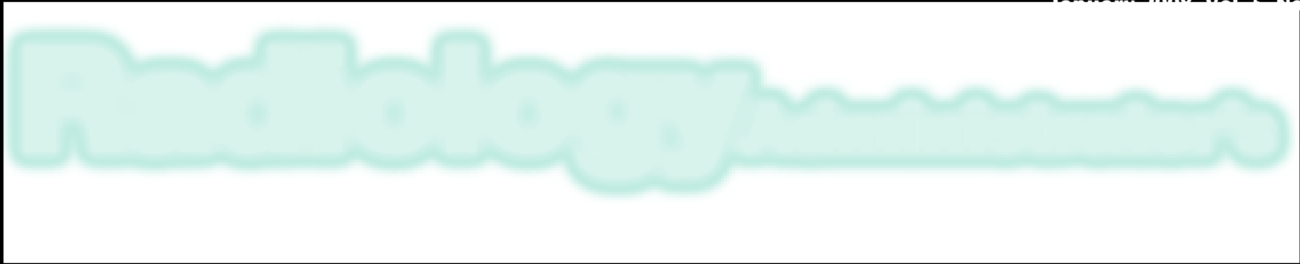
January 2008 Vol. 5 No. 1

Maintaining the house while the house is in repair

Some keys to keep a radiology department functioning in the midst of renovation

It is a well-known fact: The healthcare industry is as competitive as ever. With competition comes the need to build and expand. Healthcare construction is projected to top $45 billion this year, up from $11.6 billion from 10 years ago, according to a report on CNNMoney.com.

Radiology departments are certainly a big part of those renovations, says **Mike Clark, AIA,** design director for H&H Systems and Design, Inc., in New Albany, IN.

"They're renovating radiology departments because of things like HIPAA and new competition with outpatient centers," Clark says. "Those things are forcing them to become more patient-friendly. A lot of these facilities were built 20 years ago and were not very patient-friendly."

So how does a radiology department cope with renovations when noise, dust, and power outages can be as common as CT scans and mammograms?

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Take a look back at a year's worth of ***RACRI*** stories.

Talk, prepare

It boils down to communication and preparation, say those in the field. It is also important to instill the belief that the renovation will ultimately pay off for the hospital. For example, The Center for Health Design conducted a study based on a hypothetical facility that would lose $12 million to construction of a regional hospital. But the facility would get that back in just one year from "operational improvements such as fewer patient falls and reduced turnover among nurses," CNNMoney.com reports.

> **"The benefits in the end are better work flow and new equipment that can speed up procedures and provide better images."**
>
> *—Frank Heinz*

"These projects can be very cumbersome," says **Frank Heinz,** CEO of H&H Systems and Design, Inc. "Planning and scheduling are the obvious challenges to overcome."

Clark says communication is key. A radiology department director must meet daily with the contractor to discuss the work. "Quite honestly, every day, whoever is in charge of the construction project needs to touch base with whoever is in charge of the radiology department," he says. "The radiology head also needs to let his staff know if there are going to be issues. To the best of everyone's ability, they need to try to keep everyone as happy as possible."

But happiness isn't always easy. Some other disturbances can quickly make radiology department staff members restless, including:

➤ **Noise.** This is the biggest problem, Clark says, "because it's constant. As far as the real bad noise, it can usually be scheduled off-hours, but in a hospital, a lot of stuff is below you, and a lot of stuff is above you. And a lot of times a hospital is occupied 24 hours a day." How can staff members cope? They need to know they have a person to go to who can address a noise problem, Clark says.

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Renovation

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"Most contractors who work in a hospital know there are going to be times where you have to stop," he says.

Clark also suggests providing a balance between disruption and schedule. The more disruption the hospital can endure, the sooner the disruption is over, he says.

➤ **Dust and dirt.** Although infection control measures are in place, dirt is still tracked outside the project area, Clark says. The contractors will contain most of the dirt and dust, but the hospital maintenance staff needs to help as well. "If you see it, report it to the contractor," he says. "The hospital needs to alert the housekeeping staff so [it] can put in a little extra effort."

➤ **Utility disruptions.** Perhaps the most harrowing prospect of hospital renovation is a power outage. When utilities are reworked, they cause outages in areas outside the project area, and temporary utilities need to be in place prior to shutdowns. This is particularly cumbersome to radiology departments.

"Identifying those areas or devices affected can be difficult due to incomplete or incorrect information," Clark says. "Quite often, the hospital has added on to the utilities, and this information is not known until it is cut off. Hospital [staffs are] always notified of these utility shutdowns, but they also must check their areas to be sure all utilities are working, especially any life safety devices such as emergency power, medical gas, and emergency assist devices."

Some other pitfalls for radiology departments to watch out for during renovations, says Clark, are:

- ➤ The cost for a renovation project can be higher than new construction due to phasing and restrictions
- ➤ Construction schedules can be longer than in shell spaces (space enclosed by an exterior building shell, but not finished inside) or new construction
- ➤ Restrictions due to existing physical conditions can affect the final layouts of the space (ceiling structure height, column and utility locations, etc.)

Ultimately, a renovation can help a radiology crew keep up with the latest technological advancements and stay competitive. "The benefits in the end are better work flow and new equipment that can speed up procedures and provide better images," says Heinz. "It's a better work environment. Many departments have only been maintained. Fresh paint, flooring, and ceiling tiles can make a big difference in how the staff and patients feel about the procedures being performed." ■

Insider *sources*

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2007: The year of the Deficit Reduction Act

Administrators reflect on the year that was and look ahead to 2008

The year 2007 for radiologists and imaging specialists will perhaps be remembered as the year the Deficit Reduction Act went into effect. Signed into law in February 2006 and beginning January 1, 2007, President Bush's Act cut $2.8 million from Medicare reimbursement previously designated for imaging over five years. The American College of Radiology (ACR) estimated the cuts will actually amount to $6 billion during those five years.

So how did radiology and imaging departments cope? **Theresa Wade**, **MPHA, ACMPE,** administrator at the Elizabeth Wende Breast Clinic in Rochester, NY, and **David A. Dowe, MD,** medical director of the Coronary CTA program at Atlantic Medical Imaging in Galloway, NJ, reflect on 2007 and look ahead to 2008:

Staff needs to be kept happy

RACRI: What was your best achievement in 2007?

Wade: Working toward being totally digital, which will mean we can start to eliminate some of the paper processes we now have in place. We also tied employee increases this year directly to their evaluations, which was received fairly well by the staff.

RACRI: What was one thing you wish you could do over and why?

Wade: I need to trust my staff more and let them problem solve without my interference. Empowerment makes for a happier employee and also a more valuable employee.

RACRI: What are your goals for 2008?

Wade: To be 100% digital and to continue to work on a totally electronic emergency medical record [system], which will continue to define our work flow. We also need to figure out a good merit system that rewards and motivates employees instead of the bonus system we have had in place for the past few years. I also would like to review the insurance contracts to make sure we are receiving enough for what we do and terminate any contracts that are below our profit margin.

Cost cutting in light of DRA

RACRI: What was your best achievement in 2007?

Dowe: Restructuring our corporate debt and cost cutting in response to the Deficit Reduction Act [DRA] Part I. [DRA-2 is buried inside the SCHIP or CHAMP bills that Bush has been vetoing this year. Nobody is sure what it will look like in the end.] By doing this, we were able to preserve benefits for all of our employees and physicians at pre-DRA levels.

RACRI: What was one thing you wish you could do over and why?

Dowe: I wish I could do cost cutting and restructuring of debt in years prior to the DRA. What I have learned is that in good times and in bad, you should run your business as lean as possible. We, like many businesses in times of plenty, forget to look at every dollar and just march from day to day without thinking about it.

RACRI: What are your goals for 2008?

Dowe: To continue to respond to the challenging reimbursement environment in which we live. My other goal is to continue to fight for across-the-board national reimbursement for coronary CTA and cardiac CT. There is no doubt that coronary CTA will replace stress tests as the initial exam a patient receives if [his or her] physician is considering coronary artery disease. Coronary CTA already has replaced many elective diagnostic coronary catheterizations. This trend will continue and is unstoppable. ■

Insider *sources*

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Tips for a smooth renovation in your radiology department

If there were ever a change to a radiology department, **Angela Krause, CRT,** has seen it.

Krause, now the diagnostic operations manager for the Radiological Associates of Sacramento and the Roseville (CA) Imaging Center, oversaw in November the installation of a third MRI scanner. The facility removed radiology and Fluoro equipment. The center demolished the old Fluoro room and an open shell space to create the space for MRI 3.

Last year, Krause's team replaced two radiology rooms with two digital radiology units at Roseville Imaging. She now manages multiple outpatient centers and was part of another project in 2006 at Folsom (CA) Imaging.

"We expanded its center to another building next door and built the suite from the ground up, as well as made some modifications to the existing center," Krause said. These included changes to the reading room/tech areas, and the addition of a subwait room for patients on deck.

Below is a Q&A **RACRI** conducted with Krause about how radiology departments can handle renovations.

RACRI: How did your radiology department cope with the renovation?

Krause: Renovation is always a challenge. We try to keep staff [members] informed about what will be happening so they're aware and on board with the changes. We ask for their input in the planning process, so they're usually excited about the completed project. We ask for their patience during the process as well. We post flyers for patients to let them know we're under construction to improve our center. We ask our staff to be extra nice and apologize to the patients for our current mess. We put candy in a hard hat to hand out as a token of apology for the disruption, wait times, and inconvenience, etc. We provide treats for staff [members] to keep them going as well.

RACRI: What would you do differently?

Krause: We learn something every time we undergo a renovation project. We try to not repeat previous mistakes, but no matter how much you plan and coordinate, there are always issues that come up that no one thought of. The hard part is not knowing what you don't know. We've learned to have weekly meetings with all involved parties to make sure everyone is on the same page.

RACRI: What was the worst part?

Krause: The environment is the most challenging part. We try to work with our contractors to do the heavy work after hours.

However, our business is open seven days a week, all day, and frequently into the evenings. Despite efforts to minimize it, we always have to deal with equipment noise, dust in the air, odors, tracked-in dirt, etc.

RACRI: What kind of tips do you have for folks undergoing the same process?

Krause: It's important for the operations team [members] to work closely with the contractor. They must understand the scope of the project and have clear timelines to know when certain parts of the project will begin and end. They must also be prepared for those timelines to shift—usually backwards.

They must have a plan for operating the department during the construction and be prepared to implement contingencies or changes to the plan based on unknown factors. They must know who the key workers are with mobile phone numbers in case they need to contact them day or night. They must be prepared to apologize often and to ebb and flow as challenges arise.

RACRI: What are the benefits of the renovation in your department?

Krause: We have a better department in the end. It's painful to get there, but anything worthwhile usually is.

Insider *source*

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Right to the heart of it

CCT and CCTA provide better pictures of the heart

Cardiac computed tomography (CCT) and cardiac computed tomographic angiography (CCTA) offer physicians and patients better pictures of the motion and structure of the heart muscle.

These scans, developed in the early 1990s, revolutionized cardiac imaging and the way the world imagined heart healthcare. CCT and CCTA improved visualization of the heart's soft tissues and adjacent anatomic structures. Volumetric acquisition associated with this technology permits pictures to be taken from multiple angles and in multiple planes after a single shot. Further, these scans are less invasive than conventional angiography, and thus pose fewer clinical complications.

One way physicians use these cutting-edge exams is to determine the severity of calcium and plaque buildup on the walls and arteries of the heart. If a person builds up enough vascular plaque, the arteries can narrow and may eventually completely block blood flow to the heart.

A tool called calcium scoring helps physicians determine the extent of coronary artery disease early. The amount of calcification, expressed as a score (e.g., the Agatston scale), predicts the likelihood of myocardial infarction in the coming years. However, most payers do not cover coronary calcium scoring (either with or without a CCT or CCTA procedure).

Because the new technology—especially the use of CT for such procedures—gained popularity so quickly, coding confusion seemed inevitable.

To resolve this issue, the American College of Radiology (ACR) recommended reporting the CPT used for CTA of the chest (71275) for CCTA. But it didn't take the national organization long to rescind its recommendation.

Developing appropriate codes

High-quality CCTA requires different imaging techniques than those used for the examinations described by CPT 71275. The AMA developed CPT 71275 specifically to represent imaging of the noncoronary vessels within the chest (e.g., aorta and pulmonary vasculature), so it is not appropriate to report this code for CCT or CCTA imaging.

A change was made to the description of this code in *CPT 2007* to indicate that it is to be used for non-CCTA studies of the chest only. To resolve this conflict, the ACR joined with the American College of Cardiology (ACC) and BlueCross BlueShield to lobby for new Category III CPT codes. The new codes, they said, should describe various common combinations used for CCT and CCTA studies.

The associations were successful. The codes took effect January 1, 2007. And now, at least in most cases, radiologists can use a single code to describe more specific combinations of the services they perform.

Various organizations use the Category III codes (often denoted by four digits followed by an uppercase T) to report and collect data regarding the performance of emerging technologies, services, and procedures. Because the new codes fall into Category III, they represent an "emerging technology." The AMA and other associations also use the information to track clinical efficacy, utilization, and outcomes.

Without accurate and consistent submission of Category III codes by providers, specialty societies cannot obtain necessary utilization data for these services. It may go without saying, but with no accurate reporting, facilities have difficulty calculating physician work and practice expense information. As of January 1, 2007, the Category III codes for CCT and CCTA must be used because they accurately describe the procedure(s) performed.

Affecting code change

Think of all this in terms of the big picture. Physicians perform a procedure. To receive reimbursement, they

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Heart

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must assign a code. To stay compliant, the code must appropriately reflect the services actually rendered. When codes do not accurately reflect current physician practices, medical associations step in to lobby the AMA for new codes.

Reporting and data analysis corroborate the need for the new codes. Without evidence, the AMA may decide to eliminate the code. With enough evidence, the code moves from the "emerging technology" list and into the main body of radiology's accepted CPTs. A delay in data collection directly results in a delay of Category I code creation for these procedures.

Appropriate and adequate documentation for these services is essential in supporting creation of permanent CPT codes and uniform reimbursement for these studies. Specialty societies such as the ACR and ACC bear the burden of proving to payers that physicians use CCT and CCTA as a substitute for other tests, not just as an additional exam to garner supplemental reimbursement.

Because many ongoing clinical trials are in progress for these procedures, and because sufficient scientific evidence to support the clinical effectiveness and cost effectiveness of this technology is not yet available, the CPT editorial panel is unable to support the creation of Category I codes for the 2008 CPT cycle. Therefore, Category I codes to describe CCT and CCTA services will not be available before January 1, 2009. The ACR and ACC continue to work to obtain the necessary data to move forward with the request for Category I codes.

Besides industry instigation for reporting the new codes, the CPT guidelines require the use of Category III emerging technology codes when they exist: "If a Category III code is available, this code must be reported instead of a Category I unlisted code."

Additional code use requirements

Associations are not the only ones requiring use of the Category III codes—the federal government also requires it. The Health Insurance Portability and Accountability Act of 1996 standardized the Transactions and Code Sets Rule in 2002. It requires all providers, plans, and payers (including carriers and intermediaries) to use the medical code set that is valid at the time the service is provided. The eight new codes for CCT and CCTA include coronary calcium evaluation (calcium scoring); CCTA (CT coronary angiography); and CT evaluation of cardiac structure, morphology, function, and vasculature.

Codes and definitions

0144T CT, heart, without contrast material, including image postprocessing and quantitative evaluation of coronary calcium

0145T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology

0146T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; CTA of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), *without* quantitative evaluation of coronary calcium

0147T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; CTA of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), *with* quantitative evaluation of coronary calcium

0148T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology and CTA of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), *without* quantitative evaluation of coronary calcium

0149T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac

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structure and morphology and CTA of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), *with* quantitative evaluation of coronary calcium

0150T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology in congenital heart disease

+0151T CT, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; function evaluation (left and right ventricular function, ejection fraction, and segmental wall motion)

Tips: Verify medical policy and conditions of coverage with your individual Medicare carrier. Also, consider collecting at the time of service or offering a discounted rate for patients whose insurance does not cover investigative or elective screening examinations.

Editor's note: This is an excerpt from the HCPro, Inc., book Cardiac Imaging, Strategies for Appropriate Documentation and Compliant Coding, *by Stacy M. Gregory, RCC, CPC. Gregory is an active member of various radiology coding discussion groups and has been featured in several nationally recognized coding publications. To purchase the book, go to* www.hcmarketplace.com *or call our customer service department at 800/650-6787.*

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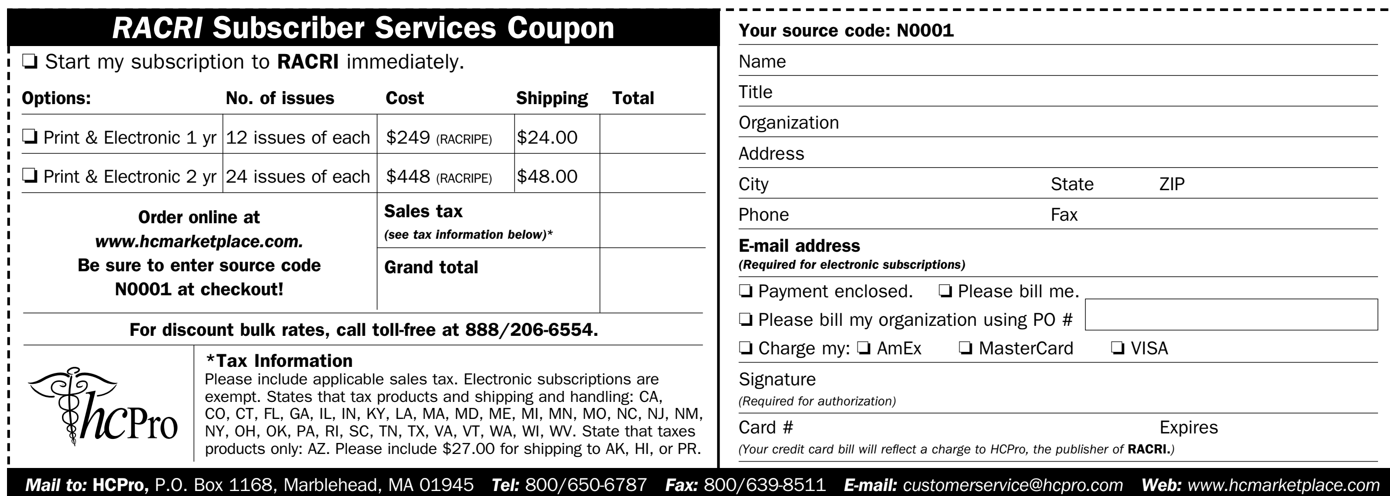
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