

# Radiology Administrator's

Compliance & Reimbursement Insider

## Settlement reveals lessons for radiologists

Fred Steinberg, MD, of University MRI in Palm Beach County, FL, will pay the federal government \$7 million to settle claims of healthcare fraud, according to an April release from the U.S. Attorney's Office for the Southern District of Florida.

"Based on my knowledge, this case clearly illustrates that the [Office of Inspector General (OIG)] and members of the U.S. Attorney's Office are serious about enforcing the enacted laws that are designed to prevent these types of practices," says **Larry W. Balmer, CCP**, compliance and HIPAA privacy and security officer at Radiology, Inc., in Mishawaka, IN. The settlement resolves charges that:

- University MRI did not perform portions of CT scans, even though the procedures were billed and reported to patients' physicians as if they were done.
- The center performed CT scans and ultrasound exams that were not ordered by physicians and were not medically necessary.

- The bills submitted by University MRI to Medicare suggested that thousands of CT scans were performed, both with and without contrast; in reality, the CT scans without contrast were not performed.
- The center paid financial inducements to physicians for patient referrals, which is prohibited under the Stark Law and the anti-kickback statute. These inducements took the form of medical directorship, clinical research, employment, and facility use and equipment lease agreements that exceeded fair market value or failed to comply with federal law.

**"This case should be a lesson to all radiologists: Participating in any kind of kickback scheme or other shady business arrangements with referring physicians may well draw the attention of the government."**

—Leonard Berlin, MD, FACR

Whistleblower action precipitated the claim.

## Beware the whistleblower

It's important to emphasize that this was a whistleblower case, says **Leonard Berlin, MD, FACR**, president of the Illinois Radiological Society and chair of the radiology department at Rush North Shore Medical Center in Skokie, IL.

A former employee who was suspicious of Steinberg's activities reported the behavior to the government. As a result of the settlement, the whistleblower will receive \$1.75 million as his share of the recovery, according to the release. Under the False Claims Act, private individuals can bring whistleblower actions for fraud on behalf of the United States and collect a share of any proceeds recovered by the suit.

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HCPPro

## Settlement

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"This case should be a lesson to all radiologists: Participating in any kind of kickback scheme or other shady business arrangements with referring physicians may well draw the attention of the government," says Berlin.

The cost of defending such charges is enormous. "Even if a radiologist is found not guilty at trial, he or she will have spent tens of thousands of dollars in attorneys' fees, not to mention the mental and physical stress," Berlin says.

This settlement demonstrates the need for imaging centers to develop and implement compliance plans and conduct audits for adherence to all government regulations, says **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**,

vice president of Southeast Radiology Management in Stuart, FL.

## Vigilance affects compliance

To encourage compliance, your facility should follow these five tips:

► **Educate referring physicians on medical necessity.** Imaging centers must ensure that they accurately document medical necessity for CT scans and other procedures. Pay strict attention to Medicare rules for ordering diagnostic tests. Don't perform a test without a documented order from a referring physician, says Buck.

Educating referring physicians about the rules is crucial. In an attempt to ease the ordering process for referring physicians, a facility might draft standard ordering forms. Beware of this method, Buck says, adding that you should make sure the "standardized requisitions are clear and not leading."

► **Ensure coding is correct.** Check the radiologist's documentation against the coding to make sure the code assigned reflects the work performed.

Many times, the heading on the radiologist's reports reflect the exam selected at order entry, says Buck.

"That is not always consistent with the work that is performed," Buck says. "Ultimately, [this] can lead to upcoding or downcoding. It is crucial that the work completed for each exam is clearly documented in the radiology report."

The American College of Radiology offers guidelines for radiology reports. If followed, all appropriate elements will be captured. "I firmly believe that qualified coders must be utilized to ensure accurate charge capture and coding," Buck says.

► **Act on employee complaints.** Reports from the Steinberg case indicate that the whistleblower tried to correct the potentially illegal activities and got fired for his efforts.

"This is an invitation to disaster," says Balmer. "It is vitally important for owners and managers of practices

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to realize that firing employees who bring up issues has dire consequences.”

Had Steinberg listened, investigated, corrected the problems, and disclosed the findings to CMS, he could have mitigated his penalties significantly, Balmer says. “I also find it amazing that practices will still resist investing in, and supporting, compliance programs that, when conducted properly, will help find and stop legal pitfalls before they become major headlines,” he says.

➤ **Create whistleblower policies.** Implement and enforce policies to protect employees from retribution, says Balmer. Non-retaliation policies are part of the OIG’s model compliance programs and demonstrate a clear commitment to compliance. (See our sample policy below.)

➤ **Audit operations annually.** Each practice must audit its entire operation, from the enterprise level down. Whether done under the auspices of an attorney or via

internal or external auditors, audits need to be very comprehensive.

They must recognize legal vulnerabilities so that problem areas can be investigated and corrected before they become situations subject to whistleblower lawsuits, says Balmer.

What’s the bottom line on the Steinberg case? All radiologists “must take great care” to practice strictly according to the law, says Berlin. ■

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### Non-retaliation policy: Create a compliant, whistleblower-free facility

*Editor’s note: Adapt the following sample policy from the Healthcare Compliance Professional’s Guide to Policies and Procedures to draft your own facility non-retaliation policy. For more compliance policy samples, visit [www.hcmarketplace.com/prod-6134.html](http://www.hcmarketplace.com/prod-6134.html).*

#### Background

It is noted that one of the requirements of the U.S. Sentencing Commission’s Guidelines for Organizations and the Office of Inspector General’s (OIG) Compliance Guidance is that an organization must provide evidence of a policy of non-retaliation/non-retribution for employees who report violations of law, regulations, policies, and the code of conduct.

#### Purpose

Positive employee relations and morale can be best achieved and maintained in a working environment that promotes ongoing open communication between supervisors and their employees. This includes open and candid discussions of employee problems and concerns.

#### Policy

We encourage employees to express their problems, concerns, and opinions on any issue, and it is our policy to provide a procedure through which employees can express problems, concerns, and opinions without fear of retaliation or reprisal.

All employees, including supervisors and managers, have an affirmative duty to promptly report actual or potential wrongdoing, including an actual or potential violation of law, regulation, policy, procedure, or the code of conduct. All levels of management will maintain an open-door policy for employees to report problems and concerns.

All reports will be acted upon in an appropriate manner. If the problem is not satisfactorily resolved, the employee may proceed up the supervisory chain to a higher level. The employee hotline is designed to permit any employee to call, anonymously or in confidence, to report problems and concerns or to seek clarification of compliance-related issues.

Employees who, in good faith, report a potential violation of law, regulation, policy, procedure, or the code of

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## Non-retaliation

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conduct will not be subjected to retaliation, retribution, or harassment.

No supervisor, manager, or employee is permitted to engage in retaliation, retribution, or any form of harassment

**Knowledge of misconduct, including actual or potential violations of law, regulation, policy, procedure, or the code of conduct must be immediately reported by employees.**

against an employee for reporting a compliance-related concern. Any supervisor, manager, or employee who conducts or condones retribution, retaliation, or ha-

arrassment in any way will be subject to discipline, up to and including discharge.

Employees cannot exempt themselves from the consequences of wrongdoing by reporting their own wrongdoing, although self-reporting may be taken into account in determining the appropriate course of action.

### Procedures

Knowledge of actual or potential wrongdoing, misconduct, or violations of the code of conduct must be immediately reported to management, the compliance office, or the employee hotline.

All managers and supervisors must take aggressive measures to assure their staff members that the organization truly encourages the reporting of problems and that employees will not get into trouble for doing so.

The following actions should be taken:

- Senior management should brief subordinate managers on this policy.
- Managers must receive and sign a copy of the policy statement on non-retribution/non-retaliation and participate in a brief discussion of the spirit, intent, and importance of this document.
- The non-retaliation policy must be posted on employee bulletin boards.
- Review with all lower-level managers the proper treatment of employees and the creation of a work environment that permits open communication.

- Require all lower-level managers to meet with their employees and complete the above actions.
- All managers and employees must understand that any incident in which retaliation or reprisal can be related to an employee raising and/or reporting a problem, either at the organization level or through the compliance program, will not be tolerated. Reports of this nature must be investigated thoroughly and expeditiously, with appropriate disciplinary actions taken, up to and including termination of employment.

### Employee responsibilities

Knowledge of misconduct, including actual or potential violations of law, regulation, policy, procedure, or the code of conduct must be immediately reported by employees to the appropriate person, including the:

- Immediate supervisor
- Department manager
- Human resources manager
- Senior administrative officer of the organization
- Compliance officer or employee hotline

Failure to report, or the concealment of knowledge of, a potential violation may result in administrative actions being taken, up to and including termination.

### References

The above policy was adapted from the "OIG Compliance Program Guidance for Hospitals," published by the OIG in a February 23, 1998, *Federal Register (FR)* notice, and from a January 31, 2005, Supplemental Compliance Guidance (see 70 *FR* 4858), available at the OIG Web site at <http://oig.hhs.gov/authorities/docs/cpghosp.pdf>.

### Questions? Comments? Ideas?

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## Computer-assisted coding may offer budget benefits

Radiology administrators need to pay constant attention to industry developments—including new imaging equipment and behind-the-scenes technology—to ensure that their organizations run efficiently, says **Andrei M. Costantino, MHA, CHC, CPC-H, CPC**, director of organizational integrity at Trinity Health in Farmington Hills, MI. To survive in the current environment of reimbursement cuts, facilities must make sure coders capture all the necessary information. This is particularly true for independent diagnostic testing facilities. Such attention to detail reduces compliance risks and improves opportunities for reimbursement, says **Andy Kapit**, CEO of CodeRyte in Bethesda, MD.

### Technology ensures efficiency

Technology can help ensure accurate coding. More importantly, perhaps, automated systems also work to capture large amounts of data. With this information in hand, radiology administrators can parse the data to analyze reimbursement patterns, coding mistakes, and dictation or physician documentation problems.

Computer-assisted coding (CAC), together with natural language processing (NLP), converts data in medical reports into information that computers can read to assign codes, analyze encounters, and look for procedure trends. You just won't get this kind of information on your own, says Constantino. Although trained coders are a vital part of the process, the added benefits of CAC systems include:

- **Enhanced compliance and efficiency.** CAC can help modernize compliance efforts by creating data that allow the examination of information flow and the elimination of missed opportunities or problems in the work flow, says Kapit.
- **Reduced denials and collection costs.** CAC acts as a data collection tool. Armed with data, you can better present your argument for reimbursement to different payers. By manipulating the data and tracking results, you can locate trouble spots, educate staff members, and reduce denials.

- **Analyzed physician narratives.** NLP provides a bridge between the current form of input (physicians' natural language) and the proposed structures needed to make electronic health records feasible, says Kapit. NLP helps identify vague physician references. By collecting this data, you can analyze trends and work to correct physician behavior.
- **Data to improve treatment, business decisions.** CAC also allows analysis of demographic, payer-mix, referral, and clinical data patterns for cross-facility comparison, says Kapit.

Keep in mind that CAC will require an initial investment, says Kapit. This may seem counterintuitive in these economically trying times. ■

### Insider sources

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### New HIPAA data released

In response to continuing interest in enforcement of the HIPAA Privacy Rule, the Office for Civil Rights (OCR) has added a new data section on its compliance and enforcement Web site at <http://hhs.gov/ocr/privacy/enforcement/data.html>.

The new site allows the public to access several aspects of the OCR's health information enforcement program, including:

- Charts showing state-specific case investigation results
- Calendar-year enforcement-results graphs and charts
- A calendar-year graph showing complaint receipts
- Yearly variation in the issues in cases resolved through corrective action

The OCR expects the charts and graphs to augment current information about the Privacy Rule, which sets important federal rights and requirements to protect the privacy of personal health information.

## Medicare preserves local coverage determination for CCTA

There's good news for patients with heart disease. CMS has decided not to restrict reimbursement for cardiac CT angiography (CCTA), instead leaving the decision about coverage in the hands of local fiscal intermediaries.

Specifically, CMS chose to make no change to section 220.1 of the *National Coverage Determination Manual*, "Computed Tomography" (Pub. 100-3, 220.1). CMS decided that no national coverage determination (NCD)

**Imaging performed on patients without chest pain would be considered screening and is not an available benefit in the Medicare program.**

on the use of CCTA for coronary artery disease is appropriate at this time, and that coverage should be determined by local

contractors through the local coverage determination process or case-by-case adjudication.

We'll tell you about the CCTA ruling, and, as an added bonus, offer some ways to prevent common coding errors on billing for cardiology procedures.

### Background on CCTA

CCTA is a noninvasive technology that produces detailed coronary-artery images, says **William Shea, MD**, vice president of 3D Imaging Services, NightHawk Radiology Holdings, Inc., in Coeur d'Alene, ID.

CMS says the increased use of CCTA stems from advances in the technology and rapid diffusion of the machines outside hospital settings. The initial single slice CT machines produced poor-quality images. In the late 1990s, four-slice CT machines were introduced, with 16-slice and 64-slice CT machines following shortly afterward. Image quality and performance reportedly increased with each model.

Although CMS noted that CCTA may reduce the need for invasive coronary angiography for certain patients, critics point to the lack of evidence on CCTA outcomes and the limitations of the technology, including uninterpretable/unassessable image segments.

This decision focuses only on the use of CCTA for the evaluation of coronary arteries in patients with chest pain, says Shea.

Imaging performed on patients without chest pain would be considered screening and is not an available benefit in the Medicare program, he explains.

CMS found, in summary, that there is uncertainty regarding any potential health benefits or patient management alterations from including CCTA in the diagnostic workup of patients who may have coronary artery disease. According to CMS:

*No adequately powered study has established that improved health outcomes can be causally attributed to coronary CTA for any well-defined clinical indication, and the body of evidence is of overall limited quality and limited applicability to Medicare patients with typical comorbidities in community practice.*

CMS said that although comments did not dispel the uncertainty of the test's clinical utility, they strongly favored maintaining the local coverage policies for CCTA.

Illustration by  
David Harbaugh



*"Coding is bringing back the giant spreadsheet of standard rejection codes you posted in their office. They suggest you read them."*

## Industry expresses general relief at ruling

"I am happy that CMS took the time to evaluate the literature and listen to the American College of Radiology, as well as other groups and political bodies," says Shea. "CCTA is a proven diagnostic tool that can spot disease more quickly, more reliably and, ultimately, at less cost."

Others are more reticent. "It's difficult to make a sweeping statement on the ruling," says **Larry W. Balmer, CCP**, compliance and HIPAA privacy and security officer at

Radiology, Inc., in Mishawaka, IN. "Nothing has essentially changed, and coverage is dependent on each carrier." It's possible that a uniform NCD can offer more clarity, he notes. Shea agrees that an NCD could provide greater clarity, but only if it were more inclusive.

Until now, physicians were reluctant to use the exam due to reimbursement concerns, Shea says. He predicts the CMS coverage ruling will give the industry greater confidence in the procedure and spur more hospitals to

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## Avoid five common billing mistakes in noninvasive cardiology procedures

The following are some common mistakes in billing for cardiology procedures, according to billing expert **Jackie Miller, RHIA, CPC**, senior consultant at Coding Strategies, Inc., in Powder Springs, GA.

### ➤ **Reporting more than one myocardial perfusion scan.**

Myocardial perfusion imaging (MPI) frequently involves performance of two or more scans. Some protocols involve scanning on two days. Regardless of the number of scans or the number of days, only one MPI code should be reported. MPI studies that include multiple scans should be reported with code 78461 for planar studies or 78465 for SPECT studies. Additional codes can be reported for wall motion (78478) and ejection fraction (78480), if performed and documented. Remember, if you are billing for a SPECT MPI, the report should indicate that SPECT imaging was performed.

### ➤ **Incorrectly reporting CCTA for heart structure.**

Codes 0145T, 0148T, and 0149T include the study of heart structure and morphology. These are detailed exams of cardiac anatomy that are typically performed in preparation for catheter ablation (e.g., pulmonary vein isolation) or insertion of a biventricular pacemaker or implantable cardioverter-defibrillator. A heart structure exam code should not be reported when the physician documents a brief description of gross cardiac anatomy as part of a CTA study of the coronary arteries. In that situation, only the coronary artery study should be reported. Coronary CTA without heart structure exam is reported with 0146T or 0147T.

### ➤ **Missed CCTA heart function studies.**

When heart function evaluation is performed as part of the CCTA

exam, add-on code 0151T can be reported with the CCTA exam code. The definition of 0151T mentions left and right ventricular function, ejection fraction, and segmental wall motion. However, these are simply examples of the type of information that might be obtained from a function study. It is not necessary to document all of these elements to report 0151T.

### ➤ **Billing for Doppler echocardiograms without supporting documentation.**

Most echocardiograms include Doppler wave form (93320–93321) and color flow (93325) studies. However, these add-on codes cannot be reported unless the Doppler exams were performed and documented. The physician's interpretive report should ideally include separate paragraphs for wave form and color flow findings. And the Doppler codes should never be assigned automatically. Some facilities have their billing software set up to generate Doppler codes every time an echocardiogram charge is entered. This is a risky practice, as the facility may submit charges for studies that were not performed.

### ➤ **Reporting a noninvasive physiologic study code for ankle-brachial index (ABI) only.**

The CPT definition of code 93922 mentions the ABI. However, most Medicare contractors feel that performance of the ABI is part of the treating physician's evaluation and management service and does not warrant reporting code 93922 unless it is part of a battery of noninvasive physiologic tests. Be sure to check your payers' published policies before reporting 93922 for an ABI done as a stand-alone test.

**Medicare**

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begin providing CCTA procedures. He also predicts the results will reduce the need for patient hospitalization, and, in turn, reduce healthcare costs.

As a substitute for invasive cardiac catheterization, CCTA would cost about \$800, compared with \$4,000 or more, Shea adds.

The proposed national policy, released in December 2007, would have limited reimbursement for CCTA to "symptomatic patients with chronic angina at intermediate risk of coronary artery disease and symptomatic patients with unstable angina at low risk of short-term death or intermediate risk of [coronary artery disease]." An NCD would have set aside local policies to authorize payment for the procedure in all 50 states.

If the proposed NCD had been approved, only procedures performed in CMS-approved clinical trials would have been reimbursed by Medicare. Such a ruling would have denied CCTA reimbursement to most of the estimated 2,000 facilities equipped with multislice scanners until the end of the trials. With Medicare leading the way, private insurers could also be expected to reduce or halt CCTA reimbursement.

**Additional changes possible**

Despite the lack of an NCD, CMS encouraged future research on the benefits of CCTA. Reconsideration of CCTA

reimbursement depends on peer-reviewed publication and critical evaluation of convincing new evidence, CMS noted.

Essentially, CMS has thrown the ball back into the industry's court for further research and studies, says Shea.

CMS also stated that current guidelines do not provide sufficient guidance

to patients and providers as to the appropriate inclusion of CCTA into the diagnostic milieu in the workup of chest pain. CMS expressed concern that providers are using CCTA as an additional test added to cardiac stress testing and nuclear imaging, rather than thoughtfully considering the appropriate mix of these tests. Some professionals agree. ■

**Essentially, CMS has thrown the ball back into the industry's court for further research and studies, says William Shea, MD.**

**Insider sources**

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