

Radiology Administrator's

Compliance & Reimbursement Insider

Self-disclosure protocol clarified

If you suspect billing mistakes in your radiology department, contact your facility's compliance officer. The nuanced logistics of reporting such mistakes require a coordinated response despite guidelines released in April by U.S. Department of Health and Human Services Inspector General Daniel R. Levinson. In the April 15 "Open Letter to Health Care Providers," Levinson instituted changes and clarifications to the provider self-disclosure protocol (SDP). The clarifications are intended to increase efficiency and to benefit providers who self-disclose.

The Office of Inspector General (OIG) released the first SDP in 1998. Since then, it has encouraged the healthcare provider community to voluntarily disclose self-discovered evidence of potential fraud. The clarifications represent great news for radiology practices, says **Michael F. Schaff, Esq.**, a healthcare attorney at Wilentz, Goldman & Spitzer, PA, in Woodbridge, NJ. "But we'll have to keep a careful eye on things," Schaff adds.

Among other changes, many radiology providers who self-disclose may no longer be required to enter into corporate integrity agreements. The following is a look at the highlights.

SDP requests must contain four elements

To improve the disclosure process, the open letter states that the initial submission must contain the following information:

- A complete description of the conduct being disclosed
- A description of the provider's internal investigation or a commitment regarding when it will be completed
- An estimate of the damages to the federal healthcare programs and the method used to calculate that figure or a commitment regarding when the provider will complete such estimate
- A statement of the laws potentially violated by the conduct

To view the "Open Letter to Health Care Providers," visit <http://oig.hhs.gov/fraud/docs/openletters/OpenLetter4-15-08.pdf>.

This information must be included in addition to the basic information described in the SDP. The provider must be in a position to complete the investigation and damages assessment within three months after acceptance into the SDP. Remember, it's a good idea to talk to your attorney before beginning the SDP process, Schaff says.

OIG promises quicker resolution

In addition, the open letter states that the OIG streamlined its internal process for resolving these cases. In turn, the OIG expects full cooperation from disclosing providers during the verification of the disclosed matter. The OIG will remove providers from participation

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Notify physicians when you deny a patient's old order. Use this sample letter to inform them of your policy and specific stale-order incidents.

HCP Pro

Self-disclosure

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in the SDP unless they disclose in good faith and respond to the OIG's requests for additional information in a timely manner.

Providers' good faith is essential

The open letter notes that the efficiency of the SDP also depends on providers' good faith determination that the matter implicates potential fraud, rather than a mere billing mistake.

The SDP intends to facilitate resolution of matters that potentially violate federal criminal law, civil law, or administrative laws for which exclusion or civil monetary penalties are authorized. Thus, you should submit billing

errors or overpayments directly to the appropriate claims-processing entity, such as the Medicare contractor, not through the SDP process.

Effective compliance program measured

To determine that a provider adopted effective compliance measures, the OIG checks to see that providers:

- Offer a complete and informative disclosure
- Respond quickly to the OIG's requests for further information
- Perform an accurate audit

When it negotiates the resolution of the OIG's applicable administrative monetary and permissive exclusion authorities in exchange for an appropriate monetary payment, the OIG generally will not require the provider to enter into a corporate integrity agreement or certification of compliance agreement.

The OIG believes not requiring a compliance agreement can recognize the provider's attempt to renew its commitment to integrity. The new SDP, the OIG says, also advances its goal of expediting the resolution of self-disclosures. ■

Insider source

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Common elements found in CIAs

The OIG offers providers the option of settling civil healthcare fraud and abuses cases through a corporate integrity agreement (CIA). The agreement, arranged between the government and the provider, allows the provider to avoid exclusion from federally funded healthcare programs.

Such exclusion is typically dubbed the proverbial death sentence for healthcare providers.

Instead, the provider has the opportunity to continue to treat Medicare patients, as long as it complies with a contract with the OIG requiring it to conduct its business according to certain principle. That contract is the CIA. CIAs are like compliance programs with a few important differences. The most important difference is that a compliance program is voluntary and you develop it yourself, considering the needs and resources of your practice.

Mandatory program pieces

A CIA is anything but voluntary, and the government's attorneys, with input from you, will decide how it should be structured and how much of your resources you should devote to it. Although there's room for limited negotiation on a case-by-case basis, all CIAs require the following common elements:

- **Training.** CIAs are specific about the type and amount of training your employees must have. Recognize that the amount of training the OIG thinks your employees need might be more than you think they need or want to pay for.
- **Auditing.** CIAs always provide for stringent auditing, usually conducted periodically by an independent review organization, such as an accounting firm that you must pay for. But if your practice already has good in-house auditing capabilities, it doesn't hurt to ask whether you may conduct the audits yourself, rather than use an independent review organization.
- **Monitoring.** The OIG might also require that an independent review organization monitor your practice

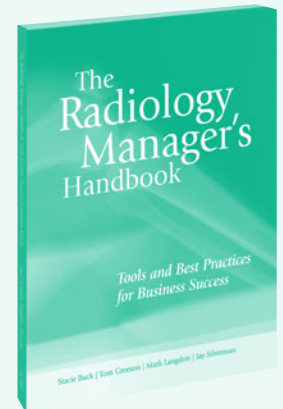
to ensure that you have systems operating properly to prevent a recurrence of a compliance violation. (It might be the same company that's providing the auditing services, or it might be another one—it depends on what the OIG thinks the problem areas are.) Just like the auditors, these monitors will be a frequent presence. And they're required to report to the OIG if they notice any problems in your practice. Additionally, the OIG can penalize you if it decides that the independent review organization isn't doing its job properly.

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Tools for success

The Radiology Manager's Handbook is a complete guide to tackling today's toughest challenges. We've talked to industry experts as well as leaders in medical groups and imaging centers, pooling their best strategic advice on:

- HIPAA compliance and training
- Billing and coding
- Managed care plans
- Employee issues, from hiring to firing
- Hospital/facility relationships and agreements



Radiology compliance has become increasingly complicated. The Office of Inspector General is cracking down on radiology claims, and many facilities are at risk of violation. Outpatient services are also under the microscope as more and more patients turn to emergency departments for imaging services.

For information about how to purchase a copy of the *Radiology Manager's Handbook*, visit www.hcmarketplace.com/prod-186.html or call our customer service department at 800/650-6787.

CIA's

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- **Reporting.** CIAs always include strict reporting requirements. Not only will your independent review organization have to report your activities, but you'll have to prepare reports as well, including:
 - Identifying your compliance officer and establishing that he or she is a high-level employee
 - Certifying that all required employee training has been completed
 - Certifying that you're complying with applicable laws, rules, and regulations

Depending on how you received your violation, your CIA may include other, sometimes substantial, reporting requirements, such as penalty fines ranging from \$1,500 to \$2,500 per day for a violation of the agreement and exclusion from Medicare.

CIA draft advice

Ideally, you'll never have to negotiate a CIA. Practicing under one is a burden, and things will never be the same.

However, if you're in trouble with the government, a CIA might be better than exclusion—at least you'll stay in business and continue to treat your Medicare patients.

Keep the following in mind if you're ever in that unfortunate situation:

- **Get good advice.** You can't do it alone. Hire the best healthcare attorney to advise you on the financial and practical implications of this agreement, and ask him or her to hire an auditor to negotiate the auditing provisions of the agreement.
- **Take a cooperative attitude.** The OIG views its CIAs as educational tools, not punishment. If the OIG believes you want to improve your operations and are willing to learn from the process, it is more likely to listen to your concerns. That means you might be in a better position to protest if the OIG wants to impose requirements that won't work for you on an operational level or don't address the previous issues.
- **Keep expectations reasonable.** Accept that operating under a CIA is going to cramp your style in some ways. Rather than protesting everything in the agreement, think about where the heaviest administrative burdens are likely to fall and try to negotiate for less onerous conditions in those areas. Also, keep in mind that the CIA teaches you how to conduct your business in a compliant manner. The OIG is more likely to listen to suggestions that foster practical knowledge and compliance after the agreement ends. ■

Editor's note: Content is adapted from the Radiology Manager's Handbook: Tools and Best Practices for Business Success, published by HCPro, Inc.

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Proposed 2009 HOPPS increases bundling for imaging

Radiology administrators have until September 2 to submit comments regarding proposed changes to the hospital outpatient prospective payment system (HOPPS) and ambulatory surgical centers for 2009. The proposal includes several shifts toward bundling payments of specific imaging services, including:

- Guidance services
- Image-processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast agents
- Observation services
- Radiation oncology imaging guidance

Packaging and bundling these services into a single payment, CMS states, creates incentives for providers to furnish services in the most efficient way, says **Sneha Soni**, economics and public policy analyst at the American College of Radiology (ACR) in Reston, VA.

HOPPS also includes a proposal to establish five imaging composite ambulatory payment classifications (APC) based on the families of codes used for the multiple imaging procedure payment reduction policy under the Medicare Physician Fee Schedule, Soni says.

These composite APCs would provide one APC payment when two or more imaging procedures using the same imaging modality are provided in one session.

CMS says this change encourages imaging efficiencies under the HOPPS, Soni notes.

Basically, the HOPPS proposed rule recommends one payment for certain multiple imaging services when provided in one session, including:

- Ultrasound
- MRI and magnetic resonance angiography (MRA) without contrast
- MRI and MRA with contrast
- CT and CTA without contrast
- CT and CTA with contrast

The new rules enable maximum flexibility to manage resources, CMS states. Hospitals will continue to bill the same way; the bundling of payments occurs on the CMS side. However, not everyone shares CMS' optimism.

"This is not good," says **Glenn Krauss, RHIA, CCS, CCS-P, CPUR**, an independent consultant in Milton, WI. CMS pays for two modalities in multiple imaging services, discounting the payment on one of the services, Krauss explains. Under the proposal, CMS will only pay for one service. "[CMS] is telling us to be more efficient and think twice about ordering. What they're doing is practicing medicine," he says.

CMS proposed these changes to eliminate unnecessary tests, but "what happens if [a test] is necessary?" Krauss says.

Conversion factor

In addition to these proposals, radiology groups should be aware that the conversion factor for 2009 is proposed at \$65.684, up from the current rate of \$63.694, Soni says. However, hospitals that fail to meet the requirements of the Hospital Outpatient Quality Data Reporting for the full 2009 payment would result in the proposed reduced conversion factor of \$64.409.

The ACR is currently reviewing the proposed changes to the 2009 Medicare Physician Fee Schedule, Soni says. ■

Insider sources

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Notify physicians of stale-order policies

Editor's note: This is the second of a two-part series on how to handle stale test orders. See the August RACRI for part one, or visit www.hcpro.com/pub-2977.html.

When patients arrive at the radiology department for a test with a stale order (i.e., an order written some time ago), your practice or facility needs to decide whether it will honor the order. A stale-order policy governs how long to honor physician orders and how to notify patients, says **Jackie Miller, RHIA, CPC**, senior consultant at Coding Metrix, Inc., in Powder Springs, GA. The risks of performing a test on a stale order can outweigh the benefits, and it's important to have a policy in place, says **Jay Silverman, Esq.**, a healthcare attorney at Ruskin Moscou Faltischek in Uniondale, NY. To inform a referring physician when a stale order has been encountered, use the following tips and adapt the model letter below.

Notify the patient

If a patient presents with a stale order and you cannot reach the referring physician, first explain the facility policy and concerns to the patient. Remind the patient of the health risks associated with performing inappropriate tests

and the importance of medical necessity. Tell him or her that the test cannot be performed without an up-to-date order from the referring physician. Remind the patient about the importance of scheduling the test promptly after it's ordered. Then cancel the patient's test and ask the patient to get another order before rescheduling.

Inform referring physician

If you cannot reach the physician immediately, send a letter to explain to referral sources why you couldn't perform the test and inform the physician that his or her patient's tests were delayed. This way, the referring physician will know that this patient requires more focused follow-up. Like our model letter, your letter should explain your stale-order policy and alert the referring physician's practice that it has a patient who delayed seeking the ordered tests, says Silverman. ■

Insider sources

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Model letter: Alert referring physician about stale orders

The following is a letter created with the help of **Jay Silverman, Esq.**, a healthcare attorney at Ruskin Moscou Faltischek in Uniondale, NY, to alert a referring physician that you canceled a stale order.

Talk to your attorney and insurance carrier about adapting this for your use.

Dear Dr. Smith,

Thank you for the referral of your patient, Mary Jones, for a [insert test, such as an x-ray or CT scan] to [insert diagnosis]. Unfortunately, Ms. Jones delayed making an appointment for the test and appeared in our offices today, September 1, 2008, with an order dated June 1, 2008.

To protect your practice, our practice, and our mutual patients, it is our policy to confirm any order for a diagnostic screening test that was written more than [insert #] days prior to the patient's presentation in our office. We were unable to contact your office today to confirm the order. Accordingly, we canceled Ms. Jones' test. We also counseled her on the importance of securing the order and rescheduling the test promptly. We apologize for any inconvenience this policy causes you or your patients, but be assured that this policy is designed to assist us in providing your patients with the best possible care.

Very truly yours,
Paul Radiologist, MD
ABC Radiology

Technologists play a major role in the revenue cycle

Editor's note: This excerpt from the Radiology Technologist's Coding Compliance Handbook will help you understand the technologist's role in the revenue cycle and in billing, coding, and documentation.

Radiology technologists play a pivotal role in the revenue cycle. This cycle begins as soon as patients are scheduled, and it can easily break down if technologists fail to:

- Review test orders
- Understand coding, billing, and Medicare regulations
- Query patients about clinical information

In the initial phases of a patient's encounter, technologists must collect accurate information and question any discrepancies.

Diligence at this stage—on the front lines of patient care—aid the facility in getting properly reimbursed for studies and complying with regulations such as Medicare.

One mistake—even an unintentional one—could cost the facility thousands of dollars.

Documentation and coding

Technologists are often the only people with clinical knowledge with whom a patient comes into contact during outpatient diagnostic testing. For this reason, technologists play a key role in ensuring documentation and coding compliance.

Because technologists possess clinical knowledge and insight that clerical personnel do not, it is their responsibility to document patient information with appropriate medical terminology and to question whether a specific diagnostic test is clinically appropriate or medically necessary based on a patient's history.

This clinical knowledge and understanding of testing protocols allows technologists to raise questions regarding these matters and to communicate effectively with physicians as necessary.

Obtain the patient's history

Obtaining and documenting the patient's history is important for diagnostic tests performed on an outpatient basis—particularly when ordering physicians have not provided a reason for the test and additional information is unavailable.

Therefore, prior to performing a diagnostic exam, technologists must take the following steps:

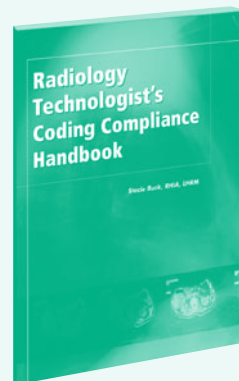
1. Query the patient to decipher any symptomology he or she is currently experiencing. In other words, find out why the patient is having the test and ask about any past or chronic health conditions that might affect how you perform it.

Tip: This information might be the deciding factor at the time of coding and billing as to whether the exam is considered medically necessary.

2. Ask whether the patient has had any adverse reactions to contrast materials during past exams.

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Technologist training



Radiology technologists do more than take and process images. Some select codes, check and verify orders, perform tests based on diagnoses, and document their activities. Any missteps along the way jeopardize not only the organization's financial stability, but compliance as well.

Give your radiology technologists *The Radiology Technologist's Coding Compliance Handbook*. This 64-page training handbook, sold in packages of 10 copies, includes 16 modality-specific case scenarios to help your technologist staff learn their place in the revenue cycle.

For information, visit www.hcmarketplace.com/prod3362.html or call our customer service department at 800/650-6787.

Revenue cycle

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Handle diagnostic test orders

The treating/referring physician must order all diagnostic tests.

According to CMS, any of the following may constitute an order:

- A written document signed by the treating/referring physician and hand delivered, mailed, or faxed to the testing facility
- A telephone call from the treating/referring physician or his or her office to the testing facility when both parties document the phone call and

the required information in their respective patient records

- An e-mail from the treating/referring physician or his or her office to the testing facility

When referring physicians do not provide diagnostic information that documents the reason for the test, ask the patient why his or her physician ordered the test or check the patient's medical record. If you take information directly from the patient, you must make a concerted effort to verify it by contacting the referring physician. ■

Payment cut of 10.6 percent reversed for 0.5 percent

This year's battle over Medicare's Sustainable Growth Rate (SGR) formula ended in July with a repeal of the previously proposed 10.6% cut to the SGR, replacing it instead with a 0.5% increase through this year and a 1.1% increase through 2009. The Medicare Improvements for Patients and Providers Act of 2008 passed by a veto-proof tally of 69–30, says **Orrin Marcella**, assistant director of congressional affairs at the American College of Radiology in Reston, VA. The bill also contains specific measures that outline an imaging accreditation demonstration project through 2010. (See the October **RACRI** for tips on how to prepare your facility.)

"This represents great news for radiology groups, but we'll have to keep an eye on things for the future," says **Michael F. Schaff, Esq.**, an attorney at Wilentz, Goldman & Spitzer, PA, in Woodbridge, NJ.

This vote total represents the necessary support to override a potential veto by President George W. Bush. Intense lobbying and grassroots support by the physician community led to the reversal of the impasse, says Marcella.

Generally, this hardly represents a major surprise for physicians. In 1998, Congress determined that payments to physicians should be contained at what it determined

was a "sustainable" rate based on a controversial physician payment formula. However, these cuts almost never stick. For the past five years, CMS has proposed the cut and Congress has stepped in before the cut could become final to reduce or eliminate it each year. Intense lobbying efforts from the AMA and imaging professionals and associations impress on Congress the very real possibility that doctors simply will stop accepting new Medicare patients. So with yet another rollback of SGR cuts, CMS must look to make up the money elsewhere.

However, Marcella says the window left open from this cut rollback could provide the proverbial window of opportunity to find grander solutions to the money shortage. "We are glad to see this impasse resolved; 18 months of relief from the SGR cuts will hopefully provide enough time for lawmakers and the physician community to explore viable alternatives to the current payment system that won't jeopardize patient access," he says. ■

Insider sources

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