How to make your radiology

medical claims cleaner and improve cash flow

Researching unpaid or denied claims is a frustrating and time-consuming process. On average, more than 25% of lost practice revenue comes from poor medical billing and revenue cycle management practices. According to the Medical Group Management Association (MGMA), the average cost of reworking a claim is $25 to $30.

Closing these gaps requires spot-on attention to patient information, treatment and diagnostic codes, and evolving billing rules and insurance regulations. Trapping all the details so your radiology claims get submitted and paid correctly on time is a challenge for many medical practices.

Listed below are some of the main reasons a medical claim may get denied and how you can troubleshoot the denial.

Missing or invalid information

Verifying a patient's insurance eligibility for the date of service and benefits is a critical first step. Always confirm pertinent information from the patient at check-in or during the data entry process for the claim. Even one required field, such as an insurance plan ID or Social Security number (SSN) will trigger a denial. Fast Pay Health ensures demographic and insurance data is correct by verifying plan coverage before submitting a claim.

According to the American College of Radiology, all imaging reports must include the following information to be complete: exam name, clinical indication/reason for exam, description of exam, sequences and/or technique, comparison studies if applicable, findings, conclusions and recommendations, and physician's signature.

Don't forget to document the actual number and specific views, such as "four views of the knee" since a knee exam has four different CPT codes based on the number and type of views.

New or established patient not clear

Patients are considered new if they have not been seen by any physician with the same specialty and sub-specialty within a group practice in the last three years. For solo providers, this is simple—if the patient hasn't been seen in the last three years, they're considered new. But for larger group practices, it can get tricky. Keeping proper records can help avoid this type of rejection. In some instances, an insurance payer may incorrectly reject a claim for a new patient exam. Most of the time this can be cleared up with a phone call to the payer, though some cases may require an appeal with medical documentation.

Referring or ordering physician not listed

In most cases, the referring or ordering physician may be the same as the rendering physician. However, failure to include this information will result in a denial and delay payment. If a required referring physician is missing, Medicare will often split those codes from the rest of a claim to expedite payment.

Provider wasn't credentialed by insurance payer

Always make sure the provider has been credentialed by the insurance plan before submitting the claim, since some insurance payers may require providers to credential (get on insurance panels/board) with specific plans individually. Fast Pay Health can help simplify the credentialing process by reviewing documentation to determine the participation status in the health plan, then submitting and tracking provider credentialing applications based on insurance plan requirements.

>> continued

Service wasn't medically necessary, covered or pre-approved

A service/procedure that was medically necessary last year may now be a non-medical necessity, which means it isn't covered by the insurance payer. Check your Local Coverage Determinations (LCD) policies on the insurance payer's website for a list of covered diagnoses. Also, make sure the service is covered by the insurance payer and, if needed, you obtain pre-approval from the insurance payer.

Incorrect/missing CPT code, modifier, PIN or NPI

Did you submit an incorrect CPT code, modifier, Personal Identification Number (PIN) or National Provider Identifier (NPI) number? The most common modifiers in radiology billing are 26, TC, 76, 77, 50, LT, RT and 59.

Modifier 59 defines a "Distinct Procedure Service" and identifies procedures/services that are not normally reported together. Modifier 59 is often used for interventional radiology coding, as well as diagnostic radiology and nuclear medicine coding when multiple services are performed in different encounters on the same date. Be careful though, as modifier 59 is one of the most used modifiers, and one that is often used incorrectly. Never attach modifier 59 to an E&M service. Depending on the local policy, if the tests are necessary due to two separately identifiable conditions, you may be able to link the appropriate diagnosis code to each CPT and add modifier 59 to the second procedure.

For example, if you are billing two or three intramuscular (IM) injections, modifier 59 would be added to the second and any subsequent injection codes listed on the claim form. Though the National Correct Coding Initiative (NCCI) edits do allow the use of modifier 59, determining if it is appropriate under the circumstances can be tricky. Fast Pay Health medical billing and coding experts can help you determine how to bill appropriate modifiers and make sure claims are clean and free from errors, before we submit them.

In addition, it's important to know when to use a professional component (modifier 26) and technical component (modifier TC). Use modifier 26 when the radiologist interpreted the films and wrote a report—this indicates the provider should receive reimbursement only for the professional component. Use modifier TC for billing for the equipment, supplies, technicians and facility.

Chief complaint was missing

When you document the chief complaint, provide a concise description of the problem—this will help you in case you are ever audited. A missing chief complaint can result in a claim denial based on incorrect levels of care.

Benefit exceeds allowed # of visits or services

Many insurance payers only allow a certain number of medically necessary diagnostic and treatment services that are covered within a calendar year and sometimes every other year. Some insurance payers may also limit the number of services within a 60-day period. Always confirm the patient's eligibility benefits with the insurance payer.

Services weren't bundled

There are some services you can't file separately and may require bundling, such as mammography, ultrasound screening for abdominal aortic aneurysm, fluroscopic guidance and Interventional Radiology (IR).

Duplicate claim or service

Did you submit the same claim twice? This often happens if you didn't receive reimbursement within 30 days. Before you re-file a claim, always check with the insurance payer first since they may be processing the claim.

Filing deadline has passed

If a claim is not submitted to the insurance payer within the permitted time frame, it will probably get rejected. Sometimes you only have up to 90 days from the date of service. In addition, if a patient has secondary insurance, you can run into timely filing denials. Many payers require you to bill a secondary carrier within a specific period, after you receive the primary payments.