

Radiology Administrator's

Compliance & Reimbursement Insider

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Get guts: Strong leadership can turn your practice into a winner

One employee with a bad attitude can put a damper on production, so stop hiring people based on skill and start hiring them for personality, says **Kevin Freiberg**, a motivational speaker who gave at presentation during June's Radiology Business Management Association 2005 Radiology Summit in Las Vegas.

Freiberg, coauthor of the book *Guts! Companies the Blow the Doors off Business-as-Usual*, says one bad employee can sour an entire workplace, drag down the culture, and harm your bottom line.

Turn your culture around by hiring positive people who will bring an entrepreneurial spirit to your facility and go out of their way for your customers.

"Bad attitudes suck the life out of practices," Freiberg said. When you hire a new employee, look for someone who will be positive and motivate others. Many organizations make the mistake of focusing on skill instead of personality.

"Hire for attitude, train for skill," Freiberg said, adding that you can bring someone up to speed on the technical aspects of the job, but you cannot give someone a new personality. In the end, an individual's personality will define his or her job performance. "You will hire people for what they do, but you will fire them for who they are," Freiberg said.

And getting rid of a bad employee is a potentially expensive and difficult task. "We all do more with less. Can you really afford to make a bad hiring decision?" Freiberg asked.

To avoid hiring missteps, focus on the character of your job candidates. Freiberg separates employees into four main categories, including those who add, subtract, divide, and multiply.

The adders and multipliers are your go-to employees, those you can count on to get the job done. The subtractors and dividers are the ones you need to weed out. Keeping them on staff will bring everyone else down.

Although it may seem impossible to hire for attitude and only choose adders and multipliers based on short interviews with people on their best behavior, Freiberg says it is entirely possible—if you ask the right questions to get an inkling about attitudes (See a list of suggested interview questions on p. 3.)

There are several attributes to watch for when interviewing potentially employees, but the most important one to look for is the fun factor.

You want people on staff who are pleasurable

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LEADERSHIP

(continued from p. 1)

to work with, Freiberg says. We all like to have fun at work, and hiring fun people will help boost your facility's spirit.

Establishing an enjoyable workplace environment may have the added benefit of bringing in better employees because a positive place to work will increase the number of people who want to work at your facility. Making solid hiring decisions can be difficult if you don't get a decent pool of applicants. But if you define your organization as a great place to work, candidates will come to you.

The Southwest story

Consider Southwest Airlines, an organization that Freiberg says has an outstanding corporate culture and has established itself as a great place to work. Last year the company interviewed 33,000 people for 5,134 new jobs. "It's easier to get into Harvard than it is to get into Southwest Airlines," said Freiberg.

How can you create an attractive work environment? "Help your people feel heroic about what they do," says Freiberg. "Those types of work environments are so rare, which makes them so appealing."

Remember to focus on your own attitude and how it affects your business. Ask yourself the following questions:

- What am I learning today that will add value tomorrow?
- What have I learned in the past three weeks that would add value to the people that I serve?
- When is the last time I studied the winners in areas where I need to improve?
- What was the last best practice I adopted?

If you can't answer these questions, ask yourself another one: "Why shouldn't my employer outsource my position?"

Remember that happy employees will help your organization perform better. "At the end of the day, the thing that separates your practice from others is your people," Freiberg said. ■

Insider source:

Kevin Freiberg, EdD, president and chief executive officer, Freibergs.com, San Diego.

Questions? Comments? Ideas?

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Hire for attitude, train for skill

The following questions were developed by **Drs. Kevin and Jackie Freiberg** to help interviewers ferret out positive employees who will add to an organization and weed out negative candidates who have the potential to sour the work environment. The words inside the brackets indicate what type of information the question seeks to elicit from the candidate.

Questions you can ask to screen for attitude

- Tell me about the last time you broke the rules to serve a customer in need. [flexibility; judgment]
- Tell me how you recently used humor to diffuse a tense situation. [fun]
- Tell me about a time when you went above and beyond the call of duty to assist a coworker when you received no recognition or no credit. [unselfishness; teamwork]
- Give me an example of how you work with an extremely difficult coworker. How did you handle it? [adaptability]
- Describe a time when a coworker failed to pull his or her weight. What did you do? [adaptability]
- Tell me about a time when you made a serious mistake with a customer or coworker. How did you reconcile it? [ability to admit mistakes]
- Tell me how you handled the most difficult customer you've ever dealt with. [service focus]
- What's the most important thing you have learned in the past six months? What new skills, knowledge, or experience have you gained? [willingness and ability to learn]
- Tell me about the last time you tried something new or took on additional responsibility when there was no guarantee for success. [willingness to take risks]
- Tell me about the last time you asked someone for feedback. What did you do with that information? [willingness to be coached]
- Tell me about the last time you had to work with others to accomplish a critical result. What did you do? [collaboration]

Another exercise you can use to screen for unselfishness and teamwork begins with asking interviewees to prepare five-minute presentations about themselves for a group interview.

As each presenter comes up to share his or her personal story, watch the audience members to determine whether they enthusiastically draw the speaker out and encourage him or her [unselfishness] or whether they make last-minute notes for and prepare their own presentations [selfishness].

Notice that these questions are not hypothetical (i.e., what would you do?) questions. These questions ask for previously demonstrated behavior as a means to determine future success.

Your questions will become more powerful and targeted if you first identify your star players in a particular function and then build a profile of the key attributes that are common to each of them. Successful screening begins with knowing precisely what it is you're looking for. ■

Editor's note: The Freibergs are professional speakers and authors of the recently released GUTS! Companies That Blow the Doors Off Business-as-Usual and bestseller NUTS! Southwest Airlines' Crazy Recipe for Business and Personal Success. To read more about Drs. Kevin and Jackie Freiberg please visit their Web site at www.freibergs.com.

MEDICARE UPDATES

By Jackie Miller, RHIA, CPC

CMS recently issued a number of policy changes that are of interest to the radiology community, including updates to the Medicare Physician Fee Schedule (MPFS) and changes to the ambulatory surgery center (ASC) payment system.

Bilateral status changes

In a move welcomed by providers, CMS has made several procedures eligible for bilateral payment for the first time. The change occurred as part of a May 6 update to the MPFS, and it is retroactive to January 1, so providers can rebill claims that were paid at the lower rate under the old policy.

The following CT codes will now be paid at 200% of the allowable (double the previous payment) if the procedure is billed bilaterally. Bilateral billing includes billing with modifier -50, with modifiers LT and RT, or as two units with no modifier.

Figure 1

73700	Computed tomography, lower extremity; without contrast material
73701	. . . with contrast material
73702	. . . without contrast material, followed by contrast material(s) and further sections

Another group of procedures will now be paid at 150% of the allowable when they are billed bilaterally.

Figure 2

19290	Preoperative placement of needle localization wire, breast
32020	Tube thoracostomy with or without water seal (e.g., for abscess, hemothorax, empyema) (separate procedure)
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm
50081	. . . over 2 cm
50200	Renal biopsy; percutaneous, by trocar or needle
64640	Destruction by neurolytic agent; other peripheral nerve or branch

Professional and technical component

CMS has changed the following procedures to include both a professional and a technical component:

Figure 3

0066T	Computed tomographic (CT) colonography (i.e., virtual colonoscopy); screening
0075T	Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiology supervision and interpretation, percutaneous; initial vessel
0076T	. . . each additional vessel

This change is retroactive to January 1. Radiologists who perform extracranial vertebral or intrathoracic carotid stent placement in a hospital setting will need to add modifier -26 (professional component) in order to receive correct payment. Screening virtual colonoscopy is still noncovered by Medicare.

To read CMS Transmittal 558 (CR-3870) in its entirety, go to www.cms.hhs.gov/manuals/pm_trans/R558CP.pdf.

ASC payment changes

CMS maintains a list of CPT codes that are eligible for payment in an ASC. Each code is assigned to one of nine ASC payment groups. CMS is statutorily required to review and update the ASC list at least every two years. The May 4 *Federal Register* includes updates to ASC payment that take effect July 5.

Peripheral PTA and stent placement

CMS initially planned to add 25 procedures to the ASC list, including brachiocephalic and venous percutaneous transluminal angioplasty (35475–35476) and transcatheter stent placement (37205–37206). However, the agency received a comment stating that these procedures were not appropriate for the ASC setting and could result in sub-standard care. Upon further consideration, CMS determined that because these procedures involve major vessels, they should not be performed in ASCs.

Other rejected procedures

CMS was asked to add discography (62290–62291) and percutaneous vertebroplasty (22520–22522) to the ASC list. The agency indicated that discography would not be added because “radiologic studies that do not include an intervention are not considered surgical procedures and are not included on the list of ASC procedures.”

Likewise, percutaneous vertebroplasty was rejected because the agency believes the recovery period for this procedure is longer than four hours and sometimes involves an overnight stay. Additionally, sacroiliac joint injection (27096) was rejected by the agency because it is “a radiological service that is furnished in the physician office setting more than half the time.”

Endovenous ablation

CMS has added the new 2005 codes for endovenous ablation of incompetent veins to the ASC list. Both radiofrequency ablation (36475–36476) and laser ablation (36478–36479) will be assigned to ASC payment group 3 (\$510).

Payment reform

The current ASC payment system has been in place since the early 1980s, but it is due to be overhauled, as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. CMS indicates that a new payment system will be implemented effective January 1, 2008, and probably will be very similar to the current hospital Outpatient Prospective Payment System.

To read the interim final rule in its entirety, go to www.gpoaccess.gov/index.html and search for the May 4, 2005, *Federal Register*. ■

Insider source:

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ASK THE INSIDER

Coding advice related to patients who have a history of breast cancer

Q: I have been told by the local Medicare official that if a woman has breast cancer on one side and undergoes a mastectomy, any further mammograms on that side should be diagnostic.

The same is true if a woman undergoes a lumpectomy. In a nutshell, I was told that Medicare states that all future mammograms on women who have had cancer diagnoses are diagnostic, not screening.

However, in the past I have read your advice on how to bill for screening mammograms on women who have undergone unilateral mastectomies.

You advised that a unilateral screening mammogram should be assigned code 76092-52 and stated, "coverage generally is not a problem."

The challenge is in getting the referring physicians to order the unilateral screening study.

Is it possible to bill for a screening mammogram on a woman who has had a cancer diagnosis as described above?

A: This issue boils down to the referring physician order; the type of exam the physician orders is what should be performed and billed for.

We generally find that most physicians believe a patient who is post-mastectomy for breast cancer should always have a diagnostic mammogram rather than a screening mammogram.

Some Medicare carriers, such as the one listed below, recognize this as a valid reason for a unilateral diagnostic mammogram.

Florida-based First Coast states in its local coverage determination (LCD): "Unilateral diagnostic mammograms may be performed when a patient has had a unilateral total mastectomy."

In order to perform a diagnostic mammogram, there must be an order for the exam from the patient's treating physician (or the exam must be ordered by the radiologist due to an abnormal screening mammogram on the same date).

However, not all Medicare contractors agree that a history of breast cancer always supports a diagnostic mammogram.

For example, the following comes from the LCD issued by New York-based insurer HealthNow:

"Diagnostic breast evaluation may be indicated in cases of a personal history of malignancy and in cases of benign biopsy-proven disease.

Once clinical stability has been established, the routine use of diagnostic mammography over screening mammography is not warranted."

If it is determined based on the referring physician's order and local Medicare policy that a unilateral screening mammogram should be performed, this service should be coded as 76092-52.

By Current Procedural Terminology definition, 76092 is the only code that is appropriate for a screening mammogram, and because it is inherently bilateral, use of modifier -52 (reduced service) is appropriate. ■

Insider source:

Melody Mulaik, MSHS, CPC; CPC-H, RCC, Coding Strategies Inc., Powder Springs, GA.

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Keep your business on track, improve accountability

The key to successful management is accountability. Without accountability, it is difficult to keep your company's mission on track, employees moving forward, and the business performing at its best, said **Marc Halley, MBA**.

Halley spoke during the Radiology Business Manager's Association meeting in Las Vegas in June.

Everyone within an organization must be accountable—from the top down. To accomplish this, the sponsors or the heads of an organization must

- set appropriate expectations
- establish a vision and strategy that can be implemented
- set policies that support expectations, vision, and strategy
- ensure capable management
- eliminate barriers to implementation
- hold management accountable to deliver desired results

In addition to setting expectations, they must also overcome barriers. To many people, accountability carries a negative connotation. However, Halley doesn't see it that way. "We cannot use accountability as a method to get rid of someone," said Halley.

An organization must have "pure motives"—which is the goal of improving the business—to establish a true culture of accountability, he said.

Beyond accountable administration and management, it is critical that you have a strong team of employees who work to bring about change. "If we harbor 'C,' or average players it's tough to create a culture of accountability," said Halley.

Identifying weak employees

Halley offered a simple tool that is designed to help managers determine how employees are affecting their organizations. Managers should think about each person on staff and determine whether he or she is

- motivated and able to perform the job
- motivated but not able to perform the job
- not motivated but able to perform the job
- not motivated and not able to perform the job.

Put each of your employees in one of these categories. Then determine whether you can train them to rise to the needed standards or whether you might need to seek out new members for your team. Your organization should look to hire and retain only "A" players and reassign or fire those who are not meeting that standard.

Setting expectations

As important as it is to track

employee performance, you must first set clear expectations and goals.

It's impossible to hold people accountable if you don't have a solid grasp of what staff are expected to do and when they are supposed to do it. It is critical to establish

- timelines
- specific and clear outcome expectations

Employee progress should be tracked regularly. "Everybody needs to be held accountable weekly by somebody," said Halley.

Successful delegation

Delegation can be used as a means of establishing accountability, said Halley. Managers should assign tasks to employees and track performance. But keep in mind that delegation is not

- abdication of responsibility
- laziness on the part of the manager
- dumping on subordinates
- loss of control
- decision avoidance
- an ego trip

Effective delegation provides training and development opportunities for your employees.

It should also help allocate resources to help achieve your organization's goals, said Halley.

Effective delegation begins as part of short-term planning.

The manager must decide what tasks can be delegated and set goals regarding the desired outcome and the time frame required to achieve that outcome. It should also be decided who the delegate will be.

After making these decisions, the manager should

- decide how to communicate with the selected individual regarding

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Editor's note

In the July issue of **RACRI**, the p. 7 story "Designated Coders can Perk up your Bottom Line" indicated that "there is not much specific training available for radiology coders." We received several responses from readers who pointed out that there are in fact a number of training resources available, including a certification program for radiology coders.

In addition to the radiology coding seminars and educational coding products offered by the Radiology Business Management Association, there are also a number of other resources offered by the American College of Radiology, the Society for Interventional Radiology, and other resources.

ACCOUNTABILITY

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the task

- meet with the candidate to discuss the assignment and expectations
- seek input from the candidate about how the task can be accomplished
- define checkpoints for holding the candidate accountable and to provide coaching

Barriers to accountability

Holding employees accountable isn't as easy in practice as it is in theory. There are several barriers, said Halley.

Attitude is often one of the major barriers to achieving a culture of accountability. Many employees will have the attitude that "this isn't high school, [I'm an adult]," said Halley. Others barriers include the following:

- The organization's culture emphasizes freedom.
- Employees feel entitled (e.g., they feel that the employer owes them because they work there).

- Risk aversion. Employees know accountability is a risky proposition.
- Retention of C-level employees. Managers who are C-level employees might surround themselves with similar people. This presents a problem when managers are looking to improve performance. C-level players may also be retained out of loyalty.
- Personal agenda. People have their own motivations and goals.
- Leniency bias. Managers aim to be nice and fair at the expense of productivity.

You must be willing to confront these issues to establish a culture of accountability.

Halley listed the following benchmarks that indicate whether an organization has truly attained a culture of accountability:

- Clear targets and timelines are established for the organization, teams, and individuals. A-leaders hire and retain only A-players.

- Performance measurement mechanisms are in place for every individual and team, and for the organization as a whole.
- Progress toward the target and timeline is documented and discussed in weekly accountability sessions for individuals and teams
- Progress toward the target and timeline is documented and discussed at the organizational level at least monthly
- Sponsors and implementers actively and objectively identify and eliminate barriers to achieving the target and timeline monthly
- Targets are achieved by the timeline
- New targets and timelines are established ■

Insider source:

Marc Halley, MBA, president and chief executive officer of Ambulatory Management Services, Inc., Westerville, OH.

IOM: Audit required for mammography facilities

A new report by the The Institute of Medicine (IOM) recommends that the FDA require mammography facilities to track their performance using new standardized measures to determine how accurate they are when it comes to breast cancer detection.

The report also suggests that reimbursement be increased to cover the costs associated with the increased workload, according to a written release issued by the IOM.

"The audit currently required under the Mammography Quality Standards Act [MQSA] is not as useful as it could be for improving the reliability and accuracy of these readings," said committee chair John Ball, executive vice president, American Society for Clinical Pathology in Chicago, in a written release. "The effec-

tiveness of mammography greatly depends on how well staff interpret breast images. We've proposed both mandatory and voluntary ways to enhance the measurements used to assess performance."

Currently, the MQSA does not require facilities to use specific statistics to determine how accurate the facility is when conducting and reading mammograms. To standardize the process the IOM report suggests the following:

- All facilities should determine the proportion of their patients who are diagnosed with breast cancer after receiving a recommendation for biopsy as a result of the reading of their breast images
- In addition, facilities should determine their cancer detection

rate, which is the number of patients found to have breast cancer per every 1,000 examined

- Facilities also should calculate the proportion of patients whose mammograms revealed a possible abnormality

The new audit requirement was recommended in a report sponsored by the FDA in preparation for the anticipated reauthorization of MQSA in 2007.

In addition to the auditing proposal, the IOM also recommended that MQSA be expanded to include other breast imaging procedures. It recommended mandatory accreditation for breast ultrasound and magnetic resonance imaging as a means of ensuring quality for what are now routinely used procedures, said the written release. ■