Prepare for the JCAHO’s visit to your radiology department

When inspectors from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) came to the University of North Carolina Health Care System, they headed to JoAnn Belanger’s radiology department first.

“I don’t know why,” she told an audience during the Radiology Society of North America (RSNA) annual conference in Chicago. “I guess they just thought radiology was the place to start.”

Belanger, a registered nurse, manages patient services and the radiology department at the endovascular clinic of the University of North Carolina Health Care System. She’s been through her fair share of JCAHO visits during her 21 years of experience.

A JCAHO surveyor who visited her department called the technology of radiology akin to the gadgetry of a Buck Rogers episode. Belanger remembers keeping a stack of notebooks to show JCAHO officials when they came in past years. Now there’s far too much information to keep on a shelf.

“Our lives have changed,” she said. “People don’t understand how different the radiology department is these days.”

Likewise, the JCAHO’s requirements of radiology staff have also changed.

Follow these tips to reduce your risk of breast cancer lawsuits

Patients or their families who file breast cancer malpractice lawsuits generally do so because of several basic factors. Awareness of these common factors can be crucial to fending off potential litigation.

Younger-than-usual patients, self-discovery of lumps, poor radiology equipment, and lack of personal connection with patients may lead to lawsuits, says Maureen Mondor, vice president of risk management at Pro-Mutual Group in Boston.

However, knowledge is power. Understanding such litigation statistics can help you address these risk factors. If your facility takes steps to fix such trouble spots, you greatly reduce your chances of being taken to court.

Mondor offers the following tips to prevent lawsuits at your facility:
**Coding Corner**

New endovascular repair codes

*by Jackie Miller, RHIA, CPC*

If your facility performs endovascular repair of aortic aneurysms, prepare for new and revised CPT codes in 2006.

Endovascular repair is the use of an endoprosthesis to seal off abnormal sections of the aorta. Endovascular repair of the abdominal aorta has had its own Category I codes for several years, but repair of the thoracic aorta has had only Category III codes (0033T--0040T). On January 1, however, new Category I codes for the thoracic aorta procedures took effect.

The new code definitions include endovascular repair of any abnormality of the descending thoracic aorta, including both disease (e.g., aneurysm) and trauma. The repair is categorized according to whether the endoprosthesis covers the origin of the left subclavian artery (thus blocking off blood flow into the subclavian). Coverage of the subclavian may be necessary if there is not enough normal aorta below the subclavian to securely hold the top edge of the prosthesis.

**Repair with left subclavian coverage**

The following codes are used to report endovascular repair of the descending thoracic aorta with coverage of the left subclavian origin:

- **33880**—Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
- **75956**—Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

**Codes replace Category III codes 0033T, 0038T**

The following new codes have been added for bypass grafting in conjunction with endovascular repair:

- **33889**—Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral
- **33891**—Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

Code 33889 replaces Category III code 0037T. It is used to report bypass grafting between the left common carotid and left subclavian, which is performed so that blood entering the carotid can also supply the subclavian circulation. Code 33891 is used to report a bypass graft from the right common carotid to the left common carotid.
Repair without left subclavian coverage

The following codes are used to report endovascular repair of the descending thoracic aorta without coverage of the left subclavian origin, replacing Category III codes 0034T and 0039T:

- **33881**—Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin
- **75957**—Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

If the initial prosthesis is placed distal to the subclavian origin but a proximal extension that covers the subclavian is added, the procedure should be reported with 33880 instead of 33881.

Endovascular repair of thoracic aortic aneurysm (codes 33880 and 33881) includes placement of distal extensions. Placement of a distal extension at a subsequent encounter should be reported with the following codes:

- **33886**—Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta
- **75959**—Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation

Endovascular repair does not include placement of proximal extensions, which should be reported separately using the following new codes:

- **33883**—Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension.
- **+ 33884**—List each additional proximal extension separately in addition to code for the primary procedure
- **75958**—Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); including radiological supervision and interpretation

If a proximal extension is needed, it must be passed up through the main prosthesis in a collapsed state and then expanded once it is in place.

Codes 33883 and 75958 are reported for placement of the initial proximal extension. If additional proximal extensions are placed, codes 33884 and 75958 should be reported for each additional extension.

As with endovascular repair of the abdominal aorta, thoracic aorta procedures require separate coding for vascular access, including open exposure of the femoral, iliac, or brachial artery. For 2006, the existing codes 34833 (iliac artery exposure with conduit) and 34834 (brachial artery exposure) have been revised so they can be used for thoracic as well as abdominal aorta repair. Codes 34812 and 34820 did not require revision.

Insider source

"This is Cindy, our head chef. She can take a denied claim, marinate it in fresh documentation, sprinkle it with medical necessity, and voila! Medicare reimburses us."
JCAHO goals

“How many people here know what JCAHO’s patient safety goals for 2006 are?” Belanger asked. Only a few conference participants raised their hands.

The agency’s top priorities include
• improving patient identification
• improving communication between caregivers
• improving accuracy of drug administration
• improving drug documentation throughout the continuum of care
• improving IV pump safety
• maintaining accurate clinical alarms
• eliminating wrong-site, wrong-patient, wrong-procedure/surgery
• reducing healthcare-acquired infections (HAI)
• reducing falls
• addressing flu and pneumonia causes in older patients
• reducing surgical/procedural fires

Along with new safety goals came the arrival of the unannounced survey process. Now JCAHO officials may appear unannounced at an agency’s front door. And rather than simply visit with heads of departments to mull over hospital policies and paperwork, they may pull a patient file and mirror his or her progress throughout the day, asking all employees involved whether they understand the underlying safety provisions.

Belanger said radiologists need to be prepared for a JCAHO auditing team to drop by at any time.

“They don’t call you up and set up an appointment,” she said. “They come in and want to make sure you know your stuff.”

Getting a radiology team up to JCAHO standards doesn’t need to be a harrowing experience, however. Belanger suggested involving the entire team because more people mean more ideas and better outcomes.

The more the merrier

Staff in Belanger’s radiology department cross-train to provide care in CT, diagnostics (adult and pediatric x-ray), breast imaging, ultrasound, nuclear medicine, magnetic resonance imaging, endovascular clinic, and vascular/neuro interventional radiology.

“The nurses work independently to provide specialized care to a diverse population of patients,” she said.

Their duties include administering medications, monitoring and managing patient crisis, and educating patients about the department. Radiology nurses oversee patient care in a technically oriented environment.

It is this type of training and teamwork that makes her department so successful, she said.

“All these ideas come from my team,” Belanger told RACRI. “They are so creative and talented.”

She’d like to increase the number of opportunities for staff to communicate their ideas for improvement.

“They have so many ideas. If you just ask, you’ll be amazed at what they can come up with,” Belanger said.

“It’s a good team effort,” Belanger said of her own group. “That’s what JCAHO is looking for within the whole institute.”

Right meds for the right patients

For example, the team resolved one JCAHO goal—improving accuracy of drug administration—by using a simple tool from elementary school. Her team started carrying around colored pencil boxes. Each box contained a specific patient’s medication to ensure that patients receive the correct doses.

“Everyone has an example of a problem like this,” Belanger said. “It’s an issue for nursing and the radiology technologists. By labeling the medications and keeping them in the right box, we can be sure the syringe doesn’t get mixed up with any other meds.”

Handwashing—no water!

To comply with the HAI safety goal, JCAHO recommends following the Centers for Disease Control & Prevention guidelines. Simply put, wash your hands at every opportunity.

But Belanger’s staff complained that there simply weren’t the facilities to keep handwashing within arms’ reach. So they recommended putting antibacterial dispensers at high traffic areas throughout the department. Within days, the number of staff who washed their hands doubled, she said. “It’s amazing what you can come up with. And these simple solutions solve life-threatening problems.”

Reconciliation of pharmaceuticals

Despite her 21 years of experience and the collective experience of her crew, certain JCAHO safety goals still cause Belanger concern.
He said that FCRm technology has been commercially available in Japan, Europe, and Australia for two years and been purchased by 1,700 sites.

Many U.S. mammography facilities have been anxiously awaiting the approval of FCRm, which is similar to a film-based system.

Fuji’s FCRm technology allows facilities to retain their existing mammography units, which are modified to produce digital images. One CR reader can accommodate three exam rooms, according to Fuji.

"With Fuji CRm’s multiroom capability, a facility’s cost per exam room may very well be less than half the cost of today’s available digital systems," says Clay Larsen, Fuji’s vice president of marketing and network development.

"Even though digital exams are reimbursed at a higher rate in some instances, that higher reimbursement has not been enough to enable facilities up to now to make the major investment in FFDM."

Affordability has presented one of the largest barriers to facilities interested in converting to digital, according to Fuji. So far, only 8% of facilities have made the transition.

Editor’s note: This article was adapted from Mammography Regulation and Reimbursement Report, published by HCPro, Inc.

FUJIFILM Medical Systems USA anticipates that its central ray (CR) digital mammography system (FCRm) will likely receive FDA approval and be on the market by the first or second quarter of 2006, says Andrew Vandergrift, national program manager for Fuji.

The company submitted its final paperwork to the FDA in March. The FDA has since been reviewing that application, a process that typically takes about 300 days. Fuji has already logged 250 days. “Our feeling is that we’re closer to approval than not,” says Vandergrift.

The next step will likely be for the FDA to issue a conditional approval, called an “approvable letter,” says Vandergrift. From there, the company will need to take additional steps outlined by the FDA before final approval is granted.

Vandergrift qualified his statements, however, by saying that these timelines are merely his own predictions and that no one but the FDA knows for certain when the system will receive conditional or final approval.

When that approval does come, Fuji officials said they anticipate a strong demand for the system, particularly in the wake of the Digital Mammographic Imaging Screening Trial (DMIST), according to a statement issued by the company (see the related box at right for more details about the trial). FCRm was one of the full-field digital mammography systems used in the DMIST trial.

“More than 20% of all the exams evaluated in DMIST were acquired with the FCRm technology, making Fuji’s the second most utilized system in the trial,” Fuji stated in a written release.

“By revealing that digital mammography has significant benefits over film screen mammography for a considerable number of women being screened, [DMIST] has already begun to increase the demand for digital among patients and has the likelihood to send healthcare facilities to see high-quality, cost-effective solutions for their full-field digital mammography needs,” said Vandergrift.

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1. Open the path to good communication.

Perhaps the biggest precursor to litigation is poor communication. It’s not just a doctor/patient problem, either. Intra- and interdepartment discussions in hospital settings often break down at one point or another.

Hold short weekly meetings with radiologists, breast surgeons, and primary care physicians (PCP) to discuss cases and prevent miscommunication, says Mondor.

Take extra steps to make sure that patients at risk for problems receive timely follow-up care when an initial examination raises concerns.

For example, if a radiologist sees a borderline image on a mammogram and thinks the patient should return in three to six months for a follow-up exam, he or she should communicate that information effectively so the PCP can help his or her patient comply.

This step also keeps the lines of communication open, Mondor says.

2. Foster patient-radiologist relationships.

Smaller women’s breast health centers—where patients benefit from more one-on-one interaction with radiologists and doctors—are less likely to face malpractice suits, Mondor says.

Personal relationships and patient rapport go a long way toward preventing potential problems, she says. A physician or radiologist who doesn’t have a personal relationship with the patient could meet more legal challenges down the line.

Encourage practitioners to take whatever steps they can to meet with, and establish a bond with their patients.

3. Encourage breast self-exams; don’t discount the results.

Breast self-exams may appear to be common practice, but some physicians still downplay their importance, Mondor says. “There are physicians out there [who] tell women they don’t need to do breast self-exams.”

Make sure practitioners stress the importance of breast self-exams. Failure to do so may leave your facility—and your patients—vulnerable to risk.

In 87% of breast cancer malpractice cases, the women filing suits found the lumps themselves, says Mondor. If a patient discovers the cancer herself, there could be a breakdown in the trust between the doctor and patient.

Often such events lead to poor communication with the physician or failure by the physician to follow up. These delays in a woman’s cancer diagnosis can lead to a lawsuit.

When a lump is discovered—even if the mammogram comes back negative—it is critical for screening centers and physicians to take such findings seriously and to ensure adequate follow-up.

4. Track follow-up measures to guarantee accurate diagnosis.

Lack of follow-up is the leading reason that patients file lawsuits related to breast cancer. That’s why your facility must develop a system to track follow-up care.

When a woman comes into your facility with a lump, designate a person to palpate and mark these findings during the mammogram. If the mammogram returns with a negative reading but the lump is still there, consider performing an ultrasound, Mondor says.

In 15%–20% of cases, a palpable malignancy cannot be visualized on a mammogram, she says. Tell patients this information because many do not understand mammography’s limitations.

5. Be mindful of breast cancer risks in younger women.

The median age of those suing for breast cancer–related malpractice was previously 41. Today, it’s about 38 or 39, Mondor says. Typically, these women have aggressive cancers.

In some cases, says Mondor, special circumstances (e.g., a current or recent pregnancy) make the circumstances all the more tragic—and lawsuits all the more heart-wrenching in the eyes of a jury. During the past five years alone, Mondor has seen 17 cases involving women who had recently given birth.

Physicians aren’t always on the lookout for these cases. This lack of awareness makes such cases particularly dangerous. Conducting breast exams at the six-week postpartum visit and at patients’ annual appointments help reduce this risk.

When working with younger women, ask specifically about family history related to breast cancer. Flag those with prevalent breast cancer cases as high-risk patients. Give them extra attention and encourage additional follow-up and screening measures.

Other young women to watch carefully are those with repeat microcalcifications, says Mondor.
6. Avoid risky reading environments.

Consider the condition of your radiology facility when considering how to avoid breast cancer malpractice lawsuits.

A ProMutual analysis found that patients are more likely to sue healthcare agencies that lack a designated reading room for radiologists, says Mondor.

At some facilities, radiologists read scans in high-traffic areas where they face frequent interruptions. This arrangement increases the likelihood that a radiologist will miss a cancer or cancer precursor. Missed cancers can lead to malpractice lawsuits.

“We see a percentage of radiologists [who] have multiple claims against them. When we go into the facility, it’s easy to understand why—it’s a three-ring circus. They are constantly interrupted when they are trying to read,” says Mondor.

In addition, make sure radiologists use adequate equipment for reading. For example, does the radiologist read exams at night? Does the radiologist who works from his or her home use a substandard monitor? Ingredients such as these could create a recipe for litigation.

7. Keep radiologists on top of their game.

Radiologist fatigue may also lead to missed cancers.

Many facilities have radiologists read exams during the day after they have worked all night on call. Although this scenario may be difficult to avoid in hospitals with limited staff, prevent it whenever possible. Such practices can result in a missed diagnosis.

In addition, don’t ignore the obvious issues that may hinder radiologist performance.

For example, “when is the last time your radiologists had their eyes checked?” asks Mondor.

If a radiologist hasn’t undergone an exam recently, his or her poor sight could be a liability issue. Require mandatory eye examinations as part of the hospital’s credentialing process.

Insider source
Maureen Mondor, vice president, risk management, ProMutual Group, Boston; mmondor@promutualgroup.com.

JCAHO VISITS (continued from p. 4)

Improving drug documentation throughout the continuum of care perhaps causes the most consternation.

“The reconciliation of medication across departments is the biggest deal,” Belanger said. “We’re a 700-bed hospital. I have 150 CT scans scheduled on any given day. How are we going to keep track of all that?”

Belanger and her team have so far resolved to document medications within the radiology department. They’ll add medications to a patient’s list if they are administered within the department. But it’s not a suitable system for outpatient services, she said.

“We have patients who come to us with enough medications to fill a garbage bag. How are we ever going to be able to track that in a radiology department?” Belanger asked.

Reduction of falls
Preventing falls is also an issue of concern for Belanger and her team. “How many of us have had a patient fall off the table?” Belanger asked the audience during the RSNA Chicago conference. “We all know that despite our best efforts, some of these patients just want to get up and go for a walk rather than sit still.”

A radiology nurse or technologist’s job makes it difficult to remain at the patient’s bedside constantly, so Belanger’s hospital established a falls committee to investigate best practices for keeping patients safe.

“Do we use restraints to reduce this risk, or don’t we?” she asked. “If we use them, they may work, but there’s also evidence that patients find a way around the restraint and possibly injure themselves worse.”

JCAHO recommends the following tips for preventing falls:

• Orient the patient to the room
• Tell the patient about the facility’s falls prevention policies and procedures
• Keep the room free of clutter and spills
• Keep the room as well-lit as possible, particularly when escorting patients to and from the room
• Provide and document patient and family education about fall precautions

Preparation and constant diligence are your most valuable assets, Belanger said.

Insider source
JoAnn Belanger, RN, radiology department patient services manager and program director of the endovascular clinic, University of North Carolina Health System, Chapel Hill, NC; jbelanger@unch.unc.edu.
Q: How have the CPT guidelines been revamped?

A: The 2006 CPT guidelines state that all ultrasounds require permanently recorded images with measurements when clinically indicated, said Stacy M. Gregory, RCC, CPC, of Gregory Medical Consulting Services in Tacoma, WA, during the HCPro, Inc., audioconference “Ultrasound: How to avoid documentation challenges and improve reimbursement” in December 2005.

Specific guidelines were developed for those examinations that have a limited code as well as those that have a complete code, Gregory said.

The American Medical Association (AMA) clarified which scans it expects to be included in a complete versus a limited examination.

For a complete ultrasound, we need to describe the scanned organs or provide a reason why the organs or other body parts did not appear on the scan. Those elements are clearly defined in the related CPT codes.

There may be other reasons why a certain body part might not be seen on an exam, she said. For example, an organ might be obstructed by bowel gas or surgically absent.

The other guidelines concern fewer than the required elements for a complete exam being reported.

For example, if staff evaluate only a limited number of organs or a limited portion of the region, the limited code for that anatomic region should be used, but only once per exam session.

Q: There’s been confusion about coding for either a complete abdominal or limited abdominal ultrasound. When a scan of the gallbladder and pancreas was ordered and charged as a complete scan, the doctor became upset. If the ultrasound extends into a second quadrant, how should we bill?

A: Even though you are evaluating more than one quadrant, if you do not evaluate everything that the CPT says must be included, you must code it as a limited exam, said Gregory.

Even if you perform an intensive examination of the organ without other components that are required to make it a complete abdomen, you may only bill for a limited abdominal ultrasound, she said.

“People think of a limited [ultrasound as] being only one particular quadrant,” said Stacie L. Buck, RHIA, LHRM, of Southeast Radiology Management Corp., in Stuart, FL. “That mindset comes before we had these guidelines from CPT.”

Insider sources

Stacy Gregory, RCC, CPC, Gregory Medical Consulting Services; 4653 N Bristol St., Tacoma, WA 98407-2014; stacygregory@wamail.net.

Stacie L. Buck, RHIA, LHRM, Southeast Radiology Management Corp., 512 St. Lucie Crescent, Stuart, FL 34994; stacie@southeastrad.com.