

# Radiology Administrator's

## Compliance & Reimbursement Insider

### ICD-10 execution date proposed: October 1, 2011

ICD-10 no longer represents some distant, implausible menace. Years of speculation came to a sudden end August 15. That's when the U.S. Department of Health and Human Services (HHS) released its proposed regulation for the transition to ICD-10-CM for diagnostic coding affecting inpatient and outpatient settings and ICD-10-PCS for inpatient procedures only.

Coders have thought about this transition for more than a decade. But when it comes, ICD-10 will change nearly every dimension of hospital operations. The conversion affects payers, software vendors, researchers, regulators, and data warehouses. And, yes, it affects radiology administrators too.

You have three years to get ready, unless the timetable changes in the final rule (which was unavailable at presstime).

"The conversion to ICD-10-CM is going to be challenging, but it is long overdue and definitely worth the

effort," says **Jackie Miller, RHIA, CPC**, vice president of product development at Coding Metrix, Inc., in Powder Springs, GA.

#### Disease classification history

HHS adopted the ICD-9-CM code sets in 2000, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Public and private healthcare organizations use these codes to report healthcare diagnoses and inpatient hospital procedures.

But ICD-9-CM was developed al-

most 30 years ago. It is widely viewed as outdated due to its limited ability to accommodate new procedures and diagnoses.

"There have been many changes in the past three decades, not just in our knowledge of diseases and disease classification, but also in the ways in which encoded data are used," Miller says.

ICD-9-CM is not large or flexible enough to meet today's needs. It contains only 17,000 codes and is expected to start running out of available codes next year, HHS notes.

By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures.

"The U.S. is the only industrialized nation in the world still using ICD-9. We have delayed the implementation of ICD-10 over and over and over again," says Miller, "but waiting is not going to make the transition any easier."

**"The U.S. is the only industrialized nation in the world still using ICD-9. We have delayed the implementation of ICD-10 over and over and over again, but waiting is not going to make the transition any easier."**

—Jackie Miller, RHIA, CPC

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Last month, we outlined several concerns regarding the implementation of a signing bonus program. Now, we offer model language, adaptable to your situation, to help you encourage potential candidates to come to your facility.

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## ICD-10

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The additional codes will help enable the implementation of electronic health records because they will provide more detail in the electronic transactions.

This level of detail will also improve efficiencies by helping identify specific health conditions, according to HHS.

## Coding future

HHS states that updated versions of current HIPAA electronic transaction standards will require the use of the ICD-10 code sets for claims, remittance advice, eligibility inquiries, referral authorization, and other widely used transactions. The currently adopted standard,

Version 4010/4010A1 of the Accredited Standards Committee X12 group, cannot accommodate the much larger ICD-10 code sets.

Under the updated transaction standards proposed rule, compliance with Version 5010 (healthcare transactions) and Version D.0 (pharmacy claims) would be required by April 1, 2010.

## Transition steps

The following is a look at what the transition will require:

➤ **Software switch.** For radiology providers, the transition requires software changes to accommodate the additional digits of the ICD-10-CM diagnosis codes, says Miller.

"But software vendors have been anticipating this change for many years, and they should certainly have a plan to accomplish the change," she says.

Several health information management (HIM) vendors already have ICD-10-compliant products due to implementation of ICD-10 in nations such as Canada, Ireland, and England, says **Gloryanne Bryant, BS, RHIA, RHIT, CCS**, senior director of coding and HIM compliance at Catholic Healthcare West in San Francisco.

Large and small facilities need to have formal vendor assessments conducted, much like those in use during Y2K and HIPAA preparation. This is the time for asking vendors tough questions, Bryant says. Some questions to ask include:

- Are vendors ready?
- If not, when are they going to be ready?
- How are they going to adjust?
- Can they conduct testing and crosswalks?
- Is there going to be a cost to compliance?

Another question HIM and information technology departments have to address is the moment of transition itself. "With October 1, 2011, [as] implementation day, what happens on September 30?" says **DeAnne W. Bloomquist, RHIT, CCS**, chief consultant and president

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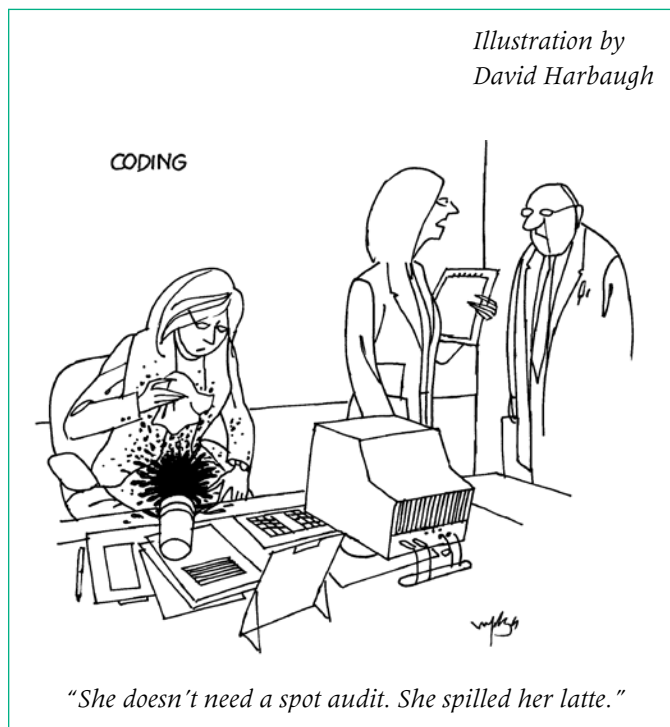
of Mid-Continent Coding, Inc., in Overland Park, KS. Bloomquist forecasts that providers will have to hold claims for a week or more before and after the transition.

"We have learned from both Y2K and HIPAA, as well as what other nations have done for implementation. There may be some delay in the first week or so, and we'll have to plan accordingly," Bryant says, adding that developers must conduct thorough testing of crosswalks before implementation.

► **Staff training.** The transition also requires staff training, says Miller. There are already many books, on-line courses, and other training aids available on the market, and there will be more once a firm transition date is set.

"The guidelines for ICD-10-CM coding are very similar to those for ICD-9-CM, so coders will not find the new system totally strange," she says.

When the American Health Information Management Association performed a pilot test of ICD-10-CM a few years ago, most participants found it relatively easy to use, says Miller. But be patient, because any type of transition can be difficult.



"Keep in mind that your staff productivity temporarily may be affected during the transition," says **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC**, vice president of Southeast Radiology Management in Stuart, FL. "Many radiology coders have the most common codes committed to memory, and with ICD-10, they will be faced with learning brand-new codes for every diagnosis and sign or symptom."

Radiology providers may wish to consider employing computer-assisted coding to increase productivity, Buck adds.

► **Revision of charge tickets.**

The transition will require revision of any charge tickets that include ICD-9-CM codes. "This will be a one-time effort, following which the yearly updates will be no more labor-intensive than they currently are with ICD-9-CM," Miller says.

On the payer side, coverage policies (driven by diagnosis codes) will need to be revised to include the applicable ICD-10 codes, she adds.

Although there will not be a one-to-one correspondence between ICD-9-CM and ICD-10 codes, there are already crosswalks available to make the conversion easier, says Miller. ■

**"Many radiology coders have the most common codes committed to memory, and with ICD-10, they will be faced with learning brand-new codes for every diagnosis and sign or symptom."**

—*Stacie L. Buck,  
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## Address test order protocol in hospital setting

Radiologists in freestanding imaging centers and private practice must get an order from a treating physician before they can perform a diagnostic imaging test for Medicare patients.

However, Medicare has different rules for hospital-based radiologists. The law permits them to order a test or modify a treating physician's order on their own initiative—that is, without a treating physician's order—but only under appropriate circumstances.

Nevertheless, many hospitals maintain internal policies or bylaws that require their radiologists to obtain an order from a treating physician. However, a policy change could benefit radiologists, patients, and your facility. A model protocol appears on p. 5 as an example of a simple, workable test-ordering policy.

### What Medicare allows

The general rule under Medicare—that a radiologist must have a treating physician's order to perform a diagnostic test—doesn't apply to diagnostic tests performed in a hospital, says **Thomas W. Greeson, Esq.**, a health-care attorney at Reed Smith, LLP, in Falls Church, VA.

In the absence of specific regulations, use Medicare's *Conditions of Participation (CoP)* for hospitals as a guide.

The *CoP* states that "radiologic service must be provided only on the order of practitioners with clinical privileges ... authorized by the medical staff and the governing body to order the services."

Because hospital-based radiologists are "practitioners with clinical privileges," says Greeson, there's no legal prohibition against their ordering tests.

There's no reimbursement issue either, he says, because any radiologic procedure ordered, performed, and supervised by an appropriately credentialed radiologist would be a covered service when performed in a hospital setting.

### Arguments for hospital order protocol

Highly trained and fully licensed radiologists should have the authority to "do the right thing" for their patients,

Greeson says, adding that this includes ordering medically necessary tests and modifying existing orders.

Patient benefits include the following:

➤ **Radiologists may order a more appropriate test than the exam requested by the treating physician.** Technology in radiology develops so rapidly that it can be difficult to keep up. That's one good reason for radiologists to order a test when they think it's appropriate, says **Leonard Berlin, MD, FACR**, radiology department chair at Rush North Shore Medical Center in Skokie, IL.

A treating physician may order a test that he or she is familiar with when a newer test is more appropriate for the particular patient. In that case, everyone benefits from a modified test order, Berlin says.

➤ **The radiologist may order a needed follow-up test more quickly than the treating physician.** If a diagnostic test results in indications that may require a follow-up exam, the radiologist could order and perform that second test right away. Further, the patient's signs and symptoms may indicate the need for an additional exam.

For example, Berlin says, the treating physician orders a CT scan of the abdomen. On review of the patient's complaints, the radiologist thinks it would be a good idea to also obtain a CT scan of the pelvis.

The radiologist should be able to order and perform the test without waiting for a treating physician's okay. That's better for the patient and more cost-effective for the hospital, says Berlin.

### Arguments against hospital order protocol

Although radiologists can legally order tests in a hospital setting, and the interests of patient care often favor additional tests, many hospitals and radiology departments require radiologists to get orders from treating physicians before performing diagnostic tests. They give the following two reasons, to which our experts respond:

➤ **Fear of increased medical liability.** Greater responsibility for ordering diagnostic tests will lead to greater

malpractice liability, some radiologists argue. Treating physicians and hospitals argue that if the radiologist alters an order and a bad outcome ensues, the patient may sue the treating physician as well as hospital.

Greeson says these fears may be exaggerated. In fact, a patient who wants to sue is more likely to sue everyone who treated him or her, regardless of who made the error.

Radiologists can minimize individual liability by consulting the treating physician whenever possible, adding tests or modifying orders only when the treating physician is unavailable.

If radiologists take these steps, Greeson says there's no reason the authority to order tests should increase liability. "The point of granting a radiologist authority to order tests is to make the radiologist a part of the treatment team for the benefit of patients, not to convert the radiologist into a treating physician," he says.

➤ **Political or cultural obstacles.** Among older physicians in particular, there's still a tendency to see

radiologists as scientists as opposed to physicians, says Berlin, noting that some treating physicians don't like the idea of radiologists having direct communication with their patients, much less suggesting a particular test or describing a treatment plan. He believes these cultural or political issues are behind many hospitals' policies barring radiologists from ordering tests or modifying test orders.

Such ideas about radiologist-treating physician interaction have changed, Berlin says. Many younger physicians recognize that with radiologic technology developing so rapidly, it's difficult for nonradiologists to keep up. In addition, as radiologists take a more active role in communicating with patients (for example, as required by the Mammography Quality Standards Act), treating physicians accept that radiologists have more direct patient contact. Treating physicians understand that radiologists aren't going to undermine the physician-patient relationship but, instead, will augment it, says Berlin. He also believes

> *continued on p. 6*

### **Model protocol**

## **Adapt radiology test order protocol for hospital use**

If your hospital bars radiologists from ordering tests, consider adapting this model protocol as an amendment to the hospital medical staff bylaws, presenting it to your hospital's credentialing committee, or adapting it as a new rule for your hospital's radiology department.

Talk to the hospital general counsel's office and your insurer.

### **Diagnostic radiologic test order protocol**

ABC Medical Center recognizes that radiologists are fully licensed medical professionals and credentials radiologists to order a diagnostic test and/or modify a treating physician's order when such an order or modification is medically appropriate in the radiologist's judgment.

If a radiologist orders a diagnostic test without a treating physician's order or modifies an existing order, the radiologist shall make every effort to communicate with the treating physician to discuss the new and/or modified test prior to the performance of the test.

In any event, the radiologist will provide the treating physician with an interpretive report of all tests performed. If the results of any such test are positive or equivocal, the radiologist shall directly communicate such results to the treating physician as soon as possible.

The radiologist must fully and completely document the reason for ordering any test or modifying any order. Such documentation should be written directly in the patient's chart or be included in the radiologist's interpretive report, as appropriate.

## Test order protocol

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that managed care has changed the physician-patient relationship—patients don't go to the same physician for decades anymore. This change has lessened the degree of paternalism that treating physicians exert over their patients and has made them more open to the concept of having a radiologist on the treatment team.

### Arguments to hospital policymakers

If your hospital's policy doesn't let its radiologists order a diagnostic test or modify an order without prior approval from the treating physician, you may want to change that policy, Greeson says. The way you go about it will depend on its origin.

The following are examples of policy origins and suggestions on how to effect change:

- **Bylaws.** Some hospitals' bylaws bar the radiologist from ordering tests. In that case, you'll need to get the medical staff to amend the bylaws.
- **Credentials.** Your hospital may not credential radiologists to order tests. In that case, you'll have to approach the credentialing committee to make the change.
- **Radiology department rules.** Some radiology departments have rules that prevent radiologists from ordering tests. In that case, you'll have to canvass the department chair and other radiologists in the

department and, if necessary, convince them that it's in everyone's interests to make the change.

### Adopt test-ordering protocol

You can use protocol language, such as our model protocol, to amend hospital bylaws, establish a new credentialing protocol, or change a radiology department rule. Like our model protocol, yours should:

- **Permit radiologist to order tests and modify orders if medically appropriate.** The treating physician is still the best source for the order of any test, Greeson says, and any protocol should reflect that. It's medically appropriate, and it will help you convince your colleagues to adopt the protocol if it's clear the radiologists aren't trying to step on the treating physician's toes, Berlin says.
- **Require radiologists to inform the treating physician as soon as possible.** Thorough documentation of the reasons for ordering any test or modifying an existing order will ease any fears, Greeson says. ■

### Insider sources

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## 2009 Stark changes to self-referral affect radiology

On July 31, CMS issued its final rule regarding the hospital inpatient prospective payment system (IPPS), including anticipated Stark self-referral final rules.

"The changes as a whole will benefit and protect radiologists and radiology groups," says **Brian Kalver, Esq.**, a healthcare attorney at Wilentz, Goldman & Spitzer, PA, in Woodbridge, NJ.

"Most significantly, the changes will help improve patient care," says **Tom Hoffman, Esq.**, associate general counsel at the American College of Radiology (ACR) in Reston, VA.

The following are highlights of the changes:

➤ **Stand in the shoes.** The final IPPS rule requires a physician who has an ownership or investment interest in a physician organization to represent, or stand in the shoes of that physician organization, says Hoffman.

CMS listed the following exceptions:

- Physicians who do not receive financial benefits such as profit shares, sale proceeds, or dividends do not stand in the shoes of the group
- Nonowner physicians and nominal owners are allowed but not required to stand in their physician organization's shoes
- Radiologists and other faculty practice plan physicians will not have to stand in the shoes of their plan if they meet the academic medical centers exception

These changes took effect October 1.

➤ **Set in advance.** Effective October 1, 2009, physicians and designated health services (DHS) entities will not be able to use a percentage-based compensation formula to decide rental charges for office space and equipment, says Hoffman, adding that CMS will extend this ban to the indirect compensation and fair market value exceptions.

Personally performed physician services may continue to use percentage-based arrangements, says Kalver.

➤ **Per-click payments.** Effective October 1, 2009, CMS will prohibit many but not all per-service or per-click lease

arrangements, says Hoffman, adding that CMS will ban per-click lease payments from physician lessors to DHS entities for services the entities render to those physicians' patients. CMS also will invalidate per-click deals in which the DHS entities are lessors to a physician or a physician organization lessee.

CMS will not grandfather existing per-click deals that otherwise would violate this final rule, says Kalver.

CMS will not prohibit time-based lease deals, including the common block lease arrangements in which a clinician rents time on an MR scanner at an imaging center for X hours per week or month, says Hoffman.

➤ **Under arrangements.** CMS will curtail many under-arrangements ventures in which physicians supply items and services to DHS entities, says Hoffman. Specifically, CMS will amend the Stark definition of "entity" to clarify that it will regard a person or entity to be furnishing DHS if it is the person or entity that has performed DHS or presented Medicare with a claim for the DHS, according to the ACR. Physicians and centers must comply as of October 1, 2009.

➤ **Period of disallowance.** CMS clarifies that before being able to bill Medicare for imaging services, a physician who received a below-market lease deal must pay monies sufficient to bring all rental payments up to fair market value, the ACR notes. Prospective fixing of a financial arrangement that flunks Stark is not enough.

➤ **In-office ancillary services exception.** CMS has not changed the in-office ancillary services exception to Stark, says Hoffman. Thus, the most controversial self-referral exception remains intact—for now. However, CMS indicated it will consider scaling back the provision in the future, he says. ■

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## Avoid the compliance traps of bonus incentives

*Editor's note: This is the second article in a series on how to offer radiologists incentives to join your practice.*

A signing bonus often helps lure much-needed radiologists to a facility or practice. Bonuses come in a variety of forms: straight salary increases, one-time monetary payments, gradual monetary adjustments, and even loans.

Regardless of the payment method, protect your practice, says **Joan M. Roediger, Esq.**, a healthcare attorney at Obermayer Rebmann Maxwell & Hippel, LLP, in Philadelphia.

Have your attorney put together a document for you and your recruit to sign that establishes the terms of the offering.

This letter of intent should define the terms of the employment and include the terms of the bonus arrangement. The candidate may try to negotiate certain points.

That's fine. Once you and the candidate come to an agreement, the attorney will use the letter of intent to draft an employment agreement. Adapt one of our model clauses, according to your needs.

Make sure you have a signed document before you hand over any money, says Roediger.

**Tip:** If your state permits restrictive covenants—agreements that bar an employee from competing with your practice after leaving your employ—document that your organization paid the employee in consideration of their agreeing to the restrictive covenant, Roediger says. That shows the employee received some benefit for agreeing not to compete with your practice and makes the restrictive covenant that much more enforceable, she explains. ■

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### Sample language for signing bonuses

*Editor's note: Adapt the following model language to your situation to help you encourage potential candidates to sign with your facility. Be sure to check with your own attorney before making a potential agreement.*

#### Clause #1N

In consideration of [radiologist's name]'s agreement to join [name of practice] and abide by paragraph [# of restrictive covenant], this practice agrees to pay the radiologist the sum of [negotiated sum], payable in five equal monthly installments of [amount], the first installment to be paid upon the practice's receipt of the fully executed employment agreement from the radiologist, and subsequent installments payable on the first day of each succeeding month until the full amount of [amount] has been paid.

Should the radiologist leave employment with the practice prior to completing two full years of service, the radiologist shall repay the practice the greater of [amount] or such

amount as has been paid pursuant to the previous paragraph hereof, reduced by 1/24th for each full month that the radiologist provided full-time service to the practice. Such repayment amount is due within 30 days of cessation of the radiologist's employment with the practice, provided, however, that should such termination of employment be due to the radiologist's death, disability, or termination by the practice without cause, no repayment shall be due.

#### Clause #2N

In consideration of the radiologist's joining the practice and agreement to abide by paragraph [# of restrictive covenant] of this agreement, the practice shall pay the radiologist the sum of [amount] following the practice's receipt of the fully executed employment agreement from the radiologist.

*Source: Joan M. Roediger, Esq., Obermayer Rebmann Maxwell & Hippel, LLP, Philadelphia.*