Part B Insider (Multispecialty) Coding Alert

Compliance: OIG: Physician Orders Missing for 9 Percent of Emergency Dept. X-Ray Interpretations

Plus: Insufficient documentation found on 19 percent of CTs and MRIs, and 14 percent of x-rays in hospital outpatient EDs.

Think your emergency department could afford to brush up on its radiology documentation? A new OIG report indicates that answer is a resounding "yes."

Last week, the OIG released its newest report, entitled "Medicare Payments for Diagnostic Radiology Services in Emergency Departments," which reveals the results of the agency's audit of 440 Part B claims for interpretation and reports of diagnostic radiology services in EDs from 2008. Although the OIG found stark errors in these services, not all of the problems were the fault of healthcare professionals--some of the problems were attributed to unclear CMS guidelines.

OIG Findings Indicate Part B Overpaid Millions

The OIG reported the following among its emergency department findings as part of its 25-page report:

19 percent of CT and MRI interpretations and reports were paid in error due to insufficient documentation, totaling $29 million

14 percent of x-rays were erroneous due to insufficient documentation, totaling $9 million

Physicians' orders were missing from the medical records in 12 percent of CT and MRI interpretation and report claims, amounting to almost $18 million

Physicians' orders were not present in the documentation for 9 percent of x-ray interpretation and report claims, totaling $5 million

Documentation was not provided to support that interpretation and reports were performed for 12 percent of CT and MIR claims, and 8 percent of
x-ray claims

In addition, Part B payers reimbursed EDs for interpretation and reports performed for 16 percent of x-rays and 12 percent of CTs and MRIs after beneficiaries left the ED--but the OIG did not specifically fault the ED for these errors, instead pointing the finger at Medicare. "CMS offers inconsistent payment guidance on the timing for interpretation," the report says. "CMS's guidance to contractors states that contractors are to pay only for the interpretation performed 'at the same time' as the diagnosis and treatment of the beneficiary in the emergency room if contractors receive multiple claims from, for example, the emergency room physician and the radiologist."

MACs, however, are not required to confirm that the interpretation was performed while the patient was still in the ED "if only one claim is received," the report states. Medicare paid over $10 million for interpretations of x-rays that were performed after patients left the hospital, which would indicate that the interpretation was not critical to the patient's diagnosis and treatment.

Payers, Auditors May Start Scrutinizing ED Claims

Even if your ED wasn't among those targeted in the audit, the results may still affect you. Now that CMS is aware of the

fact that it has overpaid millions in diagnostic interpretations and reports performed in emergency departments, MACs will probably begin taking a closer look at these claims, which means you should ensure that yours are buttoned-up before submitting any charges.

Important: Confirm that your documentation includes physician orders for all diagnostic radiology services, and that the records are complete. In addition, ensure that you only submit charges for interpretations and reports that are medically necessary.

To read the complete OIG report, visit http://oig.hhs.gov/oei/reports/oei-07-09-00450.pdf.