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Radiology Administrator's

Compliance & Reimbursement Insider

Golden rules for radiology technicians

Some need-to-knows to keep a radiology department healthy, in the black

- Know your physician's orders—and do not change them
- Document each and every step along the way
- Master the rules of HIPAA and OSHA
- If you don't, it could end up costing your healthcare facility

In the world of radiology technicians, these tips are gospel, according to three experts in the field who sat down with **RACRI** recently.

Consultant: Cohesion is the key

"In a perfect world, technologists would understand coding and reimbursement, as well as the compliance implications of things that are done [or not done] on a daily basis," says **Stacie L. Buck, RHIA, CCS-P, LHRM, RCC,** vice president of Southeast Radiology Management in Stuart, FL. "What I would love to see is technologists and coders working closely together, as each has valuable knowledge to share with the other."

Buck's golden rule for radiologist technicians is: Do not stray from the path of the ordering physician. If a technician strongly feels that a change should be made to the orders, he or she needs to talk to the physician before proceeding.

> **"In a perfect world, technologists would understand coding and reimbursement, as well as the compliance implications of things that are done [or not done] on a daily basis."**
>
> *—Stacie L. Buck, RHIA, CCS-P, LHRM, RCC*

"The technologist should not perform a test different from that which was ordered," says Buck. "The ordering physician should be consulted regarding any changes to a test order, and a corrected order should be requested from the ordering physician."

There are some exceptions to this rule. But even so, the radiologist should be the one to make those modifications, for billing reasons.

In the world of healthcare billing, Medicare runs the show. And it says, for example, that the ordering physician determines whether a screening is more appropriate than a diagnostic mammogram.

In this regard, a communication slipup with mammography is a severe problem, especially if the ordering physician requests a screening, but the technologist performs a diagnostic mammogram, Buck says.

Even if the patient says she has a history of breast cancer, "Medicare rules state [that] the ordering physician makes the determination as to whether or not a screening is more appropriate" than a diagnostic exam.

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Golden rules

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Poor communication also leads to poor public relations with patients.

If a patient gets a bill for a diagnostic exam because his or her insurance does not cover it, he or she could become irate.

Technologists should familiarize themselves with the guidelines in the CPT manual because they may often have the responsibility of selecting the CPT codes to be assigned, Buck says. Ultrasound coding is a perfect example, as there are specific requirements for proper coding of diagnostic ultrasounds.

"Another problem with orders being modified [different exam performed or different parameters] is that many diagnostic exams must be preauthorized by the payer, and many require an exact CPT code match to pay the claim," Buck says. "If there is not a code match on the claim and the authorization, the service is denied for no authorization."

Compliance officer: Ask questions, know the rules

Larry W. Balmer, CCP, compliance officer, HIPAA privacy and security, at Radiology Incorporated in Mishawaka, IN, says technologists should:

- Fully understand the specific reasons for doing diagnostic and screening studies, primarily mammograms, so that the right test is performed.
- Know when an additional order or a different order may be necessary. For example, if an abdominal CT is ordered, but the radiologist needs to further visualize the pelvic region, the technologist needs to then call the physician and request a new order for the new study.
- Comprehend how quality of care affects compliance. Technologists, Balmer says, must understand that poor-quality studies can prevent the radiologist from producing an accurate diagnosis. This affects patient outcomes and the ability to bill for properly conducted studies.
- Know their responsibilities for handling protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Technologists must be very careful not to discuss patient encounters in ways that result in improper disclosures.
- Understand the security measures in place in their work area and not circumvent them in violation of HIPAA security rules.
- Not be afraid to report violations. "I always try to stress nonretaliation and the necessity of reporting violations," Balmer says. Technologists need to be

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fully indoctrinated into an organization's reporting requirements. "This is especially important with technologists due to their interactions with both patients and physicians. They can readily recognize improper or potentially illegal actions. They then need to be fully confident that they can report wrongdoing without fear of retaliation."

- Understand Occupational Safety and Health Administration requirements and other rules and regulations that apply to safe operations in the workplace. Technologists need to be ready to make changes to promote patient safety and workplace safety as needed.

Radiologist technologists should also speak up when they recognize a test is not medically necessary.

"Question it," says Balmer.

Many times, the technologist is able to find out things about the patient's condition that may have been missed during registration. He or she "can use some sound judgment as to whether the test is truly necessary for the reason provided, or if the test may even be a wrong one," he says.

Compliance administrator: Document, document, document

An undocumented trip to the x-ray room can only cause headaches when reimbursement time comes, says **Janet Duffy, RT,** compliance administrator for Radiological Associates of Sacramento, CA, a physician-owned group.

"You must document exactly what you did—number of views, contrast given or not given," Duffy says. "Your chart documentation could be what decides whether an exam is paid for or not."

Technologists should do only what the physician ordered—no more, no less—unless an actual health emergency exists or there is a clear error. In an outpatient setting, these are rare occurrences. Something done "for the patient's convenience" does not constitute an emergency, she says.

In the outpatient setting, the radiologist cannot order exams, except changing a screening mammogram to a diagnostic mammogram when an abnormality is found.

If you take a verbal order—or change order—it must be documented correctly.

"You cannot look up records of friends, relatives, acquaintances, [or] coworkers unless you have a job-related reason to do so," Duffy says. "We do not offer professional courtesy, and you cannot have or perform an exam on a friend without a doctor's order."

If the CPT and ICD-9 code descriptions on your paperwork don't match the referral or the patient's understanding, you need to get them changed so that the entire billing chain is consistent and correct.

If you fudge the history or reason for an exam so that insurance will pay for it, even if the referring physician or patient asks you to, you are committing insurance fraud.

Losing track of a patient's care can also hurt a facility. "If it isn't documented, it didn't happen," Duffy says. "This refers to asking about pregnancy before x-raying a woman, asking about allergies, giving medication, giving any postprocedure instructions, etc. It has to be correctly documented in the medical record to be useful in a defense." ■

Questions? Comments? Ideas?

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Avoiding backlogs, communication woes

Less-than-prompt service in the radiology department can compromise quality of care

Get the diagnosis set within a day.

That is the golden rule of **Leonard Berlin, MD, FACR,** for turnaround time for a patient undergoing tests in a radiology department.

"It is the general practice that all reports get out within about 24 hours at the latest," says Berlin, professor of radiology at Rush University Medical College in Chicago. "Certainly, reports of urgent cases and emergency cases should be issued within an hour or even less."

One hospital in Australia, however, missed the boat. In fact, some of its radiology department patients have gone several months without being diagnosed, according to *The Sydney Morning Herald*.

Now, a healthcare debate is raging at Liverpool Hospital in Sydney over two lung cancer patients whose x-ray results showed early signs of the disease but were not immediately reported to the referring doctors. One of the patients died.

"The nodule was reported and a report issued, but the doctor team that requested the report never saw the report," Glen Schlaphoff, the director of radiology at Liverpool Hospital, told *The Sydney Morning Herald.*

Officials have since discovered the hospital had a backlog of 4,500 images that went unreported by a radiologist. The hospital uses a paper-based system for reporting scans.

An 'unacceptable' practice

"Having a backlog of 4,500 unread images is terrible, as is not issuing a radiology report until months after the person has passed through the emergency department [ED]," Berlin says. "This is unacceptable from any point of view. Certainly, it would not be tolerated in any U.S. hospital."

The news has radiology officials in the United States stressing the need for prompt, organized, and efficient turnaround times for patients to prevent disasters. Radiology officials say the most important steps are to have strong communication between the radiologist and ordering physicians, and invest in the latest technology that expedites the transmitting process.

However, one radiologist feels the onus is also on the patient to get results.

"The duty of the patient is to know that a test was ordered, why, and ask the [physician] who got it, what the results were and what they mean," says **Michael Brant-Zawadzki, MD, FACR,** medical director of radiology at Hoag Memorial Hospital Presbyterian in Newport Beach, CA. " . . . When you take your car in to the mechanic or your dog in to the vet, do you not do that?"

Others say the responsibility lies fully with the radiologists and ordering physicians.

"ED imaging examinations should be read contemporaneously [while the patient is still in the ED], but at the very least, there needs to be an easy-to-use and completely [documented] method for reporting critical test results back to the ED and other referring sources," says **Steven M. Walter, MS, RT(R),** director of imaging services at North Shore Medical Center in Salem, MA.

Illustrated by David Harbaugh

"She was text messaging inside an MRI . . . "

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Go digital

Walter recommends the digital system that his facility uses for critical test result reporting. He says it's a lifesaver for its quick turnaround.

North Shore Medical Center has used the system for more than a year, and it's "one of the best investments in patient care that I have ever seen in radiology," Walter says. "I can think of no significant pitfall or drawback to the system. While no system is perfect, this one is inestimably better than anything else I have seen."

The system uses a color scheme to determine the level of urgency—red, orange, and yellow. Red represents the most urgent cases. Walter says the system can work as a "big risk management tool to reduce malpractice exposure."

"This report is tracked to pickup by the referring MD or their designee, and this creates a document trail of the creation, delivery, and the recovery of the diagnosis," he says. "In the case of the patient in [Australia], the findings may have been a yellow value [least critical] but would not have gone unreported for more than a few days before it would have been automatically flagged for administrative intervention. The system works equally well for critical results that require delivery to [a] referring source in less than one hour."

Transparency, communication

But a computer can't talk; a radiologist and referring physician must communicate, says Berlin.

"When there is a significant and unexpected finding on an x-ray study, it is the duty of the radiologist to expedite delivery of the report to the referring physician," Berlin says. "This is usually done by telephone or in person. Unfortunately, we all know that written reports sometimes get lost or otherwise go astray. Hence, the direct communication practice guideline."

Sometimes HIPAA gets in the way, says Brant-Zawadzki. He uses a hypothetical situation: "An emergency room physician orders a study, and the patient's own physician does not know the patient visited the ER." This problem cannot be solved, he says, unless community health records are available. But HIPAA makes that difficult.

Ultimately, no matter what the technology, it comes down to providing quality patient care—and each healthcare facility should take every step to ensure the best care, Walter says.

"Cases like that [in Australia] are rare, but they do happen," he says. "Even cases with less tragic outcomes can have very unfavorable [effects] on patients, physicians, and hospitals." ■

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Preparing for the 2008 OIG Work Plan

What to look for as the feds come knocking on radiology doors

The Office of Inspector General (OIG) recently released its Department of Health and Human Services' Work Plan for federal fiscal year 2008. In 2006, the Department of Justice reported that it recovered more than $2.2 billion in fines for fraud and abuse from the healthcare industry.

"The Work Plan offers the provider community a sneak peek at what the OIG intends to audit, evaluate, and inspect during the coming federal fiscal year," says **Ramy Fayed, Esq.,** an associate with Sonnenschein Nath & Rosenthal, LLP, a firm of 700 lawyers and professionals in 13 U.S. cities and Brussels. "Oftentimes, the agenda items that the OIG has identified can give you a further look down the road at the possible bases for future enforcement actions."

Radiology and imaging departments are not bereft of worries about the plan. **Larry W. Balmer, CCP,** compliance officer, HIPAA privacy and security, recently conducted a Q&A session with **RACRI** about how radiologists should prepare.

RACRI: Which specific items should radiologists pay attention to in the plan?

Balmer: There are several items [in] this Work Plan that radiologists should pay attention to, most prominently:

- Payments for diagnostic x-rays in hospital emergency departments
- Skilled nursing facility (SNF) consolidated billing
- Place of service errors
- Medicare "incident to" services
- Assignment rules by Medicare providers
- Business relationships and the use of MRI under the Medicare physician fee schedule (MPFS)
- Geographic areas with high utilization of ultrasound services
- Geographic areas with high density of IDTFs
- Physician reassignment of benefits

Each of these areas offers some insight into CMS' thinking [about] these matters, and radiologists will be affected by most of these areas. Of course, not everyone in the imaging world will be concerned with everything mentioned in the plan, but each of these areas touches on radiology practices.

RACRI: In the item "payments for diagnostic x-rays in hospital ER department," what is CMS looking for when it mentions an increase in utilization of ER department x-rays with resultant payments?

Balmer: I can only assume that CMS is concerned that [it is] overpaying or paying twice for x-rays taken and read in ER departments during patient encounters. In this item, CMS may be looking at how each contractor pays for the "formal" read, and if that read is the actual one they are paying for.

In an ER encounter when an x-ray is taken, the ER physician will often take an initial look at the film to try and identify a problem and treat it expeditiously. The study is then read later by a radiologist, who confirms or expands on the finding and dictates a report. CMS wants to pay only once for the read. It says that the physician who dictates the report and formalizes the study is the one to be paid.

CMS states in the *Medicare Claims Processing Manual* that the first claim received for the service will be the one paid. So, if the ER physician bills the service before the radiologist, the ER physician will be paid. The radiologist then redoes the study and bills a second read, usually on a later date.

This results in CMS paying for the read twice, when it may not be necessary. I can only assume that CMS expects radiology groups to have firm agreements in place with their hospital partners that prevent this form of overbilling. This OIG Work Plan item will address that concern.

RACRI: Regarding the item "SNF consolidated billing," how do diagnostic services break down as far as billing between the nursing facility and the service provider?

Balmer: CMS mandated that certain diagnostic services, such as radiology diagnostic services, provided to residents of SNFs be made under arrangement. The SNF is

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paid for the technical portion of the diagnostic study under Part A of Medicare, included in the inpatient SNF DRG [diagnosis-related group].

As such, the agreement between diagnostic service providers and the SNF must specify that the SNF will be billed for the technical portion of the test and that the service provider may bill the professional component under the MPFS (Part B). Should the diagnostic physician bill both components, CMS will have effectively paid twice for the technical component. My presumption is that CMS will be evaluating the arrangements in place, and evaluate when and under what circumstances double billing occurs.

RACRI: What should radiology departments watch for in terms of "place of service" errors?

Balmer: As [it] state[s] in the Work Plan, CMS is concerned that certain hospital departments may bill for services at the higher office rate instead of the lower facility rate. Although CMS specifies in this topic that [it] will look at ambulatory surgical centers, this should nonetheless be of concern to radiology groups [that] operate departments in conjunction with hospitals. If those departments are true facility departments, they should be billed with the appropriate place of service, resulting in the proper facility payment being made.

In some cases, though the radiology group may indeed be operating in independent office locations adjacent to hospital campuses, the services should be billed out as place of service "office," which carries a higher reimbursement rate. It will be interesting to see how this turns out, and [whether] CMS determines in the future that different arrangements are in order.

RACRI: What will CMS look for in terms of "assignment rules" by Medicare physicians?

Balmer: CMS will hit one of the oldest rules in the book: don't balance bill. When you accept an assignment, you agree to accept the Medicare payment, plus any applicable deductible and copays, as payment in full. This Work Plan item may be quite extensive by [the] time [CMS] get[s] done with it. It could result in the examination of every aspect of billing and payment consolidation that a group engages in.

RACRI: OIG states that it will examine business relationships and the use of MRI under the MPFS. What does this mean?

Balmer: This looks to me to be a plan to evaluate Stark II provisions and their applicability to utilization patterns in diagnostic MRI. It seems clear there is concern that certain relationships between referring physicians, MRI service providers, and billing service operators may be suspect to a degree that cause higher utilization rates.

RACRI: Any final thoughts about the OIG's Work Plan?

Balmer: Most of the other areas are pretty self-explanatory, and I don't read much into them. I do want to add that I think the Medicare Secondary Payer issue, also self-explanatory, is of concern to radiologists as well. ■

Editor's note: The OIG Work Plan says, under the Medicare Secondary Payer issue, that it will review Medicare payments for beneficiaries who have other insurance. The payments are required to be secondary to certain types of insurance coverage. "We will assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage," the Plan says. "For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amount."

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Ask the **Insider**

Arterial and venous flow

Q When a radiologist is dictating a study for CPT 93976, is there any guideline that requires him or her to dictate on both arterial and venous flow, or is dictating only on arterial flow sufficient for this code?

A Code 93976 represents a limited abdominal or retroperitoneal duplex study. The complete abdominal duplex code (93975) is defined in the CPT manual as a scan of "arterial inflow and venous outflow of abdominal, pelvic, scrotal contents, and/or retroperitoneal organs."

Therefore, documentation of both arterial inflow and venous outflow is required in order to bill for a complete exam.

The American College of Radiology's 2006 *Ultrasound Coding User's Guide* states that 93975 is used "if the organs are evaluated in their entirety, including inflow and outflow vessels."

There is no such requirement for a limited exam. According to *CPT Assistant,* April 1996:

> *A duplex scan of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs is reported with either CPT code 93975 or code 93976, depending on whether a complete or limited study is performed. If the organ is evaluated in its entirety, then report code 93975. If only part of an organ is evaluated or the study is otherwise limited, then report code 93976. Report the duplex scan addition to the code for the abdominal ultrasound.*

A study that is limited in that it does not include both arterial inflow and venous outflow would appropriately be reported with code 93976.

A study that is limited in that it does not include both arterial inflow and venous outflow would appropriately be reported with code 93976. ■

Insider *source*

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