

# Radiology Administrator's

## Compliance & Reimbursement Insider

### Payer mandates imaging accreditation by March 2008 Freestanding facilities, physician offices scramble to start application process

The days of voluntary accreditation are over for many in imaging. If you work in a freestanding imaging facility or physician's office and expect UnitedHealthcare (UHC) payments after March 2008, accreditation is no longer a choice—it's mandatory.

Facilities that already maintain American College of Radiology (ACR) or Intersocietal Accreditation Commission (IAC) status do not need to worry about the new requirements. Although UHC initially notified providers in January giving them 14 months of total preparation time, more than 10,000 facilities nationwide now have less than nine months to achieve accreditation.

#### Practice requires more than overnight service

"If you want to be accredited by next March, you'd

better start preparing by June at the latest," says **W. Geoffrey West, M.Eng., DABR, CHP**, president of the Atlanta-based West Physics Consulting. "The problem is that many people haven't even heard about this yet."

Because the process takes anywhere from six to nine months to complete, that leaves little wiggle room for hesitation.

#### Accreditation help on the Web

- ▶ **American College of Radiology:** [www.acr.org](http://www.acr.org)
- ▶ **Intersocietal Accreditation Commission:**  
[www.intersocietal.org](http://www.intersocietal.org)
- ▶ **UnitedHealthcare:** [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)
- ▶ **American Association of Physicists in Medicine:**  
[www.aapm.org](http://www.aapm.org)

"Our best recommendation is to start sooner, rather than later," says **Sandra Katanick**, CEO of IAC, based in Columbia, MD.

Although some facilities may garner an extension due to extenuating circumstances, don't count on it.

"The primary concern is allowing adequate time to complete the accreditation process," says **Laurie Paidosh**, UHC's director of radiology programs.

#### Imaging growth drives payer regulations

Many see increased quality requirements as essential to reducing unnecessary exams and, thereby, reducing escalating costs. UHC represents one of the nation's largest payers. With the organization throwing its support behind accreditation, industry experts expect to see other insurers following UHC's lead.

"Many other third-party payers previously required accreditation as a condition for reimbursement for certain imaging modalities," Paidosh says. "We recognize that we are the first to require [this] on a broad-based,



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There is a lot to learn about the new payer requirements. We'll walk first-timers through the process and provide thumbnail sketches of the agencies involved.

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## Accreditation

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multi-modality level, but strongly believe it will advance safety and quality for all consumers of these services.”

The UHc announcement comes amid a climate of exponential growth in the medical imaging world.

Further, nonhospital imaging settings maintain no consistent standards of operation, according to a February *ACR Bulletin* article. That means no across-the-board standards of suitable staff education or training, proper maintenance of equipment, or appropriate certification for technologists.

Although certain state legislatures do maintain par-

ticular equipment and experience requirements, the regulations are disparate across the country. UHc's requirements stretch across its coverage states.

“Significant variations exist in the quality, safety, and appropriate utilization of imaging services in healthcare delivery,” says Paidosh. These variations “affect the quality, safety, and affordability of healthcare. Accreditation programs have emerged as key initiatives to advance the quality and safety of imaging studies,” she says.

## Policy requirements focus on shared standards

The policy requires UHc-affiliated practices to obtain accreditation from either the ACR or the IAC for most diagnostic radiology procedures—CT, CT angiography, MRI, nuclear medicine, PET, and echocardiography (see “Examining United Healthcare’s accreditation minutiae” on p. 4).

These represent areas, given the specialized physician experience and advanced technology required in these procedures, in which performance standards continue to gain in importance, says Paidosh.

“Accreditation assesses the overall quality of a practice, including personnel, equipment, quality assurance activities, and ultimately, the quality of patient care,” said Arl Van Moore Jr., MD, FACR, chair of the ACR Board of Chancellors, in a January UHc release.

## Associations offer similar basic requirements

Both accreditation associations maintain their own particular processes, but stay true to certain tenants of quality.

Some shared accreditation assessments include:

- ▶ Personnel certification and experience criteria
- ▶ Test-ordering protocol review
- ▶ Scanner performance
- ▶ Procedure volumes
- ▶ Radiation safety protocols
- ▶ Imaging-interpretation and quality assurance procedures

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“Diagnostic imaging, when performed in high-quality and safe centers, is critical to optimal medical care outcomes,” said Reed V. Tuckson, MD, UHc’s executive vice president and chief of medical affairs, in the January UHc release.

### Baby-steps help accreditation process begin

Accreditation shouldn’t seem too difficult, says Katanick. In fact, most facilities should find their current processes already in alignment with association accreditation standards, she suggests.

“The more organized an imaging site is, the easier it will be to complete the accreditation application,” says Paidosh.

Use the following tips to get started:

✓ **Meet the application deadline.** Order materials and start the process ahead of any accreditation deadlines, regardless of whether they are insurer-imposed. Paidosh encourages centers to submit their applications now to avoid any compliance concerns come March 1, 2008. Once you have your materials from either the IAC or the ACR, follow submission instructions carefully. Both groups maintain time-limits and strict deadlines.

✓ **Know your quality control standards.** ACR committees developed quality assurance standards for nearly every modality of radiology to help facilities establish and maintain their own quality programs. IAC also looks for documentation of quality assurance programs, so it makes good sense to review these policies with your staff.

✓ **Perform every image as if your accreditation depended on it.** Too often, jobs become routine and those performing them don’t realize the importance of their behaviors. It isn’t just a facility’s accreditation on the line when it doesn’t perform an imaging procedure appropriately or calibrate a scanner correctly—it could be someone’s life.

Make sure that you send only the finest-quality work to the accreditation body. And always have your interpreting physician review the work prior to sending your completed accreditation package.

✓ **Use all of the resources available.** Read through

the ACR manual and explore its Web site ([www.acr.org](http://www.acr.org)). Examine the various tools available on the IAC Web site ([www.intersocietal.org](http://www.intersocietal.org)) and talk to other facility managers and administrators. Ask a qualified medical physicist and your facility’s radiologists for assistance. Do not try to do it alone.

✓ **Keep accurate records and make duplicates.** Your dog didn’t eat it, and it didn’t get lost in the mail, but sometimes people misplace a file. Prevent this common mistake from costing you UHc reimbursement money or stalling accreditation by making a copy of everything you send to the accreditation association.

Keep the paperwork on file at your facility as a backup. That way, if reviewers ask questions, the paperwork and potential answers remain right at hand.

### Early prep-work prevents accreditation ogres

A lot of reimbursement money remains at risk if independent imaging facilities neglect to comply with the new UHc accreditation policy.

But fulfilling the requirements shouldn’t seem like a paperwork nightmare.

“If facilities do nothing more than download and review the standards right away, they’ll be in a better position to take on the accreditation process. It’s not an impossible task. Administrators just need to realize it’s not an overnight process,” says **Tamara A. Sloper**, IAC’s marketing director.

“The more organized an imaging site is, the easier it will be to complete the accreditation application,” says Paidosh. ■

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## Examining UnitedHealthcare's accreditation minutiae

Beginning March 1, 2008, UnitedHealthcare (UHC), one of the nation's largest third-party payers, will reimburse freestanding facilities and physician offices for magnetic resonance (MR), CT, PET, nuclear medicine, and certain other procedures only if those facilities receive accreditation from either the American College of Radiology (ACR) or the Intersocietal Accreditation Commission (IAC).

Many imaging facilities considered accreditation voluntary, though in recent years a smattering of payers started tying accreditation to reimbursement.

The UnitedHealthcare Imaging Accreditation Program includes expertise and accreditation standards developed by both the ACR and the more than 22 sponsoring organizations of the IAC.

In the highly specialized, ever-changing imaging world, "accreditation programs have emerged as key initiatives to advance quality and safety of imaging studies," says **Laurie Paidosh**, director of radiology programs at UHC. "It is important that consumers receive services from facilities that are in compliance with established performance standards."

### Meet the associations

ACR is a national professional organization serving more than 32,000 imaging professionals. It boasts more than 16,000 accredited member facilities across the United States. The IAC is a national nonprofit organization, comprised of the following five distinct groups:

- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL) for noninvasive vascular imaging
- ICAEL for echocardiography
- ICANL for nuclear medicine/nuclear cardiology/PET
- ICAMRL for MR
- ICACTL for CT

Specific medical specialty associations sponsor each of

the IAC member groups. For example, the American College of Cardiology, the American Society of Echocardiography, the Society for Vascular Surgery, and other professional groups support ICAVL.

**Sandra Katanick**, CEO of the IAC, expects imaging centers to choose the accreditation body that best meets their needs. Facilities may choose to obtain accreditation from one organization or both. Both associations maintain a three-year accreditation window.

IAC's Marketing Director **Tamara A. Sloper** says each organization maintains a slightly different focus. The IAC review concentrates on clinical case studies and peer review, she says, whereas the ACR requires heavy clinical review and phantom testing. The IAC may receive more requests for cardiac laboratories, whereas the ACR may receive more from radiology facilities, due to each group's previous experience and expertise, she says.

Both associations' fees for accreditation vary by modality and number of machines.

The IAC charges \$200–\$250 to download accreditation standards and supporting materials, and from \$1,500 for echocardiography to \$3,800 for comprehensive nuclear medicine accreditation. The ACR charges \$100–\$750 in membership dues (although membership is not required) and \$900–\$2,100 for accreditation fees, depending on the number of modules and the number of facilities. UHC worked with the ACR and the IAC over the past year to develop the new payer accreditation policy, says Katanick. "So, we've both been getting ready for the increase." ■

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## Accreditation requirements spur physicists to action

The phones at West Physics Consulting started ringing off the hook as soon as UnitedHealthcare (UHC) announced its new accreditation requirement.

In order to receive UHC payment after March 1, 2008, affiliated independent diagnostic testing facilities and physician offices operating imaging equipment need either American College of Radiology (ACR) or International Accreditation Commission (IAC) accreditation.

With more than 10,000 facilities slated for accreditation, and fewer than 100 physicists in the country able to perform the necessary equipment tests associated with ACR accreditation requirements, **W. Geoffrey West, M.Eng., DABR, CHP**, president and CEO of West Physics in Atlanta, expects an assessment gridlock.

"You really have to feel for these facilities," West says. "They're caught in a difficult situation, and many don't even know about the new requirements."

In fact, the IAC expedited its new CT accreditation requirements posting them on its Web site in April.

### CT specifics add to accreditation traffic concerns

West estimates that 65% of MRI units in the United States obtained accreditation already.

However, only 15% of CT units have received accreditation for that modality, he estimates. Also, facilities with multiple modalities (e.g., CT and MRI, or CT and PET) need multiple accreditations, which could add to the assessment bottleneck.

CT scans represent the greatest accreditation challenge from the physicist's perspective, West says. "It's very meticulous. Regions of interest must be laid out

properly. It takes hours and hours of prep work." Multi-detector CT scanners challenge physicists further, he says. "You have to know how the detector is configured. You can't just go through a simple procedure to do the accreditation."

### Increased assessment equals increased business

Typically, medical physicists operate on a "mom-and-pop" business model, with two or three physicists working in a given geographic area. Because hospitals often employ their own physicists, those staff members often moonlight their expertise to independent diagnostic imaging facilities and physician offices.

However, with UHC's new accreditation requirements, there's an increased demand for specialized physicists' knowledge. "It's really grown from a fragmented industry with limited expertise requirements to an extremely complicated analytical field," says West. "Most physicists are competent in x-ray surveys. That's what they do every day."

But fewer physicists can perform the necessary analysis on the newer, more complicated machines.

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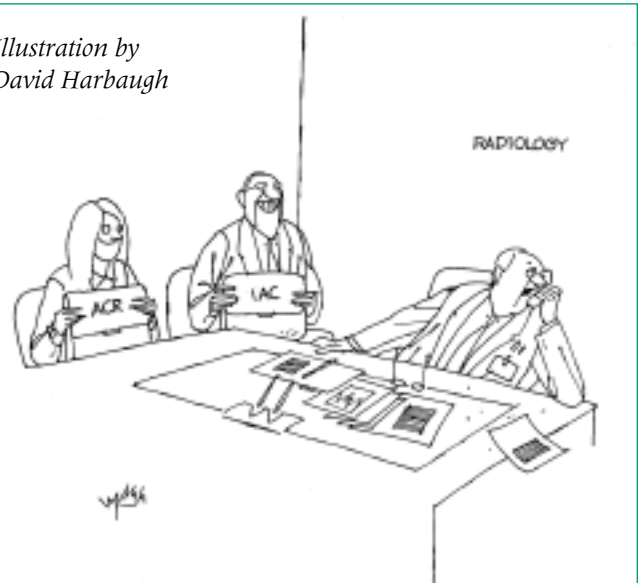
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Illustration by  
David Harbaugh



"Hold my calls. I have a double whammy here."

**Ask the Insider:****Including additional scans after findings as protocol**

**Q** Radiologists in our department have proposed to add reporting for incidental findings to our ultrasound protocols. The topic continues to surface in a variety of situations at our facility. We've discussed incidental findings in gallstones seen with a renal study, abdominal aortic aneurysms seen in a liver study, and so forth. I was trained to image the incidental finding and make note of my impressions when reporting to the interpreting radiologist. But with so many coding changes in recent years, I am unsure whether this is an appropriate practice anymore. The radiologists have proposed a protocol change to refrain from imaging incidental findings until contacting the ordering physician for an appropriate order to evaluate the finding.

Can you clarify the rules and regulations regarding incidental-finding imaging?

**A** No one likes to pay for the same meal twice. It might have tasted really good, but once it's down the gullet, it's gone. The same idea applies (in general) to imaging procedures. If you scan once, you code and bill once.

Look to the professional edition of the 2007 CPT requirement to document abnormalities for proof.

Parenthetical notes for abdominal ultrasound exams

include the required anatomical organs or regions and end with the words "including any demonstrated abdominal abnormality."

The extent of the imaging of the abnormality provided does not matter. If you have a single image of an abnormality or create a detailed photo library, the coding remains the same.

It would also be improper to perform what, in essence, would be an additional reportable procedure (e.g., cyst on kidney turns into additional images amounting to a renal ultrasound) because of an incidental finding.

Medicare frowns on charging for additional exams that the referring physician did not order, as well as providing additional services that are not coded and/or billed.

Many physicians expand their routine protocols to include additional views.

However, additional views do not mean additional charges or codes. The number of images or views one obtains does not affect ultrasound coding.

The code selection is based on the anatomical structures visualized. ■

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**Tip: Audit procedures for anti-kickback and Stark laws**

According to the Office of Inspector General's (OIG) *Compliance Program Guidance for Hospitals*, hospitals should have policies and procedures in place to address state and federal anti-kickback statutes, as well as the Stark physician self-referral law.

Such policies should provide that the following are true:

- ▶ All of the hospital's contracts and arrangements with referral sources comply with applicable statutes and regulations
- ▶ The hospital does not enter into financial arrangements

that are designed to provide inappropriate remuneration to the hospital in return for a hospital-based physician's providing services to federal healthcare program beneficiaries at that hospital

Make sure that the policies and procedures address and define the OIG's safe harbor regulations, which outline payment practices that would be immune from prosecution under the anti-kickback statute.



## He said, he said: Physicians discuss imaging ownership

Some say radiologists understand the science and art of body imaging better than anyone. Although cardiologists may agree with that premise, they say that they know the structure and beat of the heart better than the backs of their hands—and certainly better than radiologists do.

So who should perform cutting edge scans of the heart and vasculature—radiologists or cardiologists? Two experts weighed in on the matter during the December 2006, HCPro, Inc., audioconference “The 64-Slice CT Scanner: The latest battleground in specialty turf disputes.”

### Radiologists say

The primary reason to maintain cardiac imaging procedures under radiologists' supervision—if not outright ownership—is because of their expertise with the equipment, argued **Michael Nicholas Brant-Zawadzki, MD, FACR**, medical director of the radiology department at Hoag Memorial Hospital Presbyterian in Newport Beach, CA.

“Arguing that cardiologists should read a heart scan is to argue that a neurologist should read a brain CT scan or a gastroenterologist should read an abdominal CT scan,” he said.

This concern earned decades-long debate, Brant-Zawadzki said. “The role of the radiologist represents the specialization in imaging technology across the entire body. Part of a radiologist's core competence is whole-body imaging—understanding the principals with which those images are obtained,” he said.

Radiologists work on a daily basis with a variety of cutting-edge technologies for many studies. Further, Brant-Zawadzki argued, radiologists better understand radiation risks, physics, and the engineering behind equipment selection and scanner operations.

Also, radiologists know how to select the proper radiation settings, assign technologist protocols, establish policies for contrast-agent administration, and understand the myriad details that take place prior to the actual

data acquisition and analysis of the image. After obtaining the images, data-processing work for two- and sometimes three-dimensional images still remains. Such scans often require additional time dedication and a separate skill set, he said.

“All of these particulars are second nature to a radiologist,” said Brant-Zawadzki. “Some of our cardiology colleagues simply think it's a matter of looking at the images. We're seeing many cardiologists who want to get involved, but who do not understand what comes first.”

Once cardiologists understand the complete nature of new cardiac-imaging technologies—the postprocessing, slicing and dicing of arterial images and the examining of various projections—their interest in performing these complex procedures may become clearer, he said.

“These problems still need to be worked out.” Brant-Zawadzki said.

### Cardiologists say

Cardiologists know the heart—that's their primary argument for including their professional analysis into new cardiac imaging technology procedures.

Heart specialists say their interest in cardiac imaging revolves around what they're imaging, not the technology itself.

With so much information included in a cardiac CT, applying that information to a particular patient for prognosis and treatment often proves onerous. “That's my bias for cardiologists to understand this [new] technology,” said **Timothy Albert, MD**, a cardiologist at Central Coast Cardiology, in Salinas, CA.

“When we start seeing all this information, we have to go back and see the patient and ask ‘Does this information apply to him or her?’ ‘Is this a finding which requires physician follow through?’ ” Cardiologists offer the best answers to those questions, he said.

Cardiologists bring a great deal to the table, agreed

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## He said, he said

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Brant-Zawadzki. "Their knowledge of coronary artery disease [CAD] is much more in-depth than radiologists'." But, he argued, many radiology programs cover CAD basics today, and radiologists who chose to specialize in heart imaging take advance training in both technology and anatomy through cardiovascular fellowships.

Patients in need of cardiac imaging require cardiologist's care, suggested Albert. "These are patients that cardiologists are very comfortable with. It fits our professional experience very well."

Albert pointed to previous cardiology involvement with ultrasound for the heart. "We all adopted it," he said, not because it represented new technology or new payment avenues, "but because we saw opportunity for improved care.

That's why there's so much excitement" around cardiac imaging even now. ■

*Editor's note: To purchase a prerecorded copy of the audio-conference, visit [www.hcmarketplace.com/prod-4874.html](http://www.hcmarketplace.com/prod-4874.html).*

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## Accreditation

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### Finding the right physicist takes time

Freestanding facilities and physician offices with imaging equipment may not have a medical physicist on staff. In fact, says West, although most large hospitals do employ a medical physicist, it's an anomaly in the freestanding diagnostic imaging world. Unfortunately, consulting medical physicists can be hard to find. Internet searches will locate the more established firms but many firms rely exclusively on word-of-mouth marketing.

The important thing is to assess the physicist's experience and pass rate with accreditation on each modality and to compare educational credentials and board certifications (such as from the American Board of Radiology).

The practice of medical physics applies the principles and accepted protocols of physics to ensure the correct quality, quantity, and placement of radiation during the radiological procedure, according to the American Association of Physicists in Medicine ([www.aapm.org](http://www.aapm.org)).

Medical physicists take care of equipment testing, device specification, and image quality assessment, as well as ensure that all the science behind imaging mechanics works the way it's supposed to. ■

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As you open this month's issue, you will undoubtedly notice that **Radiology Administrator's Compliance & Reimbursement Insider (RACRI)** is sporting a new look. We hope you'll agree that it is a very positive change. Not only does the new design allow for easier reading and absorption of information, it also allows us to include more content. We'll provide the same in-depth coverage of important radiology concerns in each monthly newsletter. So you're getting more information wrapped up in a smart new package— isn't progress grand?



But we want to hear from you. We're committed to making sure that **RACRI** continues to deliver the expert advice you've come to expect on how to comply with the latest imaging challenges.

Your suggestions and feedback are extremely valuable. Please feel free to drop us a line at any time.

In the meantime, enjoy **RACRI's** brand-new look!

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