Part B Insider (Multispecialty) Coding Alert

X-RAY Coding: Focus On the Fine Print To Bill Portable X-Ray Claims Properly

CMS portable x-ray rules can be confusing if you don't know what to report.

Busy lives and limited medical resources have brought about the necessary increase of mobile healthcare services. From visiting medical personnel to portable diagnostics, the industry continues to strive to reach those most in need. While the benefits certainly outweigh the disadvantages, sometimes the rules and requirements confuse providers, hindering quality care. When this happens, audits are sure to follow.

"For a provider facing an audit, responding to the audit findings sometimes will involve a maze of statutes, regulations, manual provisions, and other written guidance," says **Michael D. Bossenbroek, Esq.** of Wachler & Associates, P.C. in Royal Oak, Michigan, "Properly understanding these standards may give the provider appropriate technical defenses in the audit."

Background. A New York mobile diagnostics company was found to be out of compliance with Medicare's federal and state rules regarding Part B portable X-ray payments, stated the OIG in a June 10 report. According to the lengthy findings, the OIG initiated the audit because the company "ranked among the highest-paid providers of portable X-ray services in New York and New Jersey."

With a staggering 97,279 claims equaling $7,829,074 in Medicare payments to the portable X-ray firm between Jan. 1, 2011 and Oct. 31, 2012, the OIG focused its inquiry on a small sampling of 117 claims. After a careful review, OIG found 88 claims compliant, but the remaining 29 had at least one or more billing issues that totaled $332,233 in overpayments.

High Income Could Equal A 'Target on Your Back'

Medicare is fairly specific about what must be included for portable X-rays to be covered under Part B, though understanding and applying the incidentals can be daunting and open for interpretation, especially when servicing patients across different states.

Example: One of the claims disputed in the OIG report concerned services administered in a nursing home in Connecticut. The X-ray services had been supervised by a New York physician under New York State Department of Health requirements, and the licenses and certifications of the technicians had been "periodically" checked by him. The records lacked any evidence that the Connecticut laws had been acknowledged or that a Connecticut physician had been involved at all.

Luckily, this firm had a strong legal defense to guide it through the process, but the OIG report does suggest that the firm lacked the proper compliance measures to combat the onset of the audit in the first place.

"The OIG made a point that this provider was one of the highest-paid providers in its geographic region," explains Bossenbroek, "The highest paid providers for obvious reasons have the largest targets on their backs."

Advice: He suggests that confused providers look at past compliance reports and guidelines available on the OIG website. "The OIG has published reports in the past identifying questionable billing patterns of portable X-ray suppliers," says Bossenbroek, "and will often publish compliance program guidance for different provider and supplier types."

Key to documentation: A few things are of vital importance when a patient is referred to a portable X-ray provider. First and foremost is the original request by a licensed physician. "Portable X-ray examinations are performed only on the order of a doctor of medicine or doctor of osteopathy licensed to practice in the state," advises Palmetto GBA.

The CMS ruling 42 CFR 486.106 mandates that certain criteria be evident in the documentation in order for Medicare to deem the X-ray necessary and covered under Part B. Here is a short list of questions to ask yourself to ensure your claim is viable:

- Is there a detailed record for the patient?
- Are the referral and order written and signed by a physician?
- Does the order have a clear description of why the X-ray is needed?
- Do the notes outline how many radiographs are to be taken and how many views are required?
- Is the patient's condition related to the need for the X-rays thoroughly explained in the documents?

Is this covered?

To avoid denials and get paid, portable X-ray providers must closely follow what Medicare Part B approves and excludes under the X-ray benefits. This also goes for physicians as well who need to understand what is allowable when writing up the original orders to avoid putting the X-ray providers in a precarious position.

Acceptable measures. There are more exclusions than exceptions in the CMS guidelines for what's acceptable for portable X-ray providers to perform. To keep within the "scope" of the CMS guidelines, Palmetto GBA suggests your business perform X-rays for the following services only:

- "Skeletal films involving arms and legs, pelvis, vertebral column, and skull"
- Chest or abdominal X-rays that don't use a contrast agent to enhance films
- Diagnostic mammograms from an approved and certified portable X-ray provider.

On the converse: To ensure patient safety and keep within the boundaries of both medical and mobile capabilities, Medicare clearly outlines what is excluded from coverage under the Part B benefit for portable diagnostics. Due to these precise rules, procedures that involve fluoroscopy, contrast media, the administration of special substances or manipulations, or the use of highly specialized equipment for more complicated procedures are not allowed, says Palmetto GBA.

CMS also denies claims for portable X-rays where "routine screening procedures" were performed or for any procedures that were not diagnostic. More importantly, it is always best to avoid orders that require higher-level medical expertise and reasoning—these will not be accepted because a physician must be present.

Bottom line: Many of the CPT® codes in the ranges below are payable—but there are several exclusions, so check the CMS website and your local MAC policy before you bill. Here's a closer look at the different code series':

- 70030-70380 (Head and neck)
- 71010-71130 (Chest)
- 72020-72220 (Spine and Pelvis)
- 73000-73140 (Upper Extremities)
- 73501-73660 (Lower Extremities)
- 74000-74022 (Abdomen)
- 77055-77056 (Mammography)
- 93000-93041 (Cardiography)

Strong documentation combined with a comprehensive understanding of the CPT® codes will help you avoid billing dilemmas.

Resources: For a closer look at the OIG's report about billing Medicare Part B correctly for portable x-rays, visit http://oig.hhs.gov/oas/reports/region2/21301038.pdf.

For more information about Palmetto GBA's Railroad Medicare Hub on portable X-ray services, visit http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Railroad-Medicare~8XFHF94345.