



Turn your radiology Web site into a facility asset

A radiology Web site can do wonders for your business by serving as an information portal for patients and physicians. But if your site isn't planned and designed properly, it might not do much for your facility. Worse, the site could languish and drain your organization of time and money, said **Nancy Speroni, MEd**, director of radiology Web development at Massachusetts General Hospital in Boston, who spoke at the American Healthcare Radiology Administrators annual meeting in Orlando in July.

"As radiology departments expand their reach outside traditional service areas, one of the most cost-effective ways to communicate is through a Web site," said Speroni.

An effective Web site strikes a good balance between delivering the organization's message and meeting its customers' needs, she said.

Productive sites include everything from directions to registration forms, marketing messages to communications

with customers and physicians. Conversely, poorly designed sites include confusing graphics, ineffective layouts, and dismal content. This frustrates visitors and drives potential customers away.

The key to ensuring that your site is a workhorse

and not a time-waster is solid planning and a six-step process to ensure quality.

Designate the right staff members to carry out your Web site creation from brainstorming to completion. The group should include a:

- Creative designer
- Project manager
- Information architect
- Editor
- Content developer
- Writer
- Production lead
- Technical lead html coder
- Server
- Programmer

With the team in place, begin the six-step building and review process, said Speroni. It's important not only to take the steps, but also to follow them in the proper order.

Step 1: Setting the vision

Set goals and objectives, write the mission statement, determine your target audiences, assess your competition, and establish a domain name.

To have a successful site you must decide ahead of time what you want to accomplish and how you will go

"The key is to make your site user-friendly and to direct users through the site so that they're looking at what you want them to."

—Nancy Speroni, MEd



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A recent Radiology Business Management Association survey suggests such a scenario seems likely. We run through the results.

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Radiology Web site

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about meeting that goal. People want to know how the site will look, said Speroni. But if you skip straight to construction, you might as well build a house without an architect.

With this in mind, develop a mission statement. It will guide you through the process and help insulate you from the whims of, and potential sabotage by, individuals within the organization.

It's also important to find out what stakeholders in the organization want from the site up-front. Once you determine your goals, consolidate your list.

The most important questions to ask during this phase of the Web process is:

- What are your goals?
- Who is the target audience?
- Why do you need a Web site?
- What will the Web site do for the organization?
- What features will you need on the site?
- How will you measure return on investment (ROI)?

Take the time to consider others in your marketplace. You need to know what your competition is up to. Compile a list of competitors and outline information about their Web sites.

The list need not be exhaustive. The Web makes it extremely easy to find information, but "don't go crazy focusing on a huge number of competitors," said Speroni. Choose more than six and you're wasting your time, she said.

Write down what you like and what you don't like about the sites. Find out how their sites are doing. Also, focus on where their Web sites might head in the future and how much of their audience you want to capture for your own.

At this stage, you should select a domain name—the online address for your site.

Determine how to demonstrate ROI, said Speroni. A Web site requires a significant investment of time, resources, and money. You need to prove that it provides tangible benefits to the organization in return.

Step 2: Get ready to build the site

Determine site features, gather your content and organize it, plan site navigation, and establish button names.

With the direction decided, now determine what information to make public, said Speroni.

It's okay to use existing material, she said, but keep in mind a lot of print materials need to be repurposed. Web writing is very different from writing for a print publication, said Speroni. People look at Web pages

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quickly, scanning for information they can use. Most do not read in-depth articles. Therefore, boil down content for quick-read visitors clicking through.

Also, include information about awards or accolades your facility received. "It's always a good idea to toot your own horn on your Web site," said Speroni.

This is also the time to come up with art for the site and names for the various navigation features. (See tips in related sidebar on p. 4.)

Step 3: Web site production

Design the site and put it together.

With planning complete, it's time to build the site. When entering the production phase, your site should reflect the tone you hope to convey, said Speroni.

For healthcare facilities, the image is typically that of a trusted advisor. Develop the site accordingly, said Speroni.

"The key is to make your site user-friendly and to direct users through the site so that they're looking at what you want them to," said Speroni. This is not the time for flashy graphics developed by somebody's 14-year-old nephew, she adds.

Become versed in the technical language used by Web developers, said Speroni. You need to communicate to the Web developer which features your site cannot do without and prioritize pie-in-the-sky features—such as using Flash or having a database—based on your organization's goals.

Web sites typically develop in phases, so decide ahead of time on the important items, which should appear first, said Speroni.

Design for the customer. Keep in mind you are not the customer, so what you think works might not be what the customer needs, said Speroni.

Think how others will interpret what's on the site. For example, take care when listing organizational names. A facility might refer to its radiology department as radiology operations. But a visitor to the site might think of operations as surgery. Therefore the title should be swapped out for something that is likely to be clear to the user.

"You're a business, and you have to think like your customer," said Speroni.

Step 4: Usability testing and quality assurance

Determine whether your site functions as it should.

When it comes to developing a Web site, usability testing is often the step that gets the axe, simply because it can be an expensive process and almost nobody budgets for it, said Speroni.

However, a little bit of usability testing is better than none. Figure out which areas of your site work and which ones don't before sending customers to deadend pages or broken connections. This shouldn't be a hugely expensive endeavor.

Then watch three to eight users go through the site, said Speroni. That way you determine the problem points before the site goes live.

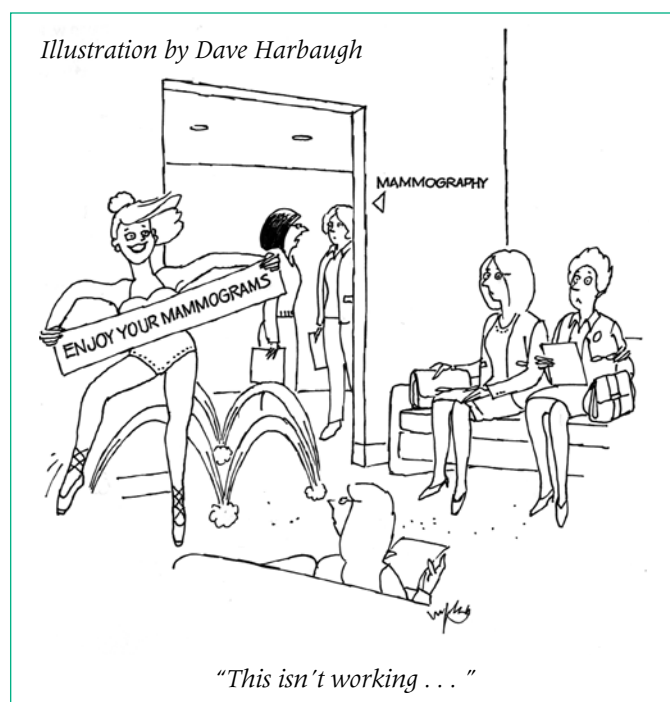
And listen when people have difficulty using certain features, she said. Don't dismiss it as their problem. If they're having trouble, it's likely others will too.

Step 5: Search engine optimization

Take steps to get the name of your site out there so customers will use it.

You can develop the best Web site in the world, but if nobody visits the site, it won't do your organization

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much good. To get good traffic, market your site, and focus on search engine placement.

To boost your site, request links from other reliable sources. If a Web site has a lot of reputable, high-ranking sites linked to it, then Google picks it as a valuable site, said Speroni. With this in mind, try to get as many links as possible, she said.

Another tip she offers is to place your URL on all outgoing e-mail. Tell anyone and everyone about your site.

Step 6: Tracking and maintenance

Keep your site running and demonstrate its value.

Once your site is up and running, you need to ensure

that it remains relevant. Check all your links regularly and update content continually. And listen to your unhappy customers; they give you critical information, said Speroni.

In addition to keeping your site in top form, you should also be tracking its performance. Check to see who is using your site, how long they're staying, and what information they're accessing.

After taking these six steps to establish a relevant, effective Web site that can boost your radiology business, you want to be certain to maintain what you've worked so hard to build. ■

The don'ts of Web design



It may seem like a good idea to include flashing symbols and complicated graphics on your Web site, but experts say flashy gimmicks just confuse and frustrate visitors.

Consider to following pitfalls when designing a radiology Web site, according to **Nancy Speroni, MEd**, director of radiology Web development at Massachusetts General Hospital in Boston, who spoke at the American Healthcare Radiology Administrators annual meeting in Orlando in July.

- **Avoid clever names for buttons.** Use clear ones. A straightforward approach is typically best.
- **Steer clear of inconsistent content.** Establish a style guide for the site.
- **Toss out confusion.** Keep the Web site organized. Try to categorize your site by disease. Many sites do this because people typically look for content related to their specific interests and their specific illnesses. Keep in mind why potential customers came to visit your site to begin with.
- **Do not include your facility organizational chart.** This information has little value to visitors.
- **Try not to get too fancy with graphics.** Flying, floating graphics or unexpected navigation features may look

good, but they'll just confuse your visitors. Keep it simple.

- **Avoid surprises.** If you fail to tell users when a link takes them to a separate Web site or causes them to download a huge PDF file, you risk jarring and annoying customers.
- **Do not use color inconsistently.** If you incorporate color, use it sparingly and make sure it has a meaning. For example, use it to mark certain common elements on your site.
- **Be careful about choosing difficult-to-read typeface.** Certain fonts appropriate in print are difficult to read on the Web. Speroni recommends sans serif fonts such as Verdana, Helvetica, and Arial. Don't go below 10-point size.
- **Dodge designs that slow the site down.** Nobody wants to wait 10 minutes for a page to load. Choose features that will load quickly and let a visitor access the site rapidly.
- **Sidestep Flash.** Some designers get carried away with Flash. Although it is useful in small doses, don't go overboard.
- **Don't let visitors get lost.** Failing to design the site to drive customers where you want them to go is a big mistake. Your site should have a "scent," drawing people to the locations you want them to visit. Fail to do this and your site will lose its effect.

American College of Radiology summary of Medicare-proposed HOPPS

If the final hospital outpatient prospective payment system (HOPPS) rule looks anything like the initial proposal, radiology may see significant reimbursement changes in 2008.

Although the precise reimbursement outlook remains hazy, **Pam Kassing**, senior director of economics and health policy at the American College of Radiology (ACR), says the number and depth of proposed changes to radiology represent some cause for concern.

Interventional radiology in particular could see a negative effect. But ACR hopes the changes will be excluded from the final rule and postponed for further analysis.

CMS wants to package many radiology services into procedural codes, according to a Web site analysis by ACR (www.acr.org). This allows CMS to make one payment for a service previously broken into several elements.

"In general, CMS believes it is appropriate to package payment for the primary diagnostic or therapeutic modalities in which they are used. CMS is proposing to not pay separately for CPT or HCPCS codes, which they describe as dependent items and services in [certain] categories, and will instruct hospitals to report costs for them in the APC where the independent services are paid," the ACR states.

The proposed changes include:

- **Guidance services**—MR, CT, ultrasound, and

stereotactic guidance bundled into the needle placement, biopsy, or various other procedural codes where guidance is usually associated

- **Image processing services**—3D postprocessing (CPT codes 76376 and 76377) will be packaged into affiliated services
- **Intraoperative services**—Codes that are reported for supportive dependent diagnostic testing or other minor procedures performed during independent procedures, such as intraoperative ultrasound
- **Imaging supervision and interpretation services**—HCPCS codes (e.g., 72240, 75671, 93555) will all be packaged into their primary procedural codes in addition to contrast
- **Stereoscopic x-ray services**—CMS will bundle CPT code 77421 with IMRT delivery code 77418
- **Diagnostic radiopharmaceuticals and contrast agents**—Payments will be packaged regardless of their per-day cost

Other changes in the proposal affect PET, cardiac computed tomography and computed tomographic angiography, and ultrasound ablation of uterine fibroids with magnetic resonance guidance, and myocardial PET, according to the ACR.

In addition, the conversion factor in 2008 will jump from \$61.47 to \$64.77, according to the ACR.

"We'll be watching the changes, collecting data, and looking at the information as far as the [effects] on radiology that remain to be seen," says Kassing.

In the meantime, "hospitals are just always encouraged to report costs and charges as accurately as they can," she says. ■

Questions? Comments? Ideas?

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Stark changes may signal start of enforcement

On August 28, CMS released the Stark II Phase III final rule. Although it appears to loosen the restrictions imposed on facilities in the past, experts say these changes must be examined along with other changes in the healthcare industry that clamp down on radiology practices. It also means the Stark law is now a complete regulation. That may kick off government enforcement, which until now has been largely limited to whistleblower actions, says **Adrienne Dresevic, Esq.**, a partner with Wachler & Associates in Royal Oak, MI.

"When you look at Phase III by itself, it seems favorable to the healthcare industry," she says. The changes have made the regulation more flexible, making it easier, for example, for facilities to recruit physicians.

Phase III came in response to public comments about the Phase II interim final rule, published March 26, 2004, in the *Federal Register*. CMS said in a statement that although the rule does not establish any new exceptions to the self-referral prohibition, it "makes certain refinements that could permit or, in some cases, require restructuring of some existing arrangements."

In Phase III, CMS made an effort to ease regulations that might unnecessarily hinder legitimate business relationships. "As guardians of the Medicare program, we must be mindful of the potential [effect] that physician conflicts of interest can have on the Medicare program and its beneficiaries," says **Herb Kuhn**, CMS acting deputy administrator, in the release. "The rule . . . strikes the proper balance between protecting patients and the program, and provid[es] needed flexibility to healthcare entities to ensure the provision of quality care to our beneficiaries without unnecessarily impeding nonabusive arrangements."

Below is an overview of the changes included in Phase III, according to CMS:

➤ **Increased flexibility for structuring "nonabusive compensation arrangements."** The rules governing physician recruitment and retention payments were loosened so facilities can bring more physicians into extended areas when needed.

- **Reduced penalties for inadvertent violations of the self-referral prohibition.** The rules permit parties that inadvertently exceed the limit on non-monetary compensation to continue to satisfy the requirements of the exception if the excess non-monetary compensation did not exceed 50% of the permitted amount and if it is repaid within 180 days of its receipt or by the end of the calendar year, whichever is earlier.
- **Easier compliance in some instances.** Entities providing professional courtesy no longer have to provide a written notice to an insurer indicating a reduction of coinsurance obligation.
- **Clearer existing regulations.** "For example, the rule clarifies which provisions in office space and equipment lease agreements may be amended during the initial and subsequent terms of the agreements," states CMS.

But although Phase III may have some benefit for providers, other regulations in the works may bring less pleasant changes for radiology, says Dresevic.

MPFS contains Stark implications too

In July, CMS released the proposed Medicare physician fee schedule (MPFS), which is due to be finalized in November.

The fee schedule includes a 9.9% decrease in payment and a number of provisions that are linked to the Stark law, and could significantly affect radiology practices, she says. The proposal would affect everything

The final Stark rule was published in the September 5, 2007, *Federal Register*. To view the rule, go to www.cms.hhs.gov/PhysicianSelfReferral/04a_regphase3.asp. For more information, visit the following link on the CMS Web site: www.cms.hhs.gov/PhysicianSelfReferral/.

from existing joint venture arrangements to a number of common radiology relationships related to reading and interpretation. Some highlights include the following, according to a client advisory issued by Katten Muchin Roseman, LLP, a law firm with offices in the United States and abroad:

- Elimination of under arrangement and other turn-key deals by changing the definition of a designated health service entity
- Modifications to the space and equipment lease exceptions under the Stark law to prohibit the use of per-unit-of-service rental payments when the lessor is the referring physician
- An alteration to the Stark law exception that allows percentage-based compensation, other than compensation based on revenues directly resulting from procedures personally performed by the physician to be considered "set in advance"
- Proposal of a new performance standard that prohibits IDTFs from sharing space, equipment, or staff members, or subleasing its operations to another individual or organization

The proposal also includes an anti-markup provision that would bar facilities from marking up interpretation reports furnished by radiologists working as independent contractors. These relationships are very common and would need to be completely restructured to allow the facilities to bill for those services, says Dresevic.

"The agency's stated rationale behind proposing many of these changes (consistent with some of its recent pronouncements) is to eliminate certain types of relationships that have developed over the years which are viewed by CMS as creating incentives to overutilize or as skirting the intent of the Stark law (albeit in ways that are legal undercurrent rules)," the client advisory states.

The American College of Radiology, according to a statement on its Web site, is urging CMS to revisit several aspects of the proposed physician fee schedule, including the following:

- Malpractice values
- Budget neutrality
- Resource-based practice expense relative value units
- Practice expense per hour
- Relative Value Update Committee recommendations
- Additional codes from the five-year review
- IDTF requirements
- Physician quality reporting initiative
- Changes to reassignment and self-referral rules [anti-markup provisions]

(To read a copy of the letter ACR sent to CMS, go to www.acr.org and click on the related item in the News Center at the bottom of the page.)

So although Phase III may appear favorable on the surface, it is only one piece in a larger puzzle. Other proposals waiting in the wings may deliver big changes. ■

Audioconference event

On September 18, HCPro hosted "Stark Law Update: The latest news and real-world compliance strategies," a 90-minute audioconference with guests **Robert A. Wade, Esq.**, partner at Baker & Daniels, LLP, and **Ramy Fayed, Esq.**, associate at Sonnenschein, Nath & Rosenthal, LLP.

To purchase a CD-ROM copy of the presentation, visit www.hcmarketplace.com or call our customer service department.

Stay tuned for additional audioconferences regarding the details of Stark II Phase III and the changes included in the final rule of the Medicare Physician Fee Schedule coming in December.

For more information or to register for any of our upcoming programs, contact our customer service department at 800/650-6787.





Survey: DRA cuts to spread to private payers

A minisurvey of Radiology Business Management Association (RBMA) members shows a majority of members expect additional payers will pick up the Medicare payment cap included in the Deficit Reduction Act of 2005 (DRA).

The survey shows administrators plan to cut staff or services to keep costs down in response.

The [DRA] capped office-based technical component payments under Medicare to the lesser of the hospital outpatient prospective payment system (HOPPS) rate or the Medicare physician fee schedule (MFPS), according to the survey.

It aimed to find out whether non-Medicare payers are implementing similar caps, and the effect of those caps on radiology facilities.

There were a total of 83 responses to the survey, which is a typical number, according to **Cynthia Vervena**, a research associate with RBMA.

The results of the survey are as follows:


- 83% bill for more than just the professional component (PC) and would therefore be affected by the DRA cap.
- 89.9% who bill for more than just the PC expect reductions due to the HOPPS cap from payers other than Medicare.

If the DRA-HOPPS cap is not overturned, a number of facilities plan to take steps to offset the reductions. The survey indicated the following:

- 78.3% plan to reduce overhead
- 66.7% will forgo imaging technology upgrades
- 62.3% will cut staff
- 56.5% will pay radiologists less
- 47.8% will forgo other technical upgrades
- 8.7% will discontinue PET
- 4.3% will discontinue PET/CT
- 4.3% will discontinue mammography

Others said they would not make cuts but strive to increase volume to offset the reductions, according to the survey. In addition, respondents appear ready to take action on this issue.

A number of respondents (63.8%) said they already contacted their elected officials about the reductions, and although some got positive responses, a majority expressed frustration at the answers or lack of answers they received. A number of people said they received either a form letter in response or no response at all. In addition, 86.7% of those who responded to the question said they would be willing to participate in a grassroots advocacy effort directed at overturning the DRA cuts. ■

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