

Radiology Administrator's

Compliance & Reimbursement Insider

JANUARY 2004

Adopt Policy on Reimbursing Non-Physician Employees for Continuing Education 1

It's important to have a policy so that employees know how much assistance to expect.

- ▶ Model Policy: Adopt Policy on Employee Training Reimbursement (p. 3)

In the News: Congress Passes Medicare Reform, Including Physician Fee Fix 5

Congress made sweeping changes to the Medicare program, including measures to improve physician reimbursement.

Dos & Don'ts 6

- ▶ Use Technical Component Date When Billing Globally
- ▶ Don't Change New ABN Form, Except as CMS Allows

Heed Compliance Issues When IR Joins Diagnostic Practice 6

Adding IRs to your practice can be a sound business decision, but you need to be aware of some compliance complications.

FCC Issues Rule Against Unsolicited Faxes 8

This rule may have an impact on your future marketing efforts.

- ▶ Model Form: Get Signed Consent Form Before Advertising by Fax (p. 9)

Annual Index 9

Show Your Lawyer 10

IN FUTURE ISSUES

- What's New for Radiology in CPT 2004
- Adopt Policy on Stale Orders
- Seven Tips to Get Your Charts Audit Ready

This newsletter has prior approval by the American Academy of Professional Coders for up to 10 CEUs per year. Granting this approval in no way constitutes endorsement by AAPC of the program, content, or the program sponsor.

Go to www.aapcnatl.org
or call the AAPC at
1-800-626-2633
for more information.



Adopt Policy on Reimbursing Non-Physician Employees for Continuing Education

If your radiology practice is typical, you reimburse your radiologists for expenses they incur for continuing medical education and allow them a certain number of days off each year to attend educational conferences and seminars. But now, many practices are also encouraging their non-physician staff members to get certified in their fields, and to seek continuing professional education. This helps to ensure that the practice has a high-quality, competent staff who are dedicated to their field—plus, having certified staff can be a great marketing tool.

Review courses, certification exams, and continuing education conferences and seminars can be quite expensive. And your non-physician staff may not be able to afford them without help. So many practices are agreeing to reimburse their non-physician employees for some or all of these expenses. If you decide to go this route, you should be clear up front about what your practice expects regarding non-physician employees' continuing education, and exactly what you'll reimburse for. That way, you avoid misunderstandings with employees that can lead to unhappy staff and personnel problems.

We'll tell you why you should consider reimbursing your non-physician staff for some of their educational expenses, and explain why it's important to have a policy explaining the benefit to your staff. And we'll give you a Model Policy (see p. 3) that you can adapt for use in your own practice or facility.

Why Employee Reimbursement Makes Sense

In general, it's a good idea to encourage your employees to engage in educational activities that will enhance and maintain their professionalism, says health care consultant Bruce Topolosky. An education reimbursement policy can help you:

Steer clear of compliance problems. Your practice or facility benefits from having employees who are on top of new technology and conversant in the various billing, coding, and compliance-related laws and regulations that affect medical practices. "Should a regulator or payor ever audit your practice, the fact that your staff is highly trained and has received proper and continuous training will reflect well on your practice," he says.

Lower insurance premiums. Sometimes malpractice insurers will discount your premium if your non-physician clinical staff are licensed or certified.

Hire and keep good employees. A policy that encourages and reimburses employee education and training can be a terrific tool to develop, recruit, and retain employees, points out Rosemarie Nelson of the Medical Group Management Association's health care consulting group.

(continued on p. 2)

BOARD OF ADVISORS**Andrei Costantino**

Parente Randolph Orlando
Carey & Associates, LLC
Harrisburg, PA

William G. Franz Jr.

Radiologix, Inc.
Dallas, TX

Alice G. Gosfield, Esq.

Alice G. Gosfield &
Assocs., PC
Philadelphia, PA

Thomas W. Greeson, Esq.

Reed Smith LLP
Falls Church, VA

Karol Handrahan

University of Pittsburgh
Dept. of Radiology
Pittsburgh, PA

Matthew Kupferberg, Esq.

Arent Fox Kintner Plotkin
& Kahn, PLLC
New York, NY

Jackie Miller, RHIA, CPC

Per-Se Technologies
Consulting Group
Atlanta, GA

Roberta J. Miller

Medical College of Ohio
Dept. of Radiology
Toledo, OH

Ronald E. Miller

Medical College of
Virginia Hospitals
Richmond, VA

Diane S. Millman, Esq.

Powers Pyles Sutter
& Verville
Washington, DC

Melody Mulaik, MSHS, CPC

Coding Strategies, Inc.
Powder Springs, GA

Claudia A. Murray

Provider Practice
Analysis, LLC
Baldwin, MD

Paula Richburg

QuadraMed
Columbia, MO

William A. Sarraille, Esq.

Sidley Austin Brown & Wood
Washington, DC

Michael F. Schaff, Esq.

Wilentz Goldman & Spitzer
Woodbridge, NJ

Jay Silverman, Esq.

Ruskin Moscov Faltischek, PC
Uniondale, NY

Tobin N. Watt, Esq.

Smith Helms Murliss &
Moore, LLP
Atlanta, GA

Editor: **Jill K. Gormley, Esq.**

Executive Editors: **David B. Klein, Esq.,**

Nicole R. Lefton, Esq., Susan R. Lipp, Esq. Janet Ray

Senior Editors: **Nancy Asquith, Heather Ogilvie**

Copy Editors: **Cynthia Gately, Graeme McLean**

Proofreader: **Lorna Drake**

Production Director: **Mary V. Lopez**

Senior Production Associate: **Sidney Short**

Production Associate: **Jennifer Chen**

Director of Planning: **Glenn S. Demby, Esq.**

New Projects Editor: **Rebecca L. Margulies, Esq.**

Dir. of Ref./Information Development: **John D. Boyd**

Marketing Director: **Peter Stowe**

Marketing Mgrs.: **Christine Chan, Michael F. Sherman**

Data Processing Manager: **Rochelle Boorstein**

Sales Manager: **Joyce Lembo**

Customer Svc. Reps.: **B. Maslansky, H. Therezo**

Director of Operations: **Michael Koplin**

Fulfillment Supervisor: **Edgar A. Pinzón**

Financial Manager: **Janet Urbina**

Asst. Office Manager: **Maria Safina**

Publisher: **George H. Schaeffer, Esq.**

Owners: **Andrew O. Shapiro, Esq., John M. Striker, Esq.**

Subscriptions: *Radiology Administrator's Compliance & Reimbursement Insider* (ISSN 1527-2338) is published monthly. Subscription rate: \$357 for 12 monthly issues. Address all correspondence to: Brownstone Publishers, Inc., 149 Fifth Ave., New York, NY 10010-6801. Tel: 1-800-643-8095 or (212) 473-8200; fax: (212) 473-8786; e-mail: jgormley@brownstone.com

Disclaimer: This publication provides general coverage of its subject area. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional advice or services. If legal advice or other expert assistance is required, the services of a competent professional should be sought. The publisher shall not be responsible for any damages resulting from any error, inaccuracy, or omission contained in this publication.

© 2004 by Brownstone Publishers, Inc. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any information storage and retrieval system, without written permission from the publisher.

REIMBURSING FOR CONTINUING EDUCATION (continued from p. 1)**Think Through Issues Before Adopting Policy**

A number of issues arise when implementing an education reimbursement policy, says Nelson. For your sake, it's important to think through various scenarios to consider how you'll handle them, and then adopt a formal policy to let everyone know what your practice will offer and what's expected of the employee in return.

For example, you don't want to spend a lot of money on a new employee's education when that employee is more likely to switch jobs. So you'll probably want to limit reimbursement to employees who have been with your practice for a given period of time, Topolosky remarks. And if you offer assistance to employees to further their education and qualify for a different job, you should protect yourself by requiring the employee to repay the practice if he leaves voluntarily within a certain period of time after receiving the credential you paid for, Nelson suggests.

In any case, you should carefully evaluate any training or certification you reimburse for employees, to ensure that it's an added value for your practice or facility—not just for the employee. Finally, you should carefully consider the sponsoring organization and the content of any training or continuing education you provide for employees and limit your reimbursement to well-established organizations offering widely recognized credentials. There are a lot of fly-by-night companies offering training, the value of which is questionable, Topolosky remarks. So make sure you're familiar with the organization offering the program or course your employee wants to attend, he recommends. And monitor the quality of the information and training presented, he adds.

Insider Says: If any part of your workforce is unionized, the collective bargaining agreement may dictate what your policy toward tuition and training reimbursement for those unionized employees must be, Topolosky remarks. So be sure to check the collective bargaining agreement before developing a policy on your own.

What to Address in Policy

We've developed a Model Policy that offers comprehensive, generous reimbursement to employees. You probably won't want your policy to include everything we've put in our Model Policy, but you should at least consider the implications of offering and not offering reimbursement under various circumstances. Here are some of the common situations your policy should address:

Whether to reimburse if certification or licensure is required. In cases where state or federal law requires certification or licensure, it's customary—though not required—that the employer pay for any continuing education that the employee requires to maintain certification or licensure, because the employee can't legally perform his job without it, says New Jersey health care attorney William Watkins. For example, under the Mammography Quality Standards Act, mammography techs must be certified to position patients for mammograms. And in many states, non-physician clini-

cal staff like radiology techs and sonographers must have certification or a license. Our Model Policy reimburses for all continuing education and other costs necessary to maintain

a license or certification required by a law [Policy, par. 1(a)].

Whether to reimburse if certification is optional. Certain non-

physician staff—such as coding staff, medical records personnel, information specialists, administrators and executives, and compliance offi-

(continued on p. 4)

MODEL POLICY

Adopt Policy on Employee Training Reimbursement

If you want to encourage your employees to get and retain excellent credentials, you should have a policy in place that tells the employees what you expect of them and what they can expect from you. The following Model Policy offers generous reimbursement to employees, and it may be more than your practice is able to offer. Even so, it will give you a place to start

to consider these issues for your practice, and you can adapt the policy to suit your needs. But remember to show the policy to your attorney and accountant to make sure that it complies with the law in your state, and protects the employees from additional tax liability.

EDUCATION REIMBURSEMENT POLICY

XYZ Radiology encourages all employees to seek, obtain, and retain professional credentials and training. Accordingly, XYZ Radiology will consider requests from employees for reimbursement for expenses incurred in pursuit of professional training and enrichment, in accordance with the following policy:

- 1. Reimbursement of training and certification costs.** Employees may be reimbursed for certification and continuing education necessary to perform their jobs, as follows:
 - a. Employees who are required by law to maintain professional licenses or certifications in order to perform their jobs may apply to XYZ Radiology for reimbursement of annual license or certification fees and mandatory continuing education expenses. Employees seeking such reimbursement must provide supporting materials such as fee invoices, meeting agendas, or seminar curricula.
 - b. Employees who seek optional training or certification for professional development and enrichment, and who have been employed by XYZ Radiology for at least one year, may apply to XYZ Radiology for reimbursement of costs associated with such training or certification. The employee must provide supporting information such as meeting agendas and seminar curricula and should be prepared to demonstrate how the additional training or certification will benefit XYZ Radiology. Such reimbursement requests will be granted only in the event that XYZ Radiology concurs that such training or certification is beneficial to the practice.
- 2. Tuition assistance available.** Employees who seek additional credentials in order to move to another position within the practice may seek tuition assistance from the practice, which may be granted on a case-by-case basis in accordance with XYZ Radiology's anticipated future staffing needs. In addition:
 - a. Employees receiving tuition assistance must commit to remain within the practice's employ for 24 months after receiving the additional credential unless practice terminates employee's employment prior to the expiration of the 24-month period.
 - b. Employees who choose to leave the practice's employ prior to the expiration of the 24-month period must agree to repay the practice for all or part of the tuition assistance granted if the practice seeks such repayment.
- 3. Payment for time spent training.** Non-exempt (hourly) employees will be paid at their regular hourly rate for time spent in training, education, or certification courses undertaken at the practice's request. Notwithstanding the foregoing, employees engaging in additional training during their off hours and receiving tuition assistance will not be paid for time spent attending such training, education, or certification courses. Employees attending training, education, or certification courses without the prior knowledge and consent of the practice will not be reimbursed for expenses incurred or time spent at such training, education, or certification courses.
- 4. Reimbursement of expenses.** Reasonable travel expenses, including mileage, air fare, and hotel (with prior approval) will be reimbursed at the discretion of the practice. Employees who must travel away from home to attend practice-mandated training, education, or certification courses will receive a per diem of [insert amount] per day for meals and miscellaneous expenses.

REIMBURSING FOR CONTINUING EDUCATION (continued from p. 3)

cers—may need specialized training to do their jobs effectively. Although typically these employees aren't required to be certified by law, medical practices often find that encouraging certification and continual training reaps dividends, says Nelson. Our policy provides a mechanism for staff who aren't required by law to have certifications to request reimbursement for training and certification [Policy, par. 1(b)].

Whether to reimburse initial certification/licensure, or just continuing education. Some practices and facilities hire only certified or licensed personnel, while others will train a good employee to take on additional responsibilities that may require certification. For example, an outstanding front desk person who shows aptitude may be offered tuition assistance to get a college degree and training as a tech. Nelson says that well-run practices do their best to identify employees with potential and encourage them to acquire credentials and develop their skill sets.

But because you want to guard against paying for the education of an employee who then takes that additional training to a competitor across town, our Model Policy asks the employee to agree to repay the tuition assistance if she voluntarily leaves the practice's employ within two years of obtaining the additional degree, license, or certification [Policy, par. 2].

How to compensate time spent in training. Ask your attorney to look into how you must pay for time your employees spend in training, says Watkins. State wage and hour laws vary, so you must get local advice. But in general, a non-exempt employee—that is, an employee who's entitled to overtime—cannot be asked to attend training sessions without pay, he says. So if a member of your coding staff attends a coding review course on the weekend after putting in a full week in your office, you probably owe that person overtime if she's pursuing the certification with your approval, for your benefit, or at your request, Watkins explains. Make sure that you're familiar with what your state law requires and take that into consideration when approving or denying requests for reimbursement, Topolosky says [Policy, par. 3].

Your policy also should address the possibility that your employees will ask for reimbursement for time spent in training that they acquire on their own, or for time spent attending night school to get a degree, for example. So your policy should state that employees will be reimbursed only for time spent in training that's undertaken at the direction of the practice. Typically a practice or facility will pay employees only for time spent in training that the employee would otherwise spend working, although the policy should recognize that some educational meetings also involve weekend attendance. And your policy should specifically decline to pay the employee for ongo-

ing after-hours training—perhaps by saying that employees receiving tuition assistance won't be paid for that after-hours training, Nelson suggests.

Whether and how to reimburse for travel expenses. Employees who travel for educational purposes should be reimbursed for expenses they incur, says Topolosky—but how much, is up to you, he adds. For example, some practices will put their staff up at luxury hotels. Other practices need to keep a tighter handle on expenses. Whatever you decide, save yourself and your employees a lot of grief by making clear up front what you'll pay for and what the employee's responsibility is, he suggests [Policy par. 4].

Insider Says: Have your accountant look over your education reimbursement policy, Watkins remarks. You want to try to set up your program so that the reimbursement isn't considered a taxable fringe benefit. Otherwise, your employees may end up paying income taxes on the amount reimbursed to them—which in some instances can almost wipe out the benefit and serve as a disincentive for additional training, he notes. ■

Insider Sources

Rosemarie Nelson: Health Care Consulting Group, Medical Group Management Assn., 114 Janet Dr., Syracuse, NY 13224; rosemarienelson@alum.syracuse.edu.

Bruce Topolosky: Bruce Michael and Assocs., 237 Hamilton Rd., Princeton, NJ 08540; btopy@aol.com.

William Watkins, Esq.: Lindabury, McCormick & Estabrook, 53 Cardinal Dr., Westfield, NJ 07091; wwatkins@lindabury.com.

IN THE NEWS

Congress Passes Medicare Reform, Including Physician Fee Fix

On Nov. 25, 2003, the Senate passed a bill that constitutes the biggest revision to the Medicare program since the program was enacted over 40 years ago. Among the many changes to the program are provisions that avert another planned fee cut for physicians and change the way that the physician fee schedule update will be calculated in the future. Although this bill, called the Medicare Prescription Drug, Modernization, and Improvement Act (the act), won't become law until it's signed by President Bush, as the *Insider* went to press, the president was expected to sign it. We'll discuss many of the significant reforms in future issues of the *Insider*. In this issue, we'll tell you what the fee fix means for your reimbursement in 2004.

CMS's 2004 Physician Fee Schedule Was Expected to Affect Participation, Access

On Nov. 7, 2003, before Congress passed the act, CMS printed the 2004 physician fee schedule in the *Federal Register*. Under CMS's proposed fee schedule, overall Medicare payments to physicians would have decreased by an average of 4.5 percent in the coming year. The decreases, had they gone into effect, would "definitely have made it tougher for physicians to decide whether to participate in Medicare," says Jennifer Miller of the Medical Group Management Association (MGMA). And at some point, decreasing physician participation in the program may have affected access to needed health care services for seniors, she adds. Miller points out that the proposed 2004 decreases came on top of an increase in practice overhead that MGMA has documented at 3 percent

annually over the past four years. This 3 percent increase doesn't fully reflect the increased cost of medical liability insurance—which has risen sharply over the last two years.

Congress Enacts Another 'Fix'

If signed into law, the act will provide a two-year window for Congress to permanently fix the problems that CMS encounters when calculating the annual updates to the physician fee schedule, says Miller. It will require CMS to increase the conversion factors for 2004 and 2005 by no less than 1.5 percent each year, which will have the effect of eliminating the 4.5 percent average decrease in annual reimbursement that was expected under CMS's 2004 physician fee schedule.

The act would also make an important change to the way that the annual updates to the physician fee schedule will be calculated. The Medicare law requires CMS to adjust the physician fee schedule up or down based on how actual program expenditures compare to a target rate that's called the "sustainable growth rate." The sustainable growth rate is itself calculated based on factors like the overall growth of the economy and the inflation rate for medical services, among other factors. Because of recent slow economic growth and the increase in health care costs, in order to make the physician fee schedule comparable to the sustainable growth rate, CMS was forced in its proposed fee schedule to decrease physician reimbursement for 2004 by 4.5 percent.

Congress made an attempt to fix the flawed formula. When the new act

becomes law, it will require CMS to use a rolling 10-year average of the gross domestic product when calculating the sustainable growth rate. This may help to stabilize physician reimbursement under the Medicare program, but it won't permanently ensure that physician reimbursement will fairly reflect the costs of providing services. In essence, the change mitigates some of the problems but doesn't get to the root cause of them, Miller says.

"Although we're very pleased with the bill that Congress passed, we recognize that we've got a lot of work ahead of us for the next two years to ensure that the formula for calculating physician payments results in fair compensation for physicians who provide professional services to Medicare beneficiaries," Miller says. She points out that no other group has its reimbursement tied to the gross domestic product. And she notes that the legislative history regarding the formula for calculating physician reimbursement is vague, so there's little justification for using the gross domestic product in the formula used to calculate physician reimbursement. "We're glad to have this temporary fix, but we believe that the time for tinkering has passed and the entire system of calculating physician reimbursement under the Medicare program must be overhauled," she says. ■

Insider Source

Jennifer Miller: Government Affairs Representative, Medical Group Mgmt. Assn., 1717 Pennsylvania Ave. NW, #600, Washington, DC 20006; jen@mgma.com.

DOS & DON'TS

✓ **Use Technical Component Date When Billing Globally**

If you have a free-standing imaging facility that submits global bills, use the date that the patient *received* the test—that is, the technical component date—as the date of service on your global bill. Doing this will minimize any confusion, says Virginia health care attorney Thomas W. Greeson.

A radiologist doesn't always interpret the test on the same day the test is performed. But you can't write two separate dates of service—one for the technical and one professional component—in a global bill. So you have to choose one date.

When a patient receives his EOB from Medicare or other insurer, he may check the bill to see if it's correct. He'll probably have a record of the day he had the test, but he may not know the date the radiologist interpreted it. So if you give the interpretation date as the date of service, the patient may call you, wanting an explanation. Or worse, he may even report you to the carrier or other insurer if he mistakenly thinks you've submitted a bill for services he didn't have. Choosing the technical component date as the date of service is an accurate way to bill, plus you avoid patient confusion, Greeson says.

✗ **Don't Change New ABN Form, Except as CMS Allows**

When producing your own copies of the ABN form that CMS has issued, make sure you don't change it in any way

that's not specifically permitted by CMS's rules for ABNs. The rules, which appeared in a program memo that became effective Oct. 1, 2002, say that the form "may not be modified in any respect," and must be "identical to the replicable" ABN forms found on CMS's Web site, except that practices may customize certain areas of the form in a limited number of ways.

If you improperly modify the ABN form, you risk losing the right to bill the patient if Medicare denies the patient's claim. "The use of any other ABNs or modified ABNs may be ineffective in protecting physicians and suppliers from liability," the rules say.

Even changing the typeface or type size or moving material around on the form can make the form defective.

According to CMS's ABN rules, you must add identifying information (name, address, telephone number) to the "header" area at the top of the form, and may add your logo, as well.

Insider Says: You can find a reproducible version of CMS's ABN form, CMS-R-131-G, at www.cms.hhs.gov/medlearn/refabn.asp. It's available in both English and Spanish. CMS's rules for ABNs are available at www.cms.gov/manuals/memos/comm_date_dsc.asp. Click on memo AB-02-114. ■

Insider Source

Thomas W. Greeson, Esq.: Reed Smith LLP, 3110 Fairview Park Dr., Falls Church, VA 22042; (703) 641-4242; tgreeson@reedsmith.com.

Heed Compliance Issues When IR Joins Diagnostic Practice

Many practices that once limited their work to consultative diagnostic radiology are adding the clinical practice of interventional radiology. There's a growing demand for interventional radiology procedures that can be provided by interventional radiologists (IRs) directly, and it often makes good business sense for established diagnostic radiology practices to consider adding these IR procedures to their practices.

But adding an IR can lead to some compliance problems because the traditional radiologist/hospital or radiologist/patient relationship is different for an interventional radiologist. Plus the rules for ordering tests and referring patients for services are different for IRs and diagnostic radiologists, and for IRs acting in a consultative capacity and IRs acting as treating physicians. And there may be different rules depending on

whether the IR is providing services in an independent office or facility or in a hospital.

We'll go over some of the differences between IRs and diagnostic radiologists from a legal perspective, explain some of the particular compliance issues that arise when an IR joins a diagnostic radiology practice, and show you how to handle these issues so that you don't get into trouble.

IRs Can Be Treating Physicians

Radiologists, generally, aren't treating physicians. They typically perform services only in a consultative capacity—that is, at the order of another physician and with an obligation to report back to the ordering physician. But IRs are considered treating physicians in certain circumstances—namely, when performing therapeutic interventional procedures and assuming responsibility for the patient's care and treatment, explains Virginia health care attorney Thomas Greeson. So practices need to get used to the idea that their IRs sometimes are considered treating physicians. The distinction is important because treating physicians order diagnostic tests and manage the care of their patients—both functions that diagnostic radiologists traditionally don't handle.

So an IR who has assumed responsibility for the care and treatment of a patient and who plans to perform an invasive therapeutic procedure on her may order a preliminary or post-procedure diagnostic test for her without getting an order from her primary care physician. That's because the IR is the treating physician for all treatment and services related to the therapeutic procedure, Greeson explains.

But when an IR is performing in a consultative capacity—that is, doing an interventional procedure at the request of another physician and reporting the results to that requesting physician—the IR is *not* a treating physician. And that means that if the IR thinks a certain test is appropriate, Medicare rules require him to attempt to secure an order for that test from the requesting physician, Greeson explains—although IRs may order tests in a hospital setting if the hospital protocols permit radiologists to order tests on their own initiative and discretion. (For more information on

ordering tests in a hospital setting, see “Get Your Hospital to Adopt Protocol on Radiology Test Orders,” *Insider*, July 2002, p. 1.)

Consulting IR May Self-Refer Under Stark

Many practices get hung up on self-referral issues when they add an IR to their practice, Greeson says. The federal Stark II law bars a physician from making a referral for certain designated health services (DHS) to an entity in which the physician has a financial interest. The Stark II self-referral prohibitions have a broad reach, and the concern is justified, he remarks. Yet Stark II is written in a way that allows radiology practices with IRs a certain amount of leeway without violating the law—at least when the IR is acting in a consultative capacity.

Consulting IR may self-refer interventional services. Although radiology imaging services are a DHS, interventional radiology services—even diagnostic interventional radiology tests—aren't, says Greeson. The final Stark II rule draws a distinction between radiology imaging and radiology services that “are themselves invasive procedures that require the insertion of a needle, catheter, tube or probe.” That means that your IR (or any other radiologist in your practice) can do a diagnostic test on a patient, then “self-refer” the patient for an interventional radiology procedure without violating Stark II. That's because the interventional procedure isn't considered a DHS—so there's no ban on self-referral for it, Greeson explains.

Consulting IR may be able to self-refer diagnostic tests. Stark II permits a radiologist to order diagnostic radiology services without violating the self-referral ban because it excludes such orders from the defini-

tion of a referral, as long as the services are “personally performed or provided by” the referring physician and provided pursuant to a request by another physician, Greeson notes. And Stark II says that a service is personally performed or provided by a physician if it's performed by the physician *or* a member of the physician's group practice *or* an employee or independent contractor of the group practice. This means that an IR may refer his patients for diagnostic tests to an imaging center in which he has a financial interest in certain circumstances, says Greeson.

Example: Let's say an IR is performing a procedure on a patient at the order of the patient's internist. The IR wants the patient to have a post-procedure imaging test to check the outcome. The IR may refer the patient to an imaging center in which the IR has a financial interest to get the test, as long as the test is performed by the IR himself, one of his partners in the group practice, or an employee or independent contractor of the practice and the results are reported back to the patient's internist.

Treating IR Needs Stark Exception to Legally Self-Refer

The Stark self-referral ban gets sticky for radiology practices when the IR has assumed responsibility for the care and treatment of a patient and so is acting as the treating physician and wants to refer the patient to his independent imaging center for a diagnostic test. In that case, the test isn't being performed pursuant to the request of another physician, and so the IR doesn't get the benefit of the Stark provision that excludes radiology services from the definition of referral. So an IR who's acting as the treating physician and wants to refer a

(continued on p. 8)

WHEN IR JOINS DIAGNOSTIC PRACTICE

(continued from p. 7)

patient for a DHS to an entity in which he has a financial interest (like his group's independent imaging center) must find an exception to Stark that applies to his circumstances, Greeson explains.

Stark's "in-office ancillary services exception" is the one that's most often applicable, Greeson reports. That exception allows a self-referral for a DHS if the DHS is performed as an in-office ancillary service of the referring practice. But the exception can be hard to meet, especially for radiology practices. Here's why:

To qualify for the in-office ancillary services exception, the DHS that the physician orders must not be the primary reason for patients to have contact with the group. In the case of a radiology practice, most patients

have contact with the group only because they're seeking diagnostic radiology services, Greeson points out. The diagnostic radiology services aren't ancillary—they're the practice's primary service, so the in-office ancillary services exception generally isn't available to radiology practices.

But a practice composed primarily of IRs who maintain a clinical practice—that is, they more often act as treating physicians than as consulting physicians—may be able to use the in-office ancillary services exception to provide diagnostic radiology services to its patients, Greeson suggests. To do so, the practice must meet the following requirements:

- The DHS that the IR orders must be personally performed or supervised by the ordering IR or another physician member of the practice;

- If the practice performs diagnostic tests in only one location, the DHS must be performed in an office dedicated to the exclusive use of the practice;

- If the practice performs diagnostic tests in multiple locations, the DHS must be furnished in the same building where the practice furnishes "substantial physician services" unrelated to DHS. In other words, the place where the patient goes to get the diagnostic imaging services must be a place where the IRs also provide non-DHS, like E&M services and/or interventional procedures; and

- The DHS must be billed by the group practice under its group number. ■

Insider Source

Thomas W. Greeson, Esq.: Reed Smith LLP, 3110 Fairview Park Dr., Falls Church, VA 22042; (703) 641-4242; tgreeson@reedsmith.com.

FCC Issues Rule Against Unsolicited Faxes

On July 25, 2003, the Federal Communications Commission (FCC) issued a *rule restricting telemarketing and telephone solicitations*. This rule bans any entity from sending a fax advertising goods or services to anyone who hasn't previously consented *in writing* to receive such faxes from that entity. This new rule applies both to for-profit and not-for-profit entities, and has serious implications for professional associations, health care facilities, physician practices, and other health care providers, says Washington, D.C., health care attorney William A. Sarraille.

The new rule isn't set to go into effect until Jan. 1, 2005, but you may need to change your marketing plans if the FCC doesn't modify the rule before then. We'll tell you what you need to know about this new rule—

and how you should handle unsolicited advertising faxes until the rule goes into effect. We'll also give you a Model Form you can use to get the written consent you'll need to send fax advertising (see p. 9).

New Rule More Stringent than Previous Rule

The FCC issued its first rule regarding unsolicited faxes in 1992. That rule banned entities from sending unsolicited fax advertisements without the express consent of the recipient. But it said that an "established business relationship" between the sender and the recipient was sufficient to establish consent. For health care providers, that meant, for example, that fax advertising could be sent to patients, referral sources, vendors, and contract partners, without violating this rule.

But if the new rule goes into effect without modification, this will change. You won't be able to send a fax advertising goods or services—say, announcing your new PET scanner to referral sources—unless the recipients have agreed in writing to receive such faxes from you.

New Rule More Stringent than HIPAA

Once the new rule goes into effect, you'll need to be especially careful about the way you use faxes to market services to your patients. That's because the FCC rule is more restrictive than the HIPAA privacy regulations regarding marketing. HIPAA generally permits advertising via fax to existing patients, Sarraille explains. For example, if you send a fax to a female patient, explaining that you're

opening a new women's imaging center and inviting her to come in for her annual mammogram, you're not violating HIPAA. But you'll be violating the FCC's new fax rule if you don't have the patient's written consent to receive such faxes from you, he notes.

New Rule Controversial

The new rule was originally set to go into effect on Aug. 25, 2003. But because the rule caused so much controversy within the business community when it was announced, the effective date was pushed back to Jan. 1, 2005, Sarraille reports. The new rule is in keeping with other initiatives, like the telemarketing registry, in which people can place their names on a "no call" list. Sarraille explains that the no call initiative was so popular with citizens that the Bush Administration implemented it despite the opposition of the business community. And he notes that the same could prove to be true for this new rule.

What Should You Do Now?

Even though you don't need to worry about this new rule for a while, you should still keep it in mind as you plan your marketing efforts over the long term, Sarraille advises. Don't assume that mass faxing is going to be a viable focus of your marketing efforts for long.

For now, you need only ensure that your marketing efforts comply with

HIPAA. But keep in mind that eventually you may need written consent before you're able to send faxes advertising goods and services to referral sources, patients, health plans, hospitals, and others without their written consent. You can use our Model Form to get written consent from people to whom you may want to send advertis-

ing by fax. So if you want to be really prudent, you can have people to whom you may advertise complete the form, and keep it on file. ■

Insider Source

William A. Sarraille, Esq.: Sidley Austin Brown & Wood, 1501 K St., Washington, DC 20005.

MODEL FORM

Get Signed Consent Form Before Advertising by Fax

If faxing is part of your practice's marketing plan—or even if you only use the fax to tell people about new products or services you offer—you should be aware that starting in January 2005, you'll need to get the recipient's written consent before you send such advertising via fax. To ensure you get this written consent, have recipients

sign a fax consent form. Here's a Model Form that's based on one developed by the firm of Washington, D.C., health care attorney William A. Sarraille. You can give this form to vendors, patients, referral sources, and others to whom you think you may market your services via fax.

FAX CONSENT

I AM AUTHORIZED TO CONSENT ON BEHALF OF THE INDIVIDUAL/ ORGANIZATION LISTED BELOW, AND I HEREBY CONSENT TO RECEIVE FAXES SENT BY XYZ RADIOLOGY TO MARKET OR ADVERTISE ITS SERVICES.

Individual/organization providing consent (*please print*): _____

Name of authorized person providing consent on behalf of organization (*please print*): _____

Fax number(s) to which advertising or marketing materials may be sent:

SIGNATURE: _____ DATE: _____

ANNUAL INDEX

This index lists all articles published in the Insider from January through December 2003.

► BILLING & CODING

- "Ask the Insider: Payment for Radiology Consultations," Nov., p. 6.
- "Ask the Right Questions Before Buying or Billing for New Devices and Drugs," Dec., p. 1.
- "Boost Your Bottom Line by Challenging Medical Necessity Denials," Aug., p. 1.
- "CMS Relaxes Requirements for LOCM Payment Under OPDS," March, p. 4.

- "Dos & Don'ts: Don't Bill Medicare Allowable Charge," Aug., p. 10.
- "Dos & Don'ts: Don't Undercode Claims to 'Play It Safe,'" June, p. 7.
- "Follow Six Rules for Correct 'Incident to' Billing," Sept., p. 7.
- "Follow These Strategies to Survive Prepayment Review," Jan., p. 7.

- "Get Familiar with New OB Ultrasound Codes," June, p. 1.
- "How to Bill for Additional Services with Breast Biopsies," Oct., p. 3.
- "In the News: CMS Announces New Coverage for MRA and PET," July, p. 3.

(continued on p. 10)

ANNUAL INDEX (continued from p. 9)

"In the News: *CPT 2003* Has Big Changes for Radiology," Jan., p. 4.

"In the News: Medicare Physician Fee Schedule Fix Becomes Law," April, p. 6.

"In the News: Senate Passes Bill to Freeze 2003 Physician Fee Schedule at 2002 Levels," March, p. 5.

"Proper Coding in Absence of Definitive Diagnosis," April, p. 9.

"Selective Reassignment Can Solve Some Reimbursement Problems," Nov., p. 1.

► **CMS (CENTERS FOR MEDICARE & MEDICAID SERVICES)**

"Find ABN Info in CMS's ABN Quick Reference Guide," June, p. 10.

"In the News: CMS Revamps Physician Web Page," June, p. 4.

► **COMPLIANCE PLANS**

"Adopt Guidelines for Dealing with Drug and Medical Device Manufacturers," Oct., p. 4.

"Beware of Compliance Problems Associated with 'Scan Brokers,'" Oct., p. 1.

"Discounts for Cash Can Lead to Compliance Problems," Oct., p. 8.

"Protect Your Practice by Setting Nonretaliation Policy," Feb., p. 8.

"Use Attorney-Client Privilege to Protect Sensitive Information," Feb., p. 4.

"Use EOBs to Maximize Reimbursement and Compliance," Feb., p. 1.

"Use OIG's 2003 Work Plan to Help Focus Your Radiology Practice's Compliance Efforts," Jan., p. 1.

► **HIPAA**

"Ask the *Insider*: Modifying Business Associate Contracts to Comply with Final Security Regs," Oct., p. 9.

"Ask the *Insider*: Small Providers Don't Get HIPAA Exemption or Delay," Feb., p. 10.

"Be Prepared to Notify Patients of Privacy Practices Even if You're an Indirect Provider," April, p. 1.

"HIPAA: HIPAA Privacy Regs Set Major Administrative Requirements," May, p. 6.

"HIPAA: Take Four Steps Now to Prepare for Claims Payment Problems After Oct. 16," Sept., p. 3.

"HIPAA Compliance: Create Script to Answer Common Patient Questions About NPP," Nov., p. 4.

"Inventory Your Business Associate Contracts to See if You Get Extra Time to Comply," March, p. 1.

"Patient Privacy: Get Set to Comply with Final HIPAA Security Regs," June, p. 5.

"Patient Privacy: Permanently Delete Health Information Before Selling or Discarding Computer Equipment," Aug., p. 8.

"Patient Privacy: Understand the Security Standards for the Final HIPAA Security Regs," July, p. 5.

"Recent Reg Changes Clarify When Incidental Uses and Disclosures Are Permitted," Jan., p. 6.

"What to Include in an Accounting of PHI Disclosures," Dec., p. 8.

► **IDTFs**

"Ask the *Insider*: Global Billing at IDTFs," May, p. 5.

"CMS Issues Integrity Manual Revisions that Clarify IDTF Rules," Sept., p. 1.

► **MAMMOGRAPHY**

"How and When to Use E&M Codes with Mammography," July, p. 8.

► **MANAGED CARE**

"Complain About Plans Anonymously to AMA via the Internet," Nov., p. 7.

"Consider Getting Pre-Authorizations Yourself," May, p. 5.

"Dos & Don'ts: Check Plan Contracts Sent Electronically for 'Hidden' Information," June, p. 7.

"Dos & Don'ts: Clarify Confusing Contract Language Before You Ask for Changes," Aug., p. 9.

"Dos & Don'ts: Don't Set Bad Precedent by Writing Off Plan's Bad Debt," Aug., p. 9.

"Managed Care: Catch Underpayments from Payors," March, p. 8.

"Managed Care: Don't Promise to Provide a Specific Standard of Care," April, p. 6.

"Managed Care: Restoring Right to Dispute Small Payment Mistakes," Jan., p. 3.

"Maximize Reimbursement by Billing Member's Auto Insurer Before Billing Plan," Nov., p. 9.

► **OIG**

"Hospital Relations: OIG Signs Off on Hospital/Radiology Practice Joint Venture," Sept., p. 5.

"In the News: OIG Announces New Source for Enforcement Information," Aug., p. 6.

"OIG 2004 Work Plan Reveals Continued Focus on Issues Relevant to Radiology," Dec., p. 5.

"Review Your Joint Ventures to Prepare for Greater OIG Scrutiny," July, p. 1.

► **PHYSICIAN HOSPITAL ISSUES**

"Hospital Relations: Beware of Hospital Demands for Fee Concessions," May, p. 8.

"Hospital Relations: Consider Getting CMS Determination for Provider-Based Facilities," Aug., p. 4.

"Hospital Relations: Get Key Protections if You Delegate Billing Function to Hospital," June, p. 8.

► **PRACTICE MANAGEMENT**

"Ask the *Insider*: Leasing Imaging Center Time to Another Practice," Dec., p. 7.

"Avoid Liability When Accepting Assignment of Provider Agreement," April, p. 7.

"Be Careful When Donating Your Medical Services," Aug., p. 7.

"Beware of Companies Claiming Endorsement by Medicare or HHS," Dec., p. 9.

"Guard Against Sexual Harassment in Your Radiology Practice," May, p. 1.

"Participation in Supergroups May Be Attractive Option for Radiologists," Nov., p. 7.

"Protect Your Radiology Practice with Disaster Recovery Planning," March, p. 6.

"Take Four Steps to Deal with Bounced Checks," Feb., p. 6.

"Use Bonuses to Recruit, Retain Radiologists," Sept., p. 8.

"Use Temporary Agencies to Help Ease Tech Shortage," July, p. 6. ■

SHOW YOUR LAWYER

For more information about the cases and/or laws referred to in this issue, show your lawyer the legal citations listed below.

■ **Rule restricting telemarketing and telephone solicitations, Fed. Reg., Vol. 68, No. 143, p. 44213.**