

Radiology Administrator's

Compliance & Reimbursement Insider

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Coding corner 2

Learn about 2006's coding hot topics and how to handle the hubbub.

ACR accreditation advice 5

Use these tips for an effortless ACR endorsement of your facility.

Audit for Stark compliance 7

We provide advice for hospitals to examine radiology contracts.

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Nuclear medicine submits to Stark

Follow these tips to ensure your facility's compliance to DHS additions

Cross the t's and dot the i's on any physician/nuclear imaging agreements before the year of the dog lets loose its last yelp.

Come January 1, 2007, nuclear imaging falls within the realm of designated health services (DHS) and the purview of the Stark law.

Nuclear new to 'designated' scene

From the outset, the Stark law included radiation therapy services and supplies and radiology and other imaging services as DHS, says **Mark Langdon**, a healthcare lawyer with Arent Fox in Washington, DC.

CMS excluded nuclear medicine when it initially adopted Stark regulations on the grounds that nuclear medicine was neither radiology nor radiation therapy.

However, since its arrival on the diagnostic imaging scene, nuclear imaging—especially PET—has grown quickly. Pointing to the exploding costs of healthcare and increasing use of diagnostic imaging, CMS says it has reason enough to add nuclear imaging to the DHS ranks.

"We believe our proposal . . . is consistent with the intent of > p. 6

The added value of accreditation

Obtaining Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) approval can be harrowing enough for a healthcare facility.

But many radiology administrators and big-time insurers believe that the JCAHO's seal of approval may not be stringent or specific enough to meet radiology's quality needs.

Enter the American College of Radiology (ACR).

The nonprofit group offers accreditation in nearly every radiological

modality, from mammography to ultrasound and magnetic resonance imagery (MRI) to PET. Although each modality comes with its own set of criteria, ACR judges quality on basic overarching themes from staff qualifications to machine optimization and patient records to image quality.

"We would never think of not having ACR accreditation," says **Shannon Gutierrez, RT**, director of radiology at North Texas Hospital in Denton. "It's just an automatic part of running things."

Although ACR's accreditation > p. 4

Coding corner**Learn to dodge radiology coding trouble spots in 2006**

CMS released several coding changes effective January 1. A few of these changes raised radiologists' eyebrows and ire. The following represent hot topics that arose during two audioconferences (see the end of the article for details):

Q: Do we need to worry about medical necessity with low osmolar contrast materials (LOCM)?

A: Medical necessity for the use of LOCM versus high osmolar contrast materials causes much consternation with CMS and other third-party payers, said **Duane C. Abbey, PhD, CFP**, president of Abbey & Abbey, Consultants, Inc., in Ames, IA.

However, CMS Program Memorandum A-02-120, April 1, 2003, significantly mitigated the agency's requirements for hospitals to justify the use of LOCMs, Abbey said.

Additional guidance shows reduced special medical necessity requirements for nonhospital providers. Transmittal 627, offered from CMS on July 29, 2005, eliminates "the restrictive criteria for payment of LOCM for nonhospitals." The agency applied the same criteria, extending LOCM reimbursement to hospitals in the final regulations released in 2006 (CMS-1501-FC), said **John Marshall, CRA, RCC, RT (R)**, of

Coding Strategies, Inc., in Powder Springs, GA.

Some hospitals use only LOCMs, said **William L. Malm, ND, RN**, of Health Revenue Integrity Services in Cleveland. These hospitals resolved the issue of medical necessity by setting LOCMs as the standard practice as a matter of policy, he said.

Such a policy "won't protect you 100%, but you will be on good ground [regarding] medical necessity," said Abbey.

Q: Should LOCM be bundled or unbundled?

A: LOCM is now considered to be a drug, is no longer bundled for reimbursement, and should be billed separately, said Marshall.

CMS reduced the payment for CT scans with contrast to compensate for the additional LOCM payment. Specifically, 42 CFR Parts 419 and 485 (CMS-1501-FC) on p. 291 states "APC's [ambulatory payment classification] 0283 and 0333 decreased by less than 3%."

It continues on p. 291 and p. 293: "Our proposal to pay separately for LOCM . . . may increase overall payments for some contrast-enhanced CT studies . . . which include unpackaging LOCM."

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The documentation states “unpackaging” LOCM, not “bundling” it, he said.

Q: Do you have any tips for billing for conscious sedation?

A: CMS does not make separate payments under its APC system, said Abbey.

“Look for the bulls-eye beside your [CPT] code,” said Marshall. “Many radiology procedures include moderate sedation as part of the procedure. These obviously cannot be billed separately. Moderate sedation can be billed with other procedures but are only paid on the physician side.”

When billing for moderate sedation by a second physician, an anesthesiologist, or another doctor, coding depends on the patient’s age and the duration of the service, Marshall said.

If the patient is younger than five, use code 99148 for the first 30 minutes of intraservice time. If the patient is age five or older, use code 99149 for the first 30 minutes.

Use code +99150 as an additional code for each additional 15 minutes of sedation, Marshall said.

Q: What is the best use of modifier 51?

A: Modifier 51 is a physician-only modifier, Malm said. Neither hospitals nor radiologists generally use it, he added.

Physicians use modifier 51 in tandem with surgical codes to indicate the performance of more than one surgical procedure, said Abbey.

“With today’s claims adjudication systems, this modifier is really unnecessary,” he said.

Such systems often use the codes on the claim itself to automatically determine whether multiple surgical procedures were performed.

Q: Can we use modifiers 52, 73, and 74 for a breast biopsy with local anesthesia?

*Illustration by
David Harbaugh*



“After setting up a PET/CT program and wrestling with all of the new billing and coding issues, you can expect some accelerated aging and cognitive impairment.”

A: The relationship between these three modifiers can be confusing, said Malm.

Use the 52 modifier if there is a reduced service and anesthesia is not involved, said Abbey.

“Starting in 2006, the 52 modifier is now a payment modifier that reduces payment by 50%,” he said.

If a patient who is scheduled to have a breast biopsy is fully prepared with local anesthesia but the procedure is discontinued, then you can consider the 73 or 74 modifiers, according to Abbey and Malm. ■

Editor’s note: The information contained in this article came in part from the HCPro, Inc., audioconference “Diagnostic Radiology Coding: Recovering Revenue and Understanding the 2006 Changes,” which took place January 12 (for information, call the HCPro Customer Service Department at 800/650-6787) and the American Healthcare Radiology Administrators audioconference “2006 Radiology Coding Update,” which took place April 11 (for information, visit www.ahraonline.org or call 800/334-2472).

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Accreditation

< p. 1

process has been around since 1963, Gutierrez says only three major hospitals in her geographical area have received accreditation, meaning that most others—including outpatient and independent imaging facilities—haven't.

Although North Texas Hospital maintains accreditation from the JCAHO, it also received ACR accreditation for MRI services in February. It sought accreditation partly because a major area payer requires it and partly because of what accreditation means for overall business and quality imaging, she says.

Payment for quality

Several insurers require some type of accreditation, generally in MRI, CT, or PET for radiology reimbursement, says **Leonard Lucey**, legal counsel and senior director of nonbreast imaging accreditation for ACR.

Insurers requiring ACR accreditation for MRI services include Aetna U.S. Healthcare, Blue Cross of California, and New York Medical Imaging, among others, according to a recent article by Auntminnie.com.

"Two to three years ago, there was a major push from third-party payers for radiology programs to have accreditation to qualify for reimbursement, but that has slowed down a bit since then," says Lucey.

A few state legislatures, including those of Connecticut and Rhode Island, require ACR accreditation of any physician who performs MRI imaging to ensure the quality of in-office MRI exams.

Accreditation choices

Although some radiology facility directors see ACR accreditation as a no-brainer, others slough off the association's process, citing the JCAHO as the premiere accreditation body. Still others, such as **Barbara Ana Perez, MSM, RT, (R)(M)(QM), RDMS**, director of imaging and therapeutic services at Jackson Memorial

Hospital in Miami, participate in both JCAHO and ACR accreditation and with other accrediting bodies as well.

Discerning which guidelines applied to which accreditation body used to be like playing pin-the-tail-on-the-donkey, says Perez. But now the various standards essentially complement one another.

For example, the JCAHO concerns itself with credentialing, patient flow and processing, patient safety, medication errors, etc.

ACR "takes it one step further," Gutierrez says. It examines film quality and resolution and requires phantom testing and case-analysis to ensure the accuracy and quality of each reading and there-

fore the quality of patient care, she says. And ACR checks that technologists are certified and specifically trained on the machine that they operate, says Gutierrez.

"ACR examines the radiology department and has great expertise in that field," says **Kurt Patton, MS, RPh**, former executive director of the JCAHO's hospital accreditation program.

The JCAHO looks outside of the radiology department to see how it interfaces with the rest of the hospital. ACR looks more in-depth within the department, says Patton.

The JCAHO does not claim to have expertise in clinical radiology, but it does have expertise regarding how radiology interfaces with other clinicians who rely on radiological services, he says.

The bottom line is that most hospital-based radiology departments will be JCAHO-accredited, but not all will be ACR-accredited, Lucey says. And although many freestanding facilities boast ACR accreditation approval, many more maintain only the minimum quality requirements specified by third-party payers or state

"ACR examines the radiology department and has great expertise in that field."

—Kurt Patton, MS, RPh

Follow these five steps to ACR accreditation

Getting that big manila envelope in the mail from the American College of Radiology (ACR) represents the first step in the seemingly monumental paperwork and review process necessary to earn accreditation from the agency. But don't despair. The following tips will help you survive and conquer your ACR accreditation:

1. Know your quality-control standards. ACR committees developed quality-assurance standards for nearly every modality of radiology to help hospitals and freestanding facilities establish and maintain their own quality programs. Understand which scans ACR deems acceptable and which reviewers may mark with red flags. Document your procedures and administer them throughout the entire year. This helps make the accreditation process run smoothly.
2. Keep accurate records and make duplicates of them, especially if you have off-site locations. Sometimes files get lost, so make a copy of everything that you send to ACR and keep the copies on file at your facility as back-up. That way, if ACR reviewers ask questions, the paperwork and potential answers remain at hand.
3. Perform every patient's image as though you need to send that film to the ACR for approval. Always send your best-quality work after it has been reviewed and approved by your radiologist. Use all of the resources available. The ACR manual is a great resource, but also ask the physicist and the radiologist for assistance. Do not try to do it alone.
4. Meet the application deadline. Submit your renewal application six months prior to the accreditation expiration date and return test materials to the ACR within 45 days. If you don't, you may not complete your review before the expiration date.
5. Use the following tips when submitting phantom images:
 - ✓ Make a test shot without a dosimeter
 - ✓ Verify that the four largest fibers are present
 - ✓ Make sure that you can see the three largest speck groups
 - ✓ Ensure that the image has an adequate optical density
 - ✓ Give all clinical images to a supervising radiologist to review and approve before submission to ACR

and federal regulators.

But if Gutierrez had her druthers, both the JCAHO and ACR sets of inspections would be standard. "They each offer different things. For me, a combination [would] represent the best of both worlds."

Paperwork and other problems

The most difficult part of handling any accreditation process—whether by the JCAHO, ACR, or another accreditor—is the sheer volume of an operation.

At least that's the case for Perez and her counterpart **Joan Maddix, RN, BSM**, Radiology Quality Assurance Manager at Jackson Memorial.

With more than 300 full-time employees, making sure

that everyone follows proper protocol takes organization and communication skills.

So on every pay day, employees receive a JCAHO newsletter. In the newsletter, Maddix places JCAHO facts and patient safety tips along with other relevant information.

At Jackson, a special committee examines best practices for administering medications. Radiology administrators complete monthly dashboards about incident reports, patient safety, and the like.

"With a department this size, sharing information is vital," says Maddix.

To make matters more difficult, Jackson isn't **> p. 8**

Nuclear medicine

< p. 1

Congress to . . . prohibit physicians from selecting treatment modalities based on financial incentives," the agency wrote in its August 2005 proposed rule.

"Some [people] had a sense that one day nuclear medicine's Stark law reprieve would come to an end," says Langdon. "Those people don't have to worry. For everyone else—everyone who took CMS at its word—this is a big deal."

Stark Law primer

The federal physician self-referral (i.e., Stark) law focuses on the financial relationship between physicians, their families, and certain entities that provide specific services called DHS. The Stark law applies only to Medicare and Medicaid DHS.

Critics of physician ownership of healthcare facilities charge that, when direct financial interest motivates physician referrals, severe healthcare consequences can result.

Stark essentially establishes the following two basic prohibitions to counteract physician referrals based on financial returns:

- 1. The referral prohibition.** For certain types of services, a physician may not refer a Medicare or Medicaid beneficiary for DHS to a healthcare entity with which the physician—or one of his or her immediate family members—has a financial relationship.
- 2. The billing prohibition.** A healthcare entity may not bill for improperly referred DHS, unless an exception applies.

Even if a physician, provider, or supplier does not intentionally violate the Stark law's provisions, he or she is still responsible (it is a strict liability statute), and the penalties can be steep.

Potential outcomes of violations include

- denial of payment, or a requirement to refund payments resulting from an impermissible referral
- civil monetary penalties of up to \$15,000 for each

impermissible referral

- possible exclusion from the Medicare and Medicaid programs

Compliant choices

Finding a way to resolve potential Stark law problems "isn't as simple as personalizing a sample agreement," says Langdon.

Nevertheless, noncompliant healthcare facilities that service Medicare or Medicaid patients have essentially two choices—divest their interests in nuclear-imaging services or restructure arrangements to meet one of the several exceptions available under Stark, he says.

And because radiology facilities are equally liable under the Stark law, administrators should make sure that they don't receive undue attention from Stark-susceptible physician practices. However, "divestment could mean reorganizing your whole business model and could be devastating to the business overall," Langdon says.

Exception to the rules

However, there are legislation loopholes. Most physicians and radiology administrators know Stark's in-office exception well.

For example, some cardiologists bought nuclear cameras and operated them through their practices, in their offices, and with their staff to make sure that they were part of the Stark in-office exception even though it might not have been necessary at the time, Langdon says.

The in-office exception began as a way for doctors in a private office to receive reimbursement for all of the incidental acts that occur during the course of a day, says **Alice G. Gosfield** of Alice G. Gosfield & Associates, PC, in Philadelphia.

"Essentially, in an office where you have one doctor

"[Stark loopholes are] one of the great confounding things of the world."

—**Alice G. Gosfield**

Sample contract audit program



To ensure that your hospital's contracts with radiologists and imaging centers comply with Stark and the anti-kickback statute, follow this six-step audit procedure:

- 1. Obtain the contract.** Verify first whether the radiologist and a proper hospital authority have signed the contract.
- 2. Verify that counsel has reviewed all contracts.** Confirm that your hospital's legal counsel has approved all contracts to ensure that administrators negotiate all contracts within the hospital's protocols.
- 3. Identify the payment rate.** Make sure that your legal counsel verifies that the hourly rate for duties performed is reasonable.
- 4. Identify an evaluation process.** Ensure that your organization has clear standards of performance or a review process to verify that the radiologist is doing his or her job, says **John McGinty**, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

5. Review payments. Ensure that the imaging organization pays radiologists and technicians appropriately. Run a check-disbursement report from the accounts payable department for all payments to physicians and physician groups. Review a sample of physician payments and verify that these payments comply with the contract.

6. Assess gifts. Ensure that your organization has a code of conduct that lists the types of gifts that employees may accept from patients and others. Ensure that everyone completes an annual conflict-of-interest statement.

Track all gifts in your compliance department. Auditors should review an accounts-payable disbursement report to identify payments coded to expense accounts for gifts and marketing. Follow up on questionable items to determine the nature of the transactions.

Insider source

John McGinty, senior consultant, The Greeley Company, a division of HCPro, Inc., Marblehead, MA 01945.

and one nurse running around like one-armed paperhangers, you needed something like this to ensure proper reimbursement," she says.

But this initial intention went by the wayside over the years, graduating into a way for physicians to achieve higher reimbursement by owning additional equipment. "[Stark loopholes are] one of the great confounding things of the world," says Gosfield.

The other exceptions include facilities located in rural settings, the personal services exception, and the space and equipment rental exceptions, says Langdon. If properly structured, the rental exceptions might allow physicians or physician groups to jointly own equipment and lease it to a third-party (e.g., a hospital or radiology group). However, the government eyes these agreements carefully, so don't enter into them lightly, he says.

How to survive Stark Law changes

Calling nuclear imaging a DHS may seem like a no-

brainer to many, but it also seems to run counter to the consistent position that CMS has taken over the years.

Some physicians and associations sought to persuade the government to not reverse its prior stance or exempt preexisting facilities from any new restrictions, but the government rejected these options.

As it stands now, those involved in questionable arrangements have only until 2007 to show compliance with the Stark law. ■

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Accreditation

< p. 5

yet a digital entity, although it plans to be 100% electronic with a complete radiology information system update later this year.

"It's a slower process not being digital," says Perez. "But I have to give this department credit; the amount of follow-through is wonderful. Everything here has a paper trail. We're in line with all the qualifications. But being digital will make it that much easier."

The cost, time, and organization associated with accreditation processes worry Gutierrez. "The process takes a long time, and we have to wait to gather all the appropriate scans [that] ACR requires."

For example, North Texas Hospital completes many neurology scans, but not many knee exams. ACR wants to see competencies for every variable on a given machine—in this case, an MRI, Gutierrez says.

The process has to be completed within two weeks unless the facility applies for an extension. North

Texas Hospital obtained an additional two weeks for its knee exams.

Fortunately, Gutierrez and her staff were able to complete all of the ACR paperwork during normal working hours thanks to their combined experience and built-in quality training and assurance programs, she says. "Some facilities have a difficult time getting through the process, especially their first time. But we are fortunate to be adamant about quality control here. It makes the process a lot easier." ■

Insider sources

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