

Radiology Administrator's

Compliance & Reimbursement Insider

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IN FUTURE ISSUES

- Understand the ins and outs of auditing and monitoring your radiology department.
- The National Oncologic PET Registry (NOPR) offers new benefits and reimbursement challenges. Learn how to cash in on NOPR benefits before it's too late.



Into the maze

Managing the precertification process

How to navigate the path to reimbursement success

It took 10 years, but the precertification plan has developed into a reimbursement labyrinth. Now, insurers, radiologists, and referring physicians must all navigate the maze created by imaging's utilization (or overuse, as payers would put it).

Precertification requires referring physicians to obtain insurer approval for imaging services prior to scheduling scans.

"Precertification is not a new con-

cept," says **Christie D. James**, radiology billing manager for the Massachusetts General Physicians Organization (MGPO), an affiliate of Massachusetts General Hospital (MGH) and Partners Healthcare System in Boston.

James' department manages the entire revenue/billing cycle for radiology professional services at MGH, including off-campus imaging centers. This adds up to an annual volume of more than 700,000 billed CPT codes, she says. > p. 4

Simple steps to effective audits

To the uninitiated radiology administrator, it's a nightmare—the audit team is on its way. It wants a wide range of documentation in a seemingly wild search for underlying billing evils. More compliance officers are asking radiology administrators to wake up to the benefits of regular audits and to conduct self-audits to head off problems.

What's an audit, anyway?

Audits are an opportunity to examine the accuracy of your records and accounts. Essentially, auditors gather and evaluate evidence to establish connections between par-

ticular beliefs and the actual information. The auditor then creates a report to communicate the results to anyone interested (e.g., managers, board members, etc.).

There are three types of auditors: internal, external (i.e., those that are contracted by your facility), and governmental.

"You don't want governmental [audits/auditors]. They don't have a clear goal. They come in and look at everything," said **Andrei M. Costantino, MHA, CHC, CPC-H, CPC**, director of organizational > p. 2

Audits

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integrity at Trinity Health in Novi, MI. He spoke during the American Health Radiology Administrators' annual meeting in Las Vegas earlier this year.

Why audit?

Auditors generally look for a variety of problems, from billing and coding mistakes to incorrect charts. Congress and the Department of Justice continue to watch hospital management. The more prepared your facility is prior to an unannounced governmental audit, the better, Costantino said.

"The government constantly looks at what we've done," he said. "You've got to keep moving forward, but you can't stop worrying about the past either."

How to conduct an audit

1. Plan and organize. Define your objective and purpose. This can be tricky, because you don't want your scope to be too broad or too narrow, said Costantino.

"You may think that there might be a problem in a certain area—start there," he said.

Pick an initial concern, such as one of the following examples offered by Costantino:

- Coding errors
- Denial issues
- Documentation problems
- Compliance concerns

A clearly defined objective influences not only the audit process, but also the outcome. The purpose that you define inherently skews the investigation and the resulting action points or decisions.

2. Outline the sample collection. Now you will need to determine what kind of data are best suited to answer your initial question or concern, said Costantino.

Auditing for radiology administrators: A sample audit checklist

- ✓ How big of a problem is _____ (your audit topic)?
- ✓ Have there been any major lawsuits or settlements lately related to problems/issues in your department?
- ✓ What are the common pitfalls that lead to this problem?
- ✓ What laws come into play?
- ✓ What documents or resources will you need to examine this issue in your facility?
- ✓ What policies and procedures affect this problem?
- ✓ Do your policies need to be updated?
- ✓ Do staff understand the related policies and procedures?
- ✓ Which departments and staff will you need to work with?

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For example, perhaps you believe that a problem exists with the billing information on the UB-92 form. Take a look at the form and the information required to fill it out. Such data include the following:

- Revenue codes
- Units billed
- HCPCS codes
- Dollar amounts
- ICD-9 codes
- Modifiers
- Condition codes
- Date of service

“There are so many opportunities for a claims denial here,” he said. “The chances to audit appropriately and improve fiscal outcomes can be great.”

Save the date

Orders for diagnostic radiology tests and the documentation required to code and bill for them are crucial elements to proper reimbursement and compliance.

Yet, it's no wonder that the topics of test orders and documentation confuse the most experienced healthcare professionals, because determining who has the right to order an exam depends on the facility and the test.

You've got questions about how to appropriately document, code, and bill for diagnostic radiology test orders, and we've got answers. Join the HCPro Inc., team for “Diagnostic Radiology Documentation: Solutions to ensure appropriate reimbursement, test designs, and orders” on Monday, November 13, at 1 p.m., EST.

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Sample these forms over time and analyze the resulting data. Experts often recommend asking someone in the office to review 10 claims per week and look for a certain problem.

“Now you have a concise window of information to work with,” said Costantino.

Keep your audit topics and data collection sets consistent year after year to help to eliminate bias and develop data continuity, he says. Of course, consistency makes your job easier, too. The next time around, you'll just have to input data, not reinvent the wheel.

3. Create a schedule. Identify the other departments or people with which you want to partner. Then talk to them.

Tell them what information you need, and why you need it. Help them to understand how the audit will improve the overall effectiveness of the facility and the bottom line. Create regular, reasonable deadlines so they'll be able to comply.

Don't ask them to get the data to you ASAP—that's a recipe for disaster. But you don't want to set a completion date so far away that your coworkers forget all about the audit. Established timelines create achievable goals, Costantino said.

Don't be afraid of audits, he added. The paperwork nightmare may just end up fulfilling your facility's fiscal dreams by uncovering subconscious mistakes.

“More often than not, audits do not uncover fraud,” said Costantino. “They discover billing errors. Of course there are bad players out there, but mostly people do their jobs to the best of their abilities. Mistakes are due to misunderstandings, lack of knowledge, technological breakdowns, and bad advice.”

Through audits, you can find these problems—and you can fix them. ■

Insider source

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Precertification

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She shared how MGPO decided to handle the precertification situation during a presentation at the Radiology Business Management Association's annual meeting in June in Miami.

The shape of precertification

If the referring physician fails to obtain a precertification, or if insurers (or their agents) refuse precertification because of lack of medical necessity, the claim for the imaging service gets denied. Thus, referring docs

don't suffer the consequences if they fail to follow the appropriate precert path.

Radiologists suffer in their stead, because insurers refuse to pay for the cost of exams without proper precertification in hand. And because insurers don't really want to wade into this warren of paperwork, they have now found a third party—imaging management companies—to further develop the precertification maze.

Use or overuse? The reality behind the regulations

At the heart of every myth lies the essence of truth. The exponential growth of imaging and its effect on healthcare's bottom line profoundly affects not only the future of healthcare, but the future of health itself.

For example, a mother can now see her unborn baby in perfect, three-dimensional (3-D) view. A grandfather with no previous history or other indications of heart trouble can see his beating heart and learn of potential risks early enough to counteract them.

Advancing technology makes these scenarios possible. But it's just one reason for imaging's rise from a supportive role to a lead character on healthcare's mythological stage. Patient/consumer demand represents another reason for such growth, **Shay Pratt**, a senior consultant at The Advisory Board Company in Washington, DC, told an audience during the Radiology Business Management Association's annual meeting in Miami in June.

Changing protocols in the world of radiology allow for more formalized procedures, which, in turn, create easier processes and better throughput. A greater number of scans become possible because the industry knows how to handle the increased caseload.

Utilization creep has also occurred in recent years, because scans once dubbed "investigational" now have CMS and local coverage determination ap-

proval, said Pratt. In essence, more payers accept more diagnosis codes for more scans.

The growth of imaging services has turned it into the "pillar of profitability," Pratt said. In 2005, hospital outpatient systems across all payers earned \$20.9 billion, according to an Advisory Board report.

However, no myth can be free of demons. Cutting-edge technology costs money, and such expansion has instigated increased scrutiny from government and private insurers alike.

A 3-D Doppler ultrasound may be beautiful, but it may not be necessary. The radiologist may find an abnormal tick in that grandfather's heart, but the cost of such a scan makes its widespread use prohibitive.

Because some see radiology as the proverbial golden fleece, the temptation to offset other practices on the back of imaging's fine fibers can be great. To balance the benefits of increased imaging use with healthcare's ever-tightening coffers, payers and governmental agencies have created challenges for referring physicians and radiologists to overcome.

For example, an overview of CMS' Medicare Physician Fee Schedule (MPFS) proposed rule for 2007 includes the implementation of the following two provisions of the Deficit Reduction Act of 2005 affect-

Needless to say, precertification creates considerable chaos for radiology departments and facilities nationwide. "It's a formidable management challenge," says James.

Although those managing radiology billing may wish to take a weed whacker to the precert process, navigating payers' mazes can be accomplished.

Computer programs and other celestial intercessions

For James, divine intervention came in the guise of her information technology department, which put a little

pixie dust into MGPO's computer programming and established several new imaging order protocols to help her team receive proper reimbursement.

The Radiology Order Entry (ROE) system is a Web-based program that includes a decision support tree for referring physicians. Associated doctors access the portal via Partners' intranet.

The ROE system brings the doctor to an exam ordering page. From there, he or she chooses the imaging modality from a pull-down menu. **> p. 6**

ing payment for imaging services under the fee schedule:

1. The first provision addresses payment for certain multiple imaging procedures, with full payment for the first procedure, but a 25% reduction in payment for additional imaging procedures furnished on contiguous body parts during the same session. This is a smaller reduction than had previously been proposed.
2. The second provision limits the payment amount under the MPFS to the outpatient department payment amount for the technical component of certain imaging services. Under this provision, the physician fee schedule payment amount for furnishing certain imaging procedures would not exceed the amount that is paid to an outpatient department.

Further, imaging practice ownership regulations continue to evolve as the industry evolves. As of January 1, 2007, nuclear imaging will fall within the realm of designated health services and under the purview of the Stark Law. Many hospitals will be forced to untangle their joint venture agreements to keep from getting bitten by government regulations.

Payers have created their own cost-cutting procedures, as well, said Pratt, which is where precertification—and imaging intermediaries—come in. These procedures include the following:

- Cost sharing

- Quality standards
- Precertification
- Tiering of services
- Coding edits
- Payment retention—imaging's answer to pay for performance

Imaging management companies offer large payers big financial returns by implementing any number of these procedural fail-safes.

For example, National Imaging Associates, Inc., measures physician ordering patterns. CareCore National, LLC, offers clinical certification, referral profiling, privileging, correct coding, and network management programs tailored to payers' imaging needs. CareCore National measures physician ordering patterns and helps payers to establish quality standards for in-network imaging providers. American Imaging Management and HealthHelp also measure physician ordering patterns and assist in developing quality standards. "These companies clearly meet a demand," said Pratt.

Precertification, or use management, may just be one obstacle in the path of our mythological storyline. However, it has clearly become the maze to navigate for imaging reimbursement, she said. ■

Insider source

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Precertification

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A requisition form prompts the physician to provide information regarding clinical indications, signs and symptoms, and known diagnoses. He or she must also include patient history and other pertinent information.

ROE's decision support framework provides physicians with immediate feedback based on Partners' own appropriateness criterion.

ROE rates and color-codes the order: Green equals high use, or okay, whereas red warns the physician that he or she requested a scan that's not typically used for the ailment described.

If the physician tries to go ahead with a red order, the program forces him or her to document the reason for requesting the potentially inappropriate exam.

Further, the program provides a link to supporting documentation for each order's medical appropriateness.

"Perhaps the most important aspect of the ROE system is that it educates physicians on the precertification process and various requirements by payers," James says.

On its scheduling screen, ROE offers a precertification quick reference, making it easy for physicians to pick up the phone and get the precert number needed to complete the order form.

Mapping the maze

The No Administrative Hassle (NoAH) program attempts to electronically systematize the precertification process through an interface between Partners and certain contracted payers.

The NoAH screen requires the patient's name, date of birth, payer, and payer identification number. It also asks for the names of the referring physician and service provider (i.e., radiologist).

The referral date, level of service, and type of testing requested must also be established.

Because it's all on one computerized form, the "system

minimizes the precertification hassle for referring physicians," says James. "It eliminates the need for the referring physician to pick up the phone and obtain the precert him- or herself."

Although NoAH may add complexity to the process, it reduces the burden on the front-end radiology clerical staff, on the back-end in reduced denials because of lack of precertification, and on the referring physicians, who don't want to spend additional time on payer paperwork.

Even after MGPO receives precertification through this process, payers still sometimes deny claims, says James.

Slay denials with precert data

The battle for reimbursement won't be won by mere muscle. But let's say you've slain the precertification monster—there's much more navigation to be done before you can escape the labyrinth unscathed.

Practical data analysis provides a trail for administrators to follow, says James.

Create a database to capture information on procedures missing a precertification number. This enables rapid, root-cause analysis. Further, it facilitates a management response and also prevents future loss of revenue.

Report all claims denied because of lack of precertification. Sort data by modality, CPT code, payer, and primary care provider, she says.

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Questions? Comments? Ideas?

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The precertification mantra: Be prepared

Put in place simple solutions to eliminate the hassle associated with imaging precertification requirements, says **Shelley N. Weiner, MD, FACR**, senior medical director at CareCore National, LLC, in Wappingers Falls, NY. The most universal tribulations are simply administrative, she says.

Use the following information to help purge precertification problems before they happen:

■ **Physician education/buy-in.** Weiner doesn't deny the deep administrative burden associated with the precertification process. She still believes that precertification is important. "We get the physicians who say, 'I never get denied. Why do I have to go through all of this?' Maybe they *rarely* get denied, but this system is in place to ensure order adequacy and medical appropriateness," says Weiner.

Many doctors in small offices have just not adjusted to the reality of managed healthcare, she adds. "But the process is what the process is. It's more costly if it's not done right." To combat such lethargy, create a package of useful precertification information and get it out to referring physicians. Schedule follow-up meetings to reiterate the importance of adhering to proper precertification protocols and go over any potential problem areas.

■ **Lack of experience.** Receptionists or other office staff often end up with the task of requesting imaging precertifications, Weiner says.

"They are unfamiliar with the [CPT] codes. When we suggest a code change, they react. 'This is the scan that's needed,' they tell us," she says.

For example, the physician may say Mrs. Jones needs a CT scan of the neck, but what he or she really means is a CT scan of the cervical spine based on the clinical indications. When the receptionist gets on the phone with the medical staff at CareCore, the receptionist may or may not understand what clinical indi-

cations go with what scan.

"If we get the doctor on the phone, we can just change the precertification scan request right then, but otherwise it can be an uphill battle," she says, which ultimately results in claim denials, lost revenue, and plenty of ill will.

■ **Lack of preparation.** Weiner often listens in on CareCore customer calls. Often, the person on the other end of the line doesn't have the necessary information at hand to answer CareCore's inquiries.

Have the patient report beside the phone when making a precertification request, she suggests. Many of the particulars are included in the report. Also, have the referring physician spend an extra minute explaining the situation to the person requesting the precertification. A two-minute conversation can save 30 minutes on the telephone or days of precertification paperwork related to a potential denial.

■ **Illegible facsimile or hand-written orders.** "If we can't read it, we can't approve a precertification for it," says Weiner. Although electronic medical records make this process easier, do not expect that all referring physicians process information electronically. Resolve this issue by offering ready-made forms for providers. CareCore provides fax forms on its Web site (www.carecore.com). At the very least, says Weiner, a typed form eliminates the legibility problem.

Overall, the biggest need is training, she adds.

"Doctors need to know how to navigate precertification, so any training they get can be extremely valuable," she says. "So, give it to them." ■

Insider source

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Precertification

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Create regular retrospective reviews complete with cross-network charts. Have an internal panel of vested interests examine and debate the report.

Ensure that the radiology billing administration receives weekly and monthly denial reports and that the reports contain pertinent information from all payers.

"Meet with everyone," says James.

Tools for the trail

As the radiology administrator, hold biweekly meetings with staff whom you've designated to keep tabs on the precertification process.

Include coders as well as key members from the radiology finance, hospital, professional billing management, compliance, and accounts receivable teams.

"This provides for a greater understanding of factors associated with high-cost radiology utilization, and allows the whole team to discuss the direction of a

radiology management program," James says. For example, a breakdown of all precertification denials at MGPO showed lack of medical necessity as the number one reason for rejection, she says.

"We use the information to see which docs are the worst offenders. Once we know that, we can focus on them, educate them, and show them how precertification works," she adds.

Essentially, James says, the key to finding your way out of the precertification labyrinth is fairly simple: Stay on target and work as a team.

"As an industry, we weren't paying attention," she adds. "Shame on us. Precertification is here now. We have to handle it." ■

Insider source

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