

# Radiology Administrator's

## Compliance & Reimbursement Insider

### IDTFs get Claims Processing Manual chapter of their own

Previously, the *Medicare Claims Processing Manual* contained no specific instructions regarding claims processing for IDTFs. To remedy this, CMS directed that information from the *Program Integrity Manual*, Chapter 10, regarding IDTF claims processing, be excerpted and added to the *Medicare Claims Processing Manual*. The changes became effective June 16.

However, the new IDTF chapter does not necessarily mean your claims processing process will need to change, says **William A. Sarraile, Esq.**, a partner at Sidley Austin, LLP, in Washington, DC. Let's examine the claims processing requirements now contained in Chapter 35 of the *Medicare Claims Processing Manual*, as outlined by CMS.

#### General coverage and payment policies applicable to IDTFs

Effective for diagnostic procedures performed on or after March 15, 1999, carriers will pay for diagnostic

procedures under the Medicare Physician Fee Schedule only when performed by a physician, a group practice of physicians, an approved supplier of portable x-ray services, a nurse practitioner, or a clinical nurse specialist in an IDTF.

#### Medicare's definition of an IDTF

An IDTF is a facility that is independent of a hospital and an attending or consulting physician's office, according to CMS. However, IDTF general coverage and payment policy rules apply when an IDTF furnishes diagnostic procedures in a physician's office.

#### Billing issues

CMS states that nothing in Chapter 35 should be construed or interpreted to authorize billing by an IDTF, physician, physician group practice, or any other entity that would otherwise violate the physician self-referral prohibition set forth in the Stark Law.

The supervisory physician for the IDTF, regardless of whether it's a mobile unit, may not order tests to be performed by the IDTF unless the supervisory physician is the patient's treating physician and is not otherwise prohibited from referring to the IDTF, CMS states.

CMS defines the supervisory physician—the person who treats the patient for a specific medical problem and uses the imaging test results in its management—as the patient's treating physician.

If an IDTF wants to bill for an interpretation performed by an independent practitioner off the premises

**If an IDTF wants to bill for an interpretation performed by an independent practitioner off the premises of the IDTF, the IDTF must meet separate legal conditions concerning purchased interpretations.**

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HCP Pro

## IDTFs

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of the IDTF, the IDTF must meet separate legal conditions concerning purchased interpretations.

## Transtelephonic and electronic monitoring services

Transtelephonic and electronic monitoring (e.g., 24-hour ambulatory EKG, pacemaker, and cardiac event detection) technicians may perform some of their services without seeing the patient.

These monitoring service entities should be classified as IDTFs and must meet all IDTF requirements. However, CMS currently does not have specific certification standards for their technicians. Technician credentialing

requirements remain at carrier discretion, but technicians must work under a supervisory physician.

Final enrollment of a transtelephonic or electronic monitoring service as an IDTF requires a site visit.

For facilities that perform specific procedures, the carrier must make a written determination that the entity has a person available on a 24-hour basis to answer telephone inquiries. Use of an answering service in lieu of the actual person is not acceptable, CMS states.

The person performing the attended monitoring should be listed in Section 3 of Attachment 2 of form CMS-855B. The person's qualifications are at the carrier's discretion. The carrier must check that the person is available by attempting to contact the applicant during nonstandard business hours.

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## Slide preparation facilities and radiation therapy centers

Slide preparation facilities and radiation therapy centers are not IDTFs, CMS states. Slide preparation facilities are entities that provide slide preparation services and other kinds of services payable through the technical component of the surgical pathology service.

Radiation therapy centers do not provide the professional component of surgical pathology services or other kinds of laboratory tests. The services radiation therapy centers provide are recognized by carriers for payment as codes in the surgical pathology code range 88300–88399, with a technical component value under the MPFS.

The services provided by these entities are usually ordered and reviewed by a dermatologist. Slide preparation

### Questions? Comments? Ideas?

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facilities generally only have one or two people performing this service.

All enrolled slide preparation facilities must enroll separately with their Medicare contractor. Radiation therapy centers provide therapeutic services and, therefore, are not IDTFs.

Radiation therapy centers must enroll separately with their Medicare contractor.

### Ordering tests

All procedures performed by the IDTF must be ordered in writing by the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in its management of the beneficiary's specific medical problem. The order must specify the diagnosis or other basis for the testing.

The supervising physician for the IDTF may not order tests to be performed by the IDTF unless the IDTF's supervising physician is the beneficiary's treating physician, CMS states.

That is, the physician in question had a relationship with the beneficiary prior to the performance of the testing and is treating the beneficiary for a specific medical problem. The IDTF may not add any procedures based on

internal protocols without a written order from the treating physician.

### Purchased diagnostic tests

A person or supplier who provides diagnostic tests may submit the claim and receive the Part B payment for diagnostic test interpretations purchased from an independent physician or medical group if:

- The tests are initiated by a physician or medical group that is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations.
- The physician or medical group providing the interpretations does not see the patient.
- The purchaser, employee, partner, or owner of the purchaser, performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. Formal reassignment is not needed.
- The purchaser files the name, the provider identification number, and address of the interpreting physician.
- The assignment is accepted. ■

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#### Insider source

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## SGR debate rages as deadline looms

The U.S. House of Representatives passed the Medicare Improvements for Patients and Providers Act June 24 by a promising vote of 355 to 59, says **Orrin Marcella**, assistant director of congressional affairs at the American College of Radiology in Reston, VA.

The battle is now waging in the Senate, Marcella says. The Senate finance committee has been working on a compromise measure, according to the ACR. If passed by the Senate, the measure would replace Medicare's sustainable growth rate (SGR) formula for physician services.

The 10.6% cut, as well as a 5% cut, occurred January 1, with a 0.5% positive update for the rest of this year and a 1.1% update through 2009, says Marcella.

"We remain optimistic that we can garner a compromise to minimize the impact of the SGR," says Marcella.

The legislation calls for providers of advanced diagnostic imaging services (i.e., MR, CT, PET, and nuclear medicine) to be accredited in order to receive payment for the technical component of those services and establishes a two-year voluntary demonstration program to test the use of physician-developed appropriateness criteria. ■

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## Eight tips to improve MRI throughput

As reimbursements shrink and radiology becomes more competitive, smart radiology practice administrators should determine how to best serve as many patients as possible without sacrificing the quality of patient care, says **Mary Ellen Tobey, RT (R)(M)**, client services manager at North Shore Magnetic Imaging Center (NSMIC) in Peabody, MA. To increase MRI throughput, you need to review all aspects of your practice in detail. Just adding one MRI exam to your center's schedule every day can make a big difference, says **David A. Dierolf**, director of performance improvement at Outpatient Imaging Affiliates, LLC, in Nashville. As a modality, an MRI generates significant income, and it's worth it for your facility to take a hard look at throughput, he adds. (See p. 5 for a model staff memo you can use to flag safety issues and avoid scheduling an MRI that a patient can't have for safety or medical necessity reasons.) The following are eight tips to improve your MRI throughput:

**1. Analyze productivity.** Look at the care patients receive from the time they walk in the door until the time they leave, says Tobey. Gather information and examine any and all appropriate data regarding staff production. Don't guess, she says.

NSMIC uses a radiology information system to make gathering data easier. Most administrative tasks are automated and computerized, and patient information is readily available on the system, Tobey says. By analyzing patient information, the facility can track any organizational inefficiencies, she says. With a paperless system, keeping track of patient records is more

**"Make sure you have all patients' information, including the referral, demographic information, risk factors, and insurance approval, before they come in the door."**

—David A. Dierolf

efficient, and it is easy to analyze and immediately determine who worked with which patient if a problem arises.

In addition, Tobey recommends investing in an automatic call distributor (ACD) to disperse incoming patient calls to staff members so they can schedule appointments efficiently. The ACD can track how many patient calls go unanswered and help you to identify the time when your facility receives the greatest number of patient calls. Also, in a growing practice, the ACD will allow you to analyze data to determine what your hiring needs are.

**2. Gather information before appointments.** Make sure you have all patients' information, including the referral, demographic information, risk factors, and insurance approval, before they come in the door, says Dierolf. If possible, get this information via e-mail, and make sure it protects patient confidentiality, says Tobey.

**3. Optimize length of appointment.** Ensure that your staff members set the right amount of time needed for MRI appointments, says Dierolf. If you set too little time, patients feel rushed, and your office gets backlogged. But setting too much time could cause you to lose potential patients and possible reimbursement dollars. Because every practice is different, analyze the optimum operation times for MRIs at your facility.

**4. Confirm appointments in advance.** Remind patients of their appointments two days in advance. This

Illustration by  
David Harbaugh



way, if you have a cancellation, you have enough room to book another appointment in that time slot.

**5. Flag safety risks prior to appointment.** Make sure staff members note any potential MRI safety risks before patients enter the facility for their MRIs. Implanted items such as pacemakers or other devices that people may have make it unsafe for them to have MRIs, says Tobey. You also do not want to waste the patients' time. And, in the tightening reimbursement environment, every MRI appointment slot is precious, says Dierolf. Your staff members must know the right questions to ask patients before their appointments. (To help you do this, refer to "Model memo for MRI patient safety" below.)

**6. Fill in cancellations.** Make the most of your center's time by filling up the schedule as much as you can, says Dierolf. Although you can't avoid some last-minute cancellations, if a patient cancels in advance, you may want to call patients scheduled later in the week and ask whether they want to come in earlier, he says.

**7. Ensure that trained staff members meet with patients before they enter the MRI.** Schedule sufficient one-on-one time with patients, says Tobey. You

need to review the patients' medical and clinical history and again ensure that there are no risk factors.

Remind patients to remove all metal items before undergoing an MRI. Currently, body piercings have been a big issue, says Tobey. Remind patients to remove their piercings and other metal items, such as hair clips, before their appointments.

**8. Extend operating hours.** Consider adding some evening or weekend hours to your facility, Dierolf says. The extra costs associated with this will be offset by the extra MRI profits, he says. It also creates an added convenience for patients who cannot take time off from work.

**Tip:** Hiring an extra staff person to increase efficiency will most likely be worth the money for your practice. The income generated by the extra MRI appointments, even if you only add one MRI per day, will more than pay for the additional staff member's salary, says Dierolf. ■

#### Insider sources

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### Model memo for MRI patient safety



The following is a model memo to staff members outlining the necessary information to help them improve MRI throughput. Speak with your hospital's attorney about using this sample memo in your facility.

To: Staff members

From: Radiology administrator

Date: \_\_\_\_\_

Re: Getting patient information in advance

1. Please call patients to confirm their appointments 48 hours in advance.
2. Ensure that the following information is in the patient's file: Correct address, allergies, referral, and health information (see #4).

3. If patients are having a contrast scan, remind them not to eat the morning before.
4. If a patient is having an MRI, ask the patient whether he or she has any of the following and check any applicable items:
  - Cardiac pacemaker
  - Aneurysm clip in brain (or surgery for cerebral aneurysm)
  - Neurostimulator
  - Dental magnet
  - Coronary artery stent
  - Implanted heart defibrillator
  - Implanted pacing leads or wires
  - Bullets, shrapnel, or bullet fragments
  - Cochlear implant
  - Cataract lens implant
  - Insulin pump

## Adopt stale order policy to protect your practice

When patients appear for a test with a stale order (i.e., an order written some time ago) your practice or facility has a dilemma. You may be at risk of performing a medically unnecessary procedure.

Although there are no hard and fast rules about how long a physician order is valid, it's a good idea to have a policy within your practice or facility that governs how long you'll honor physician orders, says **Jay Silverman**, an attorney at Ruskin Moscou Faltischek, PC, in Uniondale, NY.

In today's litigious environment, with rapidly evolving technology for different stages of treatment, it's more important than ever to ensure that you have a stale order policy. We'll explain why you should consider adopting such a policy and give you a sample policy you can adapt to your facility on p. 7.

### Malpractice risks

Honoring stale orders may jeopardize patient health if they are no longer appropriate and expose you to malpractice lawsuits, says Silverman. That's because patients who delay making an appointment for a needed test are also delaying treatment, with potentially dire consequences.

If patients have a negative outcome because of a delay in receiving a test and decide to sue, their attorney is likely to name everyone involved in their diagnosis

and treatment in the lawsuit, even if the patients contributed to the negative test results. These potential consequences for radiology practices are especially severe when the elapsed time would have made a difference in the test the treating physician ordered, says Silverman.

Refusing to honor stale orders at least ensures that the correct test will be done and establishes that the patient was derelict in scheduling the original test, he explains.

### Referral relationship problems


By accepting stale orders, you could inadvertently harm your relationship with your referral sources, says Silverman. For example, a treating physician ordered a screening mammogram. But the patient waits a couple of months before making an appointment.

When the treating physician finally gets the radiologist's report, he or she may blame your facility for the long wait.

So through no fault of your own, your reputation may be damaged and you may lose referral business. Further, a referring physician might want to order a different test if too much time has passed, Silverman says.

### Payment difficulties

You may have trouble getting reimbursed for your services if you accept old orders, Silverman notes.

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Depending on the type of test, the reason the treating physician ordered it, and the amount of time elapsed, the original test may no longer be medically necessary or appropriate.

If a payer decides the test wasn't medically necessary at the time you performed it, it might not pay you for the test.

Worse still, if your patient population is primarily Medicare or Medicaid beneficiaries, filing claims for medically unnecessary procedures could put your facility at risk for False Claims Act violations.

### Stale order sample policy

*Editor's note: Use this policy to handle stale orders. It establishes rules for staff members to follow when a patient presents an order from a referring physician that was written some time ago. Because there are no set rules about timelines of physician orders, you'll need to do some research to determine how to set your practice's cutoff point. Your malpractice insurer and major payers may be able to offer you some guidance about how long to honor physician orders, so you should check with them before developing your policy.*

#### Policy for handling stale orders

1. Only valid orders will be honored. XYX Radiology performs tests only on the valid order of a referring physician. An order for a test will be considered too old, and therefore, invalid if:
  - a. A diagnostic test was written more than [insert time period] prior to the patient's presentation in our office
  - b. A screening test was written more than [insert time period] prior to the patient's presentation in our office
2. Confirm stale orders. If a patient presents in our office with an order that is too old, and therefore, invalid, [insert name and title of the designated person] will immediately contact the referring physician by telephone to confirm the order.
3. Document the stale order. [Insert name and title of the designated person] will note that invalid order in the patient's chart and attempt to contact the referring physician.
4. Cancel the test if you are unable to confirm the order. If [insert name and title of the designated person] cannot reach the referring physician, the test must be cancelled, and the patient informed that the cancellation was due to the excessive age of the order. [insert name and title of the designated person] must instruct the patient to obtain another order before rescheduling the test and counsel the patient on the importance of scheduling the appointment promptly. [Insert name and title of the designated person] should prepare a letter with the radiologist's signature to the referring physician explaining the reason for the cancellation.

### Stale order delineations

Because there are no expiration dates on physician orders, it can be tough to determine when an order is stale at your facility. Before you draft a policy for your practice, decide when an order becomes stale. The lifespan of an order may differ based on several factors, such as whether the test is a screening test or a diagnostic test (in general, an order for a screening test may be considered valid longer), the average wait time for an appointment in your locality, and whether the screening is routine or complex. ■

#### Insider source

Jay Silverman, Esq., Ruskin Moscou Faltischek, PC; Uniondale, NY.

## Effect of Deficit Reduction Act on imaging persists

Imaging facilities have felt the effect of the Deficit Reduction Act of 2005 (DRA) since its implementation in 2007, says **Orrin Marcella**, assistant director of congressional affairs at the American College of Radiology (ACR) in Reston, VA.

The DRA capped the technical component reimbursement for physician office imaging to the lesser of the Hospital Outpatient Prospective Payment System or the Medicare Physician Fee Schedule payment.

The legislation cut reimbursement by up to 50% for many technologies, such as CT angiography (CTA) and brain or spine MRI.

### Financial frustration

The Moran Company stated that 87% of procedures subject to DRA imaging cuts (for which current data exists) would be reimbursed at a rate below what it costs physicians to provide the exam in an office setting in its February 2007 report, *Assessing the Deficit Reduction Act Limits on Imaging Reimbursement: Cross-Site Comparisons of Cost and Reimbursement, Pre and Post DRA*.

For some procedures, the Moran report found that Medicare would reimburse providers less than 20% of the cost of providing the service. Imaging reimbursement cuts included in the DRA total 16%–18% less than in the hospital outpatient department, according to the report.

### Patient care concerns

Most significantly, many believe the DRA is having an effect on patient care and access, Marcella says.

The ACR has begun researching the effect of the DRA on practices around the country, he says, including:

➤ **Closing or consolidation of smaller practices.**

The greatest effect has been on the smallest imaging practices and centers, as such businesses operate on tight budgets, Marcella says.

➤ **Less equipment purchasing.** There has been a dramatic effect on equipment purchasing. Many offices

continue to use aging equipment rather than investing in state-of-the-art technology.

➤ **Possible appointments delays.** Medicare patients who must seek care in hospital outpatient departments due to reduced availability of freestanding imaging centers are especially prone to appointment delays.

➤ **Reduced rural access.** Many Medicare patients in rural areas are being forced to drive long distances for imaging services, which deter them from keeping appointments and receiving appropriate care.

### Industry efforts

Organizations such as the ACR have proposed legislation in the Senate (S.1338) and House (H.R.1293) to impose a two-year moratorium on the DRA. But “honestly, we have no indication that Congress is willing to pass this,” Marcella says, since it would cost \$1.3 billion per year. The essence of the fight lies in preventing further cuts, he says.

In order to educate Congress and other governmental bodies on the detrimental effects of these cuts, the ACR has joined a broad coalition of patient advocacy groups, medical manufacturers, and providers to form the Access to Medical Imaging Coalition (AMIC).

AMIC represents more than 75,000 physicians, providers, and patients, as well as medical imaging manufacturers who employ tens of thousands of workers, Marcella says.

### Contact your representative

It's important for imaging professionals to contact their representatives to combat more cuts. The personal stories of aging equipment, layoffs, and long waits for patients are more compelling than theoretical arguments. These stories have the most effect, Marcella says. ■

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