

Radiology Administrator's

Compliance & Reimbursement Insider

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■ 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.



Craft a cost-effective plan for PACS

Although some people believe that the whole world went digital some time ago, many community hospitals and freestanding facilities remain hesitant to purchase a PACS.

The product, process, and price still seem futuristic and complicated to many facilities.

Once upon a time, PACS represented an emerging technology, said **Steven M. Walter**, director of diagnostic imaging services for North Shore Medical Center in Salem, MA, during the 2006 American Healthcare Radiology Administrators meeting in Las Vegas.

"No one wanted to be standing on the point where the leading edge becomes the bleeding edge," Walter remarked.

But purchasing a PACS system need not seem like an exploration into the mind of Jules Verne.

"It's not rocket science anymore," Walter said.

"PACS is a mature technology now. It is a competitive technology. It is affordable. There's nothing freaky about it. You don't need to be an expert. You can do this. You just need to trust yourself." **> p. 6**

Fair-market approach to cardiac turf war proves problematic



Editor's note: This is the second in a series regarding approaches to the cardiology/radiology debate concerning the ownership of heart imaging techniques and reimbursement.

Noninvasive cardiac imaging has advanced dramatically in its efficacy and sophistication during recent years. Few people question the important and rapidly-expanding role that such imaging plays in the

diagnosis and treatment of heart-related ailments.

Further, research demonstrates that noninvasive cardiac imaging could replace cardiac catheterization as the test of choice for patients with possible coronary artery blockages.

Average Americans see this as an advantage—both to their health and healthcare pocketbooks. Some people express exaltation for such technological advancements, but others see a dark day approaching. **> p. 4**

Ask the Insider**Reporting for incidental findings on radiology reports**

Q: I have been told that I don't need to report incidental findings on a radiology report for a patient in the emergency room. For example, a physician performed a chest x-ray for pneumonia, but found a diaphragmatic hernia instead. The physician did not render treatment. Can you provide any information about this topic other than what is published in *Coding Clinic*, first quarter, 2000, p. 6?

A: An incidental finding represents an additional diagnosis unrelated to the initial reason for an exam. The most recent mention of this topic was in the *Coding Clinic* to which you referred in your question. The *Official Guidelines for Outpatient/Diagnostic Services* states the following:

Code all documented conditions that coexist. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Do not report incidental findings of a diaphragmatic hernia in this scenario unless the physician identifies its clinical significance or renders further treatment or evaluation (e.g., mention of a consult for the hernia, prescription, etc.). Incidental findings are common in radiology. ■

Editor's note: Shannon McCall, RHIA, CCS, CPC, director of coding and HIM for HCPro, Inc., in Glen Allen, VA, originally answered this question for the RACRI sister publication JustCoding.com. E-mail her at smcall@hcpro.com.

News of note

Members of Congress approved a bill December 9, 2006, that would reverse a 5.1% reduction in Medicare physician reimburse-

ments, the *Washington Post* reports. The legislation would maintain the 2006 level of Medicare physician reimbursements this year and would provide a 1.5% increase in reimbursements to physicians who agree to report data about certain quality of care measures.

Under the bill, the increase in Medicare reimbursements would be based on the physician, and whether he or she reports the data. However, the system lays the groundwork for higher payments to better-performing physicians.

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Proper prep of audit reports ensures follow-through

No one likes to have their faults aired. Yet growth and development cannot come without honest assessment. Audits represent such assessment. So, first expect to find errors. Then expect to correct them. Conducting such actions in a positive way could mean the difference between the fiscal success of your radiology facility and its financial failure.

“Audit reports are not meant to be punitive,” says **Stacy Gregory, RCC, CPC**, president of Gregory Medical Consulting Services in Tacoma, WA. “They are meant to help you improve your business.”

With your audit findings in hand, consider the appropriate way to document and report them. Remember those college papers you used to write? Composing an audit report follows essentially the same concepts.

Make sure that you list the audit objective and its scope. Think of it as the introduction of those college-day papers. For example, perhaps you set out to discover whether medical necessity requirements were met for diagnostic mammography. Write this in your report, and then review the scope of your audit, your methodology, the total number of encounters that you reviewed, and your statistical analysis.

Make sure that the report is as complete as possible, accurate, convincing, clear, concise, and to the point. Leave any subjective analysis out of the paper. Audit material must be objective and based on the statistical data you collected. Then compose your findings, conclusions, and recommendations. Gregory and **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC**, vice president of Southeast Radiology Management in Stuart, FL, recommend using charts and graphs wherever possible.

Be sure to address the source of any issues or errors found during the audit. Identify the departments and individuals responsible.

Make sure that everyone understands the importance of compliance with state and federal laws and regulations. Then establish a plan to evaluate the errors, educate the staff, and make improvements.

Illustration by David Harbaugh



Go back to those school days again—getting bad test scores meant nothing without appropriate tutoring to better your grades. The same holds true for staff mistakes made in the real-world setting of your facility.

When an audit warrants corrective action, remind staff of the audit's importance to the health of the facility. Then make sure that your corrective-action plan outlines the scope of the problem, remediation actions, and a time frame for implementing those actions. In the event that staff will not or cannot seem to implement the corrective-action plan you've established, contact your human resource department and your legal advisor to determine the best route to handle the problem, says Buck.

As you move through this process, make sure that you also note staff accomplishments. Rewarding and presenting positive achievements often acts as a positive motivator. ■

Insider sources

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Cardiac turf war

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Tools for noninvasive cardiac imaging historically belonged under radiologists' rule—leaving invasive techniques under cardiologists' command. However, with many invasive procedures heading for extinction, the struggle for control over heart imaging is increasing.

Many cardiologists have chosen to earn additional qualifications in imaging. With these qualifications behind them, they open the door to earning reimbursement for the professional component of such studies.

This leaves radiologists staring into the extinction abyss. Because without obtaining additional qualifications themselves, they cannot discount the idea of such a fate.

"It's a balancing act that radiology needs to engage in," said **W. Kenneth Davis Jr.**, attorney with Katten Muchin Rosenman, LLP, in Chicago. Davis spoke during an audioconference presented by the Radiology Business Management Association in 2006.

"It's part science, part art," he said.

Struggling for interpretation

Radiologists typically analyze both the heart and the chest during a CTA study. However, radiologists do not have comprehensive training about the heart. Conversely, cardiologists do not have comprehensive training reading images, or in areas outside the heart.

Reimbursement codes for this procedure once included interpretation of the chest image with interpretation of the heart image. New category III codes separate out these for each procedure.

Regardless, for professional liability reasons, physicians should interpret the entire image—not just the heart portion. The question remains whether cardiologists even want to read CT or magnetic resonance studies not related to heart procedures.

Sometimes, the hospital management and contractual requirements prevent cardiologists from interpreting the nonheart portion without proper training.

And, according to Davis, there's simply not enough incentive right now for them to acquire the additional credentialing.

Finding a fair market approach

In the meantime, many cardiologists and radiologists are seeking clinically principled, commercially reasonable fair market value approaches for collaboration.

But compliance problems arise when radiologists and cardiologists attempt to share responsibility for the professional component of the interpretation, said Davis.

Such joint approaches prompt legal questions that do not have clear answers. "There's just not enough governmental guidance out there right now," he said.

That may not be what radiologists want to hear, Davis added, but "it doesn't need to be a battle."

No one owns new technologies, he said.

Most noninvasive cardiac imaging studies represent 'new' or 'found' procedures—exams that neither profession traditionally owned. So it only makes sense for each side to share the spoils of technology's discoveries, said Davis.

He believes that radiologists and cardiologists can work together without taking patients away from each other.

"When noninvasive cardiac imaging begins replacing certain cardiac catheterization procedures, it will be hard to argue that cardiologists should not at least have some role, if not the primary role, in the professional component," he said.

Choosing options

Administrators attempting to deal with skirmishes in their realm handle the situation in different ways, said Davis.

In some situations, one physician interprets the whole study and bills for the professional component.

In other situations, the radiologist interprets the entire study and bills for the professional component, but pays fair market value to a cardiologist to provide an "over-read" of the heart portion for quality improvement (QI) purposes.

Under other circumstances, the cardiologist interprets the entire study and bills for the professional component, but pays fair market value to a radiologist to provide an over-read of the nonheart portion for QI purposes.

From a regulatory and compliance standpoint, Davis dissuades physicians and administrators from filing claims with bills for incomplete procedures.

"All these alternatives are dicey from a regulatory standpoint," he said. "But the devil is in the details as to how to actually make this work."

Other tips he offered include the following:

- If the study is interpreted by one physician, determine a quality-driven, clinically appropriate method for dividing the imaging studies among the cardiologists and radiologists.
- If a false interpretation causes a negative patient outcome, be wary of patient inquiries and potential lawsuits. Under such circumstances, expect patients to ask why their studies weren't interpreted by the other physician (e.g., why didn't the cardiologist read the scan, or why didn't the radiologist perform an interpretation?).

In any event, said Davis, administrators should ensure that any agreement has statistically, quality-driven, medically necessary requirements in place. This protects the patient, physician, and practice, he said.

Ending hospital conflicts

At the risk of creating tension with cardiologists, some hospitals have stepped in to make sure that cardiologists don't practice beyond their current qualifications.

Some options include the following:

- The hospital allows cardiologists to perform the interpretations for their own patients just as they would for a coronary angiogram using catheterization

- The hospital engages the radiologists to perform a QI over-read
- The cardiologists bill for the interpretation and retain all of the professional compensation
- The hospital pays fair market value compensation to the radiologists for the over-read

"The hospital feels justified to ensure quality or just rational expectation on who reads what. It's surprising how many hospitals have actually jumped in to help radiologists," Davis said.

Clarifying the conflict

Even when cardiologists and radiologists extend their hands for a proverbial goodwill handshake, the conflict may not be resolved.

Those who govern the world of reimbursement have rules of their own that must be followed under pain of financial burdens or worse, said Davis.

Medicare generally doesn't accommodate the idea of two physicians sharing the interpretation, he said.

Essentially, when a physician submits a bill to Medicare, that person is claiming that he or she completed a specific procedure, Davis explained.

Under shared-reading agreements, however, neither physician completely rendered the service. Reporting as if they had completed the service would then earn CMS' ire.

"This is a complicated coding problem," said Davis. "The code itself implies complete reads of certain images. If an agreement for over-reads or split reads exists, then there is also a risk of filing a false claim."

To avoid this pending pitfall (while still extending that hand for the shake), query whether the billing physician legally submitted a bill.

"From my standpoint, whoever is the billing agent should take the nonofficial portion of the reading and make it a part of their own dictated report. Your workflow processes will be vital here." ■

PACS implementation

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Find the purpose for your PACS

First, decide what you expect to gain from the purchase of the PACS. Such a task may seem simple, but it requires a thorough and accurate assessment of your current systems.

“Find a vendor to meet your vision. Of course, that naturally implies that you’ve figured out what your vision is, but don’t be afraid,” said Walter.

Determine the effect of PACS implementation on the facility, business, patients, and staff.

Communicate for buy-in

No administrator advances any project without the support of both staff and superiors. For example, radiologists determined to continue reading film doom the PACS implementation process to failure.

“You have to have 100% buy-in from the radiologists,” Walter said.

Increase awareness from the CEO to the medical director and from referring physicians to radiologists, Walter said.

Walter suggested discussing the PACS during meetings and informing employees about PACS through a facility newsletter and company outreach.

For example, when the emergency department learns that images may be immediate, they also need to realize that does not necessarily mean that the radiologist’s interpretation will also be immediate.

It is all part of the learning curve, Walter said.

“They won’t come to you and ask you what you’re up to,” he said. “You have to hold it up for them. Offer individualized training and ongoing communication if you want medical staff on your side.”

For a successful program, create a PACS committee. Pull members from a variety of areas in your facility—radiology, technology, finance, and information technology (IT).

Allow the group to create its own mission as well as a vision for the system. And make sure that the committee maintains ownership and direction over the project.

Make IT part of the plan

Networking, integrations, patch management, storage, system monitoring, review-station support, disaster recovery, etc.—what does it all mean?

Ask your IT department. They know, so engage their assistance early and often.

“Most radiology staff aren’t trained in this stuff. A team effort with your IT department is necessary,” Walter said. “Collaboration is always challenging, but it is also always essential.”

Consider the facility’s current IT and radiology resources. Determine existing staff, experience, knowledge, and technology.

Many facilities typically divide operational responsibilities for the PACS system among radiology, IT, and the vendor.

Uncover the strengths and weaknesses of each. Then allocate tasks accordingly.

“If you have a strong IT department, make them responsible for IT planning. If not, keep the vendor in control. Either way, define whose responsibility it is in the PACS contract,” Walter said.

Ultimately, PACS remains a clinical tool, and the criteria for its purchase and use should be clinically-driven, not solely IT-driven, Walter added. “You can’t do it without IT, but you can’t let them take over, either.”

“Collaboration is always challenging, but it is also always essential.”

—Steven M. Walter

Determine the right system and the right price

PACS, in and of itself, does nothing to generate revenue. It simply stores and retrieves data.

"How are you going to go to the [chief financial officer] and ask for money for a project that doesn't generate any new revenue but costs \$2–\$5 million to implement?" Walter asked.

Some PACS vendors charge upwards of \$12 per procedure, whereas others start financial packages at \$4 per procedure, he said. For community hospitals, cost is crucial. In such environments, every dime counts toward the bottom line.

"It has to be affordable," Walter said. "If it is not, then all other conversations are moot."

Within the past year, Walter implemented his third break-even PACS program—each at a different community hospital in Massachusetts.

The annual PACS costs should be less than or equal to the current film-related costs, Walter said.

Determine the actual operating costs for your radiology facility or department, he added.

This will allow you to compare the future costs of your PACS against your current costs of film and related supplies.

"Be comprehensive and be real," he said.

Pick the right vendor

Over the years, PACS technology developed somewhat generically, said Walter. Nevertheless, the market remains both competitive and diverse.

"They all may be ice cream, and we all like ice cream. But you may like strawberry, and I might favor chocolate . . . they're all different flavors. It's not one-vendor-fits-all," he said. **> p. 8**

Keep workstation costs in the PACS package

To keep picture archiving and communication system costs low, vendors often trim some areas. Be aware of this when researching your PACS purchase.

Do not let vendors or your own penny pinching hamper a best practice, said **Steven M. Walter**, director of diagnostic imaging services for North Shore Medical Center in Salem, MA, during the 2006 American Healthcare Radiology Administrators meeting in Las Vegas. Make sure that you have enough workstations for all of your technologists.

"You need them," said Walter. "Everyone needs them. Don't let vendors shortchange you in an effort to reduce costs."

Beware of PACS contracts that include the following:

- **Primary-read workstations.** Radiologists may fight you on the number and scope of these stations, he said. "But if you do your research and

figure out what works best for your institution, you'll be fine." Complete that research early, and bring talking points and arguments when you meet with physicians.

- **Clinical-review workstations.** Make sure that these contain Web capabilities and that the vendor includes at least 19-inch, flat-panel, Super Video Graphics Array monitors.
- **Dual-diagnostics monitors.** Include this request for the emergency department and intensive care unit, as well as user-defined locations throughout the hospital. These should come with desktop icon access/hospital information system portals.
- **Compact disc (CD) burners with label printers.** If you plan on going digital, you need the CD burners with the label printers. Attention to such detail will help you transport, store, and identify your information and save you money later on.

PACS implementation

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Make sure that you complete a request for proposals (RFP). See related story in the December 2006 special report "Going Digital: Electronic imaging revolutionizes radiology," available online at www.hcpro.com/content/64107.cfm.

Taylor the RFP to fit the specific needs of your institution in terms of size, IT resources, training needs, etc.

Make sure to include a mix of vendor types, Walter said. "Pick some vendors from both sides of that big-guy, small-guy fence."

A small PACS vendor may be more flexible and better able to customize products to your needs, he said. However, larger companies generally maintain business stability over time.

Consider these factors when weighing your purchase choice. Take a careful look at vendors' previous experience. Examine the systems they have installed based

on the number of hospital beds, if appropriate, and the number of imaging studies per year.

With your proposals in hand, whittle down your choices based on your financial and other needs.

Measure the return on your investment

At facilities in which Walter implemented PACS, overall radiology productivity increased about 15%–40%, he said. Radiologists' productivity increased even more.

"The bottom line remains clinical improvement," said Walter. "Is the medicine better? Do we do a better job and provide a better service with PACS than with film? The answer is an unequivocal yes. It does work, it is amazing, and you can have it all." ■

Insider source

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