes. And mistakes can be expensive: errors that reduce collections by five percent cost a typical practice a quarter of a million dollars. And they increase days in A/R, delay reimbursement and can even lead to compliance violations or fines.

In today’s era of reduced radiology reimbursement, finding and fixing mistakes is more important than ever. In this whitepaper, we focus on the areas of billing and coding that are more prone to error than others, namely eligibility, referrals, and dictation. That’s because they all involve handoffs from one part of the practice to another. Special attention should be paid to these areas to avoid errors and their ensuing consequences. Here’s how to avoid these pitfalls, while making your radiology practice and/or imaging center more efficient and more compliant.

ELIGIBILITY ERRORS

We typically see eligibility errors making up at least 35 to 40 percent of denials, even in well-run groups. In a hospital-based radiology practice, we recommend that the radiology chair and his/her billing experts (internal or billing service) meet with hospital administration to review and discuss eligibility denial results. The hospital should be interested since they are most likely experiencing denials from the same faulty data. For that reason, suggesting improvements to the hospital’s process, such as online eligibility checks, can be well-received.

AT A GLANCE:

Focus on these areas to reduce errors and improve collections:

- Eligibility data and processes
- Referral procedures
- Clear documentation

The front end process is under the direct control of imaging center leadership, making it much easier to address and reduce eligibility errors. We recommend an online eligibility check at the time a procedure is scheduled, particularly MR's, CT's, and PET's. A confirming eligibility check at the front desk when the patient presents is a great "belt and suspenders" approach. Having the eligibility information readily at hand also means that the co-pay and deductible can be collected prior to the procedure.

Of course, there will be some cases where the patient is simply not covered. The policy may not cover this particular procedure, or the patient may have run out of benefits, or the insurance may have expired. The increasing popularity of high deductible plans has a similar effect: the insurance carrier isn't going to pay (though the claim must be adjudicated), so the patient will need to be billed. Imaging centers should identify and address these situations prior to performing the procedure. The best alternative is to ask the patient, "Which credit card would you like to use?" Don't underestimate the need for patient education: they probably don't know which procedures are covered by their insurance and many on high deductible plans bought them for the low premium.

REFERRAL ERRORS

It is not uncommon for a radiologist to do a study that is then denied by a commercial payor because the billed study is not the same as the referring physician ordered. Consider the case where an imaging center order and pre-cert specify an MRI without contrast. But the practice or the radiologist has published protocols to do both the study with and without contrast. If both studies are billed, the payor will most likely deny the claim because it doesn't match the referral.

Medicare doesn't require a formal pre-cert. But Medicare does require an order (Medicare has its own rules for which diagnostic tests are covered). The solution is for imaging centers to always request a written order from the referring physician and keep it on file-and insist that the referring physician document the request in the patient's record. This approach means the center can use nearly identical referral procedures for patients with commercial insurance and Medicare.

Often, hospital-based practices feel that referral errors don't apply. But commercial payors in some states do require pre-certification, at least for selected studies. We recommend following the same procedure for both Medicare and commercial payors similar to those used by imaging centers.

For imaging centers, the solution is to have rock-solid front-end procedures that require the order and precertification (commercial payors) in order to schedule a procedure and for the center to review the order and pre-cert before the appointment to make sure it matches their protocols. If it does not match, the center needs to talk with the referring physician to clarify and, if necessary, update the referral. Of course, the referring physician may be following payor guidelines.

A broader solution for centers where preferred protocols don't match payor guidelines is to write a compelling case for the recommended protocols, then follow-up with the payor. Expect a discussion with the payor's review committee. The good news is that the same arguments can be used with other payors.

If this approach doesn't work, the center can say to the patient, "We think you need a study with and without contrast. However, your insurance will only pay for the study without contrast. Therefore, we recommend you have that procedure done first, and then return for the other study, which you will need to pay for."

In our "with and without" example, we should point out that if the center or their billing company were to bill the MRI without contrast when both studies were done, it would represent "billing for payment", which is viewed as fraud. Obviously this is not an acceptable practice in today's world where compliance must be taken seriously.

DICTATION ERRORS

All radiology groups know that correct procedure codes and modifiers are needed for insurers to accept their claims and to achieve the correct reimbursement. Sometimes overlooked, however, is that the coding is only as good as the documentation, which starts with accurate dictation.

As an example, a discrepancy between the header and the body of a report is a common dictation mistake. Examples include a header that says ‘MRI of the head without contrast’ but the report says ‘with and without’; the amount of gadolinium used and amount discarded is missing from an MRI or MRA report; the amount of optiray used and amount discarded and/or the strength of the optiray (320 vs. 350, etc.) is missing from the CT report; and the header says one view chest x-ray and the report says two views.

Unusual cases need particularly good reports. For example, if a patient is unable to complete the test (they didn’t drink enough, didn’t fast long enough, etc.), the practice is entitled to bill for that procedure. However, clear documentation is needed in the report to describe the incomplete procedure in order to receive the reimbursement.

Incomplete or inconsistent documentation takes extra time for both the coding staff and the radiologist. For example, a report header for a CT of the chest without contrast where the body mentions “injection” without any more details. The coder must now contact the radiologist for an amended report. Of course, radiologists can over-complicate the process if they aren’t familiar with the bundling requirements. For example, a chest and abdomen x-ray conducted at the same time should be dictated together; if separate it looks like unbundling which is a clear compliance concern.

Leadership and education are the solution to dictation mistakes. Radiology chairs and practice leadership must stress the importance of accurate reports. The “ACR Practice Guideline for Communication of Diagnostic Imaging Findings” can be very useful—if practice leadership shows the way. A reminder about CMS guidelines can also be helpful.¹ Practices should be getting feedback from their coding and billing organization on error rates by physician to highlight those doing well and those performing poorly. Physician training is often very productive, based on quarterly or semi-annual patterns and feedback.

SUMMARY

If your radiology practice focuses on reducing these 3 errors, you will see reductions in denials which will translate to improved revenue and reduced billing costs. Be sure to monitor the trends in your monthly reports so that you become aware of any future slippage. In addition, reducing these errors means you have improved compliance and reduced audit risk for your practice.

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¹ National Government Services, the Medicare Administrative Contractor (MAC) for New York, Connecticut, Indiana and Kentucky, states that “the medical record must include a formal written report describing all the views completed. The formal written report must include the reason for the test, a description of the test, the interpretation and results of the test, and the name of the physician to whom the report is being sent.”