

Radiology Administrator's

Compliance & Reimbursement Insider

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Use Informational Brochure to Persuade Patients to Sign ABNs

It may be important to your bottom line to get patients to sign Advance Beneficiary Notices (ABNs) anytime Medicare is unlikely to pay for an exam or procedure. Without an ABN you can't bill a Medicare patient for services that Medicare doesn't cover. But many patients don't understand what an ABN is and become upset when asked to sign one. Many ask difficult questions like "Why won't Medicare pay for this?" and "Why is my doctor ordering a service if Medicare says it's not medically necessary?" These are fair questions but ones that physicians, technologists, nurses, registration staff, or other persons responsible for getting ABNs signed are often unprepared to answer. As a result, patients may refuse to sign, and may even create embarrassing scenes.

But the *Insider* has learned of an effective strategy to get patients to sign ABNs. Although created by managers for clinical laboratories, the strategy works for radiology administrators too. It involves handing out an informational brochure that answers the questions and concerns patients typically raise. Patients get a brochure when they're asked to sign an ABN. Lab managers say that presenting an informative plain English brochure often convinces patients to sign ABNs. With the help of radiology administrators and billing consultants, we've taken the form that works so well for labs and adapted it for use by radiology facilities like yours. There's a model brochure on pp 3-4 that you can use or adapt.

Three Advantages of Using Brochure

Managers say that there are three advantages of using a brochure:

Soothes patient fears, tempers. "Patients are apt to become upset and angry when told Medicare doesn't cover a particular service and they'll be asked to pay for it," notes Baltimore radiology administrator Karol Handrahan. Some patients may even create unpleasant and embarrassing scenes.

A brochure has helped lab managers prevent scenes like these, says Donna Beasley, a lab administrator in Pensacola, Fla. "Although patients still aren't happy about having to sign the ABN, the brochure definitely eases anxieties." Beasley adds that since her lab started using a brochure, she's noticed a definite "calming effect." "Patients don't raise their voices as much since we've been using the brochure."

Cuts refusals to sign. A brochure also makes patients less likely to refuse to sign an ABN. While some patients won't sign an ABN under any circumstances, lab managers say that the vast majority of their patients can be persuaded. "Patients may refuse to sign at first," says Beasley. "But using the brochure has helped us talk patients into signing an ABN."

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USE INFORMATIONAL BROCHURE (continued from p. 1)

Radiology exams and procedures are generally more expensive than lab tests. Even so, patients who come in to radiology facilities are amenable to signing ABNs, according to Arizona radiology administrator Judy Dye, a former lab manager.

Saves staff time. A brochure lifts an enormous burden from the shoulders of physicians, technologists, nurses, and others who encounter the patients. "Few of these people, especially physicians, have time to answer all the patient's questions," notes Handrahan. "Nor are they necessarily prepared to explain the legalities of Medicare payment for diagnostic testing services." A brochure answers the questions and explains the legalities for them.

A brochure can't and doesn't try to answer a specific patient's questions about services that were ordered and why the referring physician feels they're medically necessary. The answers to these questions will vary from patient to patient and can't be addressed in a brochure. These are medical questions that physicians are best able to answer.

What Brochure Covers

Our brochure uses a simple Q and A format and incorporates the recommendations of top radiology administrators from around the country. It lists the questions these administrators say patients most commonly ask and omits things they don't generally care about like a technical explanation of how the Medicare billing process works.

Although you can tinker with it, your brochure should cover the same items ours does. It should:

Remind patients of services' purpose. Don't just launch into an explanation of ABNs and Medicare billing. First tell patients that this is all about their health. Explain that their physician thinks they need services performed for diagnostic or treatment reasons or to monitor their treatment.

Introduce your facility. Introduce yourself as the facility that will be performing the radiology services. This is especially important if the patient signs the ABN at the referring physician's office before coming to your facility for the services. Administrators say that advising patients that the brochure and ABN come from you, not the physician, makes referring physicians happy because it deflects patient anger from them.

Answer typical questions. Our brochure sets out plain English answers to 12 common ABN questions. The questions are highlighted so patients can skim through the brochure and find the questions that most interest them. The questions concern the following areas:

- What the ABN is, and why the patient is being asked to sign it;
- Whether the patient can refuse to sign it, and what will happen if he or she does refuse;
- Whether a bill will be submitted to Medicare before the patient is billed;
- How much the patient will have to pay if billed, and that it may be covered by supplemental insurance; and

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► Brochure Makes Patients Feel Better About Signing ABNs

Here's a sample brochure that can make the ABN signing process less painful for patients, physicians, technologists, nurses, and registration staff. The brochure provides plain English answers to the 12 questions anxious patients most often ask.

Since different facilities may have different policies on certain matters (for example, whether to perform services for patients who refuse to sign ABNs), you'll have to select the appropriate language in some sections.

MEDICARE COVERAGE OF RADIOLOGY SERVICES

Dear Medicare Patient:

Your treating physician wants to diagnose or treat a condition you may have or evaluate how well your treatment is working. To do that, the referring physician has directed us, ABC Radiology, to perform certain radiology services.

Before we perform these services, we may ask you to sign an Advance Beneficiary Notice, or "ABN." We've prepared this brochure to answer some of the questions you may have about the ABN and why you're being asked to sign it.

Q WHAT IS AN ABN?

A An ABN is a form that lets you know that you may have to pay for a service your physician has ordered if Medicare refuses to pay for it. Once you sign the ABN, the facility may bill you for the cost of the service.

Q WHY DO YOU WANT ME TO SIGN THE ABN?

A Although the Medicare program pays for most radiology services, it won't pay for some services under certain circumstances. When that happens, ABC Radiology asks the patient to pay. Consequently, we ask patients to sign an ABN whenever Medicare appears likely to deny payment for the specific service your physician has ordered. The reason *you* are being asked to sign an ABN now is that this is one of those occasions in which we or your physician believe Medicare won't pay.

Q WHY DON'T YOU THINK MEDICARE WILL PAY FOR THIS SERVICE?

A Medicare pays only for services that it considers to be "medically necessary" to diagnose or treat a specific illness or condition. Some services are never considered medically necessary.

There are five possible reasons why Medicare is likely to consider the service your physician ordered as not medically necessary and refuse to pay for it:

- Medicare considers the service routine or for screening purposes;
- Medicare considers the service investigative or for research use only;
- Medicare considers the service medically necessary only for certain diagnoses, and either: (a) the diagnosis your physician provided isn't one of those diagnoses, or (b) your physician didn't tell us what your diagnosis is;
- Medicare will pay for the service only a limited number of times within a specified time period, and the service you are to receive exceeds that limit; or
- The service hasn't been approved for a certain purpose by the Food and Drug Administration.

Q IF MEDICARE SAYS THE SERVICE ISN'T MEDICALLY NECESSARY, THEN WHY PERFORM IT?

A Your physician has made a medical judgment that you need the service. When your physician says a service is medically necessary, he/she considers your personal medical history, any medications you may be taking, and generally accepted medical practices. When Medicare says a service isn't medically necessary, it's not making a medical decision about your health. It's acting like an insurance company deciding what it will and won't pay for. And, just like private insurers, there are occasions when Medicare won't pay for services that physicians think are important to a patient's health.

But as the ABN says, you have the option not to have the service. If you have questions about a specific service your physician has ordered for you and why it's medically necessary, ask your physician.

Q MUST I SIGN THE ABN?

A No. You have three options:

Option I: You may sign the ABN and have the service performed. You can then be billed for the service.

Option II: You may refuse to sign the ABN and choose not to have the service. However, in not having the service you'll be going against the medical advice of your physician. So we advise you to consult with your physician before choosing this option.

Option III: You may refuse to sign the ABN and go ahead with the service.

[Insert this paragraph if your policy is to refuse to do services without a signed ABN] Like many facilities, ABC Radiology makes it a policy not to perform services that we believe Medicare won't pay for unless the patient signs an ABN. So if you refuse to sign the ABN and still want the service, your physician will have to order the service from another facility.

[Insert this paragraph if your policy is to have a witness document that the patient was advised about the ABN and refused to sign] ABC Radiology will perform the service and

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MEDICARE COVERAGE OF RADIOLOGY SERVICES (continued)

you'll receive a bill—even though you refused to sign the ABN. A witness will sign the ABN to indicate that you've been advised of the ABN and refused to sign it, but still want the service. Under Medicare guidelines, we may then directly bill you for the service.

[Insert the next question if you intend to submit the claim to Medicare before billing the patient]

Q WILL I BE BILLED AUTOMATICALLY?

A No. After we perform the service, we'll ask Medicare to pay for it. Of course, if Medicare does pay for it, you won't receive a bill. You'll get a bill only if Medicare denies the claim. Remember that if Medicare denies the claim, you may contest the denial if you think it was wrong.

Q IS MEDICARE MORE OR LESS LIKELY TO PAY IF I SIGN?

A Neither. The fact that you've signed an ABN won't affect Medicare's decision either way.

Q HOW MUCH MUST I PAY FOR THE SERVICE?

A We've given your physician a list of the prices ABC Radiology charges for specific services so that he/she can relay this information to you. If you can't afford to pay for the service, discuss this with your physician.

Q WILL SUPPLEMENTAL INSURANCE PAY FOR THE SERVICE IF MEDICARE DOESN'T?

A Maybe. If you have a supplemental insurance policy (sometimes called a "Medigap" policy), contact the insurance company and ask whether the policy covers radiology services not covered by Medicare. If so, find out how to submit claims for payment under the policy.

Q MUST I SIGN AN ABN EVERY TIME A NEW SERVICE IS DONE?

A No. You'll be asked to sign an ABN only when the treating physician or facility has a good reason to think that Medicare will deny payment for the ordered service. It all depends on the service and the reason for ordering it on that visit.

Q I'VE NEVER HAD TO PAY FOR A RADIOLOGY SERVICE BEFORE. IS THIS SOMETHING NEW?

A ABNs have been around for years. But more facilities are using them nowadays because of changes in how Medicare pays for radiology services. These changes make it more likely that Medicare won't pay for certain services. And since facilities aren't getting paid by Medicare, they must ask the patients to pay. This explains why ABNs are becoming more common.

Q I'VE NEVER BEEN ASKED TO SIGN AN ABN BEFORE. WHY MUST I SIGN ONE TODAY?

A There was no reason to believe Medicare would deny payment for the services your treating physician ordered for you during previous visits. But we think that Medicare won't pay for the service you'll be getting today. Here are some likely possibilities:

- Your treating physician ordered different services on previous visits. This is the first time he/she is ordering this particular service;
- This is the same service your treating physician ordered before, but your diagnosis has changed—that is, the treating physician is ordering the service for a different reason; or
- This is the same service and the same diagnosis. But since your last visit, Medicare changed the rules and no longer pays for the service with this diagnosis.

USE INFORMATIONAL BROCHURE (continued from p. 2)

■ Whether the patient must sign an ABN every time services are performed.

You'll have to adjust the questions to suit your policies—for example, some facilities may not perform the service unless the patient signs the ABN.

How and When to Distribute the Brochure

Once you prepare the brochure, you need to get it to the patient at the right time and place—that is, just before

the patient gets a copy of the ABN to sign. If you give the patient both documents at the same time, tell her to consult the brochure before signing the ABN.

Some facilities rely on the office of the physician who orders the service to ask patients to sign ABNs. If so, you'll need to distribute a supply of brochures to the office of your referring physician so that staff members can give out the brochure when they present the ABN to the patient. You can also have your own staff—registration personnel, receptionists, nurse, technologists, or physicians—

present the ABN when the patient arrives at your facility. That's fine, as long as you give patients the brochure and get the ABN signed before you perform any services. ■

Insider Sources

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I N T H E N E W S

► **CMS Delays 2002 OPSS Changes Indefinitely**

On Dec. 31, 2001, CMS issued a *Federal Register* notice delaying the 2002 changes to the hospital outpatient prospective payment system (OPSS). CMS says that Medicare will continue to pay hospitals for outpatient services—and make transitional pass-through payments—at the 2001 rates until no later than April 1, 2002. For services provided on or after Jan. 1, 2002, hospitals should continue to use 2001 HCPCS codes and definitions; no new 2002 HCPCS codes should be used, including the new observation code. CMS plans to issue a final rule in the *Federal Register* to announce when revised 2002 rates, a revised calculation of the uniform reduction in transitional pass-through payments, and new HCPCS codes will go into effect.

This *Federal Register* notice supersedes all previously issued communications from CMS about the 2002 OPSS changes. CMS had previously said it would delay implementation of the 2002 OPSS changes and payment of 2002 OPSS claims until April 2002.

To see the *Federal Register* notice, go to www.access.gpo.gov/su_docs/fedreg/a011231c.html and scroll down to “Centers for Medicare and Medicaid Services.”

► **Part of Stark II Delayed**

CMS recently announced that the effective date for one part of Phase I of the Stark II regulations will be delayed a year. Stark II—also known as the physician self-referral law—generally bars a physician from referring a patient to get a designated health service from an entity with which the physician has a financial relationship. Several exceptions under Stark II require written agreements that set the amount of compensation in advance. But according to Phase I of the Stark II regulations, “percentage compensation arrangements do not constitute compensation that is ‘set in advance’ in which the percentage compensation is based on fluctuating or indeterminate measures or in which the arrangement results in the seller receiving different payment amounts for the same service from the same purchaser.”

CMS got many complaints about this position on percentage compensation arrangements. Many providers argued that they’re commonly paid for their services using a formula that takes into account a percentage of a fluctuating or indeterminate measure (for example, revenues billed or collected for physician services). So thousands of con-

tracts would have to be renegotiated to comply with this one sentence in the Stark II regulations.

In response to these comments, CMS agreed to delay the effective date for this sentence until Jan. 6, 2003, to allow it to examine the issue.

This is good news for the many providers who have percentage compensation arrangements with other providers or health care entities because it allows providers to maintain percentage-based arrangements until Jan. 6, 2003, says health care attorney William Sarraille. But the delay affects only the analysis of those arrangements under Stark II, he cautions. The arrangement may still violate antikickback, tax exemption, fee-splitting, and other laws. Percentage compensation arrangements could, for instance, also be considered improper payments by hospitals to encourage physicians to reduce Medicare and Medicaid services to hospital patients, he notes.

You can find the notice announcing the delay in the Dec. 3, 2001, *Federal Register* on pages 60154 to 60156. Or you can access it online at www.access.gpo.gov/su_docs/fedreg/a011203c.html. Scroll down to “Centers for Medicare & Medicaid Services.”

► **Providers Can Get More Time to Comply with HIPAA Electronic Transaction Standards**

On Dec. 27, 2001, President Bush signed into law legislation that allows providers to delay implementation of HIPAA’s electronic transaction standards beyond the Oct. 16, 2002, deadline. Under the new law, providers can get a one-year extension if they submit a plan by Oct. 16, 2002, detailing how they’ll bring their operations into compliance with the standards within one year. The law also says that any provider that doesn’t either comply with the Oct. 16, 2002, deadline or submit a compliance plan by that date can be excluded from Medicare participation.

The new law requires the compliance plan to include certain things and contains other information you should review. The law doesn’t change the privacy rule’s compliance deadline, which is April 14, 2003, with small plans having until April 14, 2004. To see the full text of the bill, go to <http://thomas.loc.gov/> and search for “H.R. 3323.” ■

Insider Source

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2002 CCI Contains Some Changes for Radiology

The newest version—8.1—of the Correct Coding Initiative (CCI) is out. And there are some changes that radiology practices should know about. The CCI is a software program that CMS requires carriers and intermediaries to use to combat overbilling and fraud. The CCI automatically bundles certain CPT* codes and makes some other CPT codes mutually exclusive. Its purpose is to prevent providers from billing separately for certain combinations of tests and procedures by rejecting claims that seek reimbursement for two or more procedures and/or tests that the CCI either bundles or deems mutually exclusive.

This latest release of the CCI contains some new edits, and deletes some edits from the previous version. We'll tell you what's new in CCI Version 8.1 so that you, your physicians, and your coders can get familiar with it and avoid rejected claims and payment delays.

New Edits that Bundle Certain Radiological Procedures

The new version of the CCI contains several new edits that bundle certain codes that radiology practices often use, says Georgia radiology billing consultant Melody Mulaik. Here's a list of new bundles that her company compiled:

- CPT 76003 (fluoroscopic-guided needle biopsy) and 76003 (reconstruction) are now bundled into CPT 75989 (radiological guidance for percutaneous drainage of abscess or specimen collection with placement of catheter, radiological supervision, and interpretation);

- CPT 76085 (screening mammography digitization) is bundled into the codes for diagnostic mammography—CPT 76090 and 76091;

- CPT 76986 (intraoperative ultrasound) is bundled into CPT 76490 (the new code for ultrasound guidance and monitoring of tissue ablation);

- CPT 76375 (reconstruction) is now bundled into fetal biophysical profiles (CPT 76818 and 76819), fetal echocardiography (CPT 76827 and 76828), ultrasound of infant hips (CPT 76885 and 76886), and ultrasonic guidance (CPT 76930 and 76936); and

- CPT 36000 (introduction of needle or catheter), 36011 (selective catheter placement), 36406 (venipuncture, under age 3), 90780 (IV infusion for therapy/diagnosis administered by a physician), 90783 (therapeutic, prophylactic, or diagnostic intra-arterial injection), and 90784 (therapeutic, prophylactic, or diagnostic intravenous injection) are all bundled into all CTAs and MRA.

Edits that Designate New Mutually Exclusive Codes

The new CCI makes some codes mutually exclusive, so that you may no longer bill the following codes together:

- CPT 76003 (fluoroscopic guidance for needle placement) with any of the following: CPT 76000 and 76001 (basic fluoroscopy), CPT 76095 and 76096 (stereotactic or mammographic guidance for needle placement in the breast), CPT 76360 (CT-guided needle placement), CPT 76393 (MRI-guided needle placement), or CPT 76942 (US-guided needle placement);

- CPT 76005 (fluoroscopic guidance for spinal injections) with CPT 76393 (MRI-guided needle placement) or CPT 76942 (MRI-guided needle placement);

- CPT 76393 (MRI-guided needle placement) and 76942 (US-guided needle placement) with CPT 76096 (mammographic needle placement in the breast);

- CPT 76393 (MRI-guided needle placement) with CPT 76095 (stereotactic biopsy or needle placement in the breast);

- CPT 76393 (MRI-guided needle placement) with 76360 (CT-guided needle placement); and

- CPT 76942 (US-guided needle placement) with CPT 75989 (radiological guidance for percutaneous drainage of abscess or specimen collection).

Three Sets of Mutually Exclusive Codes Deleted

Mulaik has identified three sets of codes that were mutually exclusive in past versions of the CCI that won't be mutually exclusive in the new version. This means that you'll now be able to bill the following codes together:

- CPT 76003 (fluoroscopic guidance for needle placement) may now be billed with CPT 20550 (shoulder arthrography injection);

- CPT 76003 (fluoroscopic guidance for needle placement) may be billed with CPT 23350 (trigger point injection); and

- CPT 76092 (screening mammogram) may now be billed with CPT 76090 and 76091 (diagnostic mammograms). ■

Insider Source

Melody Mulaik: Coding Strategies Inc., 168 N. Johnston St., Ste. 103, Dallas, GA 30132.

* CPT codes are copyright 2001 by the American Medical Association.

FDA Warns of Pediatric Radiation Risk from CT Scans

In November 2001, the FDA issued a safety alert about the risk of radiation exposure to children and “small adults” who get CT scans. The FDA, which is responsible for regulating the use of devices that emit radiation, isn't suggesting that CT scans are unsafe for smaller patients. But it does suggest that more care be taken when performing CT scans on them.

We'll tell you what prompted the FDA's safety alert. And we'll give you the FDA's suggestions on how you can reduce the risk of radiation exposure to your patients.

Children Are More Sensitive to Radiation

The FDA's safety alert is a response to a growing concern about the effects of radiation on young patients, says a spokesperson for the FDA's Center for Devices and Radiological Health. Several scientific organizations have emphasized the importance of minimizing a child's exposure to ionizing radiation.

The FDA safety alert points out that it's accepted within the medical and scientific communities that radiation poses a greater risk to children than to adults. That's because a child's cells are still dividing, and any radiation exposure to a child may interfere with the proper division of the child's cells. So radiation exposure increases the risk that a child's cells may be damaged. And damaged cells increase the risk that the child eventually will develop cancer. Plus radiation exposure has a cumulative effect over time—and a child has a longer life expectancy than an adult. So exposure to radiation early in life may be more harmful than exposure to the same dose of radiation later in life.

CT Overexposure Not Uncommon, Not Easily Detectable

Over the past year or so, several articles and studies about radiation exposure from CT scans have appeared in medical journals. These articles and studies point out that sometimes small people—that is, children or undersized adults—receive more radiation when they undergo CT scans than is necessary to get a good quality image. That's because most CT scan providers calibrate CT scanners to provide an appropriate radiation dose for a typical adult and don't always recalibrate their equipment when the patient is smaller than the typical adult.

According to the safety alert, it's not clear when a CT scan patient is being overexposed, which makes the problem even worse. If a patient receives too much radiation during an x-ray, it's apparent because the x-ray film will be overexposed and too dark. But too much radiation isn't evident on a CT scan. So you could be overexposing small patients without realizing it. The FDA issued the safety alert to remind CT scan providers to ensure that each patient receives the minimum radiation dose necessary to generate a good quality image.

Follow FDA's Three Recommendations to Reduce Unnecessary Exposure

In its safety alert, the FDA made three recommendations for how CT scan providers can protect their smaller patients. You can find the full text of the safety alert at the FDA's Web site, www.fda.gov/cdrh/safety.html. Here's a summary of the safety alert's recommendations:

1) Make sure CT operating conditions are appropriate for the patient. Consider the patient's weight and/or the size of the patient's anatomic area of interest, and adjust the settings of the CT equipment accordingly. In other words, the FDA suggests that you consider reducing the tube current, depending on the patient's size and, especially, the diameter of the anatomic area you're examining. The FDA also recommends that you develop a chart listing appropriate tube currents based on patient weight or the diameter of the anatomical areas of interest. The safety alert says that the manufacturer of your CT scanner can help you formulate such a chart. The FDA also recommends that you evaluate whether increasing the table increment or pitch will permit you to obtain a good quality image with less radiation. Again, this is something that your CT scanner manufacturer can help you to assess.

2) Reduce multiple scans. Often when a patient gets an injection of contrast material, a CT scan is performed before, during, and after the injection. The safety alert suggests that pre-injection scans may not always be medically necessary. So physicians should consider eliminating the pre-injection image where medically appropriate. If a radiologist gets an order for a pre-injection scan—and the medical necessity of that order isn't readily apparent—the radiologist may consider contacting the treating physician to discuss whether the pre-injection scan is necessary.

3) Consider other modalities. In its safety alert, the FDA suggests that sometimes conventional x-ray, sonography, or MRI may provide the

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PEDIATRIC RADIATION RISK

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required diagnostic information. All of these modalities expose the patient to less radiation than a CT scan does. The FDA recommends

that referring physicians consider other modalities when seeking diagnostic information about their patients. And radiologists who get an order for a CT scan when another modality may provide the needed

diagnostic information should contact the referring physician to get a more appropriate order, according to the safety alert. ■

Consider Compensation Options for Interventional On-Call Duty

Most medical practices have a system for handling night and weekend on-call duty. Often, these on-call shifts are split equally among all members of the practice. Sometimes, the more senior members of the practice take less on-call duty, leaving the evening and weekend on-call shifts primarily for the younger physicians in the practice.

Radiology groups that include interventional radiologists (IRs) have special challenges allocating on-call shifts. Although the IRs can manage general radiology calls, the general radiologists can't perform interventional procedures and so can't take interventional calls. So IRs typically wind up taking extra on-call duty—and often they expect extra compensation for it. Deciding how to provide that compensation can be a contentious issue within a practice. And given the current shortage of radiologists, particularly IRs, it's important for practices to develop an on-call system that everyone can live with. Otherwise, an unhappy IR may decide to go elsewhere.

The *Insider* surveyed practice administrators around the country to find out how they handle IR on-call duty. We'll describe several systems that have been successful for practices that include both general and interventional radiologists—maybe one of them will work for your practice. We'll also tell you what the experts advise about how to make sure all the physi-

cians in your practice accept whatever system you choose.

Time Is Money

Our survey of practices found that the most common way for radiology practices to compensate IRs for the extra on-call duty they must take is to pay them extra. There are several different ways that practices do this:

Flat rate for being on call. Some practices pay the IRs extra just for carrying the beeper. This system recognizes and compensates for the inconvenience that IRs experience by having to be on call more often than general radiologists, says New Jersey health care consultant Bruce Topolosky. This "beeper fee" may be nominal, especially if the IR also gets paid an extra per-call payment for each call he actually handles during "off" hours. But if the practice doesn't make a per-call payment, then the "beeper fee" is usually higher. One practice the *Insider* spoke to pays its IRs \$500 for every weekday evening or weekend day they carry the beeper, whether the IR gets a call or not. Other practices assign on-call duty on a weekly basis and pay the IRs extra for being available for general and/or interventional calls.

Per-call payment. IRs may get extra payments if they must go into the hospital during their on-call hours. Some practices give the IR a flat payment if he's called into the hospital

during off hours, regardless of how many cases he handles while he's there. Other practices compensate on a per-case basis by paying the IR either a percentage of the billings for the case or a flat per-case rate.

Year-end bonus. Some practices don't compensate for extra on-call duty during the year. Instead, they factor an IR's extra time and productivity into his year-end bonus. This system tends to be less popular with IRs because it doesn't compensate them for the inconvenience of being on call more often. But it's more popular with other members of the practice, because the IRs' additional compensation is tied to their productivity, Topolosky says.

Money Isn't Everything

Extra money isn't the only way to compensate IRs for the extra on-call duty they must take. Some practices can't afford to pay the IRs extra—and some practices have philosophical objections to giving IRs extra money for taking on-call duty. In those practices, the IRs may get reimbursed by getting extra days off to compensate for the extra time spent on call, Topolosky comments.

A practice can give extra time off in several different ways. The way your practice handles it will depend, in part, on how much extra on-call time the IRs must take in your practice. For example, in a 10-radiologist

practice with five IRs, the IRs will be on call twice as much as the general radiologists. A few extra days off may be sufficient to compensate the IRs in that practice. But in a 10-radiologist practice with only two IRs, the IRs will be on call five times as much as the general radiologists. In that situation, perhaps an extra week or two of vacation, or a shorter work week, will be perceived as fair and competitive compensation for the extra time on call.

Base Your Decision on Data

Regardless of whether you choose to pay IRs extra money, give them extra time off, or craft a plan that combines money with time off, it's crucial that all the physicians in your practice—not just the IRs—perceive the arrangement as fair, notes Topolosky. The only way to be sure your solution is fair is to make sure it's based on objective data, he says.

Practices frequently hire consultants to analyze the time and work the IRs put in and come up with an equitable compensation strategy. But Topolosky says that most practices could do the legwork themselves. He suggests that you review the practice's records for the past six months to one year and do the following:

- 1) Determine how often each IR was called into work on his off time. Compare that number to the number of times the general radiologists in the practice were called in on their off time.

- 2) Compare how many weekday evenings and weekend days the IRs were on call, as compared to the general radiologists.

- 3) Calculate the amount of revenue the IRs generate for the practice, as compared to the revenue the general radiologists generate.

- 4) Analyze the kinds of cases the IRs handle—do they add to the prestige of the practice? Do they draw referrals? Is your interventional practice expanding or contracting in your locality? Are any of your contractual relationships with hospitals or managed care plans dependent on having an IR in your practice? In other words, if you don't have an IR in your practice, will you lose referrals to another practice that has one?

- 5) Consider the role of geography. If your practice is located in an area where vascular and GYN surgeons and cardiologists do some of the procedures that IRs do, your compensation structure for IRs may be less generous than in other locales. That's because the cardiologists and vascular surgeons are doing some of the most lucrative interventional procedures, so the IRs may not be much more productive from a revenue standpoint than the general radiologists in the practice. The same holds true if you live in an area where there are teaching hospitals that train IRs. There may be a larger pool of well-trained IRs to choose from, so you can get away with asking more of them.

It's not always easy to put a dollar value on extra on-call duty or referral-generating capacity in a way that's acceptable to everyone in your practice, Topolosky says. But if the data you collect shows that the IRs are putting in more time and/or generating substantially more revenue than the general radiologists, it may be easier to convince the general radiologists that the IRs should get extra money or time off. Conversely, if the data shows that the IRs aren't working significantly more hours or producing substantially more revenue than the other radiologists in the practice, you have data to back up a refusal to meet an IR's demands for extra money or time off.

Insider Says: If you don't want to analyze past data, Topolosky suggests that you track the five factors mentioned, for the next three months, and then make compensation adjustments as the data indicates. Then, continue to track them for the rest of the year and make a permanent adjustment going forward.

Tailor the Solution to Your Practice

Assuming that your data shows the IRs deserve some extra compensation, the solution you choose must be appropriate for your practice, Topolosky emphasizes. Each practice has its own culture, and the on-call compensation solution must reflect that culture. For example, more money isn't much of a reward if the IR is more concerned with spending time with family. Whether an IR should be compensated in time, money, or a combination of both will depend on the age and quality of life concerns of the physicians in the practice, Topolosky remarks. The only way to get an accurate picture of these core values is for the physicians to communicate about these issues, he says. ■

Insider Source

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ASK THE INSIDER

The Insider welcomes questions from subscribers. You can 1) send your questions to Brownstone Publishers, Inc., "Ask the Insider," 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 2) fax them to (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail them to jgormley@brownstone.com

Radiologists Must Provide Reports to Patients Upon Request

Q Recently, one of our patients asked for a copy of the radiologist's interpretation of his MRI. Although we discuss the radiologist's findings with the patient and the radiologist answers the patient's questions, we usually send the interpretive report to the referring physician, not the patient. Because the patient asked for it, we gave him a copy of the report. But the radiologist is uncomfortable because the patient may not fully understand the radiological interpretation. Can we refuse to provide the interpretive report to a patient who requests it?

A In most states, if a patient requests a copy of his medical record, you must provide it, says New York health care attorney Jay Silverman. And in many states, an interpretive report that's intended for a referring physician is considered part of the patient's medical record—so the patient is entitled to access to it, he adds.

But a patient's access to his medical record isn't unlimited, Silverman notes. Most states' laws acknowledge that the medical record is the property of the physician who generated it, he says. In many states, a patient

must request a copy of the record in writing, and the physician must respond to the patient's request within a given period of time. In some states, a patient must request that the record be sent to another health care provider, rather than directly to the patient. Plus most states permit a physician to keep original records and charge the patient a duplication fee for copying them. Some states set a rate the physician may charge for copies or just permit the physician to recoup his copying costs. And, usually, state laws make some provisions for the physician to withhold the records under certain circumstances, Silverman explains. For example, in some states, mentally ill patients may be "protected" from their medical records, and family members may "protect" a terminal patient from learning he's terminal. Contact your attorney or state medical or radiological society for detailed information about your state's laws, Silverman suggests. ■

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