

# Radiology Administrator's

## Compliance & Reimbursement Insider

SEPTEMBER 2006

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Supply special reports to ensure reimbursement on procedures using emerging technology.

### E-zine updates

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### IN FUTURE ISSUES

- Learn JCAHO rules for avoiding medication errors in the radiology department.
- Ten tips for managing the cardiology/radiology turf wars.



## Keeping beat with cardiac imaging

### Understand code changes to reap reimbursement

There's no denying that cardiac imaging is the next big development in healthcare.

"Radiology is one of those fields [in which], when something new comes out, everyone has to have it. [Most] consumers are well aware of the improvements in cardiac imaging technology. They want the latest non-invasive scan," says **Stacy Gregory, RCC, CPC**, president of Gregory Medical Consulting Services in Tacoma, WA.

That's why Medicare and other payers watch reimbursement for car-

diac imaging procedures so closely, she says.

"Heart image codes are among the most used, which is probably why CMS put them on its most watched list," said **Walter C. Blackham, MS, RCC**, president of Specialty Medical Services, Inc., in Lorain, OH, during the June Radiology Business Management Association meeting in Miami.

### Straight from the heart

Concern over compensation associated with cardiac imaging is one of the biggest issues in > p. 4

## Special certs for special talents

### SIIM readies qualification program for PACS administrators

Everything is digital these days—x-rays, ultrasounds, and even your grandmother's recipes.

Managing the electronic information flow associated with Italian wedding soup may not require specialty knowledge, but moving billions of bytes of imaging data from radiologists to physicians and patients and back again requires a certain kind of intellectual fortitude.

That's why hiring a Picture Archiving and Communication System

(PACS) administrator can be such tricky business.

The term "PACS administrator" previously applied to someone with any radiology, medical, technical, or informational skills. But the Society for Imaging Informatics in Medicine (SIIM) wants to quantify those skills by establishing a new set of certification criterion.

SIIM recently announced sponsorship of Certified Imaging Informatics Professionals, a new > p. 6

## Coding corner

# Documentation makes all the reimbursement difference

Everyone knows the so-called golden rule of radiology coding—if it isn't documented, it didn't happen, and if it didn't happen, you're not going to get paid.

But, as everyone knows, providing proper documentation isn't easy, said **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**, vice president of Southeast Radiology Management in Stuart, FL. Buck spoke during a **RACRI**-sponsored audioconference in April titled "Radiology Orders for Diagnostic Testing: Appropriate documentation for proper reimbursement."

Make sure that physicians, technologists, and coders understand and follow the CPT documentation requirements outlined by CMS and the American College of Radiology (ACR). That alone is a big task, she said.

But it's an important one, as evidence by a 2004 fraud case that resulted in a Florida radiology facility paying \$2.5 million to settle claims that it billed for studies that physicians did not order.

"Practices must know what rules apply to each place of service [i.e., hospital, freestanding, or office setting]," said Buck. "The suit reinforces the need for radiologists to communicate with referring physicians and document their efforts to obtain adequate orders and clinical indications when necessary for a requested study."

## Meet five criteria for additional tests

by Stacie L. Buck

It is strongly recommended that radiology facilities attempt to obtain an additional order from the physician prior to performing additional tests. Otherwise, follow these tips:

1. Make sure that the test originally ordered by the referring physician is actually performed
2. Make sure that the additional test is medically necessary based on results of the initial test.
3. Ask whether delaying performance of the test would have an adverse effect on the patient.
4. Make sure that the results of the additional tests are communicated to the referring physician and that those results are used in the patient's treatment
5. Make sure that the interpreting physician documents why additional testing was performed.

Following are a few of the documentation requirements of which you should be aware:

- **42 CFR 482.26:** Radiology services must be provided only on the order of practitioners with clinical privileges, practitioners qualified/authorized by state law, or other practitioners authorized by the medical staff and governing body to order the services.

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- **42 CFR 410.32:** All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary (e.g., the physician who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. However, there is an exception for those performing mammography under this rule, Buck says. A physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary.

- **42 CFR 410.33—Independent Diagnosis Testing Facilities (IDTF):** All procedures performed by the

IDTF must be specifically ordered in writing by the physician who is treating the beneficiary. The facility's supervising physician may not order tests, unless the IDTF's supervising physician is in fact the beneficiary's treating physician.

The IDTF may not add any procedures based on internal protocols without a written order from the treating physician. ■

*Editor's note: The HCPro, Inc., audioconference "Diagnostic Radiology Testing: Strategies for Test Designs and Appropriate Orders" with Buck and Stacy Gregory, RCC, CPC, principal of Gregory Medical Consulting Services, will be held November 13. For more information, visit [www.hcmarketplace.com](http://www.hcmarketplace.com).*

#### Insider sources

**Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**, vice president, Southeast Radiology Management, 512 SW St. Lucie Crescent, Stuart, FL 34994, 772/600-0324; [stacie@southeastrad.com](mailto:stacie@southeastrad.com); [www.seradmgt.com](http://www.seradmgt.com).

### Ask the Insider

## Understand signature rules for diagnostic documentation

#### Check state regs for abbreviated signature rules

**Q: Many referring office receptionists sign the doctor's name themselves or sign the doctor's name and then put their own initials next to it. Do Medicare and other payers require the doctor's official signature on the order?**

**A:** The ordering physician or practitioner needs to authenticate all test orders, says **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**, vice president of Southeast Radiology Management in Stuart, FL.

#### Who else can sign

**Q: Can we accept orders from physician assistants and nurse practitioners without a doctor cosigning them?**

**A:** State law governs whether professionals other than doctors can order diagnostic tests, but most states allow it, Buck says. "In fact, off of the top of my head, I can't

think of [a state] that does not allow these individuals to order tests."

*Editor's note: This month's "Ask the Insider" was adapted from the April HCPro audioconference "Radiology Orders for Diagnostic Testing: Appropriate documentation for proper reimbursement." For more information, visit [www.hcmarketplace.com](http://www.hcmarketplace.com).*

#### Insider source

**Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**, vice president, Southeast Radiology Management, 512 SW St. Lucie Crescent, Stuart, FL 34994, 772/600-0324; [stacie@southeastrad.com](mailto:stacie@southeastrad.com); [www.seradmgt.com](http://www.seradmgt.com).

#### Questions? Comments? Ideas?

Contact Managing Editor Melissa Varnavas

Telephone: 781/639-1872, Ext. 3711

E-mail: [mvarnavas@hcpro.com](mailto:mvarnavas@hcpro.com)

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## Cardiac imaging

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imaging today, says **Shelley Weiner, MD, FACR**, senior medical director at CareCore National in Wappingers Falls, NY.

Although government and private payers are beginning to provide payments and guidance concerning such innovative imaging procedures, financial support varies according to carriers coverage policies.

“Technology is changing so fast, and the rules are changing just as fast,” says **Diane Millman**, an attorney with Washington, DC-based Powers Pyles Sutter & Verville, PC, who represents an association of cardiologists.

“It’s a ‘now you see it, now you don’t’ world in terms of technology,” she says.

Because of this increased public interest, the American College of Radiology and American College of Cardiology joined forces with BlueCross BlueShield to create new Category III CPT codes for cardiac imaging.

The new codes, which took effect January 1, describe various common combinations of cardiac CT and CTA studies, says Gregory.

In most cases, the CPT uses a single code to describe the combination of services performed.

### Battle plans

Just knowing the codes may not be enough to win you compensation for cardiac imaging procedures, warned **Melody W. Mulaik, MSHS, CPC, CPC-H, RCC**, of Coding Strategies, Inc., in Powder Springs, GA.

Mulaik presented diagnostic coding conundrums during the American Healthcare Radiology Administrators’ audioconference “Diagnostic Radiology: Hot topics and updates” on June 28.

“We are not seeing across the board that people are getting reimbursement for these procedures,” she said. “It may be a really great procedure but we’re just

beginning to find out what’s being paid and what isn’t in regard to CT/CTA coronary.”

There are no relative value units for Category III CPT codes, said Mulaik.

Physician reimbursement for these services depends on carrier fee schedule and local coverage determinations (LCD) requirements, she said.

The majority of payers—private and Medicare alike—do not currently reimburse for cardiac CT angiography (CCTA) or calcium scoring, says Gregory.

Blackham said most payers appear willing to pay for CPT code 0146T—CT, heart, without contrast material, followed by contrast materials and further sections, including cardiac gating and 3D image postprocessing; CTA of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium.

“[Because] it’s the most popular study, it’s probably also going to be the most watched study, as well,” said Blackham.

### Investigational trouble

Many payers, carriers, and fiscal intermediaries still consider cardiac imaging procedures investigational procedures, Gregory says.

Without specific CMS guidance or instructions to the contrary, providers and other healthcare professionals should use Category III codes, by CPT definitions, for the purpose of tracking new and emerging technologies, Gregory says.

“In most cases, medical benefits for these services have not yet been defined or validated,” she says. Further, there is no guarantee of reimbursement, she says.

### Slicing the pie

**David Dowe, MD**, a radiologist with AtlantiCare Regional Medical Center in Atlantic City, NJ, sees big financial challenges in cardiac imaging.

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"It comes down to splitting the [radiology reimbursement] pie into smaller and smaller pieces for reimbursement money that is not there to begin with," says Dowe. "It's an insurance issue. Management is making it hell to get any exam, never mind a cardiac CT."

There are exceptions that are specifically described in various CMS instructions (e.g., change requests, manuals, or LCDs), and contractors may make individual considerations—in which case the code may be billed and reimbursed according to their fee schedule, says Gregory.

Those payers/carriers who do cover CCTA have specific policies, clinical indications, and criteria to meet to receive reimbursement for the procedure.

Mulaik suggested researching the payment practices of the top 10 payers in your area to determine whether each offers payment for cardiac imaging.

"Don't rely on rumors about who's paying for what," she said. "Do the research."

"The papers are saying that [cardiac imaging] is extraordinary, that it's a miracle," Dowe says. "Soon it will be that everyone 30 or 40 [years old] or older will have a heart scan as part of their routine physicals," he says. "But how are we going to pay for that?" ■

#### Insider sources

**Walter C. Blackham, MS, RCC**, president, Specialty Medical Services, Inc., 221 West 8th St., Lorain, OH 44039, 440/245-8010, Ext.10; [Walt@spmeds.com](mailto:Walt@spmeds.com).

**David Dowe, MD**, AtlantiCare Regional Medical Center, 1925 Pacific Ave., Atlantic City, NJ 08401-6713, 609/652-3400.

**Stacy Gregory, RCC, CPC**, president, Gregory Medical Consulting Services, 2661 N. Pearl St. #364, Tacoma, WA 98407, 253/566-2494; [stacy@gregorymedicalconsulting.com](mailto:stacy@gregorymedicalconsulting.com).

**Diane Millman**, Powers Pyles Sutter & Verville, PC, 1875 Eye St., NW, Twelfth Floor, Washington, DC 20006, 202/466-6550; [diane.millman@ppsv.com](mailto:diane.millman@ppsv.com).

**Melody W. Mulaik, MSHS, CPC, CPC-H, RCC**, Coding Strategies, Inc., 5041 Dallas Highway, Suite 606, Powder Springs, GA 30127, 877/6-CODING; [melody.mulaik@codingstrategies.com](mailto:melody.mulaik@codingstrategies.com).

**Shelley Weiner, MD, FACR**, senior medical director, CareCore National, LLC, 169 Myers Corners Road, Wappingers Falls, NY 12590, 845/298-8155; [sw@carecorenational.com](http://www.carecorenational.com).

## Follow these recommendations for CT and CTA coding

With new coding guidelines for cardiac imaging released in January, radiology facilities need all of the help that they can get when it comes to understanding the cardiac coding nuances.

Often, coders mistakenly report the administration of contrast separately when using the new cardiac computed tomography angiography (CCTA) procedure code.

"Do not do this," says **Stacy Gregory, RCC, CPC**, president of Gregory Medical Consulting Services in Tacoma, WA.

"The injection of the contrast material is [considered] part of 'with contrast' and is included in the new code," she says.

Payers may require a special report when reporting

new and emerging technology services denoted by a Category III CPT code.

This report should accompany the claim to determine whether the service(s) provided are medically necessary and appropriate for the patient.

Include the following information in the special report to payers as requested:

- Description of the nature, extent, and need for the procedure
- Time, effort, and equipment used
- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems
- Follow-up care ■

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## PACS

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certification initiative to professionalize the PACS administrator position.

The PACS Administrators Registry and Certification Association (PARCA) established a certification program in early 2005, and other radiology groups have offered their own fee-based certifications.

But SIIM hopes to standardize its program through the National Commission for Certifying Agencies, which officially endorses certification bodies, **J. Anthony Seibert, MD**, professor of radiology at University of California Davis and chair of the SIIM certification committee, tells **RACRI**.

"We want to separate ourselves from other certification processes," he says.

**Charles Socia**, vice president of operations for Synergy Imaging in Little Rock, AR, and a member of the committee adds that "PARCA and some other organizations are set up like schools—you pay to take their exam—whereas our certification exam more resembles a medical professional exam, such as that for respiratory therapists."

SIIM hopes that certification creates an accurate measure of the knowledge and skills of imaging informatics professionals, offering a means for employers to better evaluate their qualifications for PACS-related positions.

The committee put draft test content online ([www.scar.net/ciip](http://www.scar.net/ciip)) and is soliciting input from PACS administrators on eligibility requirements and the weighting of the test's various elements, Seibert says.

He projects that the first test will be available in September 2007, and exams initially will take place twice per year at multiple locations nationwide.

The increasingly technical nature of PACS and the complex range of its functions have produced PACS administrators with widely divergent aptitudes, backgrounds, and experiences. The SIIM certification process reflects the changing nature of PACS managers, Seibert says.

The program will incorporate interpersonal, business, and technical elements, he says.

"We want to make sure that there's a minimal competence in all three areas. If a facility hires a PACS administrator without looking at [his or her] credentials, it could have a problem. After all, you don't hire a radiologist unless [he or she is] board certified," says Seibert.

The committee wants to create a universal certification standard without unfairly disqualifying anyone from taking the exam, Socia says.

"We want to make sure that everybody who should take the test will be able to do so," he says.

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Eligibility requirements for the exam will require two years of experience, plus continuing education and a certain level of performance, Seibert says.

However, "if somebody has a [radiology technologist] background, [he or she] won't have to have an equally strong IT background to take the test, but will have to have basic knowledge about how the PACS system functions," he says. (The eligibility formula is available at [www.scarnet.net/ciip/eligibility.htm](http://www.scarnet.net/ciip/eligibility.htm).)

The exam and resultant certification are voluntary, says Socia. Nonetheless, he fully expects that a large number of experienced PACS administrators will participate. Outcry from experienced PACS administrators over the hiring of less experienced workers became a driving reason for the program, he says.

"There was also confusion over their job description. The catalyst for our job task analysis was our desire

to know what PACS administrators really do. After taking our exam, we [believe that] they'll be able to be competent across the board. The ideal candidate should be able to step into a medium-sized hospital and develop a full PACS program from scratch," says Socia.

Facilities hiring PACS administrators before the SIIM exam rollout should visit [www.scarnet.net/ciip](http://www.scarnet.net/ciip) and look at the framework developed by the certification committee, Seibert recommends.

SIIM plans to periodically place sample exam questions on its Web site before the test's September 2007 debut, which will give prospective employers an idea of whether their PACS administrators are eligible.

"Our hope will be that a full bachelor and/or master's level degree program will come of our certification program," Socia says. ■

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## New cert requirements for rad techs considered

The American College of Radiology (ACR) hopes to add the designation of radiologist practitioner assistant (RPA) to that of radiologist assistants (RA), according to a press release from the group.

Although initially thought to be a divisive issue, the American Society of Radiologic Technologists (ASRT) voted in June during its annual meeting "to recognize and support the RPA as a pathway for advanced practice radiography," according an ASRT release. In addition, the delegation approved an amendment that calls for recertification of RPAs every 10 years, the release states.

The primary differences between RAs and RPAs lie in educational curriculum, the certification examination, and scope of practice.

An RA is an advanced-level radiologic technologist who works under the direct supervision of a radiologist to enhance patient care by assisting the radiologist in a diagnostic imaging environment, according to the ACR.

Each designation has separate certification examinations and credentials. The ASRT, ACR, and American Registry of Radiologic Technologists (ARRT) support the RA model of advanced practice and have previously worked together to develop it.

Professional organizations have worked to promote the matter on the national political stage, pushing for the passage of Senate bill 1197, the Consumer Assurance of Radiologic Excellence bill (also known as RadCARE).

The proposal would establish minimum educational and credentialing standards for personnel who plan and deliver radiation therapy and perform all types of diagnostic imaging procedures.

However, with the absence of federal regulations, some states mandate specific training standards, whereas others require no certification standards at all, relying on professional organizations and educational programs to fill the void. > p. 8

## RPAs

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The Ohio Radiological Society and the Illinois Radiological Society (both chapters of the ACR) plan to introduce RA legislation in their respective states soon.

Tennessee, Mississippi, and Florida have already passed RA laws, according to a release from the ACR.

The Tennessee and Mississippi laws allow the state medical board to define the scope of practice of the RA and require that these rules be consistent with guidelines adopted by the ACR, ASRT, and ARRT, among others.

A new Florida law requires radiologic technologists to complete an educational program and credentialing process and then apply for certification from the Florida Department of Health.

Signed into law June 9, the bill requires RAs to complete advanced academic educational programs and a radiologist-directed clinical preceptorship, which cul-

minates in the award of a bachelor's degree, postbaccalaureate certificate, or graduate degree.

In addition, the law requires RAs to complete the ARRT certification program prior to applying for state certification.

The Iowa Department of Public Health (IDPH) already imposed similar regulations.

In that state, an RA now must hold a current permit to practice as a general radiographer, possess three years of experience as a general diagnostic radiographer, apply for a permit to practice as an RA, and satisfactorily complete both an advanced academic program and proficiency exam approved by IDPH.

The required training must incorporate a nationally recognized RA curriculum that includes a radiologist-directed clinical preceptorship. ■

### Radiology Administrator's Compliance & Reimbursement Insider Editorial Advisory Board

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**Executive Editor:** Melissa Osborn, [mosborn@hcpro.com](mailto:mosborn@hcpro.com)

**Managing Editor:** Melissa Varnavas, [mvarnavas@hcpro.com](mailto:mvarnavas@hcpro.com)

**Stacie L. Buck, RHIA, LHRM**  
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Stuart, FL

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Virginia Hospitals  
Richmond, VA

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