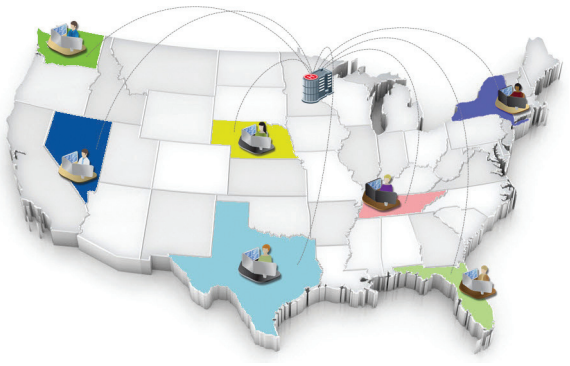
RADIOLOGY SERVICES

νRad® a MEDNAX® Company

MEDICARE BILLING FOR TELERADIOLOGY



Remain in compliance with CMS, avoid cost and effort – let νRad handle your Medicare billing for teleradiology

When you partner with νRad for Fee-For-Service Final Interpretations, we bill for the Medicare patients we serve and remit payments back to you. This allows you to:

- Remain in compliance with CMS rules requiring professional component bills be submitted with the Medicare Administrative Contractor (MAC) where the teleradiologist performs the interpretation
- Avoid the cost and effort of enrolling with every MAC
- Continue receiving reimbursement by avoiding compliance issues with CMS

νRad is the leader in Medicare billing for teleradiology

Since 2007, νRad has helped our clients navigate and remain in compliance with strict CMS billing rules. We offer comprehensive billing solutions for our teleradiology services including traditional Fee-For-Service and Payer Direct – minimizing your financial exposure for studies sent to νRad. As the leader in Medicare billing for teleradiology, νRad:

- Worked with CMS and the U.S. Senate to clarify the proper billing procedures for teleradiology
- Enrolled in every MAC jurisdiction in the U.S., maximizing reimbursement speed
- Consults with our clients on strategies to avoid compliance pitfalls
- Serves clients with our in-house billing operation, partnering with MedData – a MEDNAX Company and sister organization to νRad that has specialized in medical billing services for over 35 years

Common misconceptions about Medicare billing for teleradiology

"We've used teleradiology before and will bill as we have in the past."

CMS rules are clear that the professional component must be submitted to the MAC where the teleradiologist performs the interpretation. As with any provider, it is common for teleradiologists serving your facility to reside in multiple MACs – which is why νRad has invested heavily in Medicare billing to assist our clients.

We encourage our clients to seek guidance from their local MAC and retain a copy of correspondence confirming their billing method is acceptable. Choosing to decline νRad's Medicare billing service is reflected in the client contract, but we would be happy to revisit the conversation if future assistance is needed.

"I'm planning to bill like I do for locums – is that okay?"

Billing locums is acceptable by Medicare when νRad is covering for a physician who is not providing services at that same time, for up to 60 consecutive days.

"We're an IDTF or mobile imaging unit and we like to manage the Medicare billing."

This practice used to be known as "purchased services." You should first verify that you qualify to bill anti-markup tests to your local carrier – it is not sufficient to be an IDTF only. The IDTF or mobile unit also needs to be the entity ordering the actual test.

νRad's ethics and compliance leadership

Your partner matters. If your teleradiology partner is not billing Medicare on the studies they read, you could be out of compliance.

νRad's comprehensive Medicare billing process

νRad minimizes the work burden for our fee-for-service clients by managing all aspects of Medicare billing for teleradiology services.

1) νRad submits teleradiology professional charges to Medicare, secondary insurers, etc.
2) νRad collects reimbursements
3) νRad remits reimbursements back to you each month, less a collections fee

Related information from the Centers for Medicare & Medicaid Services

Claims must be submitted to the B/MAC where the reading radiologist is located–not where the patient is.

"Though a supplier or provider may reassign payment for his services to another entity, suppliers are still required to bill the correct B/MAC for reassigned services when they are paid under the MPFS. The billing entity must submit claims to the B/MAC that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria stated in chapter 10 of the Program Integrity Manual in order to be able to bill for reassigned services."

Source: Medicare Claims Processing Manual, Chapter 1, 10.1.1.3

Revised and clarified Place of Service (POS) coding instructions

"If the same physician or other supplier entity does not furnish both the TC and PC of the diagnostic service, or if the same physician or other supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier-26 by the interpreting physician. When the physician's interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier-26, the interpreting physician (or his or her billing agent) must report the address and ZIP code of the interpreting physician's location on the claim form."

Source: Medicare Claims Processing Manual, Chapter 13, 150

Independent Diagnostic Testing Facility (IDTF)

"If an IDTF wants to bill for an interpretation performed by a physician who does not share a practice with the IDTF, the IDTF must meet certain conditions concerning the anti-markup payment limitation.

"If a physician working for an IDTF (or a party related to the IDTF through common ownership or control) does not order the TC or PC of a diagnostic test (excluding clinical diagnostic lab tests), it would NOT be subject to the anti-markup payment limitation." [But, if such a physician or other party related through common ownership or control does order the TC or PC, then it IS subject to anti-markup. If the IDTF is subject to anti-markup, it can submit the bill to its local Medicare contractor. If the IDTF is not subject to anti-markup, it cannot, according to the billing rules. The IDTF must include the zip code of the actual location of our radiologist on any billing claims it submits. – νRad]

Source: Medicare Claims Processing Manual, Chapter 35

νRad Snapshot

- Founded 2001 — a MEDNAX Company (NYSE: MD)
- 500+ U.S. board-certified and eligible radiologists, the majority whom are subspecialty trained
- 2,100 hospital, health system and radiology group facilities served in all 50 states
- U.S.-based, 24/7 operations and technical support center
- World's largest and most advanced PACS
- 18 issued patents for innovation in telemedicine workflows and data normalization; additional patent pending on deep learning applications for computer assisted diagnostics
- The largest — and only — radiology patient care benchmarking platform (vRad RPC℠ Indices) for statistically significant national and peer performance comparisons
- Standard-setting Quality Assurance program emphasizing performance improvement since 2004 — delivers 99.7% accuracy
- Trusted by stroke and trauma centers around the country — patent-pending stroke and trauma workflows increase the speed of high-quality radiology

Contact us to speak with a Client Success Manager at 800.737.0610 or visit us at www.vrad.com.

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