Build bonds to help reduce denials

A positive affiliation with your carrier allows you to feed it vital information about imaging payment trends, emerging technologies, and the latest clinical findings for rare (but valuable) radiology exams.

And armed with that information, even carriers can see things from the provider’s point of view.

“Understanding the process of your major carriers for determining their medical coverage policies can assist you in building influential relationships with the carriers,” says Kelly Davies, director of operations for the East Region of CBIZ Medical Management Professionals in Knoxville, TN.

Such connections help you work out potential payment problems before they ever happen.

Communicate to create connection
The first step to building a positive relationship comes from generating an initial connection and then establishing a common ground. To do so, you need to understand your payers’ various policies, Davies says. In short, she says, do the research.

Search carrier Web sites and use the institutional knowledge

Cool cardiac imaging conflicts with contract know how

Editor’s note: This is the fifth in a series about approaches to the cardiology-radiology debate over professional ownership of heart imaging techniques and reimbursement.

One resolution to the cardiology/radiology turf war lies in contract negotiations between the physician groups and the hospital.

Radiology administrators may play a major or a minor role in guiding physicians and hospital higher-ups, depending on their sphere of influence and professional obligations.

By simply understanding the benefits and detriments of these agreements on the department and the physicians attempting to use them, administrators may help ease the conflict—and their own turf war battle fatigue.

Not-so-exclusive agreements
Many hospital-based radiology practices have “exclusive” agreements with hospitals for radiology services.

In Future Issues

- IDTF requirements
- AMI redo
- Coding corner
- Imaging Weekly
- In Future Issues
- Learn how to handle new payer accreditation requirements.
- Use these tips to stay ahead of the pay-for-performance curve in your radiology department.
Exclusivity contracts can help navigate turf war trouble

Present the following sample contracts to your radiologists as discussion points toward resolving cardiac imaging ownership disputes.

Make sure to have your attorney examine the language beforehand to suit your specific needs.

**Exclusive right sample contract**

a. Hospital engages XYZ Radiology to perform and bill for all professional radiology services performed in hospital, and agrees that, pursuant to this agreement, XYZ Radiology shall have the exclusive right to perform and bill for such services.

b. “Professional radiology services” is defined as: (List services by name and/or CPT/HCPCS code).

c. This agreement set forth in this clause shall be for a term of 36 months, renewable automatically, provided that either party may terminate this agreement upon 12 months’ written notice.

d. From time to time, the parties may, by mutual agreement, add or delete services from subparagraph (b).

**Shared responsibility sample contract**

a. The parties agree that responsibility for providing certain cardiac imaging services enumerated in subparagraph (b) hereof will be shared among the members of the cardiology department and the radiology department.

b. The following cardiac imaging services are subject to this agreement: (List services by name and/or CPT/HCPCS code).

c. One member of each department shall interpret and submit a written interpretation of each test described in subparagraph (b) hereof within 24 hours of its performance. If a member of one department fails to interpret the test within the 24-hour period, the member of the department who has interpreted the test may assume the sole responsibility for interpreting the test and the sole right to bill for the service.

d. Interpreting physicians may each bill for an interpretation using the appropriate modifier indicating that responsibility for the service was shared. Parties agree that all coding and billing for the procedures subject to this agreement will be handled in accordance with all applicable laws, rules, and regulations.

e. The agreement set forth in this clause shall be for a term of one year, and shall renew automatically unless one party gives 30 days’ written notice of a desire to amend or terminate this agreement.

*Editor’s note: Find this and other helpful contract information in HCPro, Inc.’s The Radiology Manager’s Handbook: Tools and Best Practices for Business Success. To learn more, visit www.hcmarketplace.com/prod-186.html.*
Imaging conflicts

But exclusive agreements don’t automatically give radiologists the right to read every exam.

Instead, “exclusive” may mean that one radiology practice is the only radiology practice allowed to work at that particular hospital.

It may not mean it is the only specialty allowed to interpret radiological tests, says Michael Schaff, JD, attorney and chair of the healthcare team at Wilentz Goldman & Spitzer, PA, in Woodbridge, NJ.

“Hospital-based radiology practices should negotiate in their contracts a broad exclusivity provision that focuses on the services they provide,” says Schaff.

For example, if your hospital plans on becoming the premiere heart care center in your area, you’ll want to help both sides focus on the needs of those clients and your radiology department services.

Options for contracts

Essentially, two choices exist for exam ownership. Physicians can try to use their influence to obtain an exclusive right to perform those services, or they can share the pie, Schaff says.

For hospital management, both of these resolutions represent workable opportunities.

Shared responsibility contracts allow two physicians to split the professional fee by using a modifier to denote shared responsibility.

Or, the radiologist can agree to overread the cardiologist’s interpretation for a fair market value fee that the cardiologist pays to the radiologist, or vice versa.

“Many radiologists see shared contracts as an opportunity for other subspecialties to grab a share of radiology,” explains healthcare attorney W. Kenneth Davis Jr., JD, partner at Katten Muchin Rosenman LLP, in Chicago. “Radiologists worry that this kind of shared agreement may set a precedent—if they let cardiologists read, then the neurologists will want to read, too.”

Choice evaluation

Make sure to assess all the pros and cons of both arrangements prior to encouraging either exclusive or shared contract choices with hospital management, Schaff says.

Talk to your facility attorney, gather more information about potential arrangements, and consider the following items first:

- **Income analysis.** Get a good idea of the overall revenue the tests will generate. Break down the professional component and the technical component portions of the fiscal balance sheet. This information could help you understand physician motivation further down the line—and understanding often represents the best bargaining chip.

- **Control.** Obtaining exclusive rights to interpret certain tests means more control over the quality of the imaging equipment, the scheduling of the service, and other administrative aspects of performing the technical component of the test. This could ultimately prove to be a detriment or a bonus for your facility.

Review the following potential detriments to such agreements prior to throwing your support one way or the other:

- **Less free time.** Many radiologists have used the current shortage of radiologists to negotiate shorter work weeks or freedom from on-call duty nights and weekends. But if radiologists demand exclusive rights to interpret certain tests, the hospital may insist on 24/7 interpretation availability.

- **Credentialing concerns.** Expect additional continuing medical education credits or other requirements on radiologists in exchange for exclusivity rights. See the April RACRI online at www.hcpro.com/pub-2977.html for a related article, “Resolve privileging conflicts between cards and rads.”

Insider sources

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already at your command. You have an invaluable resource in your existing staff.

Also, ask your local provider representative for information about the carrier’s medical director and gather basic background information regarding his or her experience in the field.

Identify any underlying common concerns you share. Perhaps you both attended the same undergraduate program, or you both hail from the same native soil. Even though these discoveries may take more time to unearth, such gems often prove valuable as the foundation for business relationships.

Request a conference call with the medical director and introduce yourself and your practice or department.

“Just call and say, ‘Hi,’ ” says Mark Canada, MHA, CPC, vice president of the mid-Atlantic region for Medical Practice Management, Inc., in Richmond, VA.

Remember, says Davies, most correspondence that the medical director receives comes from the appeals process.

By that point, the relationship turns adversarial. By creating a positive relationship upfront, you can eliminate that automatic negative response and improve your claims appeal success rate.

Expand discussions to the coverage policy committee

Once your carrier’s medical director knows and loves you, learn how the coverage policy committee is structured. Show the medical director how you can make committee members’ lives easier.

Give the group the gift of “real-time” experiences by offering them an opportunity to visit your facility and see first-hand how things operate, says Davies. “We live in a bubble and think everyone understands the inner workings of our facilities the way we do ourselves. But that’s just not the case. Show them you are proud of the work you do and ask them if they want to take a tour.”

With introductions complete, it’s time to understand the inner workings of the payer’s policies committees. Determine the following general details about committee dynamics:

- **Frequency of meetings.** Ascertain if the group meets monthly or bimonthly.

- **Geographic area.** Figure out if the group meets across various regions, remembering that Medicare guidelines often fluctuate depending on the area. Also, ask if the members of this particular group have general experience with national coverage information, and specific experience with radiology coverage determinations.

- **Information affinity.** Everyone maintains some particular nuance to gathering new information. Ask the medical director about reading habits. Find out what journals and papers he or she reads and what associations he or she belongs to.

- **Guest appearances.** Ask if the group maintains an open-door policy and if it welcomes input from outside speakers or experts, and offer your facility resources.

- **Best response.** Determine the best way to communicate to the coverage policy committee. Perhaps a letter or conference call might garner you additional appreciation.

“Your willingness to partner with the carrier’s medical director and his or her committee could be your secret weapon to front-end denials management,” Davies explains.

Editor’s note: Kelly Davies and Mark Canada presented this information during HCPro, Inc.’s February 15 audioconference “Tracking and preventing radiology denials: Tools to ensure appropriate reimbursement.” For more information, visit www.hcmarketplace.com/ prod-5009.html.

Insider sources

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Proposed Medicare membership rules nixed

Implications of axed language remain

Imagine hiring only full-time radiology technologists. Picture a consistent, dedicated radiologist at your facility. Think about not needing to share time on the MRI, or share a central waiting room with another practice. It’s just what CMS hoped to require in its Medicare Program Integrity Manual Transmittal 187, released January 26, relating to independent diagnostic testing facilities’ (IDTF) enrollment in Medicare.

All these items may sound terrific, but the reality of life at IDTFs isn’t that dreamy. Some of these items represent the necessary realities of day-to-day business in radiology, but federal healthcare officials didn’t quite see it the same way.

Where’d that come from?
The proposed changes for IDTFs originally appeared in the Medicare Physician Fee Schedule final rule, according to a release from the American College of Radiology (ACR). And, initially, they represented little concern for the imaging industry. But Medicare later amended the requirements adding further restrictions on IDTFs in the transmittal. “The additional language added by CMS to this transmittal, which was to have been implemented in an unusually short 30-day timeframe, appeared to exceed CMS’ authority,” the ACR release states.

“The language in the transmittal was where the rubber hit the road. These were potentially disruptive situations,” says Wayne Blank, cochair for public policy for the National Coalition for Quality in Diagnostic Imaging Services in Houston, TX, which lobbied the agency to rescind its IDTF requirements. “They took the language to a new level, reaching far beyond what the IDTF standards as initially published in December 2006.”

They wanted to do what?
CMS included other requirements, too, says Thomas W. Greeson, Esq., of Reed Smith, LLP, in Falls Church, VA. Greeson summarized additional transmittal highlights that could ultimately affect imaging in the future—which could adversely affect IDTFs—including the following:

- Prohibition of IDTFs sharing space and equipment with other IDTFs and suppliers
- Denial of payments for services performed prior to IDTFs’ Medicare enrollment date
- Required use of full-time technologists
- Additional enrollment requirements for physicians
- Independent verification of IDTFs’ insurance coverage by the Medicare carrier/contractor

Now what are we going to do?
Blank says CMS simply wasn’t aware of the implications behind the new requirements.

Quick conversations between the government agency and imaging association representatives reversed the requirements in February.

However, the language—and the intent behind it—continues to echo like a bad nightmare.

“Essentially, at the heart of the matter, CMS seems to be trying to address quality concerns, and fraud and abuse standards,” says Blank. “While it may have been well-intentioned, it didn’t translate in a practical sense to the imaging industry.”

Medicare officials listened carefully to the objections of the imaging industry and worked with a variety of officials before ultimately eliminating the new requirements, Blank says. If radiology administrators think they can breathe easier, a rude awakening may be in their future. “These underlying concerns aren’t going away,” says Blank. We have to address this ourselves, as an industry. It doesn’t do any of us any good if there are bad players out there.”

Insider sources
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Imaging update

Moratorium, not delay, proposed for the DRA

Congress reintroduced the Access to Medicare Imaging Act (AMI) (HR1293) on March 1. The initial proposal, brought forward in August 2006, proposed to pause the negative effects to the imaging industry of the Deficit Reduction Act of 2005 (DRA).

The latest version seeks a two-year freeze on the related reimbursement reductions. A contentious congressional election and imaging lobbyists’ late start led to the demise of the 2006 AMI in December.

“In essence, it’s the same bill,” says American College of Radiology’s (ACR) Senior Director of Government Relations Josh Cooper. “But we needed to work with our new congressional counterparts, line up new supporters, and deal with the details of the language of the bill.”

Determining DRA’s detriment

The DRA caps the technical component reimbursement for physician office imaging to the lesser payment of the hospital outpatient prospective payment system or Medicare fee schedule payment. In addition, the law cuts technical component payments for scans performed on contiguous body parts.

“The DRA was a total public policy disaster,” said Cindy Moran, assistant executive director of government relations for the ACR, during the February 5 GE Healthcare Webcast, “Facing the DRA together.”

Some see cuts as an effort to curb overuse of expensive radiological exams by making it more difficult for non-radiologists to perform imaging exams.

Prognosticating future reimbursement

A report by the Moran Company, located in Arlington, VA, released by the Access to Medical Imaging Coalition, anticipates a drop in freestanding facility payments to 18% below total reimbursement for similar services in hospital departments. Further, center directors should expect less-than-adequate funding for 89% of cut procedures.

“How the AMI proposal plays out over the coming legislative year remains anyone’s guess, he adds. The bill might morph into a larger Medicare overhaul scheme, or pick up amendments along the way.

“We’re in a good place to make the case that the DRA was a mistake from many different vantage points,” he says. “Nevertheless, it’s going to be a nail-biter again.”

Insider sources

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AMI action items on the Web

Imaging officials encourage grassroots efforts by imaging center administrators and other radiology professionals in dealing with the Access to Medicare Imaging Act of 2007 and the law it’s meant to mitigate—the Deficit Reduction Act of 2005.

To learn more about what you can do, visit the following Web sites:

- Access to Medical Imaging Coalition: www.imagingaccess.org
- American College of Radiology: www.acr.org
Coding corner

What a difference calcium scoring makes to payers

Medical necessity guidelines for cardiac computed tomographic angiography (CCTA) procedures vary widely among payers with universal exclusion for asymptomatic patients.

Three particular codes—0144T, 0146T, and 0147T—represent nothing but trouble for hospitals and imaging centers alike, due to perspectives on calcium scoring.

“A couple of carriers say they are not paying for calcium scoring of CCTAs,” says Jim Collins, CPC, ACS-CA, CHCC, president of The Cardiology Coalition in Matthews, NC. “They say it’s tainted fruit.”

The American Medical Association adopted a number of new codes in the 2007 CPT Manual to describe various common scan combinations used for cardiac computed tomography (CCT) and CCTA studies.

As with all Category III (new) codes, the CCTA codes caused some dismay, but the concern with calcium scoring offers its own snags.

That’s because three of the new codes contain some form of calcium scoring within their description, says John Marshall CRA, RCC, RT(R), prospective payment coordinator for interventional vascular and radiology at Sarasota (FL) Memorial Healthcare System.

Most payers do not cover coronary calcium scoring, says Marshall. “Medicare and most payers consider calcium scoring (0144T) to be a screening test. However, many payers have applied this rationale to the other CCTA studies because they include minor calcium scoring components within the relatively extensive CCTA procedure. But this is the ultimate moving target. It varies by payer, by region, and seemingly, by day of the week.”

Payers don’t want to reimburse for these screening exams, agrees Melody W. Mulaik, MSHS, CPC, CPC-H, RCC, copresident of Coding Strategies, Inc., in Powder Springs, GA. “A true screening means there are no signs/symptoms, and payers see that as an awfully expensive test for someone with no signs/symptoms of heart disease. They don’t want physicians ordering CT scans of the coronary arteries when the real intent is the calcium scoring,” she says.

Stick to the rules

Calcium scoring helps detect the amount and potential effect of coronary artery disease early.

CCTA is not a covered service for asymptomatic patients. Additionally, three of the new Category III codes contain a calcium scoring component that CMS has classified as a ‘screening exam,’ Marshall says.

Resolve calcium scoring confusion

Despite payers’ hesitancy to come through on reimbursement for calcium scoring, physicians—both cardiologists and radiologists—agree that the scoring element remains critical for “with contrast” scans to adjust images and remove false positive findings, says Collins.

Even though CMS approved calcium scoring as a component of some of the CCTA exams in its
Calcium scoring

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draft local coverage determination template, says Marshall, “most payers adopted three of the diagnostic exams but excluded reimbursement of the other two exams because they include a relatively minor calcium quantification [scoring] component.”

The confusion could spur a “big negative effect,” Collins says, particularly if physicians stop performing the scoring portion of the exam, document their work inaccurately, or if coders improperly assign the new codes.

Category III temporary codes help tell the healthcare industry who uses what procedures and why. Inappropriate use of these codes leads to collection of inaccurate data and further billing and coding problems down the line, says Collins.

That’s why it’s vital for everyone to become familiar, not just with the new code definitions, but with the multiple requirements of various payers, says Collins. Examine individual payer newsletters. And when you can’t find the information, call and ask. It may seem overly simplistic, but sometimes the best route is the most direct route.

“A clear understanding of payer guidelines [coverage and coding] is critical to materializing income projections,” Collins says. “If payer guidelines are not favorable, they should be appealed.”

Editor’s note: Learn more about cardiac imaging coding and reimbursement challenges in the recently released HCPro, Inc., publication, Cardiac Imaging: Strategies for Appropriate Documentation and Compliant Coding, available at <www.hcmarketplace.com/prod-5008.html>.

Insider sources
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