

What's in the Setting?

By Bhawna Oberoi, RPA

With so much confusion about billing and supervision, I want to get to the bottom of these issues once and for all. I had addressed them once before when I was a student and scared out of my mind about what was legal and what could get not only me, but also my radiologists in trouble. There are too many people out there who are ready to put doubt and fear into play any chance they get. I hope to relieve at least some of your fears with this article. The focus will be on setting, supervision and using a billing modifier code.

The subject of supervision is often thrown about as a negative connotation when associated with the RPA. One thing of importance is the out patient setting vs. the hospital setting. Speaking with RPAs at the conference, there is appears to be a good mixture of hospital and outpatient practice. For the people in the hospital setting, I have this to share:

When I asked the ACR to clarify hospital supervision rules I was given the following information in a fax from the ACR economics department:

“Note also there are procedures that include Fluoro (e.g., barium enemas and various GI studies) that are not “supervision and interpretation” codes. The hospital supervision regulations do not specifically address these types of services. Therefore, you would follow the internal hospital policies in order to identify appropriate level of supervision”

I also asked them to clarify the ACR article that caused so much stir in 2003 titled “Medicare’s Supervision rules and the role of radiologists”, for which they had this response:

“To clarify, the January article applies to the free standing setting. Services provided in the hospital inpatient and outpatient settings follow JCAHO accreditation standards, which require physicians to follow internal hospital policies”

What does this mean for you? Check with your hospital to see if your outpatient center is also owned or affiliated with the hospital. If it is, then the hospital guidelines should be followed, not the Medicare rules for supervision.

Furthermore, supervision codes that are listed as personal supervision, (i.e., GI studies) as level (3) must be examined with some latitude. For instance transvaginal sonograms performed for early pregnancy and early OB ultrasounds are also at level (3). How many times has a radiologist been seen scanning these patients? In addition, in the modern age of image processing, Level (3) supervision is also applied to 3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality requiring image post-processing on an independent work station. Does this mean that the radiologist has to watch the technologist do this the entire time it takes to process the images or does this mean that

the physician is just present in the area? Or is the physician merely there if he's needed? The writing couldn't possibly imply that the physician has to perform the entire post processing himself? Something to consider...

You can see the entire list of exams and procedures on the PDF link below:
https://www.cahabagba.com/part_b/enroll_update_your_records/enroll_idtf_list.pdf

Another point that has been brought up is using a -52 modifier and personal supervision for interventional procedures. Below is section 15022(E) from the Medicare carriers' manual.

“E. Supervision and Interpretation (S&I) Codes and Interventional Radiology.--

1. Physician Presence.--Radiologic S&I codes are used to describe the personal supervision of the performance of the Radiologic portion of a procedure by one or more physicians and the interpretation of the findings. **In order to bill for the supervision aspect of the procedure, the physician must be present during its performance.** This kind of personal supervision of the performance of the procedure is a service to an individual beneficiary and differs from the type of general supervision of the Radiologic procedures performed in a hospital for which intermediaries pay the costs as physician services to the hospital. The interpretation of the procedure may be performed later by another physician. In situations in which a cardiologist, for example, bills for the supervision (the "S") of the S&I code, and a radiologist bills for the interpretation (the "I") of the code, both physicians should use a -52 modifier indicating a reduced service, e.g., the interpretation only. Pay no more for the fragmented S&I code than you would if a single physician furnished both aspects of the procedure.”

The billing specialist for my employer states that since we as RPAs do not have independent PIN numbers for billing, the services we provide would never use a -52 modifier as the Medicare rules are currently written. The -52 modifier is only used to prevent double billing by two physicians doing two separate portions of one procedure.

Another thing that I hear a lot about is a free standing clinic vs. an IDTF (Independent Diagnostic Testing Facility). What qualifiers do you have to meet to be considered an IDTF? The Medicare definitions are listed below.

What is an IDTF?

Federal code, 2 CFR 410.33, states that an Independent Diagnostic Testing Facility (IDTF) may be a fixed location, a mobile entity, or an individual non-physician practitioner. It is independent of a physician's office or hospital; however, these rules apply when an IDTF furnishes diagnostic procedures in a physician's office. Furthermore, the Medicare Program Integrity Manual Chapter 10 § 5.1 notes that if a substantial portion of a physician or group practice of physicians business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to warrant enrollment as

an IDTF (it is considered independent for purposes of enrollment). In that case, the physician or group can continue to be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. However, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice. The carrier should advise the entity (physician or group practice) how to bill for physician office tests versus IDTF tests and advise the claims personnel of the dual enrollment.

In other words, some suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, are required to enroll as an Independent Diagnostic Testing Facility (IDTF). However, not all suppliers that perform the diagnostic tests are required to enroll as an IDTF. Generally, entities can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital
- A facility that primarily bills for physician services and not for diagnostic tests
- A facility that furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions

However, if a substantial portion of the facility's business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficient separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. Therefore, the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not regular patients of the physician or group practice.

(References: Enrollment Form for Contractors (CMS Form 855B)
http://www.medicarenhic.com/cal_prov/articles/clinicidtf_0306.htm
www.reimbursement.respironics.com/downloads/FactSheetIDTFs.pdf)

Here's a clarification from the gurus at the Trailblazer (CMS in Texas) that was printed on 10/17/07 by the billing specialist as our new imaging center was ready to apply for Medicare billing privileges. This was from their web site and was scanned into this document. For more information you can contact your own state CMS or use this one for Texas: www.trailblazerhealth.com

Radiology Groups

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally very different from those of other physicians because radiologists usually do not bill E & M codes or treat a patient's medical condition on an ongoing basis. Nevertheless, a radiologist or a group of radiologists should not necessarily be required to enroll as an IDTF. The following features would indicate that a radiology practice is not "independent from a physician office or hospital":

- The practice is owned by radiologists, a hospital, or both;
- The owner radiologists and any employed or contracted radiologists regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled entity indicate that the entity is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., the enrolled entity should not bill for a significant number of purchased interpretations, it should rarely bill only for the technical component of a diagnostic test, and it should bill for a substantial percentage of all of the interpretations of the diagnostic tests performed by the practice);
- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

IDTF Important Information January 2007

While this continues to be confusing it is starting to make a little bit of sense to me. The intent of this article is not to clarify everything having to do with supervision and billing, but to give you another side of it. Hopefully, this will give you the confidence to ask questions and explore solutions for your particular scenario.