More and more insurers require that physicians obtain precertification, or preauthorization, for costly imaging procedures.

This added requirement puts paperwork pressure on referring physicians and leaves the financial bite of non-compliance on radiology departments and imaging facilities that suffer from denied claims. Under this scenario, both sides lose.

To resolve the difficult situation and improve imaging reimbursement, many radiology administrators set out to ease referring physicians’ burdens.

Some radiology practice managers have tried:
- Placing their own front desk staff in the referring physician’s office for a set amount of time each week
- Creating a third entity solely responsible for obtaining precertifications on behalf of the referring physician
- Hiring third-party billing companies to handle the preauthorization requirements on behalf of referring physicians

Those contemplating such agreements, however, must consider potential anti-kickback violations.

“The anti-kickback statute is strict,” says Leora F. Ardizzone, Esq., an attorney with Ruskin Moscou Faltischek, PC, in Uniondale, NY. Any remuneration can be considered an inducement to refer” and a violation of the statute, she says.

A no-win situation

Ardizzone represents a variety of clients on all sides of the complex equation. On one hand, she says, referring physicians and their office staff juggle enough responsibilities. However, insurers need to ensure medical necessity for expensive imaging exams.

Under this logic, the referring physician understands his or her patients’ medical needs best. Therefore, it seems to make the most sense for the referring physician to complete the appropriate paperwork—just not the most fiscal sense. “The referring physician doesn’t benefit from this extra work, work which translates into employee time and practice money,” says Ardizzone.

On the other hand, when patients enter the radiology department/imaging center, they enter with the expectation of obtaining an exam. If a patient arrives without a preauthorization, only three options remain for the radiology facility—turn the patient away, perform

“They think, ‘I don’t see the anti-kickback police walking around here.’ Well, maybe not, but insurance investigators, claims auditors, and whistle-blowers are everywhere.”

—Leora F. Ardizzone, Esq.
Anti-kickback < continued from p. 1

the exam and risk payment denial, or obtain the precertification for the patient in the imaging facility.

The first two options offer less than opportune business practice. Turning patients away won’t earn your department or facility any more business. And performing an expensive exam that may or may not be reimbursed could cost big bucks. So, says Ardizzone, many facilities accept the anti-kickback risk and offer to obtain precertifications for referring physicians.

“From their perspective they’re trying to do the best thing for referral sources and for the patients who need these exams,” she says.

Creative, but inappropriate, solution

Ardizzone relates the parameters of the Stark Law and federal anti-kickback statute to her clients, but some persevere with creative solutions to the precertification problem. For example, one radiology facility considered placing one of its own staff members in the referring physician’s office. For a set time each week that person would help the physician’s office fill out the needed precertification forms. Even this, says Ardizzone, represents a breach of the anti-kickback law.

“The location of the individual doesn’t matter,” she says. “If you trained them, and if your facility pays their salary, then this could be considered remuneration, or an incentive for that referring physician to send you his or her clients.”

Further, if one radiology department/imaging center offers such services, it creates an unfair business advantage, forcing others to offer such services, too.

So some radiology managers “take the calculated risk.” Ardizzone says. “They think, ‘I don’t see the anti-kickback police walking around here.’ Well, maybe not, but insurance investigators, claims auditors, and whistle-blowers are everywhere.”

Calculated, but expensive, risk

Those offering precertification assistance don’t think they’re doing anything wrong, and they believe they’re helping everyone out, says Ardizzone. “They don’t think this is such a big nut,” she says. But under the anti-kickback statute, any remuneration counts as a violation.

> continued on p. 8
**Coding corner**

**New angioplasty-of-dialysis fistula/graft codes cause dismay**

by Jackie Miller, RHIA, CPC

Arteriovenous (AV) grafts and fistulas provide long-term access for hemodialysis in patients with end-stage renal disease. Interventional radiologists frequently treat complications of grafts and fistulas, including thrombosis and stenosis. Coding for angioplasty of dialysis fistulas and grafts became more complicated in 2007 when CMS implemented new Healthcare Common Procedure Coding System codes for these procedures.

Apply codes G0392 and G0393 for Medicare payment under the hospital outpatient prospective payment system, as well as the physician fee schedule. The new codes apply regardless of imaging setting.

In addition to the G code, report the radiological supervision and interpretation of the angioplasty with CPT codes 75978 (venous angioplasty) or 75962 (arterial angioplasty).

**Pay attention to separately reportable items**

Be careful to report angioplasty once for each vessel treated. For coding purposes, define an AV graft or fistula as a single vessel beginning at the arterial anastomosis and extending through the body of the graft, the venous anastomosis, and the outflow vein. All of these structures are part of the fistula or graft, so code only one angioplasty regardless of the number of stenoses treated within the area.

However, angioplasty of a central vein is separately reportable. This includes, for example, AV fistulas or grafts in the arm, subclavian vein, and/or brachiocephalic vein.

So when angioplasty is performed in the AV fistula or graft, and also in a central vein, code for two angioplasties.

For coding purposes, consider the entire fistula or graft as a vein. When the physician performs an angioplasty of the arterial anastomosis along with angioplasty of the body of the graft, the venous anastomosis, and/or the outflow vein, code for only one venous angioplasty. Depending on payer policy, it may be appropriate to report an arterial angioplasty if the arterial anastomosis represents the only area treated.

**Use these cases to practice appropriate coding**

These examples of appropriate code assignment for angioplasty of AV fistulas and grafts can help comprehension. If the payer does not accept G codes, you should report the corresponding CPT code:

- **Procedure:** Angioplasty of the venous anastomosis and the axillary vein (radiocephalic graft)
  - **Codes:** G0393, 75978
  - **Note:** Code only one angioplasty, because the axillary vein is considered part of the AV fistula or graft

- **Procedure:** Angioplasty of the arterial anastomosis and the venous anastomosis
  - **Codes:** G0393, 75978
  - **Note:** Treat this as an angioplasty of a single vein

- **Procedure:** Angioplasty of the arterial anastomosis alone
  - **Codes:** G0392, 75962
  - **Note:** You can report treatment of the arterial anastomosis alone as an arterial angioplasty, if payer policy permits

- **Procedure:** Angioplasty of the venous anastomosis and the subclavian vein (radiocephalic graft)
  - **Codes:** G0393, 75978, 35476, 75978
  - **Note:** When the physician treats both the graft/fistula and a central vein, report two angioplasties

With careful attention to coding guidelines, coders will soon learn how many—and what type of—angioplasties to report in these AV fistula/graft cases.

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Editor’s note: This is the final installment in our series regarding best practices and practical approaches to resolving the cardiology/radiology debate over professional ownership of heart-imaging techniques and reimbursement.

Joint venturing, contract negotiations, split reads—radiology administrators face a variety of options for handling turf war trouble between cardiologists and radiologists.

For Brook Ward, executive director of clinical and ambulatory services for Bronson Healthcare Group in Kalamazoo, MI, the secret to implementing a successful cardiac-imaging program included all of these items. But the success relied on one more aspect—communication.

Ward began resolution with basic discussions

Conversations with both cardiologists and radiologists began in the research phases for Bronson's new CT scanner. “We didn’t want to wait until the machine was here to figure out what we were going to do with it,” he says.

Use of CT machines for cardiac imaging began as a trickle, Ward says. But as clinical experience with the scan grows, so does its use. “We’re seeing a big deluge of hospitals purchasing, or thinking about purchasing, these machines now,” he says.

Group starts conversations between parties

Ward investigated several potential pitfalls and possible opportunities when considering the purchase of a new CT scanner. He asked himself the following questions and brought his queries to the physician groups to foster communication:

- What does the CT machine mean to healthcare?
- Who is interested in performing cardiac-imaging scans?
- What can cardiac-imaging do for patient care?
- What does it mean to our facility?

Radiologists understood the implications of the cardiac-imaging technology, Ward learned. But as it turned out, at least one Bronson-associated cardiology group opted out of cardiac CT talks altogether. “They just weren’t interested,” Ward says.

Contractual traps stall progress

At Bronson, radiologists already maintained an exclusive contract that gave them rights to perform imaging procedures, Ward says.

So if Bronson planned to include cardiologists performing cardiac-imaging procedures using its new CT machine, it had to renegotiate radiologists’ exclusive contracts and draw up new contracts with the cardiologists.

That took conversation—and lots of it, he says. “I have to say that communication was the key for us,” Ward says.

Cardiologists and radiologists at Bronson discussed operating under a joint venture contract, with half the procedure going to the radiologists and half benefiting the cardiologists.

“This is an area that is rife with legal land mines,” said Todd Sagin, MD, JD, vice president and national medical director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, who spoke during HCPro’s audioconference “The 64-Slice CT Scanner: The latest battleground in specialty turf disputes” (www.hcmarketplace.com/prod-4874.html).

Regardless of which approach your facility picks—joint-readings, overreads, or alternate billing arrangements—be sure to “establish a clear legal basis for it, because the false claims act, antitrust concerns, and Stark violations all have an impact on some of the schemes out there,” Sagin said.

“We don’t know how the government will view them in the future,” he said.
Joint venture worries force further discussions

Although the joint venture option seemed to excite both sides at Bronson, “it just didn’t work out legally for our particular situation,” Ward says.

Through numerous discussions, Bronson officials finally helped facilitate an agreement in which radiologists retained their exclusive contract with the hospital but subcontracted additional interpretations to the cardiologist practice. The radiologists get paid, and they pay the cardiologists, Ward says.

“No matter what you chose to do, you need to keep an eye on the legal department and work closely with it, so if something changes [legally], you won’t be on the hook [in violation],” says Ward.

In the end, the hospital radiology administrator acts as a facilitator of the relationship. As such, he or she keeps the teamwork rolling while fostering dialogue and collaboration to establish a winning situation for all.

Henry Ford unearths a way to harmony

Some institutions find themselves in better collaborative positions than others. That’s the case at the Henry Ford Hospital in Detroit, says Radiology Administrator Cheryl Martin.

Henry Ford’s long academic history of working across departments and specialties helped reveal opportunities for continued relationships when it came to implementation of cardiac-imaging protocols, she says.

“Our physicians work as a group, so the determination of patient management is based on a team approach,” Martin says.

A collaborative approach is ideal for several reasons, says Timothy Albert, MD, cardiologist at Central Coast Cardiology in Salinas, CA. “In general, most hospitals don’t have a [cardiac-imaging] specialist. That represents an opportunity for both sides to bring something to the table,” he says.

Henry Ford maintains a joint cost center where it pours all revenue from cardiac-imaging procedures into one account and divides it according to fair market value to both services, says Martin. “When performing joint readings, the cardiologists get the heart portion, and the radiologists get the rest,” she says. Henry Ford files a single bill with a modifier -59 to signify a distinct procedural service, remaining careful not to bill twice for the same procedures.

That doesn’t mean Martin established cardiac-imaging programs without turf war trouble. She simply managed them by communicating early and often, she says, to keep parties from fighting over procedures. “I’m here to tell you that turf wars are real,” says Martin. “Everyone has certain items they need to work out. Without open dialogue, how will you ever be able to surpass that conflict and work for the best interest of the patient?”

Credentialing charts pathway to peace

One primary discussion circled around maintaining an appropriate knowledge base to perform these complicated cardiac-imaging scans, says Martin. That meant establishing criteria for privileging and credentialing standards for performing cardiac-imaging scans.

She suggests that radiology administrators talk to vested parties and facilitate the following steps:
1. Establish a cardiac-imaging credentialing policy
2. Obtain recommendations from medical staff members and interested parties
3. Research association suggestions (e.g., American College of Radiology, American Association of Cardiology, etc.)
4. Establish an agreement between the parties
5. Propose the agreement to the privileging committee

“It worked here because of communication,” Martin says. “Keep going back to what’s in the best interest of the patients.”

Insider sources
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Face it. Some of us would rather lose a tooth than sit down to develop the annual department budget. But procrastination often leads to more detrimental losses than those most often felt in the dentist chair.

If the budget process intimidates you, you’re not alone, said David Sack, radiology director at Stamford (CT) Hospital. Sack discussed budgetary basics in his presentation “Winning the Jackpot: The Keys to Budget Creation, Review, and Defense,” during the 2006 American Healthcare Radiology Administrator’s annual meeting in Las Vegas. (The next meeting takes place in Orlando, FL, July 8–12; visit www.ahraonline.org for information.)

Many radiology administrators such as yourself worked their way into a management position after years in the trenches.

So although many department leaders perhaps didn’t major in radiology business management, they still must create that annual budget and present their fiscal prowess to upper management.

“The annual budget process is vital for your success in your position,” Sack said. “It allows you to prioritize initiatives and strategies, and provides a method to measure overall performance against established goals. That’s something everyone can understand.”

The numbers drill

Creating a budget requires an enormous time commitment. First, you must sort through the various pieces of the budgetary puzzle. Historical data and previous accounting often offer misleading, inaccurate, or just plain confusing data.

Further, earlier radiology fiscal wizards might have placed items in strange cost centers or used complicated terms to describe topics no more complicated than your budget at home. For example, Jason Newmark, operations manager for Stamford Hospital’s ambulatory radiology facilities, discovered a $2,400 line item labeled “purchased services,” which he eventually learned paid for regular cleaning of the offices’ aquarium.

Combine all of these difficulties with a general fear of fiscal management, and compiling the annual budget starts to feel like the Novocain might be wearing off.

“People, in general, are afraid to make mistakes. They’re afraid to ask for help because it could show some sign of weakness,” Sack said.

Conversely, those in charge of your hospital’s fiscal management don’t necessarily understand radiology either, he said. “That’s why it’s so important for radiology administrators to understand the budget process.”

A budget bit

The annual budget allows you to prioritize initiatives and strategies. Need to improve patient flow but need additional staff members to do so? The annual budget helps you make that case to the hospital higher-ups. Further, it offers you options to measure overall performance against the goals you establish.

“The budget process is vital for your success. It enables you to step back and look at the big picture,” said Sack.

People formulate a budget in a variety of ways. Some use an annualized budget to forecast their expenses, others develop a fixed, or flexed, budget. Still others operate from zero-based budgeting (see “Budget terminology” on p. 7).

All options represent appropriate accounting tactics, but each offers a unique focus—a focus that may or may not work out well for your department in the long run.

Labor: The biggest bite

Every radiology administrator, like every business manager, knows his or her greatest annual expense stems from labor costs. At Stamford Hospital, Newmark uses a spreadsheet to break down full-time staffing expenses:

- By modality
- By number of rooms
- By number of hours of operation
By productive hours per day
By productive hours per week

Every department maintains a set number of non-productive hours for sick time, vacation days, personal days, and so forth, Newmark explained. So be sure to factor that in to the whole budget process.

“You have to make the administration understand that this part of the budget is purely bodies to cover minimally what the hospital currently provides as services,” said Newmark. When an administrator or hospital plans expanded services, it comes with expanded staffing obligations, he said.

Understand the department’s workflow

Take the time to understand the department’s workflow, Newmark said. Every piece of equipment and every room operates at a particular capacity. “You can’t be booked 100% of the time,” he said.

So be realistic when creating a labor budget and accurately represent the amount of time and staff it takes to complete each procedure.

With a full understanding of existing staff and performance conditions, you can better argue your overall departmental needs to the hospital/facility chief financial officer by projecting future staff needs. Take the time to model your plans for department growth both in modality use and in the staffing level it takes to manage that growth, Newmark said.

Developing a staff budget won’t seem like subclavial surgery if you seek assistance from employees. Get them involved, said Newmark.

Staff members hold much of the process and hands-on information you need to formulate this year’s annual budget, discover the previous year’s pitfalls, and plan for future development.

Insider sources

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Jason Newmark, operations manager, Stamford Hospital, 30 Shelburne Road, Stamford, CT 06904; jnewmark@stamhealth.org.

Budget terminology

Fixed: In this type of budget process, the amount budgeted equals the amount spent. A fixed budget does not account for possible changes in business activity. Such a budget works well for those without changing costs and without alternating incomes. Otherwise, a fixed budget tends toward inaccuracy over time.

Flexed: Your radiology department budget calls for the performance of a certain number of procedures. It actually performs more scans than expected, but the costs increase, too. Under a flexed budget, as long as the expenses and revenues balance out, you’re fine. A flexed budget represents various levels of production.

Benchmarking: Comparing one radiology department to another based on a predesignated set of criteria. At times, such comparisons may help radiology administrators better govern their spending habits based on similar facilities in similar demographics. But true apple-to-apple comparisons are rare. Before embarking on a benchmarking document, carefully categorize the differences and similarities between organizations.

Annualized: Forecasting year-to-date expenses. Some hospitals formulate a budget at different times of the year. An annualized budget takes the amount of money already spent and extrapolates that spending forward throughout the remainder of the fiscal or calendar year.

An annualized budget, however, assumes that everything spent in the first six months will be spent again in the next six months. Although that may be partly true with some items, such as staff salaries and basic supplies, other items, such as equipment maintenance costs, may throw an annualized budget out of whack.

Zero-based: This budget begins every year with a clean slate. Under such arrangements, administrators assume a zero-dollar assignment for everything and move forward to justify each line item independent of the work completed the year before.

Under such a budget, managers use historical data but are not governed by it.
Anti-kickback < continued from p. 2

And violations of the law come with steep penalties. An insurer may threaten to terminate a provider agreement with a facility or practice that attempts to thwart precertification protocols. Additional penalties include:

- Denials of payment
- Refunds of payments resulting from an impermissible referral
- Possible criminal prosecutions under the anti-kickback statute, punishable by a maximum fine of $25,000, imprisonment of up to five years, or both, and potential civil prosecution, carrying monetary penalties of up to $10,000 for each item or service
- Possible exclusion from the Medicare and Medicaid programs

Some believe anti-kickback violations don’t carry as much weight as the current precertification burden. But don’t fall prey to such thinking, says Ardizzzone. “The pressure to get patients in is so great that some risk potential violations to anti-kickback,” she says. “Beware: If you get terminated by a major payer or prosecuted for violating federal law, you may lose more than you stood to lose if you just said ‘no.’”

Insider source
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Stark, anti-kickback primer

Stark Law
The federal physician self-referral law, commonly referred to as the Stark Law, establishes two basic principles:

1. The referral prohibition: A physician may not refer a Medicare beneficiary to a healthcare entity where a fiduciary relationship exists
2. The billing prohibition: A healthcare entity may not bill for improperly referred services unless an exception applies

Anti-kickback statute
The federal healthcare program’s anti-kickback statute is considered the older cousin of the Stark Law. This broad criminal statute prohibits one person from knowingly and willfully giving, or offering to give, remuneration of any kind as an inducement for business or business referrals for which payment may be made under a federal healthcare program.

Remuneration includes anything of value. The term “inducement” means any act intending to influence a person’s judgment (i.e., influence them to refer patients to your facility).

Editor’s note: This passage is excerpted from The Compliance Officer’s Handbook, published by HCPro, Inc. To order or for more compliance information, visit www.hcmarketplace.com.
Imaging Accreditation

FAQs to help you through new payer requirements

A supplement to Radiology Administrators’ Compliance & Reimbursement Insider
Get on board the accreditation locomotive

Learn how in this RACRI special report

Dear Reader,

In January, UnitedHealthcare (UHC) stated that any independent imaging provider within its network offering particular diagnostic exams must undergo one of two accreditation processes—and achieve accreditation no later than March 2008. It’s now July. Both the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC)—the two UHC-approved accrediting bodies—suggest a six- to nine-month time frame to complete the process. And there’s only eight months left before the UHC deadline.

If you always considered accreditation an option rather than a necessity, it’s time to change your thinking. UHC represents one of the largest payers to jump on the accreditation bandwagon. A few others already require it, and imaging insiders expect more payers to follow suit. As imaging costs add exponentially to healthcare’s overall bottom line, the imaging industry faces payer and governmental scrutiny across the continuum of medical care. To ease imaging growth, payers offer a variety of approaches, including exam quality initiatives, medical necessity requirements, precertification and preauthorization mandates, credentialing directives, and more.

Accreditation, according to some, represents a common ground for both the payer and provider communities. “Accreditation programs have emerged as key initiatives to advance the quality and safety of imaging studies,” says Laurie Paidosh, director of radiology programs for UHC, in our special report Imaging Accreditation: FAQs to help you through new payer requirements.

You’ll also hear from representatives of The Joint Commission, the ACR, and the IAC regarding the importance of accreditation procedures. Each expert offers tips and best practices to help you succeed on the accreditation path. You’ll also receive tools from our expert consultants to survive accreditation stress. We’re sure you’ll find this special report useful, not only if you’re embarking on UHC’s new requirements, but also if you’re contemplating which, if any, accreditation trail to follow. Good luck!

Regards,

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UnitedHealthcare states its case for accreditation

When did UnitedHealthcare (UHc) first consider implementation of accreditation standards?

UHc recognizes that significant variations exist in the quality, safety, and appropriate utilization of imaging services in healthcare delivery. Variations from evidence-based scientific literature and professional society guidance affect the quality, safety, and affordability of healthcare.

As such, acting on behalf of our customers, UHc worked with external, expert physician advisory groups to develop programs that promote appropriate and rational use of imaging services.

Accreditation programs emerged as key initiatives to advance the quality and safety of imaging studies, particularly in the areas of CT, CTA, MRI, MRA, PET, nuclear medicine, nuclear cardiology, and echocardiography.

Given the specialized physician experience and advanced technology required in these procedures, it is important that consumers receive services from facilities whose equipment, technologists, and physicians are in compliance with established accreditation performance standards for these procedures.

What type of facilities/practices does this affect?

The UHc imaging accreditation requires freestanding facilities and physician offices that use a CMS 1500 claim form and perform CT, CTA, MRI, MRA, PET, nuclear medicine, nuclear cardiology, and echocardiography outpatient imaging studies to obtain accreditation as a condition for reimbursement.

This guideline applies to any UHc-contracted network provider.

What are the problem areas?

The primary concern is allowing adequate time to complete the accreditation process. UHc provided advanced notice of this accreditation requirement in January for this reason.

On average, it takes six to nine months to become accredited. However, there may be certain extenuating circumstances that extend the accreditation process for some imaging sites.

The more organized an imaging site, the easier it will be to complete the accreditation application. UHc encourages facilities to submit applications now to avoid delay for compliance by March 1, 2008.

What behind-the-scenes preparations has UHc performed?

UnitedHealthcare worked with both accrediting agencies (the American College of Radiology [ACR] and the Intersocietal Accreditation Commission [IAC]) to electronically transfer provider-specific accreditation information to our systems.

There is no need for providers to contact UHc upon applying for or receiving accreditation.

The ACR and IAC will send the accreditation information to UHc electronically.

Providers may also access information about the accreditation program through the UHc provider portal at www.unitedhealthcareonline.com.

Should imaging centers expect other major payers to implement similar guidelines?

Accreditation programs have emerged as key initiatives to advance the quality and safety of imaging studies.

Many other third-party payers require accreditation as a condition for reimbursement of certain imaging modalities.

We recognize that we are the first to require accreditation on a broad-based, multimodality level, but strongly believe it will advance safety and quality for all consumers of these services.

Insider source
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IAC says apply early to meet new payer deadlines

Why is Intersocietal Accreditation Commission (IAC) accreditation important?

IAC accreditation programs offer laboratories a mechanism through which they can demonstrate their commitment to quality to insurance carriers, referring physicians, and patients. Many facets contribute to an accurate diagnosis based on diagnostic imaging examinations.

These factors include the skill of the person performing the examination, the type of equipment he or she uses, the interpreting physician’s background and knowledge, and quality assurance measures.

IAC accreditation programs provide laboratories with a process whereby they first conduct a self-evaluation to determine compliance with nationally recognized guidelines and then demonstrate adherence to quality initiatives by submitting detailed data and case studies.

The laboratory’s preparation of the application, combined with the application review findings, result in improved patient care.

How does IAC differ from the American College of Radiology?

IAC accreditation exists with the support of multiple, national sponsoring organizations.

The IAC accreditation programs offer a multidisciplinary approach by uniting all related specialties when developing an accreditation program. Collectively, specialty representatives create “the standards,” an extensive compilation of documents defining the minimal requirements for a quality laboratory in the specific modality being accredited.

Once an accreditation program is developed, a board of directors governs the ongoing process; representatives from each of the sponsoring organizations comprise this board. The board of directors steers the program, overseeing revisions to “the standards,” determining accreditation decisions for applicant laboratories, and developing policies and procedures for the organization.

IAC accreditation programs provide a method for laboratories to evaluate and demonstrate quality in imaging, interpretation, and reporting, as well as, most important of all, the overall quality of patient care they provide. The case studies and corresponding final reports are especially helpful in this regard.

What burden does the new UnitedHealthcare (UHC) accreditation initiative place on the IAC?

The IAC views the new payment policy as an opportunity to assist additional laboratories with the value of participating in the accreditation process.

The IAC is fully staffed with both clinical and administrative members in each modality and receives ongoing support from its volunteer networks of board members, as well as from highly trained application reviewers and site visitors.

What is the biggest challenge for imaging centers and physician offices embarking on the IAC accreditation process?

Timing. It is critical that laboratory staff members realize that completing an accreditation application takes time. To meet the March 1, 2008, application deadline instituted by UHC, laboratories should begin work on their applications right away.

What three tips would you offer to those new to the IAC accreditation process?

The IAC strongly encourages laboratories embarking on accreditation to thoroughly review “the standards” prior to, and in conjunction with, completing the application. These documents represent the foundation of each accreditation program. They outline the recommendations and requirements for quality testing. “The standards” are available for review and download on each of the IAC Web sites, accessible from www.intersocietal.org.

> continued on p. 8
American College of Radiology offers assessment input

Why is American College of Radiology (ACR) accreditation important?

ACR accreditation assesses the overall quality of a practice, including personnel, equipment, quality assurance activities, peer review, and, ultimately, the quality of patient care. ACR accreditation is an efficient process of both self-assessment and independent, external auditing, based on ACR guidelines and technical standards.

How has the ACR accreditation process changed over the years?

We periodically review and streamline the accreditation process as technology affords us opportunities to make it more user-friendly. For example, late in 2006 we instituted a process to allow facilities to apply online.

Has the importance of the accreditation process changed over the years?

Accreditation has become a recognized tool for demonstrating quality.

What burden does the new UnitedHealthcare (UHC) accreditation initiative place on the ACR?

Resources. However, the ACR planned for this contingency by increasing staff and equipment capabilities, and expanding its capacity to handle the workload.

What is the most difficult challenge for imaging centers and physician offices embarking on the ACR accreditation process?

Like anything else, when you do something for the first time, it can be a little confusing. We have expert technologists available to assist new facilities with any questions about the accreditation process. We also provide a great deal of information to facilities and continually update and change the information to make it more easily understood.

What top three tips would you offer to those new to the ACR accreditation process?

1. Use the new online application process at www.acr.org
2. Read the instructions carefully
3. Involve physicians in the accreditation process and the selection of clinical images for review

Which of the accreditation modalities do you think is the most challenging?

I do not believe any program is more challenging than another. As long as facilities follow the suggestions mentioned above, they should be able to achieve accreditation with a minimum amount of effort.

Are there any tools or checklists to help new facilities start the accreditation process?

Yes. The ACR offers the following resources:
- Accreditation tutorials on compact disc
- Quality control manuals
- ACR practice guidelines and technical standards
- ACR staff members available to answer questions, including registered technologists
- FAQs on the ACR Web site

Does the ACR expect other major payers to follow UHC’s example and initiate similar policies?

There are other regional payers that require accreditation in some imaging modalities, but we are not aware of any other major payer with plans to require accreditation.

Insider source
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There are many different accrediting bodies. Can you outline the ones with which you are familiar?

The American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC) are the two main bodies whose programs we encounter in our work.

The main difference I notice is that ACR programs are very broad-based—for example, the CT and MRI programs are targeted at practices performing whole-body imaging—and IAC programs allow for more specialization (although they generally are appropriate for whole-body imaging, as well).

Both programs maintain standards for image quality—demonstrated through image submission—as well as detailed requirements for ongoing quality control testing of the imaging equipment and the roles of the various staff members involved.

How has accreditation changed over the years?

Generally speaking, the longer an accreditation program has been in place and the more sites participating, the more detailed the requirements and standards will be.

As a peer-based system, an accreditation program operates initially with less-defined standards and gathers data from participating sites regarding what are typical practice patterns.

After several years, when enough data have been collected, the program directors are able to set meaningful standards based on reasonably achievable goals by participating sites while distinguishing high-quality practice from average work.

What is the role of the medical physicist in the accreditation process?

The medical physicist occupies a central role in the process. He or she is responsible for the equipment and instrumentation quality control—either performing it personally or training other staff members to perform tests, setting pass/fail criteria, and reviewing results.

The physicist also advises the physicians about optimizing imaging protocols. He or she provides training to technologists and other staff members regarding the accreditation process and requirements.

The physicist also offers general guidance on improving quality and patient safety.

Often, the physicist is best situated to understand the big picture in an accreditation effort. He or she regularly serves as a central point of contact for technologists, physicians, and administrators in navigating the process.

What is the role of the radiology technologist (RT)?

The RT has the greatest direct involvement of anyone in the practice. He or she usually implements the optimized protocols that the physicians and physicist develop. The RT also often selects the best possible cases to submit for accreditation.

Once a facility obtains accreditation, the RT maintains primary responsibility for quality control as he or she goes about daily activities.

The RT offers quality feedback to the radiologist, physicist, and field service engineer regarding problems with equipment, changes to protocols, and other items that may require follow-up attention.

How can facilities prepare?

Accreditation is a team effort. Make sure you have a good team in place going into the process.

A designated lead person—either a manager or a senior/chief RT—should coordinate accreditation activities and collect all of the materials.

Be sure to notify your physicist as soon as you have decided to apply for accreditation—if you don’t have a staff physicist, now is a good time to find one.

It is also a good idea to contact your vendor’s applications support and field service departments to notify
The Joint Commission offers other accreditation options

Can you recap a brief history of The Joint Commission’s ambulatory care accreditation program?

The Joint Commission’s ambulatory care accreditation program began in 1975. This program uses its own set of standards, published in the Comprehensive Accreditation Manual for Ambulatory Care, and an on-site survey process designed for the freestanding ambulatory environment.

The Joint Commission accredits 1,500 ambulatory facilities. This program has grown at a rate of more than 10% annually for the past five years. The Joint Commission accredits nearly 150 freestanding imaging organizations, representing more than 700 sites of ambulatory diagnostic care.

Is there a big difference between The Joint Commission’s requirements for hospitals versus freestanding facilities?

All of The Joint Commission’s accreditation programs adhere to core standards, which are similar across settings (e.g., hospital and ambulatory).

The ambulatory care accreditation program requires facilities to demonstrate compliance with modified standards that recognize the uniqueness of the ambulatory setting.

For example, the ambulatory program standards for credentialing and privileging of licensed physicians are presented in the human resources chapter; the hospital accreditation manual lists these requirements in the medical staff chapter.

Are there specific radiology requirements?

Because the ambulatory care accreditation program covers more than 50 types of care settings, some standards are specific to individual types of care settings. The new manual, 2007 Standards for Diagnostic Imaging Services, is a guide to the ambulatory standards for diagnostic imaging organizations.

Is there cooperation between The Joint Commission and other accreditation bodies?

Most organizations see patient safety and quality of diagnostic care and services as a keystone in their accreditation processes.

The Joint Commission focuses its evaluation on the total imaging organization and the systems and processes in place to protect patients, staff members, and visitors.

Most organizations share similar aims in communicating the value of accreditation to the policymaking, legislative, and regulatory audiences in Washington, DC, and across the country to government bodies at the state level.

How does The Joint Commission see itself in light of new accreditation requirements from payers?

The Joint Commission regularly meets with members of the payer community, such as UnitedHealthcare, to demonstrate how the ambulatory care accreditation program meets their aims and concerns in the areas of utilization and quality of services.

Payers, on a national and regional basis, regularly rely on The Joint Commission’s accreditation process for network participation or credentialing requirements. In addition, The Joint Commission recognizes the unique role played by radiology benefit management firms. The Joint Commission designed its work with those firms to eliminate duplicate oversight activities through on-site reviews.

The Joint Commission expanded its investment in the payer community more than a year ago by adding the position of associate director of payer relations. This position focuses on educating and coordinating complementary activities with the payer community.

Insider source
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For each of the IAC accreditation programs, the case studies are the most important aspect of the application. Staff members responsible for their collection should critically review each case selected for submission to ensure that it reflects the standards. This also applies to laboratory-specific protocols.

Once IAC grants accreditation, each laboratory receives a detailed, customized application review document. Laboratory staff members should closely review this document and implement recommendations, as the IAC will review these areas in subsequent applications due on a three-year cycle.

Which of the accreditation modalities do you consider the most challenging? Why? Can you offer any advice to help overcome these challenges?

Each of the IAC accreditation programs is equally comprehensive in evaluating its respective imaging modality. Applicant laboratories should be aware of the many resources that the IAC provides and feel free to contact the IAC staff for assistance as they encounter specific challenges.

Insider sources
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What three tips would you offer to those new to the accreditation process?

1. Start early. Getting accredited takes six to eight months, typically, from the time you apply.

2. Be flexible. Most sites have to make at least some minor changes in their routine practices (e.g. imaging protocols or quality control procedures) to meet the accreditation standards.

3. Be confident. You will be successful, even if you experience some unanticipated difficulties. The process is difficult, but remember that you have a team of professionals doing what they do best to help you complete your accreditation.

Insider source
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