

Assess the DRA's impact on your hospital now

If you think the Deficit Reduction Act of 2005 (DRA) affects only independent diagnostic testing facilities (IDTF), think again, said **Robert A. Maier**, CEO of Regents Health Resources, in Brentwood, TN.

"It's going to get worse for hospitals," he said. "Hospital radiology administrators don't understand the impact. [Imaging] supports a lot of other things that go on in the hospital that otherwise couldn't be supported."

In July, Maier spoke to a packed auditorium at the American Healthcare Radiology Administrator's annual meeting in Orlando, warning hospital radiology administrators and freestanding imaging directors alike about the financial fears associated with the DRA.

Battleworn

The politically savvy have battled the DRA since its first appearance back in 2005 with arguably minimal success. When President George W. Bush signed the

bill into law in February 2006, the act included cuts on everything from college loans to child welfare. It affected healthcare by implementing new rules for Medicaid compliance and cutting Medicare radiology reimbursement, as well as creating many other changes.

Specifically, the DRA cuts reimbursement for the technical component for several high-cost scans. The American College of Radiology

(ACR) estimated the reductions would cost the imaging industry nearly \$1 billion. Although imaging associations continue to lobby Congress for some form of mitigation, they aren't optimistic.

The cuts apply primarily to services performed in IDTFs and physician offices and were made in order to rein in exponential growth in reimbursement costs.

But "these [cuts] are going to hit hospitals, too," said Maier, who outlined a number of reasons why hospital radiology managers need to pay attention to the DRA.

Consolidation game

Many hospital radiology departments include some mix of joint ventures, either with a radiology physician practice group or with an IDTF. Consider the impact of these arrangements as they pertain to the overall reimbursement returns, and evaluate the equity structure of such arrangements, Maier said.

For example, because the DRA reduces payments on particular procedures, it might make more sense to bring PET scans back onto your hospital campus.

"In time, volume increases and imaging efficiencies will outweigh reimbursement cuts. The DRA may get a reprieve, but it will not go away."

—Robert A. Maier



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Impact of DRA

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Many hospitals own an IDTF outright. If this pertains to you, "check your payer mix," said Maier. If your system owns an IDTF, but Medicare is your primary payer, consider liquidating the freestanding facility and bringing equipment and exams back into the hospital.

"IDTF regulations are onerous, and they are becoming more difficult all the time," said Maier.

More and more freestanding and physician practice-owned facilities will partner with hospital radiology departments to offset their own losses. Hospitals often have greater pull with payers and can thus help

everyone involved in the joint venture ameliorate the spectre of private payer cuts that loom in the DRA's wake. If your hospital retains imaging center partnerships, use this leverage to negotiate greater imaging reimbursement.

Further, with block leasing and per-click arrangements dying a slow death, it makes sense to reevaluate any hospital imaging joint venture agreements, said Maier.

"The DRA presents an opportunity to consolidate. It used to make all the sense in the world to open an IDTF. That time is over," he said.

"Sure, five years ago, it was better to have an imaging center. And we got five years of good reimbursement. But that's drying up," Maier said. "The industry as a whole needs to be aware of how these changes will affect everyone."

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Money matters

Hospitals charge more and receive better reimbursement than freestanding radiology facilities, but that tradition may change now that CMS and other payers have hospitals in their sights.

Third-party payers see the difference in reimbursement between hospitals and freestanding facilities. Soon these payers will start to examine the reasons for those discrepancies. Hospitals should prepare to justify their costs.

Overworked and underpaid

Expect your radiologists to look to offset their own reimbursement hits through hospital negotiations. "Your radiologists suffer from reduced reimbursement and increased scrutiny, too. You can expect them to lay those losses at the hospital doorstep," Maier said. He said you can expect the following:

- Radiologists that express hesitation about covering the emergency department
- Physicians that seek subsidies for extended hours
- Requests for salary guarantees and bonus initiatives

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"[Radiologists] are overloaded," said Maier. "Once upon a time a radiologist read 18,000 scans—now they're expected to read 24,000 plus, per physician."

This leaves them no time for making callbacks, writing reports, or addressing the other additional requirements for appropriate patient care and consultation, he said.

Furthermore, radiology groups are finding it difficult to recruit new staff members due to increased salary expectations and overall reductions in the physician work force.

Add these factors to an ever increasing procedure volume, and radiologists can't keep up. So practices turn to locum tenes coverage and ask the hospital to pick up the costs.

Tips to succeed

Although the situation is dire, Maier said, it's no time to panic. The current forecast supposes stagnation on behalf of the imaging industry. "It assumes we don't do anything," he said.

Although it may not be time to panic, it is time to increase your facility's procedure volume and reduce expenses—even expenses normally considered fixed costs (e.g., contracts and capital equipment purchases). Administrators can expect to see an increase in procedure volumes due to faster technologies, equipment proliferation, and demographic changes, he said.

"In time, volume increases and imaging efficiencies will outweigh reimbursement cuts. The DRA may get a reprieve, but it will not go away," Maier said. ■

DRA reimbursement countdown

March 2005: The American College of Radiology and the National Coalition for Quality Diagnostic Imaging Services appear before the House Ways and Means Committee on Health to discuss the growing financial effect of imaging procedures on the healthcare industry. Diagnostic imaging alone represents a \$100-billion industry and the fastest-growing type of physician service expenditure, according to the Medicare Payment Advisory Commission.

October 27, 2005: Senator Judd Gregg (R-NH) introduces the Deficit Reduction Act of 2005 (DRA) (S. 1932, H.R. 4241) to provide for reconciliation for the fiscal year 2006 budget.

November 3, 2005: Senate passes the DRA with amendments by a 52–47 vote.

November 18, 2005: The DRA measure passes the House without objection.

December 19, 2005: The House files its conference report, which is approved 212–206.

December 21, 2005: The Senate amends and approves the conference agreement, 51–50, with Vice President Dick Cheney casting the deciding vote.

January 27, 2006: Congressional Budget Office reports that the DRA would reduce direct spending by \$35 billion

between 2006 and 2010.

February 8, 2006: President George W. Bush signs the DRA into law, No. 109 171.

June 28, 2006: Representative Joseph Pitts, (R-PA) introduces the Access to Medicare Imaging Act (H.R. 5704; S. 3795) to provide a budget-neutral, two-year moratorium on certain Medicare physician payment reductions for imaging services. The proposal garners 128 cosponsors.

July 18, 2006: The House Energy and Commerce Subcommittee on Health hears testimony from the American College of Radiology, among other organizations, regarding the fiscal effect of the DRA on imaging services and the importance of the Access to Medicaid Imaging Act.

September 30, 2006: Congress is in recess until after November midterm elections.

November 9, 2006: Congress returns to session.

January 1: Budget considerations included in the DRA take effect.

Editor's note: This timeline appeared in the special report Deficit Reduction Act: Strategies for Survival in March. It is available only to RACRI subscribers and only at the HCPro Web site: www.hcpro.com/content/67199.pdf.

Despite CMS delay, NPI compliance could cause problems

Don't wait to participate in the process

It's September. Spring and summer came and went. And although you meant to start that National Provider Identifier (NPI) compliance project, something always seemed to come up—such as vacuuming the swimming pool. You heaved a sigh of relief when CMS delayed NPI enforcement in May, but with the delay came an environment as unsteady as passing summer thunderstorms: CMS may decide to enforce NPI compliance at any time.

Benefit or bother

"The [May] guidance is both a blessing and a curse," says **Sally Klein, RN, MBA, PMP**, project manager for FOX Systems, Inc., in Scottsdale, AZ. "It's a blessing because it gives us more time to [implement NPI]. We all know that many providers weren't ready. But it's also a curse because we're going to be in chaos for another year."

Although CMS extended its final NPI compliance deadline—from May 23 to May 23, 2008—it reserved the right to enforce NPI on a case-by-case basis as soon as it deems enough of the industry to be compliant. And that could be at any moment. "I think there will come a moment when those who don't have [an NPI] will have real issues," says **Alice G. Gosfield**, of Alice G. Gosfield & Associates, PC, in Philadelphia. "And I think that moment is looming."

Conditions of contingency

To be in compliance, providers must use an NPI for all transactions covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that require an identifier. For example, if a radiologist transmits a transaction with only his or her legacy identifiers (unique provider identifier numbers [UPINs], which were used previously), or if an outpatient mammography clinic files a claim that contains both legacy identifiers and NPIs, the transaction does not comply, according to a April guidance from the Department of Health and Human Services (HHS) (www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf).

Therefore, only those currently working to implement NPIs can relax completely as the chilled air begins to close out summer. According to the HHS guidance, complaints trigger enforcement. For example, if CMS receives a grievance regarding NPI noncompliance, the agency will notify the entity in writing. The healthcare provider—be it an independent diagnostic testing facility (IDTF) or hospital outpatient MRI facility—will then have the opportunity to:

1. Demonstrate compliance
2. Document its good faith efforts to comply with the standards
3. Submit a corrective action plan

"As long as covered entities . . . continue to act in good faith to come into compliance, meaning they are working toward being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners," the guidance states.

In determining whether an entity made a good faith effort, CMS intends to emphasize sustained actions and demonstrable NPI implementation progress, such as:

- The possession of an NPI and the ability to use it on HIPAA transactions
- A provider's increased external testing of NPI with its own healthcare partners
- A concerted effort in advance of the May 23 initial NPI implementation deadline and continued efforts to conduct outreach and testing

Apply for an NPI—it's simple

To apply for a national provider identifier (NPI), visit the CMS Web site: <https://nppes.cms.hhs.gov>. You can also call 800/465-3203 to request a paper application.

After applying, your facility will receive an NPI number and an official correspondence. Save both, because this single provider identifier replaces the different identifiers that you currently use to conduct business with your health plans.

NPI decisions

NPIs fall under two different categories—Type 1 for individual healthcare providers such as physicians and Type 2 for organizations.

HIPAA-covered entities must obtain at least one NPI and can obtain additional NPIs for their subparts. For example, if an IDTF also includes a specialized mammography facility, it could obtain one NPI number for the facility or multiple sets of NPIs for individual units.

To decide which option works best for your facility, look at the legal structure of your organization, says **Susan A. Miller, JD**, independent consultant and chief operations officer at HealthTransactions.com in Massachusetts. Miller, a member of the Southern Healthcare Regional Administrative Process, a public and private industry partnership, joined CMS in a panel discussion of NPI issues in July.

Your facility's approach to NPI implementation depends on its governance, corporate strategy, and

business mindset. If, for example, the different branches of your radiology facility operate under different sets of senior management, or if the various entities of your company are separately incorporated or licensed, you may decide to obtain separate NPIs.

Elements of an NPI team

If you're an administrator of a hospital radiology department, make your compliance officer, C-suite executives, and billing departments aware of the new NPI process. Continue to pass NPI information to the rest of your staff. Facilitate the hospital NPI compliance program throughout your department.

Those who have not yet gathered all of the necessary personnel and plans need to start building a NPI team as soon as possible.

Include the following groups/individuals in your NPI team as you move from legacy identifiers to the new NPI:

- **Corporate office or board of directors.** Including these organizations in your NPI team is critical because they can:
 - Provide legal advice about using the NPI as you draft new policies and procedures and update old ones
 - Provide input as you refresh policies about how to enumerate authorization from physicians.
 - Help determine how staff members get providers' permission to disseminate NPIs
 - Have the corporate office or board review governance, legal requirements, and health licensing to determine whether you should obtain one or multiple NPIs.
- **Administration.** Discuss with administration strategic plans and the effect of payer contracts and affiliation agreements on the organization.
- **Billing staff.** Billers need to add their depth and understanding of billing and payments, chart the changes, and oversee testing and implementation of NPI use. However, a variety of NPI-related billing errors are already being detected, according to a special *Medlearn Matters* article released on July 5. Most

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Get a handle on NPI history

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the creation of national provider identifiers (NPI). The act attempts to standardize electronic—and, in most cases, paper—transactions, including the following:

- Eligibility inquiries and responses
- Claim status inquiries and responses
- Referrals
- Remittance advice

The NPI is a completely random, 10-digit alphanumeric identifier. Under previous systems, identification included hidden markers that potentially indicated the geographic location, type of facility, or provider.

The NPI affects everyone in the imaging healthcare continuum—from hospitals, to freestanding radiology facilities, to radiology group practices, to radiologists, to referring physicians.

NPI compliance

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payers built a “crosswalk bypass” logic into their system to allow claim payments despite NPI/legacy inconsistencies. Nevertheless, radiology administrators need to be aware of any error messages and take corrective action to ensure proper payments once payers lift the bypass logic. Further, CMS says if you receive a reject or return-to-provider message, first double-check your data on the National Plan and

Provider Enumeration System at nppes.cms.hhs.gov.

- **Admissions.** These staff members collect the first level of data that directs claims and payment. Admissions staff may now need to collect additional data. Include them in workflow decisions proactively.
- **Information technology.** These staff members bring their understanding of all of the technical tools and vendors to the team. ■

Ask the Insider

Create an effective process to communicate critical results

Q What steps should I take to make sure my radiology department appropriately communicates patient safety data, especially critical results data relative to The Joint Commission's National Patient Safety Goals?

A First, make sure the medical staff members and the radiologists sit down together to define the types of critical results that require immediate communication. Often this includes diagnoses such as a subarachnoid hemorrhage or the presence of an aneurysm. Once the radiologists identify which critical results to include for your department, the hospital's medical staff or the medical executive committee needs to review and approve them.

Also, try to instruct everyone involved in how your radiology department operates. Explain your department's work flow and staffing procedures. Explain how, during some portion of the day, the radiologist is on-site, but that he or she may not be on duty in the evening.

In some hospitals, one of the following entities might provide coverage in the radiologist's stead:

- An outside firm
- The radiologist using automation from his or her home
- The ordering physician in the emergency department who may be screening the films

Make sure that those who seek critical care informa-

tion understand how long it takes to obtain the valuable data—from the time a film is taken until the time the radiologist reads it. Tell them how the radiologist reads films and dictates, or otherwise documents, findings.

It's your job to establish a standardized process for radiologists to report critical results data to the treating physician as soon as possible. This may be done immediately if the radiologist brings it directly to the physician. Sometimes the radiologist will stamp it “critical” and hand it over to support staff members who reach out to the treating physician.

Either way, help your department members understand how their performance stands against the hospital's established expectation for turnaround time. Help your radiologists know which results fall into your medical staff-approved critical results categories and how they should report them. Also, make sure that the radiologist and your support staff members know how to use the hospital's escalation process if they are unable to reach the treating physician in a short time. That way you'll be ready when The Joint Commission comes to visit. ■

Editor's note: Kurt Patton, MS, RPh, answered this question. He is the retired JCAHO executive director of accreditation services and is currently the principal of Patton Healthcare Consulting, LLC, in Glendale, AZ.

Negotiate a better third-party carrier agreement

by Mark B. Canada, MHA, CPC

Many hospital-based physicians practice under exclusive provider arrangements with their partner hospitals, whereby the individual or group is expected to participate in all insurance plans with which the hospital chooses to do business. The upside of exclusive arrangements, of course, is little or no direct competition in the market compared with other medical specialties. The biggest downside is having less negotiating power with carriers that know (to some degree) that your hands are tied.

Insurance companies increase their profitability by paying fewer dollars per claim or by denying claims altogether, and when they have a captive audience, they have little incentive to meet your demands. Because participation in fixed-price government health plans is standard for most hospital-based physicians, your ability to understand and negotiate mutually agreeable contract terms with private carriers is critical to your group's financial well-being.

Pay particular attention to the following terms when reviewing these agreements, and consider these tips for protecting your interests throughout the term of your commitment:

- **Include term and termination:** These determine the life of the contract and under what circumstances either party can be relieved of their obligations to the other. A long-term agreement (three to five years) protects you from market-based reimbursement fluctuations if you lock in your fees or negotiate annual increases. Include "termination without cause" language (180 days is usually sufficient) to enable you to exit the agreement should unexpected expenses make the agreement a financial burden.
- **Ensure reimbursement on a consistent methodology for all CPT codes:** Most agreements develop fee schedules using a fixed dollar amount per relative value unit (RVU). Understand how this compares to the Medicare fee schedule, as carriers often use this language to compare their fees to the rest of the market.

Make sure that the carrier applies this tactic to all CPT codes, not just a sample schedule that it shares with you. If this is a multiyear agreement, make sure that the carrier offers an allowance for newly introduced CPT codes and temporary codes.

- **Use "blind provider clauses" to protect hospital-based physicians from medical denials over which they have no control:** By the time diagnosticians (e.g., radiologists and pathologists) provide interpretations, the studies have already been ordered and performed. Many carriers recognize this and use language in their agreements that exempt these physicians from medical necessity denials.
- **Review multiple procedure rules:** In surgical cases in which multiple CPT codes describe a procedure, carriers often pay the allowable on the highest RVU procedure and a portion of the allowable (50% or 25%) on successive codes. If it appears that this will have a significant financial impact on your group, quantify the effect and address this with the carrier's representative.
- **Review the credentialing and malpractice coverage criteria:** If your carrier's coverage requirements exceed your current limits, your group will not qualify for participation. Unless you want to increase your limits (and malpractice expense), request a change in this language to match your current coverage.
- **Extend the appeal time for denied claims:** An overly narrow appeal window works in favor of the carrier when the billing staff may need more time to gather necessary documentation.
- **Understand the "hold harmless" language:** Make sure this section protects the physicians in your group, as well as the patients at the end of the contract term.
- **Review requirements to participate in same-carrier plans:** Many carriers require you to participate in all of their plans (including Medicaid managed care plans) as a condition of network membership. Be aware of each of these plans and how reimbursement rates affect you. ■

Enhance your understanding of ultrasound coding

by Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

Q We were told that when performing a lower extremity arterial duplex (93975), we can also bill a bilateral iliac artery duplex (93978) because we look at common, internal, and external iliac arteries. Can you confirm this?

A Correct coding initiative (CCI edits consider 93978 a component of 93975. You cannot report modifier -59 with this particular code pair.

Q We often get asked to perform an Ankle/Brachial Indices with a Lower Extremity Arterial Duplex (93925). Can we bill for a limited physiological assessment with the duplex study?

A There are no CCI edits in place that preclude billing both of these codes together. However, most Medicare contractors take the position that the performance of both physiologic studies and duplex studies during the same encounter usually are not medically necessary. These will be covered during the same encounter only when physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal disease. In most cases, only the code for the duplex scan will be assigned.


Q When performing a soft tissue ultrasound on a superficial nodule anywhere on the torso (i.e., chest, abdomen, or pelvis), which CPT code is most appropriate to report?

A The American College of Radiology and the AMA published guidance about this very question in a recent *Clinical Examples in Radiology*. If the nodule is on the chest, assign 76604, if on the abdomen, 76705, and pelvis, 76857.

Q When performing an abdominal aorta ultrasound, which code is more appropriate—93978 or the combination of 76775 and 93976? We are examining the kidneys and the abdominal aorta as well as checking blood flow with spectral Doppler. We were told that the second option is acceptable and is common practice.

A First, both exams should be ordered and medically necessary. Code 76775 may be billed in conjunction with either 93978 or 93976, so the more appropriate code of the two should be selected in addition to 76775. Further, the -59 modifier needs to be appended to 76775. ■

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