

# Radiology Administrator's

## Compliance & Reimbursement Insider

JANUARY 2007

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Interventional radiology coding in a hospital outpatient setting.

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Watch for these problems when tracking claims denials.

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You tracked claims denials, mapped your top 10 offending codes, and nailed your offending coders, so maybe it's time to start talking to your physicians.

#### Imaging Weekly

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#### IN FUTURE ISSUES

- The Deficit Reduction Act of 2005 caused turmoil throughout the imaging industry in 2006. **RACRI** presents a special section on how to handle the changes and where the government plans to lead radiology reimbursement next.
- W. Kenneth Davis Jr. offers alternatives for handling cardiac imaging turf battles.



## Avoid claim denials by tracking data

Everyone wants to get paid appropriately for the work that he or she performs. In healthcare, that elemental economic process just isn't that simple.

Radiology managers, perhaps, understand this truism best of all. Industry estimates indicate that 30% of all initial radiology claims get denied, said **Joe Lineberry**,

**CPC, CHC**, vice president of compliance for Per Se Technologies in Alpharetta, GA, during the American Healthcare Radiology Administrators' annual conference in Las Vegas in August 2006.

"I don't know of any other business where you provide a service and 30% of the time you don't expect to get paid," Lineberry said. **> p. 4**

## Credential to handle imaging dispute

*Editor's note: Over the coming year, **RACRI** will examine the conflict between cardiologists and radiologists regarding imaging of the heart. We'll collect expert advice from healthcare lawyers and talk to radiology administrators seeking best practice tips and case scenarios.*

In this, the first of our yearlong series, we'll examine how credentialing can ease some of the turf-war tension.

In November, the American College of Radiology (ACR) concurred with a 2005 Medicare Payment Advisory Commission report seeking to set quality and safety standards for medical imaging. It reiterated that "radiological procedures (CT, MRI, PET, etc.) are medically prescriptive in nature and should only be uti-

lized by appropriately trained and certified providers under medically necessary circumstances."

Although it is a particular problem between cardiology and radiology, regardless of specialty, practitioners who want to get into the field of cardiac imaging may not have the appropriate training to perform the test, warns **Joseph Schoepf, MD**, Associate Professor of Radiology and Medicine at the Medical University of South Carolina in Charleston. "Administrators need to ensure that the [practitioner] who is best suited to do this is credentialed to do so," he says.

"This is a classic privileging dispute," says **Richard Sheff, MD**, chair of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. "Before moving forward, **> p. 8**

**Coding corner****Coding IR in an hospital outpatient setting**

by Lolita Jones, RHIA, CCS

Interventional radiology (IR) procedures are minimally invasive, targeted treatments that use imaging for guidance. These procedures are often less risky, less painful, and have a shorter recovery time than open surgery.

Unlike traditional radiology procedures, certain IR procedures require anesthesia.

Unfortunately, CMS has not specifically addressed the use of modifier -52 in these situations.

In the absence of a formal, written directive from CMS or its fiscal intermediary (FI), hospitals need to develop an internal policy to address the use of modifier -52 or -73/-74 for discontinued IR procedures that involve anesthesia.

**Guidelines for discontinued single procedures**

Following are the official guidelines for modifiers -52, -73, and -74, as published in CMS *Transmittal 442*, Hospital Outpatient Prospective Payment System:

- Use of modifiers -52, -73, and -74 for reduced or discontinued services: All of the definitions took effect February 22, 2005
- For purposes of billing for services furnished in the hospital outpatient department, the definition of

anesthesia includes local, regional blocks, moderate sedation/analgesia (i.e., conscious sedation), deep sedation/analgesia, or general anesthesia:

- **Modifier -73:** Use this modifier to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated because of extenuating circumstances or circumstances that threatened the patient's well-being after he or she had been prepared for the procedure—including procedural premedication, when provided—and taken to the room in which the procedure was to be performed, but *prior* to the administration of anesthesia
- **Modifier -74:** Use this modifier to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., the incision was made, intubation started, and the scope was inserted) because of extenuating circumstances or circumstances that threatened the patient's well-being
- **Modifier -52:** Use this modifier to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia

**Scheduled/discontinued multiple procedures**

Use the following guidelines to report discontinued procedures that the hospital planned to per-

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form along with other procedures during the same patient visit:

- Report completed procedures as usual when hospital staff complete one or more of the planned procedures.
- Do not report procedures that were planned but not started. If a physician starts the first procedure (e.g., scope inserted, intubation started, incision made, etc.) or the patient has received anesthesia, use modifier -74.
- Do not report the procedure if it is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -73 or -74.
- Use modifier -73 or -74 as appropriate for discontinued pain management procedures (e.g., diagnostic and therapeutic spinal injections) if they involve the use of anesthesia.

Following are two case studies that put these guidelines into practice. The body of the operative report in each case study includes appropriate codes/modifiers and support for their assignment.

#### **Case study #1: Injection report**

**Procedure:** Attempted three-level lumbar discogram. The procedure was aborted because the patient began vomiting once anesthesia was initiated (62290-74). Therefore, anesthesia was discontinued.

The airway was protected and oxygen was given. The patient's oxygen sats, which had fallen into the 80s, came back up to 98.

At that time his vital signs were stable, and he was transferred to the recovery room.

The patient will reschedule this lumbar discogram.

**Coding rationale:** Assign code 62290-74 (Injection procedure for discography, each level; lumbar—procedure discontinued after the administration of anesthesia) to reflect the administration of the anesthesia for the scheduled discograms, although none of them were attempted.

#### **Case study #2: Thoracic facet arthropathy**

**Operation:** Right T3 through T6 thoracic facet median branch nerve block with fluoroscopic localization.

**Operative procedure:** The patient was brought to the operating room and placed in the prone position. Anesthesia and monitoring were applied. I observed an adequate scout view of the thoracic spine.

The thoracic region was prepped and draped in the usual sterile fashion (1% preservative-free lidocaine was used for local throughout using a 22-gauge spinal needle for the procedure).

The area of pain in the thoracic region was localized with fluoroscopy from T3 through T6 (76005).

On the right side, the needle was advanced with a 3-c. syringe of lidocaine attached.

It was placed in the medial aspect of the T3, where the median branch lies. It was then advanced to T4, T5, and T6. At each level, 1.5 cc of 0.5% bupivacaine was injected using 20 mg of DepoMedrol in toto (64470-RT, 64472-RT, 64472-RT).

The plan was to perform similar treatment on the left side. However, the patient had a degree of emesis and began coughing. She also moved in such a way that the needle could not hold this position.

Therefore, the procedure on the left was aborted.

The patient was placed on a stretcher and brought to the recovery room awake, alert, and in good condition.

**Coding rationale:** Assign codes 64470-RT, 64472-RT x2, and 76005 to report the completed procedures.

Do not report the scheduled left-side procedures, because they were not attempted. Modifiers -52, -73, or -74 are not necessary because no procedures were discontinued. ■

*Editor's note: Jones is principal of Lolita M. Jones Consulting in Fort Washington, MD. E-mail her at lolitaMJ@aol.com.*

## Claim denials

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Essentially, the problem works out like this: A patient presents for an MRI. The MRI costs \$1,500, so you bill for \$1,500. The potential collection amount on any given charge is fixed, but the cost associated with collecting on that same charge is variable.

Every time a person touches the claim, it costs money and slows the revenue cycle, Lineberry said. Each step in the billing process adds cost to the bill and, in essence, reduces payment.

“Resources are limited. Tracking, researching, and resolving denials takes time . . . a lot of time. So get focused in how you deal with claims. Ultimately, the plan is to allow every practice to achieve its maximum income potential,” he said.

The maximum income potential equals the greatest amount you could possibly collect for a given service.

### Denial basics

Denials and rejections come in many forms. A rejection is an incorrect claim stopped *prior* to entering the payer's system and resulting in nonpayment. Denials, on the other hand, are inappropriate claims stopped *after* entering the payer's system and resulting in nonpay-

ment. Many denial codes exist. And many of these denial codes mean essentially the same thing, said Lineberry.

Multiply the number of denial codes by the number of payers, and sorting and tracking hundreds of codes becomes problematic.

**“Ultimately, the plan is to allow every practice to achieve its maximum income potential.”**

**—Joe Lineberry, CPC, CHC**

### Measurement equals management

The bottom line is that you cannot manage what you cannot understand. You also cannot manage what you cannot measure. “It's a simple business principal,” said Lineberry.

Look for overlap where volume and reimbursement are high. Pinpoint procedure and diagnosis code combinations with the maximum recompense to the facility.

For example, Lineberry said, head and abdomen scans offer the greatest financial return, so in this case you'd sort by body part, not modality.

Identify denial types in order of their highest influence on the practice and then deploy resources accordingly, he said. “This will speed up your cash flow significantly,” he added.

When a technological solution remains out of reach because of either time or expense, don't give up on denial tracking, said Lineberry.

“It's okay to start off small,” he said. At a minimum, create a manual process for employees to track denials themselves.

Choose a topic to target. Medical necessity, uninsured patients, diagnosis-prognosis mismatch, and bundled services are all good subjects to start with.

Next, create a translation table to post standard rejection codes in an easy-to-see spot. Have coders and your front-end support staff keep the sheet nearby. Then, make an easy-to-use spreadsheet to track specific denials daily. At the end of the week, collect > p. 6

### Tracking tips

Ideally, radiology managers should create a systemic technology solution that

- is capable of tracking all denial types
- maps to American National Standards Institute codes
- is capable of sorting management reports by
  - denial type
  - volume
  - dollar impact
  - procedure code
  - ICD-9 code
  - performing physician
  - referring physician

## Practice problems lead to claims denials

An industry rule of thumb states that approximately 40% of all radiology exams return normal or with no findings.

Under such circumstances, coders assign the order diagnosis and bill for the procedure. But the order diagnosis comes from parties outside of radiology's control—either from referring physicians or other departments within the facility.

“So, 40% of the time, our reimbursement depends upon other individuals,” said **Joe Lineberry, CPC, CHC**, vice president of compliance for Per Se Technologies in Alpharetta, GA, during the American Healthcare Radiology Administrators' annual conference in Las Vegas in August 2006.

“And don't forget that different ordering physicians have different ordering practices,” he added.

And there's more to worry about. Lineberry pointed to several problems to watch for, particularly in a hospital setting, including lack of

- contact at the time the patient presents
- ability to review the initial order
- opportunity to determine whether the order is medically necessary
- chance to query the patient regarding presenting signs/symptoms
- control over the front-end registration process
- influence over insurance verification and advanced beneficiary notification processes

Radiology administrators can regain control not only of the remaining 60%, but of 100% of the payments that they are owed by understanding and preventing claims denials, said Lineberry.

### Staff trouble

Radiology billing and accounts receivable management is a complex and changing environment.

You need qualified and knowledgeable staff to handle these procedures.

Everyone must learn how to handle specific payer denials, Lineberry said. In some areas, two practices in the same ZIP code report two entirely different claims denial patterns because the essential issues affecting each can be different, he said. Further, CPT codes change every year, and payer policies also change constantly.

Employees will always leave, and new employees will arrive to fill their places. These inevitable changes require training, training, and more training, Lineberry said. “Reimbursement is a moving, breathing animal. Payers change their policies all the time. If you're not watching for it, you lose money—big money,” he added.

### Outside interference

Like others before, Lineberry pointed to several reasons for reductions in radiology reimbursements—reasons such as increased payer and government scrutiny. Among these reasons are

- the Deficit Reduction Act of 2005
- increased managed care
- increased claims edits
- increased scrutiny from CMS

“We are working in an era of declining reimbursement,” Lineberry said. “We're all working harder for less [money].” ■

## Upcoming events

HCPro, Inc., presents the audioconference “Defining the Legal Health Record in a Hybrid Environment” on Thursday, January 11, at 1 p.m. EST.

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## Claim denials

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that information. Such practices raise awareness and reduce denials, said Lineberry.

Now that you have all of this information, let the data drive your decisions. Once you know which denials cost you the most money and which occur the most often, develop individual plans for each type.

Once you track the reduction of that area of claim denials and the facility's fiscal improvement associated with it, you should be able to obtain more resources and expand your denial prevention program.

### Get cash quick

To realize the fiscal effect swiftly, move remedial actions to the front end, rather than the back end, of your financial management system.

"We all understand the back-end administration process. We all know it's not the ideal situation," Lineberry said.

*Illustration by  
David Harbaugh*



*"Melissa, you need a break. Take some quality time and find ways to receive reimbursements for cardiology imaging. I hope you're not allergic to denials."*

**"Working toward a front-end solution while simultaneously working denials that slip through on the back end is critical."**

**—Joe Lineberry, CPC, CHC**

Regardless of specialty, administrators are moving away from a back-end (i.e., business office) collection system. The front-end (i.e., the registration offices and patient processing) have started taking on more fiscal responsibility.

Due in part to human nature, it is easier to collect for services before the services are rendered. And it's easier to eliminate payment roadblocks prior to treatment than after the work is done, said Lineberry.

Working denials on the back end is a critical safety net that's vital to patient correspondence, carrier correspondence, explanation of benefits, etc., Lineberry warned. But back-end focus by itself "slows down cash flow and increases costs," he added.

"Working toward a front-end solution while simultaneously working denials that slip through on the back end is critical," Lineberry said.

### Maximize efficiency

To boost the competency of back-end denial management, take the following steps:

- Train employees to work with particular payers.
- Train interested staff to work on particular subspecialties. "Get them to know the codes inside and out," Lineberry said.
- Make sure that back-end staff prioritize denial management.
- Train accounts receivable (AR) to follow up with coding staff.
- Have AR send coding-related denials back to the coding department. "Returning denials to the coders serves as a training mechanism. It allows the coders to see the mistakes they made and keeps them from repeating them," said Lineberry.
- Train coders about local coverage determinations.
- Perform spot audits on specific coders. ■

### Insider source

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## Denial management: Talking to physicians

You tracked claims denials. You mapped your top 10 offending codes, nailed your offending coders, cleared out your accounts receivable, and shifted some of the heavy lifting to your front-end fiscal management team.

Your denial rates should be nil. But they're not. What's the problem?

Maybe it's time to start talking to your physicians.

### Standing in their shoes

During **Frank A. Madonna's** residency, his nursing home patients paid him for his work with personal checks. Most added up to a pittance, but for Madonna, taking the small sums from such needy people filled him with sympathy.

He hesitated to cash the checks, and piles began to form. Finally, the stack grew too tall to turn in. He'd lost quite a bit of money and he couldn't recoup a dime, he told attendees during the American Healthcare Radiology Administrators annual conference in Las Vegas in August 2006.

He learned a major lesson—that even pennies count.

"Doctors are used to being spoon-fed all their lives," said Madonna, a doctor at Lucien Diagnostic Imaging in Pittsburgh. "All [doctors] know is academia. [Schools] don't teach them about basic business practices, about basic profit and loss. They don't understand basic accounting."

Add this understanding of physician behavior to the quintessential doctor stereotype (i.e., "Which way to the golf course?") and radiology administrators face a significant reimbursement obstacle to overcome.

"Doctors will ask, 'What are *you* going to do about it?' " said Madonna.

"All doctors want to talk about is how to get out the door at five o'clock and, 'Can I get out of here in time for my kid's baseball game?' " Madonna added.

"All these issues hit docs in the face when it comes to reimbursement. And that's denial management."

### Data conversion

Armed with understanding, radiology administrators must take the next step and convince physicians of the importance of medical necessity and claims denial tracking. That's how you'll convert physicians to your way of thinking.

"Show them. Give them data. Prove to them the \$1 million dollar difference. Show them that payable claims equal medically necessary claims. It's more money, [and] it's more money faster," said Madonna.

Determine where the problem lies, then focus on the size and solution. For example, do a lot of referring physicians make similar errors over and over again? If so, it might be wise to hold an information night and invite a broad swath of customers.

"You don't want to target a blanket of referring physicians" if only one physician exhibits a particular problem, said **Joe Lineberry, CPC, CHC**, vice president of compliance for Per Se Technologies in Alpharetta, GA, during the conference.

If the trouble appears limited to one physician, show that physician the collected data and let him or her know how such denials affect the bottom line.

"Bring this data measurement point home to your referring physicians," said Madonna. "Show it to the doc who is doing it. Explain why it is a problem, and help resolve the problem."

"There is a ton of money sitting out there," added Lineberry. "You just have to go digging after it." ■

### Insider sources

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## Credentialing

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hospitals need to have a policy for addressing turf battles or privileging disputes, and create an orderly process to step through this issue.”

### Two diverse backgrounds

The dispute between radiologists and cardiologists is compounded by the fact that the specialties—both with great interest in conducting the test—come from extremely different clinical backgrounds and will require additional training to perform the test. “Hospitals need to tease out competency issues,” says Sheff.

“Both groups have limitations coming from various backgrounds to cardiac CT imaging,” says Schoepf.

The ACR recently published a White Paper on split decisions to provide its members with assistance in navigating this minefield. The paper is available on the ACR Web site ([www.acr.org](http://www.acr.org)). This issue is further complicated as laws surrounding these questions vary from state to state.

### A wide range of training available

Currently available training programs in the area of CT imaging vary significantly in duration and extent of content.

For example, consider the following training options:

- The Medical University of South Carolina offers a two-day practical course for level 1 certification in cardiac CT for radiologists and cardiologists using the newest generation of dual-source CT scanners
- Mayo Clinic in Rochester, MN, offers a one-year clinical fellowship in cardiac imaging for cardiologists
- South Florida Medical Imaging in Boca Raton offers a two-and-a-half-day course for radiologists and cardiologists with limited experience with cardiac CTA for level 1 certification.
- A Jacksonville, FL, program offers a three-month training course on routine applications of cardiac magnetic resonance and CT. ■

*Editor's note: This article originally appeared in the HCPro, Inc., publication **Briefings on Credentialing**.*

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