

Radiology Administrator's

Compliance & Reimbursement Insider

JULY 2006

Coding corner 2

Learn how a designated radiology coder can help harvest greater financial returns for your healthcare facility.

Radiology reimbursement 4

Don't forfeit reimbursement, hire a radiology coder.

Imaging Weekly

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IN FUTURE ISSUES

- Proper documentation makes all the difference in diagnostic radiology reimbursements.
- Ten tips for managing the cardiology/radiology turf wars.



Prepare now for payer precertification

Physicians affiliated with Blue Cross Blue Shield in the state of Alabama have changed the way in which they conduct radiology business.

As of April 1, physicians associated with the insurance giant are required to receive approval for imaging services from independent radiology management company CareCore National prior to referring or scheduling scans.

Similarly, Colorado's Anthem Blue Cross Blue Shield recently joined the ranks of insurance companies that require imaging precertification. To manage its radiologists, the Colorado

insurer hired National Imaging Associates (NIA). NIA reviews radiology providers and their practices.

Anthem even outlined standards of training and quality assessment that imaging providers must reach to remain within the network.

Precertification basics

What is precertification, and how does it affect the way in which you do business?

Essentially, precertification requires referring physicians to seek approval for imaging services *prior* to referring and scheduling scans. > p. 5

Avoid IR

Prevent coding whirlwind with basics

Landing in the world of interventional radiology (IR) coding can make you feel like Dorothy in *The Wizard of Oz*—cyclone-tossed in a foreign land.

Proper radiology coding is difficult under the best of situations, particularly so for those who are struggling to understand the nature of IR reimbursement.

IR uses imaging techniques to help perform minimally invasive procedures for diagnosing/treating dis-

eases. The images provide the road map—the proverbial yellow brick road—that physicians follow to guide instruments through the body to areas of concern.

Understanding specific IR terms and procedures helps coders comprehend the often confusing systems of IR reimbursement. Consider the following simple suggestions to help dissipate coding conundrums.

You're not in Kansas anymore

You're in a foreign land, so > p. 6

Coding corner

Hire designated coder, increase radiology reimbursement

Money doesn't grow on trees. If it did, radiology managers and chief financial officers (CFO) would certainly pluck their fill from the outstretched branches. But imagine picking \$400,000–\$500,000 of extra revenue for your facility.

That's the amount that **Jamie Heldt**, director of imaging and cardiology at Oakwood Healthcare System's Heritage Hospital in Dearborn, MI, says her department gathered by hiring its own radiology coder. Although there remains much debate over bringing a coder on board, Heldt believes that her coder's green thumb helped the radiology department's finances grow.

Step #1: Plant the seeds

Robin Russ, director of imaging and cardiology at Oakwood's Annapolis Hospital, works in a 200–280-patient facility. At 180 patients, "we're screaming busy," she jokes.

But with more than \$50 million in annual business transactions, imaging reimbursement is no laughing matter, she says. Especially since an independent auditor found her radiology department captured only 20% of billable revenue.

It's not a problem unique to Russ' department, either. Many radiology facilities simply leave the money on the tree for a variety of reasons. Some do not track

claims denials, others do not validate medical necessity, and still others code incorrectly. For all of these reasons and more, says Russ, a designated radiology coder represents the vital financial farmer that facilities need. "We had to figure out something to resolve this issue," she says.


Step #2: Germinate ideas

Russ joined the Oakwood system's leadership training group. The group included roughly 25 people from all walks of hospital life. Together, the team debated the pros and cons of hiring a specific coder, planted the concept in the minds of their superiors, and communicated the suggestion up the leadership chain to the CFO. The CFO then approved the radiology coder position.

A year and a half after the designated coder started, Russ says, her organization had saved hundreds of thousands of dollars. "It's worked out great," she says. When Heldt saw her counterpart's success, she moved to enact a similar program in her own radiology department.

Use data to support coder claims

Provide comprehensive financial data to prepare others for change, says **Jim Sutton**, radiology director at May Health Systems Fairmont Medical Center in Fairmont, MN.

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“Understanding the overall fiscal benefits impresses the higher administrators,” says Sutton. “If you show them how hiring a designated coder increases revenue, then you will convince them.”

Take the following steps when making the case for a designated radiology coder, he suggests:

- Perform a retrospective audit. Learn how much money *isn't* being collected and why.
- Compare fiscal data of your facility to data of other demographically similar facilities.
- Include the financial burden of salary and other benefits assumed in hiring a radiology coder.
- Perform additional audits to determine how much lost revenue your facility could save by implementing this new strategy.

The more data presented to decision-makers, the better.

“You can extrapolate out what your facility might save,” he says. In the case of some facilities, Sutton saw up to \$11 million collected.

At Oakwood's Heritage Hospital facility, different charges stemmed from different mistakes, says Heldt. She and her team plotted the mistakes and showed how much the hospital could save by hiring a radiology-specific coder.

Looking back at the data, “we could see actually when our coder started,” Heldt says. “Now, we have zero errors.”

Step #3: Nourish the idea

Whereas some centers perform self-examinations through front desk staff and computer programs, others use a designated coder, Sutton says. Asking “why” and “how” to collect reimbursements is as important as “how much” money you will collect, he says.

When auditing the radiology department, shake the reimbursement tree for additional information as well, he says. Missing data—not entry mistakes—accounted for 73%–78% of claims denials, says Sutton. “We really

needed to have someone looking at [these] data on a consistent basis,” he says.

Step #4: Harvest the growth

In Heldt's Heritage Hospital radiology department, a technologist disenfranchised with advancing imaging technologies sought to retire from her post. “We saw this as an opportunity,” says Heldt. “We wanted to simultaneously provide a new career opportunity for someone we didn't want to lose and boost our reimbursement rates.” The former technologist became the department's new coder.

The coder examines numerous variables in reimbursement. And, says Heldt, because the coder knows the radiology business, she speaks the clinical language needed to communicate

between departmental silos—from radiologists to technologists to referring physicians.

“She talks to a lot of different departments and to the different offices. She tells them what we need and why we need it,” says Heldt.

Sutton encourages facilities to migrate radiology technologists into designated radiology coding positions. “The technologists know the medical side of the procedures,” he says. “It's far easier for a technologist to look at an interventional radiology report and know that a certain step of the procedure isn't documented.”

To start collecting the fruits of the radiology department's labor, put all of these harvesting tools together. “The money we saved far outpaid the cost of the position,” Heldt says. “We recovered \$400,000–\$500,000, and that's well worth it, in my opinion.” ■

“If you show them how hiring a designated coder increases revenue, then you will convince them.”

—Jim Sutton

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To code correctly, hire a radiology specialist

by Melody W. Mulaik

Ensuring correct coding for the services provided in their departments remains one of the greatest challenges facing radiology administrators today. Correct coding of charges should equal correct reimbursement, at least in theory. In reality, many denials for radiology services stand in the way of reimbursement—even for correctly billed charges.

In the past few years, many hospitals' struggles with coding functions have become evident. Contributing factors to this phenomenon include complicated data flows, regulatory compliance, and constantly changing coding guidelines, to name a few. All contribute to the complexity of this issue.

Radiologists recognized some time ago the crucial nature of hiring individuals dedicated only to ensuring accurate radiology reimbursement. Many freestanding imaging facilities reached the same conclusion.

Following are natural questions related to this issue:

- How do I know whether a dedicated radiology coder would benefit my organization?
- What expertise and background should this individual possess?

Join **RACRI** advisor **Melody W. Mulaik, MSHS, CPC, CPC-H, RCC**, of Coding Strategies, Inc., in Powder Springs, GA, for her presentation "How to Justify a Radiology Coder," during the American Healthcare Radiology Administrators' annual conference at the MGM Grand in Las Vegas on Tuesday, August 1, at 8 a.m.

Attendees will receive a staffing model to take back to their organization. They can complete the model with facility-specific data and exact scenarios in order to assist with financial justification.

For more information about the conference, visit www.abraonline.org.



- How can I justify such a position when our facility is already in a budget crunch?

In most facilities, knowledgeable radiology reimbursement specialists earn their annual salary many times over. Audits reveal that many facilities miss technical charges on even the most common interventional procedures.

For example, you forfeit valuable reimbursement if your facility codes an abdominal aorta study with bilateral runoff with only the imaging code 75630 when the radiologist actually performs and documents an abdominal aorta study (75625) from a high position, plus a lower extremity runoff from the bifurcation (75716).

Using Medicare outpatient ambulatory payment classification reimbursement numbers, you learn that assigning 75630 yields only \$1,215.14. However, appropriately assigning 75625 and 75716 yields \$1,215.14 and \$1,215.14, which equals \$2,430.28 for the imaging studies. If the radiologist also performs a selective injection in the leg, then also assign 75774. Skipping this code forfeits another \$517.67 for the institution.

The revenue opportunities quickly add up. ■

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Precertification

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This means that before a radiologist conducts any exams, the front office needs to make sure that the insurer approved the test.

"If the referring physician fails to obtain a precertification, or if the precertification is not approved due to lack of medical necessity, the claim for the imaging service will be denied," Alabama Blue Cross Blue Shield said in a letter sent to its member physicians.

Politics behind precert

But precertification remains a somewhat controversial issue, even as more payers begin to adopt it as standard practice.

"It's an attempt by payers to do what Stark was supposed to do in the first place," says **Larry W. Balmer, CCP**, compliance, Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy, and security officer for Radiology Incorporated in Chicago.

Stark has not been as effective in controlling escalating radiology expenses due to what's commonly referred to as the "in-office exception," Balmer says.

The in-office exception began as a way for private practice physicians to receive basic reimbursement for important, albeit incidental, office imaging. From its humble beginnings, however, the exception evolved into a way for physicians to achieve higher reimbursement by owning additional equipment.

So, payers began implementing additional requirements to slow overuse of imaging, says Balmer.

"All health plans are going to have some sort of

review process," says **Alan Muney, MD**, chief medical officer for UnitedHealthcare of the Northeast and Oxford Health Plans, in Trumbull, CT. Oxford implemented precertification requirements some time ago.

"The costs of healthcare are high," he says. "That's the bottom line. We have to decide how to manage the affordability of these services."

The precertification requirement involves additional effort and the potential loss of both revenue and customer satisfaction, Balmer and Muney agree.

"There's not a bright line" showing who owns responsibility for which step, says Balmer. Such uncertainty creates additional paperwork and increases financial frustrations, he adds.

For example, imagine a case in which a physician refers a patient to a radiologist. The patient makes the appointment and on the designated day of the week, arrives for his or her scan. However, if the physician did not submit the information for the medical necessity precertification or the radiology intermediary denied the procedure, then the patient will be left standing in the radiologist's lobby, wondering why this wasn't already worked out.

"It creates a burden on the system and fundamentally takes away the ability to care for the patient from those most directly involved in patient care—the doctors and the radiologists," says Balmer. "From the physicians' and the radiology administrators' perspective, [precertification] is difficult because it adds another step in the process," Muney adds. But the intent of precertification is to add both quality and fiscal safeguards to the imaging industry, he says.

Muney points to recent governmental cuts to imaging reimbursements as motivators for the precertification change. "It's about imaging affordability and appropriate use," he says. "We are trying to drive appropriateness toward quality guidelines. Precertification may be just one step in the process, but it's a necessary one." ■

Questions? Comments? Ideas?

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IR coding basics

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learn the language used in the land of IR, says **Linda Gates-Striby, CCS-P, ACS-CA**, principal at Gates Physician Services in Indianapolis.

First, decide whether the physician performed a selective or nonselective procedure, she says.

For a selective procedure, bill only for the end point for each vascular family addressed, not for all the “stops along the way,” she says.

If the physician moves the catheter to another vascular family, watch to see whether the procedure is selective or nonselective.

For example, interventional codes are “per vessel.”

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So, if multiple problems occur inside one vessel, do not bill for them, says **Jim Collins, CPC, CHCC, ACS-CA**, CEO of the Cardiology Coalition in Matthews, NC.

Keep an eye out for signposts—key phrases that signal either a selective or nonselective procedure, Gates-Striby says. Following are a few key phrases:

- “Into the ostium” means in that vessel, and is therefore selective
- “Selectively engaged” means in that vessel, and is therefore selective
- “At the orifice” means outside the vessel at the opening, *not* selecting that vessel, and therefore is not selective

The terminology used in an IR report makes all the difference when coding a procedure, says Collins. Proper coding tells the insurer that the physician performed X procedure in Y artery.

“Radiologists don't always understand the importance of the documentation they provide,” says Collins. “If they don't use the right words, they can cut reimbursement in half.”

One healthcare system lost \$43,000 because of dictation errors. “Look at what a big difference proper word choice makes to your bottom line,” says Gates-Striby.

The buddy system

Just as Dorothy never traveled without Toto, don't code in the land of IR without using the buddy system, says Collins. “If [you don't], you are leaving a chunk of money on the table,” he says.

For example, pair pain procedure codes with the appropriate supervision and intervention codes, says Collins. There is not a one-to-one correlation with diagnostic and interventional procedures, just with the surgical code (3xxxx) and the accompanying imaging code (7xxxx). This holds true for each of the peripheral vascular interventions other than carotid and vertebral interventions.

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“Interventional radiology coding differs from other types of coding because it involves component coding,” says **Melody W. Mulaik, MSHS, CPC, CPC-H, RCC**, of Coding Strategies, Inc., in Powder Springs, GA.

Poisoned poppies, flying monkeys, and other hazards

Count on coding pitfalls and numerous obstacles when traveling in the land of IR. Follow these tips to improve reimbursement:

- **Use a map** or diagram to illustrate how the physician performed the procedures, says Gates-Striby. This allows coders and carriers to visualize the procedure.

It gives the codes more meaning, and the coders gain greater understanding of their effect on the revenue of the overall healthcare system.

“Make a transparency with IR codes on it,” she says. “When you receive a report, simply flip to the chart and trace the path of the procedure, entering codes as you go. The billing systems will do the work for you after that.”

- **Hone communication skills**, says Mulaik. Encourage physicians to use appropriate language and keep the lines of communication open.

“Everybody’s struggling with this,” Mulaik says. “Work together and make sure both sides bill appropriately and that it’s all supported by documentation.”

IR reports can get lengthy, and they should be, she says.

“You’re asking for a lot of money and you need to justify every single code that’s assigned,” says Mulaik.

- **Apply “the black pen test”** to IR documentation, she suggests. Cross out documentation related to a specific procedure and see what documentation remains to defend coding for any additional operations.

“There should always be information to defend every single code assigned,” Mulaik says. “The procedure

should never be implied. Good documentation contains all the information spelled out.”

Overcome IR denials

When Dorothy presented the witch’s broom to the Wizard of Oz, he didn’t celebrate her accomplishment. In fact, he tried to turn her away.

Chances are, insurers will do the same to you.

“Getting accurate codes accounts for only half the problem, believe it or not,” says Gates-Striby. “Then you have to get paid.”

For example, codes for Medicare catheter placements and interventions are paid based on multiple surgical rules, she says.

Insurers pay 100% reimbursement for the first procedure and 50% for the next four.

If more procedures require reimbursement, insurers essentially base payment on information contained in the report.

Further, each code has a relative value unit (RVU). Medicare reimburses approximately \$36 per RVU.

Make sure that coders know and understand these simple facts, says Gates-Striby. “You could potentially cut reimbursement in half at the point of entry if you’ve swapped the reporting order of procedures,” she says. “You want the highest RVU on the first line.”

Enter the highest RVU code on line one of the claim, the second highest on line two, and so forth.

“You want to be paid 100% of the highest code, not 100% of a lower code,” Gates-Striby says.

Pull back the curtain on insurance claims by graphing the previous three months’ worth of reimbursements from commercial entities, says Gates-Striby.

Consider setting up an Excel file to track procedures, especially for commercial payers.

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“Look at what a big difference proper word choice makes to your bottom line.”

—Linda Gates-Striby

IR coding basics

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"Typical techniques do not catch decreased and inconsistent reimbursements," says Gates-Striby.

Be on the lookout for duplicate denials on the same CPT codes, watch for access codes denied with percutaneous transluminal angioplasty (PTA) codes, and keep an eye on stents inappropriately bundled with PTA, she says.

"You may be very surprised at what you find," she says. "We program ourselves to watch for denials, not underpayments. If you watch for this, you'll save money."

Nevertheless, Gates-Striby says, "there remains no clean, clear-cut, across-the-board method to avoid denials."

Although Dorothy had the power to return to Kansas all along, she needed to learn a few things first. "When you have the same code for the same patient

on the same day, denials are inevitable. What gets through without an issue this week will likely get denied next week."

"Keep at it and don't get discouraged," Gates-Striby says. "But it does get easier the more you know." ■

*Editor's note: This article contained excerpts from the HCPro publication **Briefings on Coding Compliance Strategies**. Information contained in this article originated from the HCPro audioconference "Interventional Radiology CPT Coding: Step-by-step strategies for arterial procedures," presented in April. Visit www.hcmarketplace.com to purchase a recording.*

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