

Radiology Administrator's

Compliance & Reimbursement Insider

2009 MPFS offers imaging implications

On June 30, CMS posted its proposed updates to the Medicare Physician Fee Schedule (MPFS) for 2009. The updates, in addition to proposing a 5.4% payment decrease, include a proposal to require IDTF enrollment of physician office-based imaging providers and significant revisions to the purchased diagnostic test rule.

With the help of **Thomas W. Greeson, Esq.**, health-care attorney at Reed Smith, LLP, in Falls Church, VA, we summarize the proposed updates and rules and their potential effect on diagnostic imaging arrangements.

If adopted, these changes could be effective as early as January 1, 2009. The CMS comment period ended August 29.

Physician offices required to enroll as IDTFs

Physicians and nonphysician practitioners (NPP) who perform diagnostic testing services for their patients—known as physician entities—are currently not required

to enroll with Medicare as an IDTF, Greeson says. As a result, Medicare maintains a dual standard with respect to imaging services provided to its beneficiaries, he explains. IDTFs must perform imaging services in accordance with certain recently expanded performance standards, whereas physician entities are not subject to any of the quality standards.

CMS expressed concern in the 2009 MPFS proposal that such physician entities might be providing diagnostic testing services without the benefit of qualified nonphysician personnel.

In an attempt to address its concerns regarding the quality of services provided by physician entities, CMS proposed adding a new provision to the IDTF performance standards. It would require any physician or NPP organization furnishing diagnostic testing services (with the exception of diagnostic mammography services) to enroll as an IDTF and be subject to most of the enrollment requirements for IDTFs. (See “Requirements and exceptions for IDTF enrollment” on p. 3.)

CMS wants to define a physician or NPP organization as any physician entity that enrolls in the Medicare program as a sole proprietorship or organizational entity, such as a clinic or group practice, Greeson says.

Further, the rule would apply to radiologist- and nonradiologist-owned imaging offices.

“The rule, as currently proposed, would have the sweeping effect of requiring essentially any physician

“The rule, as currently proposed, would have the sweeping effect of requiring essentially any physician or NPP office that performs diagnostic imaging services” to enroll in Medicare as an IDTF.

—Thomas W. Greeson, Esq.

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or NPP office that performs diagnostic imaging services" to enroll in Medicare as an IDTE, Greeson says.

"Bluntly, this proposal is a frontal attack on self-referral," he adds.

If this rule is adopted, it could result in a significant decline in the number of physician entities that offer diagnostic imaging services to their patients because it could be difficult for nonradiologist-owned offices to secure properly qualified nonphysician personnel, Greeson says.

In addition, if Medicare contractors continue to interpret the proficiency requirements to essentially require radiologist supervision of diagnostic imaging

services, it could be difficult for other specialty practices to satisfy the proficiency requirements, Greeson says.

Finally, the proposed rule could result in a demise of leasing arrangements in which two or more physician groups lease an imaging center on a part-time basis in order to bill third-party payers for imaging services provided to their patients at the facility, he adds.

This proposed rule will undoubtedly generate controversy, Greeson says, noting "it could significantly limit the ability of nonradiologist specialty groups to bill for imaging services provided to their own patients."

If adopted, the rule would become effective September 30, 2009, for physician entities already enrolled in Medicare. Any newly enrolling entities would be subject to the rule effective January 1, 2009.

Other revisions

Greeson says to clarify the language of the provisions and address public concerns and comments, CMS sought public comment on the following two alternative proposals for revising the anti-markup provisions:

- Under one approach, the anti-markup provision would apply if the professional or technical component of a diagnostic test is ordered by a billing physician and is either:
 - Purchased from an outside supplier
 - Performed or supervised by a physician who does not share a practice with the billing physician or physician organization

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A performing or supervising physician can be considered to share a practice if that physician is employed by, or contracts with, a single physician or physician organization on a full- or part-time basis. However, a performing or supervising physician does not share a practice with the billing physician or organization if that physician is an employee of an independent contractor with more than one billing physician or organization.

Thus, supervising or interpreting radiologists who provide supervision or interpretation services to more than one physician or physician organization cannot share in

Requirements and exceptions for IDTF enrollment

Under the Medicare Physician Fee Schedule proposal, physician offices that perform diagnostic imaging tests would need to enroll in Medicare as IDTFs. As such, physician offices would need to abide by IDTF performance standards, such as:

- Maintaining proper licensure and certification for non-physician personnel who perform diagnostic imaging services
- Designating a supervising physician with proficiency in the performance and interpretation of each diagnostic test the practice performs
- Prohibiting an IDTF from:
 - Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization
 - Sharing its practice location with another Medicare-enrolled individual or organization
 - Leasing or subleasing its operation or practice location to another Medicare-enrolled individual or organization

However, the physician practice would be exempt from:

- Maintaining additional liability insurance for each practice location
- Maintaining a formal complaint process
- Posting the IDTF standards
- Posting a sign with its business hours
- Separately enrolling each practice location

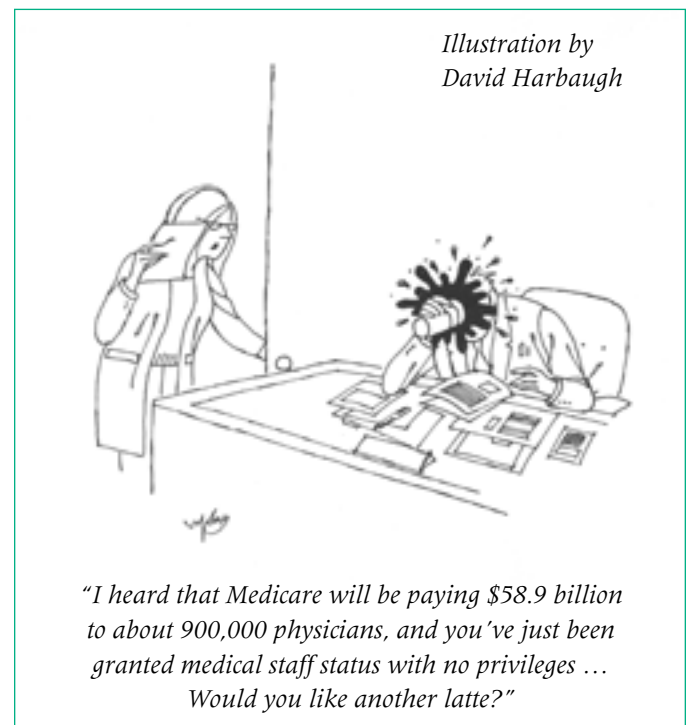
that practice. Their services could trigger the anti-markup restriction, Greeson says. (See “Anti-markup provisions and the 2008 final rule” on p. 4.)

Greeson says he is concerned this first proposal, if adopted, could have the unintended consequence of decreasing the quality of diagnostic imaging services provided to Medicare beneficiaries.

This would happen by precluding nonradiology practices from contracting with radiologists to provide supervision services, he explains. Instead, nonradiology practices would use one or more of their own physicians to provide such supervision services. Whether the supervising physician provides quality services would likely depend on whether the proposed IDTF enrollment requirements are adopted and, if so, how CMS determines whether a supervising physician satisfies the proficiency requirements, Greeson says.

CMS is proposing to more broadly define the office of the billing physician or other supplier to include space in which diagnostic testing is performed.

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► Under a second approach, CMS would maintain the current regulatory text that applies the anti-markup provisions to the technical and professional components of diagnostic tests performed outside the office of the billing physician or other supplier, Greeson says.

However, CMS is proposing to more broadly define the office of the billing physician or other supplier to include space in which diagnostic testing is performed, provided it is located in the same building in which the billing physician or other supplier regularly furnishes patient care. The term "same building" does not include services provided in vehicles, vans, or trailers in the parking lot of a medical office building.

"The above change in definition," Greeson says, "would address concerns expressed by physicians who had previously structured diagnostic testing arrangements

in reliance on the same building requirements of the in-office ancillary services' exception to the Stark Law that those physicians would now be forced to terminate the arrangements because they would no longer be financially feasible." If this change is adopted, it could significantly decrease the expansive scope of the anti-markup provisions, he explains.

Thus, it would have little, if any, effect on the proliferation of imaging services billed by ordering physicians, since such physicians tend to structure their imaging arrangements to meet the same building requirements of the Stark Law, Greeson says. ■

Insider source

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Anti-markup provisions and the 2008 final rule

CMS states it suspects physicians who profit from self-referrals might be fueling the significant increase in diagnostic testing utilization, says **Thomas W. Greeson, Esq.**, healthcare attorney at Reed Smith, LLP, in Falls Church, VA. To limit that growth, CMS expanded the scope of the purchased diagnostic test rule and the Medicare reassignment rules in its 2008 Medicare Physician Fee Schedule (MPFS) final rule.

At the time, CMS applied the anti-markup prohibition to the technical and professional component of diagnostic tests when billed by the ordering physician. This anti-markup prohibition applies to all diagnostic tests other than tests paid under the Medicare clinical diagnostic laboratory test fee schedule, Greeson explains.

Greeson says the anti-markup prohibition would apply if the ordering physician bills for the technical and/or professional component of a diagnostic test and if the technical or professional component is:

► **Performed in a location outside the office of the billing physician.** If the billing physician is part of a group practice, the office of the billing physician

is defined as the space in which the physician substantially provides the full range of patient care services that the group practice provides generally, Greeson says.

► **Obtained from an outside supplier.** An outside supplier is any entity that is not an employee of the billing physician and does not reassign its right to Medicare payment to the physician practice. Lack of reassignment triggers this component, Greeson says.

CMS originally intended the anti-markup provisions to take effect January 1. However, shortly after CMS released the 2008 MPFS final rule, the healthcare community inundated the agency.

The public requested clarification on definitions and additional guidance on how the rule would apply to various previous legal arrangements under the new Stark Law rules, Greeson explains.

In order to respond to these requests, CMS issued a final rule delaying the applicability of the above changes to the technical and professional components of most diagnostic testing services until January 1, 2009, Greeson says.

MIPPA mandates imaging accreditation for all providers

Facilities have two years to earn ACR or IAC approval

Are you ready for accreditation? The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which was passed in July, calls for providers of advanced diagnostic imaging services (e.g., MR, CT, PET, and nuclear medicine) to be accredited in order to receive payment for the technical component of those services by January 2012.

"This is a very positive development for the imaging industry and provides a focus on quality. It could not have come at a better time," says **Sandra Katanick, CAE**, CEO of the Intersocietal Accreditation Commission (IAC) in Columbia, MD.

This is a step forward for the industry, says **Krista Bush**, director of diagnostic modality accreditation at the American College of Radiology (ACR) in Reston, VA.

"The accreditation process will be good for radiologists and their practices," says **Thomas W. Greeson, Esq.**, healthcare attorney at Reed Smith, LLP, in Falls Church, VA. Accreditation will help improve or eliminate imaging facilities that are not up to standard and, thus, will benefit those who are already accredited or who can meet high standards, he explains.

The bill requires providers of advanced diagnostic imaging services, inclusive of nuclear medicine, MR, CT, and PET, obtain accreditation as a condition for Medicare reimbursement by 2012, Bush says.

In addition, Katanick says, it establishes a two-year voluntary program to collect data regarding physician compliance with criteria to determine the appropriateness of advanced diagnostic imaging services furnished

to Medicare beneficiaries. Most importantly, the legislation and accreditation will result in improved patient care, Katanick and Bush say. Katanick says the portion of the legislation requiring accreditation states:

- Accreditation programs must ensure physicians and staff maintain the proper level of training and education
- Facilities use imaging equipment that adheres to strict standards of performance and operates under proper safety guidelines
- All imaging providers establish and maintain a quality assurance program, thereby upholding the standards of quality care for patients, particularly senior citizens

Providers of advanced diagnostic imaging services, inclusive of nuclear medicine, MR, CT, and PET, must obtain accreditation as a condition for Medicare reimbursement by 2012, says Krista Bush.

ACR and IAC likely accreditors

CMS has not yet chosen the accrediting bodies but will do so by 2010. Although not set in stone, CMS will likely choose the ACR and the IAC since both organizations have extensive experience accrediting imaging entities under current requirements by private insurers and some states, Bush says. In the case of the ACR, the mammography accreditation program is a federally recognized program under the Mammography Quality Standards Act and administered by the FDA. Both are national nonprofit organizations that provide a peer review process of accreditation designed to evaluate and accredit diagnostic imaging facilities.

Note: RACRI subscribers can access a special report with questions and answers from the ACR and the IAC at www.hcpro.com/content/71716.pdf; scroll to p. 9.

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Questions? Comments? Ideas?

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Accreditation

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During the past several years, various health insurers and medical specialty societies have set accreditation requirements. (See "Current accreditation program mandates" on p. 7 for a list of some of the requirements.)

For example, UnitedHealthcare requires freestanding outpatient facilities and physician offices that perform diagnostic imaging services to meet accreditation standards developed by the ACR and the IAC, or forego reimbursement.

The IAC currently maintains five accrediting divisions providing accreditation for facilities performing noninvasive vascular testing, echocardiography, nuclear cardiology, general nuclear medicine, and/or PET imaging, MRI, and CT scanning.

For the ACR, a committee of ACR members, each an expert in a specific imaging modality, develops and supervises accreditation for that division. Each module evaluates clinical and phantom images based on set criteria.

The ACR's peer review accreditation program includes mammography, breast ultrasound, stereotactic breast biopsy, ultrasound, radiation oncology, CT, MRI, nuclear medicine, and PET.

Reasons to comply

In addition to accreditation now being mandated before CMS will pay for certain procedures, accreditation also offers the following benefits for your practice:

- **Improved patient care and image accuracy.** This is the foremost benefit, Bush and Katanick say.
- **Opportunities for educational and organizational growth.** The assessment of your practice should be a positive exercise. "It's not a punitive process," says Katanick.
- **An impetus for change.** A qualified voice can prompt your practice to improve and draw attention to weaknesses, such as aging equipment that administrators previously might have been reluctant to replace, Bush says.

- **Improved patient and payer confidence.**

Approval from qualified peers demonstrates the organization takes industry standards and government requirements seriously. It shows dedication to image quality and the quality of care provided to patients.

- **Resolution of additional mandates.** Your practice may use the review to meet additional state, federal, or third-party payer reimbursement criteria.

Three tips to prepare for accreditation

The accreditation process takes approximately four to six months, Bush says. The ACR and the IAC accredit for a three-year period. Bush and Katanick offer the following tips to prepare for accreditation:

- **Obtain relevant reference materials.** Visit www.acr.org and www.intersocietal.org to view the specific accreditation guidelines and standards. Pay attention to the systematic instructions offered in the online applications, Katanick says, adding that both sites provide a wealth of information.
- **Get organized.** Gather information regarding all imaging modalities your facility offers from the ACR and the IAC Web sites. Collect other information such as:
 - ACR or IAC accreditation identification numbers
 - Contact information for supervising physicians and technologists
 - Basic technical and modality-specific information for each unit
- **Ask for help.** The ACR has technical experts available at 800/770-0145, or you can reach IAC technologists at 800/838-2110. ■

Insider sources

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Current accreditation program mandates

The following chart lists several current accreditation requirements for imaging facilities. Note that it is not comprehensive and does not include all accreditation requirements. Talk to your attorney and insurer about specific questions on accreditation.

**American College of Radiology/accreditation program statistics
Third-party payers requiring accreditation**

Medicare	Mammography
State governments	
<i>(unlawful to operate without accreditation)</i>	
California	OB ultrasound (for prenatal diagnosis centers)
Massachusetts	Stereotactic breast biopsy
New Jersey	Radiation oncology
New York	Radiation oncology (must have review every five years by approved body)
Ohio	Freestanding radiation oncology facilities
Connecticut	MRI
Rhode Island	MRI
Private third-party payers	
Aetna U.S. Healthcare	MRI, mammography, OB ultrasound
Anthem BCBC of the Midwest	Nuclear medicine, ultrasound, MRI, CT
Anthem Blue Cross of VA	MRI, CT, nuclear medicine, and PET
Auto Insurance Regulations in Florida	MRI
Blue Cross/Blue Shield of AL	MRI, CT, PET
Blue Cross of CA (NIA)	MRI
Blue Cross of GA	PET, CT, MRI
Blue Cross of NJ	(have set minimum quality standards for any provider of imaging)
Blue Cross of Western New York	PET, MRI
Blue Cross of PA	OB ultrasound
Blue Cross-NEPA/FPH	MRI
Cigna of CT	OB ultrasound
Health Net of Northeast, Inc. (NIA)	OB ultrasound
Health Now New York, Inc.	MRI
Highmark BC/BS of PA and Keystone Health Plan West	MRI, OB/GYN/vascular ultrasound, nuclear cardiology
Intermountain Healthcare of UT	OB ultrasound
Medical Mutual of Ohio	All radiology services (freestanding sites)
New York Medical Imaging, PLLC	MRI, CT, PET, nuclear cardiology, ultrasound
One Call Medical	MRI
Oxford Health Plans	CT, PET, nuclear cardiology
PHS Health Plans (NIA)	OB ultrasound
Regence Blue Shield	MRI
State of Connecticut	MRI
State of Rhode Island	MRI
United Healthcare of Wisconsin	Nuclear cardiology
United Healthcare (nationally)	CT, MRI, nuclear medicine, PET, CTA, MRA, echocardiography

State Medicare carriers requiring or recommending accreditation for vascular ultrasound

AK, AZ, CA, CO, DC, DE, HI, ID, IL, MA, MD, ME, MN, MS, NC, ND, NH, NJ, NY, NV, OH, OR, PA, SD, TN, TX, VA, VT, WA, WI, WV, WY

Source: American College of Radiology. Reprinted with permission.

Use bonus incentives without getting burned

Editor's note: This is the first article in a two-part series on offering radiologists incentives to join your practice. Look for model language you can adapt to your specific negotiations in the November RACRI.

Radiologists are always in demand—even in a challenging economy. For a practice looking to add a radiologist, the competition can be difficult. Despite tough economic times, offering a joining bonus might be necessary. It could mean the difference between a radiologist choosing your practice or choosing another, says **Mark Smith**, executive vice president at Merritt, Hawkins & Associates, a physician recruitment company based in Irving, TX.

But offering bonuses can be risky if you don't do it carefully. Bonuses can complicate your taxes and cost you more than you bargained for. We'll explain how to structure a bonus program for your radiologists that will increase your practice's attractiveness as an employer, encourage long-term commitment from your radiologists, and be tax-efficient.

Signing bonus often works

Radiology practices have begun enticing new radiologists to join them in several creative ways, including offering flexible work schedules, increased vacation time, and accelerated partnership tracks, Smith says. But for

practices that can't offer a lot of flexibility, good old-fashioned cash still works, he says—especially when you're trying to hire a young physician who might be carrying a large education debt.

It lets new radiologists retire some of their debt and establish a decent standard of living as soon as they begin working, and that's hard to resist, says **Joan Roediger, Esq.**, healthcare attorney at Obermayer Rebmann Maxwell & Hippel, LLP, in Philadelphia. She urges practices seeking radiologists to consider offering a substantial financial incentive if they can, especially if the practice can't be flexible on work hours or the number of years a radiologist must wait until partnership.

Tracking the offer

In their zeal to rope in an attractive candidate, some practices pay a cash bonus before the new physician starts working. Occasionally, a recruit will take the money and run and never show up for work. For this reason, some practices prefer to structure the bonus payment as a loan and then forgive portions of the debt at regular intervals.

Remember, a signing bonus should act to induce the candidate to join your practice instead of another. A bonus as loan might be less attractive to a candidate and pose some tax complications for the practice and the candidate, Roediger says. ■

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