Radiology Administrator's
Compliance & Reimbursement Insider

MARCH 2005

Do's and don'ts 3
Billing bilateral procedures and ensuring proper documentation.

Stay on top of CPT code changes 4
New CPT coding guidelines are increasing documentation requirements for transcatheter procedures.

Keep good hotline records to improve compliance 5
Having a hotline won't help—and may even hurt—compliance without proper documentation. We'll tell you what you need.
- Model form: Sample hotline report form (p. 8)

In future issues
- Examining the CPT code changes
- Focusing on PET coding
- How organizations are ensuring good quality images when working with special populations

Imaging Weekly

Subscribe to our free electronic newsletter **Imaging Weekly,** which covers news and practical how-to advice on government and state regulations, Medicare updates, malpractice, mammography, billing and coding, safety, technology, and much more. Go to *www.hcmarketplace.com* to sign up.

This newsletter has prior approval by the American Academy of Professional Coders for up to 10 CEUs per year. Granting this approval in no way constitutes endorsement by AAPC of the program, content, or the program sponsor. Go to *www.aapc.com/education/CEUs/ceus.html* or call the AAPC at 800/626-2633 for more information.

Digital mammography: Easing the transition for radiologists

Many organizations have made the leap and purchased full-field digital mammography equipment, and many more are contemplating doing the same. Although the new digital systems are touted as a means to reduce operating expenses and improve efficiency, the initial transition to digital can be burdensome for radiologists who must use both film and digital images until all images are digitized.

Switching from one medium to the other can lead to physical strain and extended read times, and it has the potential to increase the likelihood of errors. Although digital equipment could eventually speed up the interpretation process for radiologists, the transition period may tack on an extra 15 minutes to what would currently be an hour-long session, says **Shirley M. Long, RTR, CBI.** Radiologists need time to become familiar with this modality; a learning curve is an unavoidable part of this process.

Although there is no way to alleviate all the issues related to the transition from film to digital, there are ways to ease the process, says Long.

Focus on ergonomics

The first step is to ensure that your radiologists' workstations are as comfortable as possible, Long says. "Make sure the station is efficiently laid out," says Long.

Also ensure that

• radiologists don't have to get up from their chairs when switching from the film-viewing station to the digital monitor. Provide a chair with wheels to allow the radiologists to move back and forth quickly and efficiently.

• the film viewer and monitor are adjusted to the same height so radiologists don't have to move their heads up and down when switching between modalities.

• whoever mounts the films organizes them the same way as the digital images so radiologists aren't hunting to match images for patients. This also helps minimize errors and needless confusion during the interpretation process.

• paperwork and needed tools are readily accessible at the workstation.

The atmosphere in the room is also important, says Long, citing the following as important items to be aware of:

• Low-level ambient lighting is critical for visual acuity.

• Keep the room cool and dry to prevent

(continued on p. 2)

(MAMMOGRAPHY continued from p. 1)

drowsiness; good air circulation is also important.

• Strive to minimize noise and interruptions in the reading area. "Probably a lot of people will smile at this thought, because it's not always possible," says Long. "But working toward this goal will create the most ideal setting for interpretation."

• Encourage your radiologists to take brief breaks to reduce eyestrain and fatigue.

Working out a solution

Keep in mind that when radiologists work between two different modalities it can raise the potential for error. There are a number of innovative plans that organizations have adopted to make the transition easier, says Long.

For example, some organizations have decided to digitize prior film images during the transition period. This is certainly not ideal, she says, because detail is lost in the digitization process and image detail is key in mammography.

Some might argue that using the digital modality is the clearest way to view mammography images. In addition, the older film images can be examined if the digitized version isn't adequate, but Long still thinks this is something that organizations should avoid.

Long also knows of a handful of organizations that print out all digital mammography images so they can be examined on film viewers along with the prior film study. She says this is an ineffective idea—one she hopes few organizations will adopt.

This protocol defeats the purpose of going digital, Long says. Again, the printing process results in reduced image quality, and therefore the potential for error arises. "It's going backwards," she says. "It's like buying a Cadillac, stepping out of it, and going back into the Volkswagen."

Also, radiologists will undoubtedly want to view the digital study on high-resolution computer monitors at some point in the process, which defeats the purpose.

Printing digital images is also a large expense, involving both the purchase of a high-quality printer and the ongoing cost of printing materials, says Long.

These dollars might be better spent on a computer aided detection (CAD) system. Although CAD systems are not foolproof, they can provide a safety net of sorts, catching errors that might otherwise slip through the system. This is particularly beneficial and comforting during the initial transition, when the potential for error is a concern.

Learning new tools

Because digital equipment offers radiologists the opportunity to use a host of new tools when examining images, it may also initially prove to be more time-consuming. Radiologists have more power with digital imaging to

BOARD OF ADVISORS

Andrei Costantino
Parente Randolph Orlando Carey & Associates, LLC
Harrisburg, PA

William G. Franz Jr.
Radiologix, Inc.
Dallas, TX

Alice G. Gosfield, Esq.
Alice G. Gosfield & Assocs., PC
Philadelphia, PA

Thomas W. Greeson, Esq.
Reed Smith LLP
Falls Church, VA

Karol Handrahan
University of Pittsburgh Dept. of Radiology
Pittsburgh, PA

Matthew Kupferberg, Esq.
Arent Fox PLLC
New York, NY

Jackie Miller, RHIA, CPC
Coding Strategies, Inc.
Powder Springs, GA

Roberta J. Miller
Medical College of Ohio Dept. of Radiology
Toledo, OH

Ronald E. Miller
Medical College of Virginia Hospitals
Richmond, VA

Diane S. Millman, Esq.
Powers Pyles Sutter & Verville
Washington, DC

Melody Mulaik, MSHS, CPC
Coding Strategies, Inc.
Powder Springs, GA

Claudia A. Murray
Provider Practice Analysis, LLC
Baldwin, MD

Paula Richburg
QuadraMed
Columbia, MO

William A. Sarraille, Esq.
Sidley Austin Brown & Wood
Washington, DC

Michael F. Schaff, Esq.
Wilentz Goldman & Spitzer
Woodbridge, NJ

Jay Silverman, Esq.
Ruskin Moscou Faltischek, PC
Uniondale, NY

Tobin N. Watt, Esq.
Smith Helms Murliss & Moore, LLP
Atlanta, GA

Kelly Bilodeau, Managing Editor
Paul Nash, Group Publisher
Suzanne Perney, Publisher

Radiology Administrator's Compliance & Reimbursement Insider is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: $227/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

Copyright 2005 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy.

For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail *customerservice@hcpro.com.* Visit our Web site at *www.hcpro.com.*

Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the Marketing Department at the address above.

Opinions expressed are not necessarily those of **Radiology Administrator's Compliance & Reimbursement Insider.** Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. **Radiology Administrator's Compliance & Reimbursement Insider** is not affiliated in any way with the Joint Commission on Accreditation of Healthcare Organizations.

manipulate images, such as zooming in on problem areas and enlarging, reducing, and lightening dark spots, says Long. But although these tools will eventually be a boon, they may initially be a bane for those unfamiliar with how to use them efficiently. Radiologists need to experiment with the image-manipulation features of the equipment.

"Going digital is definitely something that will be more time-consuming initially until radiologists develop a comfort level with their new equipment," says Long. Some may attempt to use all the digital tools on every image, but this practice is highly unlikely in the long run, she says. Once their confidence level is raised, they will begin to read the images more quickly. Eventually radiologists' interpretation will settle back into a standard pattern and efficiency level, but at first it is important for them to determine which tools are most helpful with different breast and tissue types. ■

Insider *source:*

Shirley Long, RTR, CBI, Mammography Consulting Service Ltd., Alberta, Canada.

DO'S & DON'TS

✓ Use -52 modifier to bill 'bilateral' procedure on one side

Make sure that you add the -52 modifier when you perform a bilateral procedure on only one side of the body, says radiology coding expert **Melody Mulaik.** Many Current Procedural Terminology* (CPT) codes for common radiology procedures such as screening mammograms describe a procedure performed on both sides of the body at one time, so they're considered bilateral procedures.

By adding the -52 modifier, you inform the payer that although the procedure you're billing for is considered bilateral, you performed it only on one side of the patient's body. Use of this modifier is necessary in several situations, such as in the absence of a body part. For example, if a patient who has had a mastectomy comes to your office for a screening mammogram and you take films of only her remaining breast, code 76092-52.

It's important to use this modifier because reimbursement for bilateral codes is based on the time, effort, and materials necessary to perform the procedure on both sides of the body. Submitting the claim without the -52 modifier could be considered a false claim because you didn't perform the procedure you're coding, Mulaik explains. When you submit a claim with the -52 modifier, your payer will reduce the reimbursement amount to reflect that you didn't do a complete bilateral procedure, she says.

Insider *source:*

Melody Mulaik, Coding Strategies, Inc., 5041 Dallas Hwy., Ste. 606, Powder Springs, GA 30127.

** CPT codes are copyright 2002 by the American Medical Association.*

✓ Ensure tech documentation is readily available in chart

Make sure that your techs' documentation is properly filed and secured in patient charts—not just randomly stuffed in, or worse, scribbled on a film jacket. Techs' notes provide an essential portion of the roadmap to the radiologist's decision-making, explains Atlanta radiology compliance expert **Jackie Miller.** Although the radiologist should really dictate the salient aspects of a tech's notes into his or her interpretive reports, that doesn't always happen, she says.

For example, your techs may take patient histories 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 to perform an x-ray of the orbit before an MRI. And the techs' notes often reveal whether the patient can tolerate certain tests (e.g., a bending view of a limb may not be possible for 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 techs' findings in his or her report, you need to produce the techs' notes to justify your medical decision-making and coding selections. It's important to keep the techs' notes with the main body of the patient chart and arranged chronologically and seamlessly with the other entries. ■

Insider *source:*

Jackie Miller, RHIA, CPC, Per-Se Technologies Consulting Group, 2840 MountWilkinson Pkwy., Atlanta, GA 30339; *jackie.miller@per-se.com.*

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com.*

CPT code changes increase documentation requirements for transcatheter procedures

New CPT coding guidelines are increasing documentation requirements for transcatheter procedures. In the past, providers could bill separately for diagnostic arteriograms and venograms performed during the same session as a transcatheter procedure. Such exams are now only separately reportable if they meet certain criteria, says **Jackie Miller, RHIA, CPC.**

To protect your organization from receiving denials or submitting claims without adequate documentation, it is critical to understand the guideline changes and ensure that radiologists are aware of these new requirements, says Miller.

Most transcatheter procedures have a surgical component and a radiological supervision and interpretation (S&I) component. For example, transcatheter stent placement has a surgical component (37205–37206) that represents the actual placement of the stent, as well as an S&I component (75960) that represents use of imaging guidance to perform the procedure. As of 2005, CPT defines the following services as being part of the S&I component:

- Contrast injections, roadmapping, and guidance for the intervention
- Vessel measurement
- Completion angiogram (except following transcatheter embolization and infusion)

Because the above services are represented by the S&I code, Miller says, a diagnostic angiogram should not be charged when these are the only imaging services provided.

A diagnostic angiogram can be billed in conjunction with a therapeutic procedure if it is a separate, medically necessary exam. According to the new CPT criteria, a diagnostic exam can be billed together with the therapeutic procedure if there is

- no prior catheter angiogram available, a full exam is performed, and the decision to intervene is based on the current exam
- a prior catheter angiogram is available but the patient's condition has changed, the prior films are inadequate, or there is a clinical change during the procedure that requires a new exam outside the target area

Additionally, the diagnostic angiogram is separately billable if it is performed at a separate setting from the interventional procedure.

Providers should be aware that several therapeutic procedures include a diagnostic angiogram by definition, including cervical carotid stenting (37215–37216), TIPS (37182–37183), and vertebral artery stenting (0075T–0076T), cautions Miller. Do not code separately for a diagnostic angiogram in conjunction with these procedures, even if such coding meets the new guidelines listed above.

Note: When the diagnostic angiogram meets the criteria for separate reporting, use modifier -59 so the diagnostic imaging will not be bundled with the S&I service, says Miller. For example, if the radiologist performs a diagnostic unilateral selective renal arteriogram (75722) on a patient who has not had a prior renal arteriogram and decides to proceed to renal artery stenting (37205 and 75960), the renal arteriogram must be reported with modifier -59 (75722-59).

The American Medical Association (AMA) began developing the new guidelines in 2004 after catching wind that CMS was considering adding correct coding edits that would bundle diagnostic angiograms with therapeutic procedures. Despite the AMA's decision to institute new guidelines, CMS approved the new Correct Coding Initiative edits last fall. ■

Insider *source:*

Jackie Miller, RHIA, CPC, senior consultant, Coding Strategies, Inc., 5041 Dallas Hwy., Ste. 606, Powder Springs, GA 30127; 770/445-5566; *jackie.miller@codingstrategies.com.*

Coding update

CMS issued a transmittal on January 14 that modified the diagnosis codes allowed for screening mammography claims effective July 1, 2004. The change allows providers to report diagnosis code V76.11, screening mammogram for high-risk patient, if it more accurately describes the patient's status, says **Stacie L. Buck, RHIA, LHRM,** president of HIM Associates, Inc., in North Palm Beach, FL.

Since January 1, 1998, providers could only use diagnosis code V76.12, other screening mammogram, on screening mammography claims. But now providers can either use V76.11 or V76.12, whichever is more appropriate. The change was made to ensure accurate coding and create improved data quality for reporting purposes, says Buck, and it will allow the identification of high-risk patients who are having screening mammography. ■

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com.*

Keep good hotline records to improve compliance

Many facilities have hotlines that employees can use to report fraudulent practices and other potential violations to management. Having a hotline discourages employees from filing whistleblower suits against your organization and shows the government that you're serious about compliance. But simply having a hotline isn't enough, warns **Alex Schillaci,** a Connecticut compliance consultant.

"Anybody can get a special phone number and claim they have a hotline," he says. However, you must be able to show that you not only take calls, but that you also take them seriously. To do this, keep thorough records documenting each call you received and how you responded to it.

But experts say providers—including radiology facilities—have a tendency to overlook the importance of good records and therefore don't create systems for tracking this vital information. Experts also say there's a simple way to correct the problem: Create a hotline report sheet and have your operators complete it for each call they field. Below is information that explains how these forms work and how to create one you can use. To help, we've provided for you a model form of a hotline report sheet that you can adapt (see p. 8).

What's a hotline report sheet?

A hotline report sheet is a one-page form that outlines the essential information an operator needs to get from a caller. Each sheet has its own serial number so each call can be tracked. Hotline operators must fill out a sheet every time they field a call.

Three ways report sheets further compliance

Using hotline report sheets aids your compliance efforts in three ways:

1. Funnel complete information to your compliance officer. Hotline report sheets ensure that operators quickly relay information to the appropriate person, says **Stacey Schleifer,** an attorney with an Alexandria, VA, hotline service company. At the end of their shifts, operators assemble all the sheets they've completed and send them directly to the compliance officer or to another designated person. This way the compliance officer gets all the sheets on the same day or, if the call comes in after business hours, by the next business day.

Giving operators hotline report sheets to fill out also acts as a check against sloppy and incomplete fact reporting.

Giving operators hotline report sheets to fill out also acts as a check against sloppy and incomplete fact reporting. "It's like a phone script showing operators what to ask callers," notes Schillaci. That's important because it ensures that operators get all the information the compliance officer needs to decide to handle the calls, he adds.

Finally, the hotline report sheet forces all operators to report information the same way, notes New York–based compliance consultant **F. Lisa Murtha.** "Standardization of reporting formats makes the information easier for the compliance officer to process," Murtha says. If you don't require operators to use a standard form, they're apt to provide vague narratives or invent their own formats.

2. Win points with the government. Various Office of Inspector General (OIG) compliance plans (e.g., for labs, hospitals, third-party billing companies, etc.) specifically recommend creating a hotline. They also say "the OIG will be critical of compliance programs that exist on paper but are not earnestly implemented or enforced."

Hotline report sheets can help you demonstrate to the OIG—and any other enforcement agencies—that you have implemented your hotline program. "The government doesn't want guesses and estimates—it expects specific data about the calls you're getting and how you respond to them," Murtha says.

***Insider* says:** Enter the raw data from your hotline report sheets into a log. The OIG requires you to maintain a log of all calls "that suggest substantial violations of compliance policies, regulations, statutes, or program requirements of federal, state, and private insurers," including "the nature of any investigation and its results."

3. Enhance effectiveness of internal audits. The OIG says providers should conduct regular compliance audits of their operations. Use hotline report sheets to identify problem areas to audit. This enables you to solve potential problems before they become major liability risks. It also helps you verify the effectiveness of corrective measures you've taken to resolve past problems. That's important because the OIG suggests that audits focus on making sure that past problems are corrected and won't recur.

How to create a report sheet

The operator who answers a hotline call fills in most of the report sheet for that call. The operator then sends the report sheet to your compliance officer or another designated contact.

(continued on p. 6)

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com*

HOTLINE RECORDS (continued from p. 5)

The compliance officer or contact fills in the rest of the report sheet. Our model hotline report sheet form is based on one developed by National Hotline Services, Inc., a company that manages hotlines for hospitals and other providers. As with our model form, your hotline report sheet should cover the following 13 items:

1. Confidentiality warning. A hotline report sheet contains highly sensitive information that should be seen only by the operator, the compliance officer, your attorney, and any other authorized persons. Put a warning at the top of the sheet in boldface, italics, or another attention-drawing typeface. Note that the report sheet is proprietary, confidential information and that photocopying it or revealing the information in it to a third party without authorization is forbidden. No matter how careful anyone handling report sheets is, the forms may be misplaced or accidentally sent to an unauthorized person. Include a phone number people can call if they find a misplaced sheet.

2. Serial number. Each sheet should have its own printed serial number so you can track each call individually. Also have the operator read to each caller the serial number on the report sheet being used for that call. Callers may later want to find out what you're doing about the problem they reported. If they made their calls anonymously, they can use the serial number to identify themselves during subsequent calls.

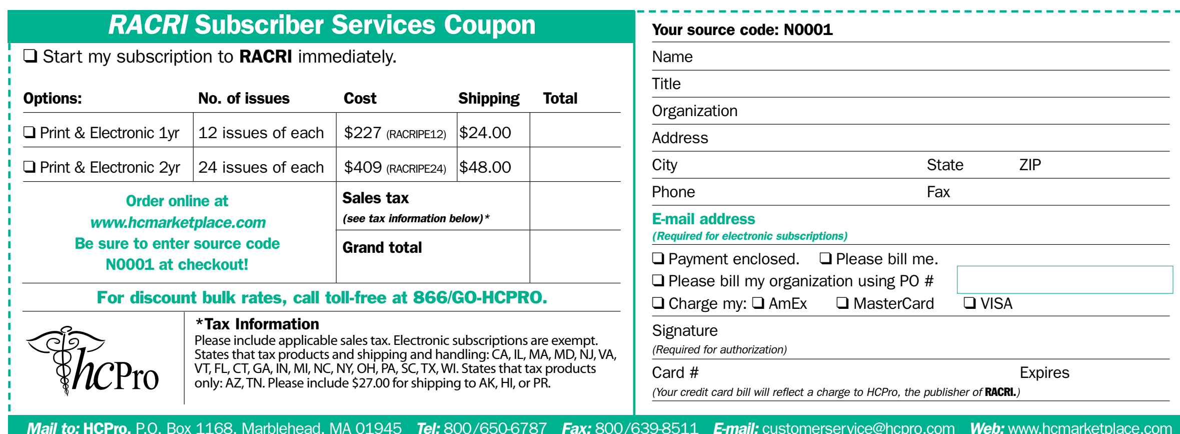
3. Date, time, and operator's name. Noting the date and time that calls are received is critical. It enables you to monitor how quickly you respond and which information you'll need to demonstrate the effectiveness of your program. Also provide a space for the operator's name. If you have questions or concerns about a report sheet, you'll know exactly who to contact.

4. Caller's acknowledgement of right to anonymity. A hotline typically greets callers with a prerecorded message that explains the rules and procedures. Among other things, the message reassures callers that they can remain anonymous or give their name but ask that the information remains confidential. Although you can promise confidentiality, you can't totally guarantee it. That's why the various OIG compliance plans say providers should "explicitly communicate" to callers that their "identity may become known or may have to be revealed in certain instances where governmental authorities become involved." This should be part of your prerecorded message. The first thing an operator should do when answering a call is ask whether the caller heard the prerecorded message and understood the options and limitations with regard to confidentiality. Our model form has yes and no boxes in which the operator can indicate the caller's response.

5. Whether caller gave identity. Although callers have the right to remain anonymous, they needn't do so. Include yes and no boxes in which the operator can indicate whether the callers identified themselves. If so, the operator should note the caller's name, phone number, and division. Also include yes and no boxes in which the operator can indicate whether the caller's identity was given in confidence.

6. "Material facts" of allegation or concern. Have the operator list the "material facts" of the caller's allegations or concerns.

7. Promises or representations made. Some providers tell operators


***RACRI* Subscriber Services Coupon**

❑ Start my subscription to **RACRI** immediately.

Options:	No. of issues	Cost	Shipping	Total
❑ Print & Electronic 1yr	12 issues of each	$227 (RACRIPE12)	$24.00	
❑ Print & Electronic 2yr	24 issues of each	$409 (RACRIPE24)	$48.00	
Order online at *www.hcmarketplace.com* Be sure to enter source code N0001 at checkout!		Sales tax *(see tax information below)**		
		Grand total		

For discount bulk rates, call toll-free at 866/GO-HCPRO.

HCPro

***Tax Information**
Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, IL, MA, MD, NJ, VA, VT, FL, CT, GA, IN, MI, NC, NY, OH, PA, SC, TX, WI. States that tax products only: AZ, TN. Please include $27.00 for shipping to AK, HI, or PR.

Your source code: N0001

Name

Title

Organization

Address

City State ZIP

Phone Fax

E-mail address
(Required for electronic subscriptions)

❑ Payment enclosed. ❑ Please bill me.

❑ Please bill my organization using PO #

❑ Charge my: ❑ AmEx ❑ MasterCard ❑ VISA

Signature
(Required for authorization)

Card # Expires
(Your credit card bill will reflect a charge to HCPro, the publisher of RACRI.)

Mail to:* HCPro,** P.O. Box 1168, Marblehead, MA 01945 ***Tel: 800/650-6787 ***Fax:*** 800/639-8511 ***E-mail:*** customerservice@hcpro.com ***Web:*** www.hcmarketplace.com

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com.*

not to give advice or make any promises or representations (i.e., statements indicating an opinion) to callers. Some providers want operators to reassure callers by saying a report will be filed with the compliance officer. In either case, ask operators to indicate what—if any—advice, promises, or representations they made.

8. Whether the problem has been resolved. Some matters can be resolved immediately over the phone. For example, the operator may be able to convince the caller that the information being reported is a patently false rumor that has already been examined.

Give operators yes and no boxes in which they can indicate whether the problem has been resolved. Also give them space to indicate the resolution if the answer is yes. A yes answer generally tells the compliance officer that no follow-up is necessary. However, sometimes operators make mistakes and follow-up is needed anyway. For example, the operator may be wrong about the caller's information being a rumor.

9. Whether follow-up arrangements were made. If the matter isn't resolved, the operator should note any follow-up arrangements that were made. For example, the caller may have agreed to try to learn more about the situation and call back in a week.

10. Date and time the sheet was forwarded and to whom. The last item operators should note is the date and time the completed hotline report sheet was forwarded to the compliance officer or other designated contact. If the sheet was forwarded to a designated contact, the operator should fill in that person's name.

11. Date and time the sheet was received. It's up to the person who receives the hotline report sheet—the compliance officer or other designated contact—to complete the remaining items on the sheet. This includes the date and time the sheet was received.

12. Any referral made. In some cases, the compliance officer may refer the matter to a more appropriate person. For example, the personnel department may handle sexual harassment complaints. If so, the time and date of the referral should be noted, along with the name of the person to whom the referral was made.

13. Acknowledgment of entry in log. Include a check box for the compliance officer to indicate that the information on the hotline report sheet was entered into the hotline log. This helps ensure that this step isn't overlooked. It also helps prevent the same report from inadvertently being entered twice.

***Insider* says:** Once a sheet is completed, the compliance officer should open a correspondence file for it, explains Murtha. The compliance officer should keep records of all follow-up actions taken to deal with the problem and attach them to the report sheet. When the matter is resolved, the compliance officer should create a final report indicating what the resolution was and the date it took effect. That report should also go in the file. ■

Insider *sources*:

F. Lisa Murtha, KPMG LLP, 345 Park Ave., 39th Fl., New York, NY 10154.

Alex Schillaci, Deloitte & Touche, Stamford Harbor Park, 333 Ludlow St., Stamford, CT 06902-6982.

Stacey Schleifer, Esq., National Hotline Services, Inc., 112 S. West St., Alexandria, VA 22314.

NEWS BRIEFS

New cardiac computed tomography society formed

A new organization related to cardiac computed tomography (CT) has been formed, according to PR Newswire. Cardiac CT scanning, some predict, will revolutionize coronary artery disease diagnosis. "But exactly how and when to use it is not yet clear," Daniel S. Berman, MD, director of Cardiac Imaging at Cedars-Sinai Medical Center in Los Angeles told PR Newswire. "In order to truly capture the power of this new method, it is critical that we optimize the methods, train physicians to perform and interpret the test, ensure the high quality of the examinations performed, and develop guidelines for its cost-effective use." The society will focus on these goals in addition to fostering research in Cardiac CT, according to PR Newswire.

Radiologists using iPods to store medical images

A new software program is allowing radiologists to store medical images on their Apple iPods, according to iHealthbeat. The iPod is a device typically used to store music files, but the adaptation allows radiologists to display and manipulate medical images and to send and receive e-mail and instant messages. The iPod software was developed by two radiologists, iHealthbeat reported.

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com.*

MODEL FORM

Sample hotline report sheet

Hotline report sheet

Important: *This report is proprietary and contains information that is confidential. Photocopying this report or disclosing information it contains without authorization is strictly prohibited. If you find this report or receive it in error, please call 202/123-4567 immediately.*

Serial number: ___________________________ Date: ______________________ Time: _______________________

Call received by: ____

Introductory questions

Did caller acknowledge hearing and understanding the prerecorded message? yes ❑ no ❑

Did caller specifically acknowledge hearing and understanding the rules and limitations of anonymity/confidentiality explained in the prerecorded message? yes ❑ no ❑

Did caller identify self? yes ❑ no ❑

If yes, caller's identity and phone number: ____

Caller's division: ____

Did caller ask that identity be kept in confidence? yes ❑ no ❑

Material facts provided about allegations/concerns: ____

____

Advice, representations, or promises you made to the caller: ____

Was problem resolved? yes ❑ no ❑

If so, explain: ____

Arrangements made for follow-up contact: ____

Date and time report was forwarded to compliance officer or designated contact: _________________________________

To whom was report referred? ____

For compliance office use only

Date and time report was received: ____

Was report referred? yes ❑ no ❑ If yes, to whom?____

Date and time of referral: ____

Check this box to acknowledge that the report has been entered into the log. ❑

Source: National Hotline Services, Inc. Reprinted with permission.

© 2005 by HCPro, Inc. Any reproduction is strictly prohibited. For more information call 800/650-6787 or visit *www.hcmarketplace.com.*