

Radiology Administrator's

Compliance & Reimbursement Insider

DECEMBER 2004

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Doc group bands together to battle managed care firm

Several New York-based providers are involved in litigation with one of the nation's leading imaging utilization management firms CareCore. These providers claim that the company allowed contracts with radiologists to expire without renewing them and then funneled the business to its owners—a group of more than 40 practicing radiologists, says **David Follett, MD**, a radiation oncologist who heads a group of practices that want federal oversight or legislation of companies with such practices and their owners.

A state investigation is underway, and a possible Department of Health and Human Services query may follow, as Follett's group of about 30 radiologists may have enough ammunition to claim breach of contract and file a class-action lawsuit against CareCore.

"[CareCore] has tried to cut down on the overutilization of imaging services in certain areas," says **Mike Carlin, MD**, the owner of a small radiology practice in New York City. "They control the network—they're throwing good doctors out and forcing some practices to close," including some that offered mammography, he says.

Not true, says radiologist **Susan Weiner, MD**, a radiologist and women's imager who's been a medical director for CareCore since January. She and CareCore legal counsel Mike Briggs spoke with our editors on August 30. "We don't control the network. That's the health plan's job," Weiner says.

Some providers dispute Weiner's claim. For example, she cites Oxford, how owned by United Healthcare, as one such plan. Oxford pays the claims and CareCore manages them, says Carlin, who is involved in separate litigation against CareCore and Oxford for allegedly being thrown out of their network without cause. "They've taken patients and put them into their own centers," he says.

Follett adds that Oxford still owes his large group practice some \$550,000 in unpaid claims, and CareCore manages those, he says.

New York's Department of Health disagreed, disputing the radiology group's claim. It audited CareCore, and in a 22-page letter to the radiologists, the state "denied" any illegal activity by the firm. Follett says CareCore sent a group of about 20 lawyers to the state offices for three weeks to address the case.

A cautionary tale for others

Follett's radiologist group requested documents from the state's audit under the Freedom of Information (FOI) Act.

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Radiology Administrator's Compliance & Reimbursement Insider is published monthly by HCPro, Inc., 100 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$357/year; back issues are available at \$25 each.

Postmaster: Send address changes to **Radiology Administrator's Compliance & Reimbursement Insider**, P.O. Box 1168, Marblehead, MA 01945

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DOC GROUP BANDS TOGETHER

(continued from p. 1)

"The information was returned to us in 14 months," he says. The problem was the government is required to respond to FOI queries within 90 days.

Document these details and the dates of response; you may need it to make your case, says attorney **Martin Fraser** from West Hartford, CT.

Briggs had no comment on the state investigation or lawsuit when contacted by **RACRI**.

Mammography noncompliance

Weiner echoed that her firm does not control the network or set the fees for mammography. "In fact, we're big supporters of getting more mammography into network," she said.

Follett and other radiologists say that's a false promise. "If that's true, they should force their owner members to provide mammography." Some 60% of radiologists have stopped offering screening mammography in the New York area in the last few years.

Today, there's a five-month wait time for patients, which several providers admit makes them noncompliant with FDA regulations. One larger practice says it has no choice because CareCore created the backlog years ago by chopping reimbursement below the costs the providers incur.

CareCore later upped the rate above the roughly \$61 cost threshold. CareCore used a full capitation formula to shed more risk to providers. The reasoning is that by lowering the number of providers in the network, they can cut down on overutilization of imaging services, he says.

Reimbursement improvement

Follett concedes that CareCore is making an effort to improve communications during the negotiations and has made progress in certain areas. Weiner adds that the firm will offer an incentive to radiologists in 2005: It will pay more for those mammographers who follow the American College of Radiology's breast imaging reporting system, known as BI-RADS. The payment incentive will take effect in January. "You won't be thrown out if you don't follow this," Weiner says.

Settlement pending

On August 24, the radiology owners from Follett's group received an e-mail with a settlement offer that was less about money and more about reinstating groups like HIP or Aetna, one physician said through his attorney. One stipulation, however, is that the centers can't start new services. "It's a tough concession," says the physician through his attorney.

The issue also has nationwide implications. Some providers say they are vulnerable in New York because the state lacks "any willing-provider laws," which are set up to protect providers. Follett says it's unlikely the state will see a law like this anytime soon; however, he's optimistic that through public education the government will hold managed care firms more accountable for how they manage money. ■

ASK THE INSIDER

The **Insider** welcomes questions from subscribers. Direct your questions to 1. bcote@hcpro.com; 2. HCPro, Inc., "Ask the Insider," Radiology Editor, 200 Hoods Lane, Marblehead, MA 01945; 3. fax 781/639-2982; or 4. call 888/639-5900, Ext. 3149 to speak with the editor.

Billing for catheter change

Q Our interventional radiologists are frequently called upon to change a patient's catheter and check that it functions properly. The dye flush to check for efficacy sometimes takes a considerable amount of time, and the radiologists want to bill for this. It's my understanding that testing for efficacy is a part of the code for catheter change and can't normally be billed separately. Is that correct?

A Yes it is, says radiology billing and coding expert **Donna J. Richmond, RCC, CPC**. Although there are some exceptions pertaining to catheters draining certain organs (e.g., nephrostomy tubes), in general a dye flush to ensure that a catheter is functioning properly is part of the service and cannot be coded separately.

It's true that some dye flushes can take up to one hour, and radiologists may complain that they're not being paid for this time. But as far as Medicare and most other payers are concerned, you may not bill for individual components of a service no matter how time consuming. Doing so is unbundling, which has been on the Office of Inspector General's hit list for some time now. Just as surgeons must place as many sutures as necessary to stem bleeding, regardless of how long it takes, radiologists must wait for dye to pass successfully through a catheter before they can bill for a complete service, she says. ■

Insider source

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Improve biopsy reimbursement rates

Q Payers are inappropriately denying claims for biopsies performed in my practice. What can I do?

A Many payers are quick to deny the radiology component of claims, unless you add modifier -59 to the appropriate code, says **Cam Teems, CPC**, former practice administrator at Breast Care Specialists in Atlanta. Make sure you add the modifier when it's necessary.

Radiologists typically take more than one sample from a biopsy site to improve chances of detection. "But some payers don't understand the reason behind the multiple samples and deny them," Teems says.

Some in breast imaging say you would be better off bringing the patient back another day. "But don't do that," says Teems. "Tell the payer that it is multiple left [LT] and right [RT], if bilateral, and use the -59 in all situations. That's what we do."

The center's reimbursement from biopsies has skyrocketed since it began correctly using the -59 modifier. "We're up 40% in revenue on these procedures alone since the fall [of 2002]," says Teems.

How to list line items

A breast center in Michigan had similar issues with biopsy related denials, says the center's director **Annie Stepp**.

For example, a woman arrived for an exam after she felt a lump, so the technologist performed a screening mammogram. The evidence was inconclusive, so the radiologist ordered an ultrasound. "But we couldn't see the lesion," says Stepp. Next the doctor performed an ultrasound-guided breast biopsy. Results were conclusive, as he spotted a clear lesion that needed to be removed.

Sometimes you need the full workup to properly diagnose a patient. You need the ultrasound guidance in order to do the biopsy, says Teems.

Stepp says her payer denied the claim, and Teems thinks she knows why. "The trick is to list line items on the claim from highest to lowest dollar amount; don't bundle the services on the claim in terms of the order in which you did them," she says. ■

Insider source

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Questions? Comments? Ideas?

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Radiology carve outs: Ask for what can be justified

Payers often carve out services that are not payable under contract language. Many managed care organizations refuse to acknowledge modifier -25 when an arthrocentesis is performed at the same time as an office visit.

Consider the following:

Your orthopedist is following a patient for shoulder pain. The practice schedules a follow-up visit. During the meeting, the patient complains about something else: knee pain. The physician thinks there may be fluid behind the knee, so she performs an arthrocentesis during the visit.

Many practices bill modifier -25 here along with the appropriate office visit code, but some payers, according to 78% of 175 practices polled by HCPro in a survey August 2004, deny electronic claims with the -25 modifier; "they tell us we can't do two separately identifiable procedures at the same visit," one survey respondent commented. The physician practice disagrees, arguing that in no way would they insert a needle into a patient if it wasn't medically necessary.

Examples from those who did it

Michael N. Linver, MD, director of mammography for X-ray Associates of New Mexico, PC, and clinical associate professor in the University of New Mexico School of Medicine's Department of Radiology in Albuquerque says the following:

When negotiating with HMOs, we used our own mammography outcome data to demonstrate that finding earlier, smaller cancers with mammography translates into savings for the HMO. Further, if one's callback rate is low and positive biopsy rate appropriately high, one can argue even more effectively for the savings to the HMO.

Mary Turnbaugh, RN, CNOR, administrator at Grandview Surgery Center Mechanicsburg (PA) says the following:

We wanted to demonstrate the need for a separate implant reimbursement charge [for knee implants], and to prove that we weren't overcharging our payers for implants . . . we first showed them the vendor's original invoices for these devices. We explained that if implant costs increased, it would be impossible for us to absorb that cost plus the cost of the rest of the case. Most of our payers then agreed to carve out the cost of the

implant [and pay more than the fee schedule allowed].

Tip: Invite the payer representative for an inservice on the data the department has gathered and perhaps on the modality itself. Draft an official letter requesting review of the fees requested and insist on resolution within a specified time frame. If the data are justified, the higher reimbursement is often just around the corner. ■

Insider source

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MODEL PROCEDURE

CARVE OUTS

A carve out that benefits a healthcare facility starts with a provider's review of services. Do the following:

- Run a report of the department or center's CPT code usage and use it as a starting point
- Examine modalities across departments and decide whether one piece of equipment offers a unique service to be bargained for
- Determine which service(s) could generate more reimbursement
- Find out what reimbursement increase you can justify with quantitative or qualitative data

Radiology negotiation: For computed tomography (CT), breast, and magnetic resonance (MR)

Once you gather your data, strategically review their outcomes to help you negotiate higher rates from payers. Start with these queries:

- Is your department's CT the only one within a 100-mile radius? *Negotiation tactic:* Proximity for a payer's members should be worth something.
- Is the department's positive predictive value (PPV) consistently 99% or more when reported to the FDA for the MQSA? *Negotiation tactic:* Although payers may need education on PPV for malignancies, they can certainly appreciate the benefit of radiologists whose BI-RADS does not waste money on unnecessary biopsies.
- Does the MRI department offer "dedicated imaging," such as osteo-articular imaging? Does it offer a breast coil? *Negotiation tactic:* These can bring in more money if you explain their value to the payer. ■ [E-TOOL](#) ■

Specialty MRIs: Will they really offer a better sweet spot?

According to the scientists and physicians at Aurora Imaging in North Andover, MA, a better sweet spot exists—at least in the area of breast imaging.

Their system's magnet, patient table, radiofrequency (RF), and gradient coils are specifically designed for breast imaging, including uniform simultaneous imaging of both breasts.

Additionally, the uniquely contoured examination table allows the patient's breasts to be suspended away from the chest wall, without compression.

Logic says such suspension would, indeed, provide a better breast image.

With help from his colleagues, **Steven Harms, MD**, director of imaging research in the University of Arkansas department of radiology in Little Rock developed RODEO (rotating delivery of excitation off resonance) as a proprietary pulse sequence that provides “robust, fat-suppressed magnetization transfer contrast in an efficient high-resolution MRI acquisition.”

Magnetization transfer contrast is used to reduce signals from normal ductal tissue and avoid false-positive enhancement from benign lesions and dense fibroglandular tissue common in young women.

Applying the RODEO fat-suppression technique in breast MRI after contrast injection (gadolinium) enables physicians to focus on diseases affecting ductal or glandular tissue without the distraction of fat tissue.

Such contrast avoids what Harms calls the “snowman in a snowstorm” effect in which fat and cancer are both bright on the MRI. Typically, fat sup-

pression is not possible when both breasts are imaged and is not fast enough to generate dynamic curves. ■

Insider source

Steven Harms, MD, director of imaging research in the University of Arkansas department of radiology in Little Rock.

Such contrast avoids what Harms calls the “snowman in a snowstorm” effect in which fat and cancer are both bright on the MRI.

MODEL POLICY

Medical necessity for breast MRI

Breast magnetic resonance imaging (MRI) reimburses well—it can be compared to brain MRI with contrast. You may consider the procedure medically necessary under these seven conditions:

1. When there is suspected leakage of a silicone implant and the implant was previously inserted due to reconstructive surgery
2. As a screening tool in patients at high risk for breast cancer, which includes
 - those with known breast cancer gene 1 or 2 (BRCA) mutation
 - those who are at high risk of BRCA1 or BRCA2 mutation due to a known presence of the mutation in relatives
 - those with a pattern of breast cancer history in multiple (two or more) first-degree relatives (e.g., parent, sibling, child) or a personal current diagnosis or history of breast cancer
3. As a screening technique of the contralateral breast in patients who have breast cancer
4. For detection of a suspected occult breast primary tumor in patients with axillary nodal adenocarcinoma with a negative mammogram and physical exam
5. For presurgical planning in patients with locally advanced breast cancer before and after completion of neoadjuvant chemotherapy (MRI may be performed before and after completion of neoadjuvant chemotherapy to permit tumor localization and characterization)
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor
7. As a screening technique for the detection of breast cancer when the sensitivity of mammography is limited (e.g., young women [less than 40 years] who have dense breasts or women with breast implants) [E-TOOL](#)

Prompt-payment laws require awareness and documentation for enforcement

Prompt-payment laws were enacted by Congress as a result of public complaints about insurers' disregard for standard payment terms across the marketplace.

Physician practices and hospitals often find that their clean claims sit in a payer queue or are simply held in accounts payable until the money is ready for release. Such arbitrary decisions regarding payment terms by payers can have devastating effects on cash flow for small physician practices.

Placing the issue on legislators' radar screens and crafting bills to stem payer abuses has had a beneficial effect, but the resulting statutes

are so riddled with loopholes that the net effect has hardly been a total fix.

Many physicians either aren't aware of their rights under the laws or are uncertain how to access the statute to claim their overdue money. Further, in some states, payer contracts supersede the prompt-pay laws, so physicians may not benefit from some of their provisions.

Members of the health-

care community must take it upon themselves to police their payers compliance with prompt pay rules.

This requires coordination within the billing department and use of technology to monitor the actual time from submission of the clean claim to remittance. If a practice or hospital wants to use the legislation to demand payment, it must be able to document abuse by their payer. Most states will not intervene without quantitative data of the outstanding receivables. ■

Insider source

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Placing the issue on legislators' radar screens and crafting bills to stem payer abuses has had a beneficial impact, but the resulting statutes are so riddled with loopholes that the net effect has hardly been a total fix.

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MODEL PROCEDURE

Using prompt pay laws to your advantage

The following are a few pointers for using the prompt-pay laws to your advantage:

- Know what the prompt-pay rules are and how they vary by payer. For example, self-insured Employee Retirement Income Security Act plans may be exempt, and Medicare and Medicaid managed-care plans are subject to different pay rules. The Medicare+Choice laws stipulate that 90% of clean claims must be paid within 30 days (the remaining 10% simply allows for margin of error, according to the Centers for Medicare & Medicaid Services).
- Carefully review your payer contracts to ensure that they're not at odds with the law. For example, your contract with a large payer may define a clean claim in a more narrow way than the prompt-pay law, leaving the physician or hospital with no remedy. Also, payers may send contract amendments, tucked away in fine-point type, that either modify claims requirements or require physicians to accept a lower interest rate than the law outlines. These come in envelopes with preprinted addresses that often are tossed as junk mail.
- Have your billing department staff document discussions with payers, noting the date, name of the representative, and issues discussed when they call to follow up on an unpaid claim. Most states with formal grievance processes require such documentation to commence an investigation.
- Use the billing information system to your advantage—make sure your system allows for detailed tracking of claims and payments. This may require a custom report written by your information technology department or system provider. ➡ E-TOOL ◀

How new overtime staffing regs affect technologists

In April, the U.S. Department of Labor (DOL) released new regulations governing overtime pay designed to make it easier for employers to determine which employees will be exempt from overtime pay and who is entitled to receive it.

The regulations appear to provide several much-needed updates and clarifications to exemptions from the Fair Labor Standards Act (FLSA).

These improvements will likely limit lawsuits and could ease recruitment. However, it will require an increase in payroll budgets for many institutions.

Old standards were ambiguous

The previous standards for determining whether a worker was eligible for overtime left employers in a quagmire. Exemption status was not always clear, and court rulings on overtime have been difficult to predict.

In this environment, there have been a plethora of lawsuits and class-action judgments on the FLSA have reached as high as \$90 million.

New regs provide clarity

The new regulations do not represent a major policy shift. However, they do provide some clarity to the numerous grey areas that have developed in the past 50 years.

For example, the regulations clear up the question of "discretion and independent judgment." Previously, exempt employees "used discretion and independent judgment in their position," according to the description. There was no description of how to measure this critical variable.

The new regulations, however, provide explicit guidance, incorporating

case law and the experience of DOL caseworkers to give employers a better indicator of which occupations involve sufficient discretion to qualify as exempt.

One large substantive change expands overtime coverage for some small department supervisors. Until now, workers making as little as \$8,060 per year—below minimum wage—could be considered "white collar." The new regulations raise that minimum standard to \$23,660. This change will be a windfall to low-level supervisors, and many will now automatically receive overtime pay.

Particularly helpful for healthcare employers are the learned professional examples and explanations that illustrate how to apply the exemption, including occupations that are now classified as exempt from overtime, such as

- registered or certified medical technologists who have four years of college and coursework approved by the Council of Medical Education of the American Medical Association. Each state has different requirements for licensing or certification of technologists that may require an academic degree. Check each state's regulations when reviewing these exemptions.

- registered nurses who are registered by the appropriate state examining board (same as the current regulations; licensed practical nurses generally do not qualify for the learned professional exemption).

- Physician assistants who have completed four academic years of study approved by a designated credentialing body. ■

Insider source

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Ensure tech documentation readily available in chart

Make sure your technologists' documentation is properly filed and secured in the patient chart—not just randomly stuffed in, or worse, scribbled on a film jacket. A tech's notes provide an essential portion of the roadmap to the radiologist's decision-making, explains Atlanta-based radiology compliance expert **Jackie Miller**. Although the radiologist should dictate the salient aspects of the tech's notes into his or her interpretive report, that doesn't always happen, she says. For example, your techs may often take a patient history and ask about allergies or occupational exposure to metal.

The answers to these questions will determine certain medical decisions, such as whether to use nonionic contrast media or perform an x-ray of the orbit before a magnetic resonance imaging test. A tech's notes often reveal whether the patient can tolerate certain tests—for example, a bending view of a limb may not be possible in an arthritic patient.

Having well-organized tech notes readily available can help if you're ever audited, says Miller. Otherwise, if the radiologist doesn't mention the tech's findings in his or her report, you'll need to produce the tech's notes to justify your medical decision-making and coding selections. It's important to keep the tech's notes with the main body of the patient chart and arranged chronologically and seamlessly with the other entries. ■

Insider source

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CAD payer strategy among '05 business suggestions, MDs advise

Signs of success are cropping up in the longstanding struggle to make mammography profitable. Although the field is still largely a loss leader, reimbursement rates have increased in the past few years, advanced technology and equipment are spurring more efficient practice, and improved marketing strategies are boosting bottom lines.

"As long as we're not losing money per patient, which we were at one point, we don't have to turn anyone away," says **Wende Logan-Young, MD**, director of the Elizabeth Wende Breast Clinic in Rochester, NY, which performs about 75,000 mammograms a year. "We're struggling along," she adds, noting her center's average reimbursement is about \$75 per mammogram. "But God knows what will happen when they cut back Medicare in 2005 for 2006. Everybody's on edge."

William Poller, MD, director of radiology at Allegheny General Hos-

pital in Pittsburgh, says technology advances, especially computer-aided detection (CAD) "can put a facility over the top" in profitability. "If you own your own imaging center, MR [magnetic resonance] and CAD will be of great value, financially and otherwise."

Phil Evans, MD, director of the University of Texas Southwestern Center for Breast Care in Dallas, whose 1998 study established the basis for FDA approval of CAD for screenings, says "there's a wealth of data proving that CAD can find cancers otherwise undetected."

Evans suggests the following strategy for stressing the value of CAD to payers:

Show that CAD is part of treatment, not an add-on. Both Evans and Poller say nearly all their CAD screenings are now reimbursed by

insurance. In 2002, when a major insurer in Texas declined to pay for CAD, "we talked to them, presented the data that CAD was effective, and they paid," Evans says.

This may take persistence. Getting paid for CAD currently is "the biggest challenge for the financial person," says **Melody Mulaik**, president of Coding Strategies in Atlanta. "Some insurers say it is not medically necessary, it's an add-on, or nice to have, and the facility has to swallow the cost." ■

Insider sources

Wende Logan-Young, MD, director of the Elizabeth Wende Breast Clinic in Rochester, NY.

Melody Mulaik, president of Coding Strategies in Atlanta. E-mail Mulaik at Melody.Mulaik@CodingStrategies.com.

William Poller, MD, director of radiology at Allegheny General Hospital in Pittsburgh.

QUICK MONEY TIPS

✓ Recruit retirees and consider subsidizing fellows in an effort to bolster your practice, says **James Paul Borgstede, MD**, who manages a 17-provider radiology practice in Colorado Springs, CO. Colorado Springs Radiologists hired eight of its 17 full-time physicians during the past five years, Borgstede says.

The group's growth—a 12.5% increase in exams per year—and Borgstede's decision to offer round-the-clock in-house calls paved the way for the staffing boom.

✓ Subsidize two radiologists through fellowships. "Fellows need money

to stay in training, plus this costs us nothing," Borgstede says. "We take the money from the fellows plus the dollars they earn in the first year and then distribute it over a two-year period."

✓ Hire early for future needs. Borgstede's practice has one more full-timer than it needs, "and that should level out," he says. "But most practices wait until they're one [full-time equivalent] down, and then they hire. I don't think that model works."

✓ Share on-call shifts and use physician extenders. Also look into teleradiology, Borgstede says—but be

prepared for Medicare problems.

✓ Try exceeding the cap and hiring more residents for your practice to lure more women—one of the three subspecialties with the highest demand—to fill your mammography openings. "Consider it; our practice does," says Denver-based radiologist **Carol Rumack, MD**.

"Medicare caps reimbursement, but our hospital is willing to exceed the cap" and seek other sources of payment, she says. Paying a resident's salary costs less than paying most other physicians, such as faculty, says Rumack. ■

Medicare reform update

Section 306 could cause Medicare shortfall

Some urging CMS to go back to Congress

Money intended as healthcare reimbursement to providers and suppliers will go to an administrative bucket that helps run Medicare, not back to the Medicare provider trust fund, according to a piece of section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). This could cause a Medicare shortfall, said a senior official with a government subcontractor. Taxpayers contribute to the trust fund through their paychecks to help the government fund health services (e.g., reimburse physicians) whereas income taxes go to the administrative bucket.

The impetus for the provision may have come from collection agencies, which lobbied Congress hard in fall 2003 hoping for a piece of action in the reform law. The agencies said they could help the Centers for Medicare & Medicaid Services (CMS) save money if they received debt cases earlier. Historically, uncollectible debt has been referred to the treasury too late.

Three-year pilot problem

Companies will bid to become “recovery audit contractors” (RAC) under Section 306 of the MMA law. CMS officials will select as many RACs as necessary to help Medicare identify those providers and suppliers it has overpaid. CMS will initially award contracts in three states: New York, California, and Florida (lawmakers wanted to test this in large states). Contractors will recover and collect the money from providers (e.g., hospitals) and then receive a percentage of what was collected as their fee. The rest of the money will go to an administrative bucket, rather than the trust fund. RACs may subcontract the work to collec-

tion agencies, but some of these agencies do business for providers and the government. “It’s a conflict of interest, absolutely,” says one hospital provider who wished to remain anonymous, but there’s nothing in the MMA to address this. The only conflict reduction measure is that current carriers and fiscal intermediaries (FI) may not bid.

How it will work

FIs and carriers currently collect overpayments. To ensure that RACs don’t duplicate work, they will periodically send CMS a list that identifies the providers and suppliers that have been overpaid. CMS will send this list to FIs and carriers, which will then cross off those they’ve been investigating.

Getting milked over carrier probes

New government guidelines in 2002 gave Medicare carriers the green light to go after providers for false claims and overpayments. Carriers used so-called “probe letters” to reopen claims for medical review. Sample sizes for these claim reviews have not been the petite versions from the old insurance racks; they’re much broader. This means carriers have had the ability to uncover more mistakes—even a hint of fraud—and possibly forward your case to the Office of Inspector General.

“The government is encouraging providers to come forward, but [it also collects] more on refunds and penalties than it spends to go after providers,” says Philadelphia attorney **John Knapp** of the government’s overpayment

Section 306 (cont.)

recovery effort.

It's a revenue cow that's reimbursing Medicare, but some providers—too scared to challenge official probe letters—are giving up too quickly, Knapp says. "You have legal options to make sure the carriers are conducting fair reviews."

The recovery audit-contractor changes in the MMA further signal a push to reduce and collect overpayments to providers. Giving up and repaying your carrier for an overpayment may dramatically affect other claim reviews, so challenge the sample size and check whether the carrier even has the right to reopen a claim. ■

MODEL POLICY AND PROCEDURE

Model policy: Challenging carriers during pre- and postpayment reviews

The following is an example of how to challenge reviews by peppering carriers with questions during the pre- and postpayment reviews:

- Ask for the audit's sample size. If the carrier reviewed 10 claims since January and you have 10,000, this isn't fair, Knapp says. Suggest a larger number, at least 100 for example.
- What's the time period from which the sample was drawn? Make sure carriers take samples for periods of time after your office has updated policies. Sometimes, says Knapp, you'll find a sample period that doesn't reflect what you're doing.
- If the carrier limits the review to one type of service, ask why. The review may be too narrow and not a fair assessment of your billing.

Procedure: Overpayment communication

Carriers can reopen claims that are less than one year old for any reason. To reopen claims that are from one to four years old, the carrier must be able to prove fraud or another reasonable cause, such as new evidence brought forward by a former employee. Beyond that, the rules tighten specifically for overpayments.

"If the carrier tells you it's an overpayment, you

may not necessarily be liable for it," says Knapp. "Medicare carriers must assume providers are without fault after three years from the date of the initial claim."

Consider this scenario: You challenged the carrier's sample size. You think it's reasonable, but there's an overpayment. Are you responsible, or is the patient? First, expect the carrier to follow up with you on an overpayment. "But don't just send a check in for [however much they ask for]," Knapp says.

"Provide details and analysis to limit your review and avoid additional expenses."

Include the following in your overpayment note to the carrier:

- Your process. "We discovered an overpayment through the routine operation of our compliance program. So we performed a random sample of 50 claims."
- How you chose these claims, and for what time period, providers, and tests.
- Why you believe there was no fraud.
- Circumstances behind the overpayment, including all findings relevant to your investigation. ■

Insider resources: *John Knapp, attorney, Cozen O'Connor, 1900 Market Street, Philadelphia, PA 19103; Call 215/665-2000.*