Protect Your Practice with ‘Stale’ Order Policy

If you’re an independent practice or facility, or an independent diagnostic testing facility (IDTF), you may occasionally get a patient who appears for a test with a physician order that was written some time ago. Whether or not to honor an old order is a question many practices and facilities struggle with. Even deciding when an order should be considered too old—that is, “stale”—can be difficult.

Although there are no hard and fast rules about how long a physician order is valid, it’s a good idea to have a policy within your practice or facility that governs how long you’ll honor physician orders, says New York health care attorney Jay Silverman. We’ll explain why you should consider adopting such a policy and give you some pointers on putting a policy together. We’ll also give you a Model Policy, on p. 3, that you can adapt for use in your practice or facility. Plus, we’ll give you a Model Letter (see p. 4) that you can adapt and send to referring physicians when you have to cancel a patient’s test because of a stale order.

Stale Orders Pose Several Risks

Sometimes practices go ahead and perform tests on stale orders because they don’t want the hassle of having to reschedule the patient. Or they don’t want to inconvenience referral sources by contacting them for a new order. But this may be putting your practice at risk. According to Silverman, the risks of performing a test on a stale order outweigh the benefits. The risks take several forms:

- **Damage to your relationships with referral sources.** If you honor stale orders, you may endanger your relationship with referral sources, Silverman says. Say a treating physician orders a screening mammogram for a patient, and the patient waits a couple of months before making her appointment. When the treating physician gets the radiologist’s report, he may think that your facility has a long waiting period for an appointment for screening mammograms—which may not be the case at all. If the treating physician believes that your facility can’t promptly see his patients for screening exams, he may decide to send his patients elsewhere. So through no fault of your own, your reputation may be damaged and you may lose business.

- **Difficulty getting paid.** You may have trouble getting reimbursed for your services if you honor stale orders, Silverman notes. Depending on the type of test, the reason the treating physician ordered it, and the amount of time that has elapsed, the test that was ordered may no longer be medically necessary or appropriate, he points out. And if a payor decides that the test wasn’t medically necessary at the time you performed it, it may not pay you for the test.

- **Increased exposure to malpractice lawsuits.** Honoring stale orders may increase your chances of getting involved in a malpractice suit, Silverman says. That’s because a patient who delays a needed test is also delaying treatment,
**STALE ORDER POLICY** (continued from p. 1)

potentially dire consequences. And when a patient has a bad outcome and decides to sue, her attorney is likely to name everyone who had a hand in her diagnosis and treatment in the lawsuit—even though the patient herself contributed to the bad result. These potential consequences for radiology practices are especially severe when the elapsed time would have made a difference in the test the treating physician ordered, Silverman says. Refusing to honor stale orders at least ensures that the correct test will be done and establishes that the patient was derelict in scheduling the original test, he explains.

**Benefits of Refusing Stale Orders**

Although you may think that refusing stale orders will be a hassle for your practice and your referral sources, that doesn’t have to be the case. Checking the date of the orders and trying to confirm a stale order will inconvenience your staff and the patients to a certain extent, Silverman says. But the risks of performing tests on stale orders and the possibility that you won’t get paid for the test should outweigh those considerations.

In fact, refusing to honor stale orders can benefit your reputation among referral sources. One reason has to do with patient care: A referring physician may want to order a different test if much time has passed since he last saw the patient, and he’ll appreciate a “heads up” from your practice or facility. Another reason has to do with risk management: A referring physician would probably appreciate knowing that he has a noncompliant patient who waits an inordinate length of time before fulfilling his orders, Silverman remarks.

**Define ‘Stale’ Orders**

Before you can draft a policy for your practice, you need to decide when an order becomes stale. Because there are no expiration dates on physician orders, it can be tough to figure out when to consider an order stale. And the “lifespan” of an order may differ based on several factors, such as:

- Whether the test is a screening test or a diagnostic test (in general, an order for a screening test may be considered valid longer);
- The test is a routine test or a specialty test;
- Whether the test is a new test or a repeat test;
- Whether the test is ordered by a specialist or a generalist;
- Whether the test is ordered by a primary care physician or a specialist;
- Whether the test is ordered by a private practice or a hospital;
- Whether the test is ordered by a single physician or a group of physicians;
- Whether the test is ordered by a referring physician or a local physician.

**Develop Policy for Handling Stale Orders**

Here are some tips on how to create a policy on handling stale orders. Like our Model Policy, your policy should:

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**Subscriptions:** Radiology Administrator’s Compliance & Reimbursement Insider (ISSN 1527-2338) is published monthly. Subscriptions for 12 monthly issues are $357. 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

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Set time limit. Establish a time limit for physician orders. Our Model Policy sets different limits for screening tests and diagnostic tests [Pol., par. 1].

Designate contact person. Require a designated person to contact the referring physician to confirm an order that is older than the time limit your practice sets [Pol., par. 2]. The designated contact person can be a member of the reception staff, a scheduler, a tech, or anyone else—just be sure that the person you designate has a polite manner with patients and referral sources, since the delay is likely to upset the patient, and the call is an inconvenience to the referring physician.

Record results of conversation. Require the designated contact person to document the result of the call in the patient’s record, as follows:
- If the referring physician confirms the order, note the confirmation and the date in the record, then the test can proceed [Pol., par 3a];
- If the referring physician cancels the test, note the cancellation in the record [Pol., par. 3b]; or
- If the referring physician changes the order, note that fact in the record [Pol., par. 3c]. It’s prudent to ask for a new written order from the referring physician at this point, says Silverman, although Medicare rules permit an oral order under these circumstances.

(continued on p. 4)

POLICY FOR HANDLING STALE ORDERS

1. Only valid orders honored. XYZ Radiology performs tests only on the valid order of a referring physician. An order for a test will be considered too old and therefore invalid if:
   a. A diagnostic test was written more than [insert time period, e.g., 10 days] prior to the patient’s presentation in our office.
   b. A screening test was written more than [insert time, e.g., 30 days] prior to the patient’s presentation in our office.

2. Confirm stale orders. If a patient presents in our office with an order that is too old and therefore invalid, [insert name and/or title of designated person] will immediately contact the referring physician by telephone to confirm the order.

3. Document stale order. [Insert name and/or title of designated person] will note the invalid order in the patient’s chart and the attempt to contact the referring physician.
   a. If the referring physician orally confirms the order, the fact will be noted in the patient record and the test may proceed.
   b. If the referring physician cancels the order, the fact will be noted in the patient record and [insert name/title of designated person] will explain to the patient that the referring physician cancelled the test.
   c. If the referring physician changes the order, the fact will be noted in the patient’s record. [Optional: Designated person will request the referring physician to provide a written order for the alternative test.] The patient may receive the test or be rescheduled, as appropriate.

4. Cancel test if unable to confirm order. If [insert name/title of designated person] cannot reach the referring physician, the test must be cancelled and the patient informed that the cancellation was due to excessive age of the order. [Insert name/title of designated person] must instruct the patient to get another order before rescheduling the test and counsel the patient on the importance of scheduling the appointment promptly. Designated person should prepare a letter for the radiologist’s signature to the referring physician, explaining the cancellation.

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Develop Policy for ‘Stale’ Orders

Here’s a policy on handling “stale” orders, which we developed with the help of New York health care attorney Jay Silverman. It establishes rules for your staff to follow when a patient presents an order from a referring physician that was written some time ago. Because there are no set rules about timeliness of physician orders, you’ll need to do some research to figure out how to set your practice’s “cut off” point. Your malpractice insurer and major payors may be able to offer you some guidance about how long to honor physician orders, so you should check with them before developing your own policy. Get this Model Policy online: enter KEY # RACRI0001
STALE ORDER POLICY (continued from p. 3)

Set procedures if physician can’t be reached. If the referring physician can’t be reached, the following should be done:

■ The patient should be instructed that the test cannot go forward without an up-to-date order from the referring physician and be counseled about the importance of scheduling ordered tests promptly [Pol., par. 4];

■ The patient’s test should be cancelled and the patient asked to get another order before rescheduling; and

■ A letter signed by the radiologist should be sent to the referring physician, explaining your practice’s policy on expiration of orders and asking that a new order be issued, Silverman suggests. Like our Model Letter, your letter should explain your stale order policy, alert the referring physician’s practice that it has a patient who delayed seeking the ordered test, and encourage the referring physician to follow up with the patient.

Insider Source
Jay Silverman, Esq.: Ruskin Moscou & Faltischek PC, E. Tower, 15th Fl., 190 EAB Plaza, Uniondale, NY 11556; (516) 663-6606; jsilverman@rmefpc.com.

Send Letter to Referring Physicians When Test Must Be Cancelled Due to Stale Orders

If a patient presents with a stale order and you can’t reach the referring physician to confirm it, you should send a letter to the referring physician, explaining the problem. The letter serves two purposes: It explains to referral sources why you couldn’t perform the test, and it informs them that their patient is derelict in getting ordered services. That way, the referring physician will know that this patient requires more focused follow-up. Get this Model Letter online: enter KEY # RACRIO002

[Insert date]
Douglas Doe, MD
Main St. Internal Medicine Assocs.
567 Main St., Ste. 8
Anytown, USA
Dear Dr. Doe,
Thank you for the referral of your patient, Sam Smith, for a [insert test, e.g., chest X-ray] to [insert diagnosis, e.g., confirm diagnosis of pneumonia]. Unfortunately, Mr. Smith delayed making an appointment for the test and appeared in our offices today, Feb. 18, 2004, with an order from you dated Nov. 28, 2003.

To protect your practice, our practice, and our mutual patients, it is XYZ Radiology’s policy to confirm any order for a [diagnostic/screening] test that was written more than [insert #] days prior to the patient’s presentation in our office.

When we attempted to contact your office today to confirm the order, we were unable to do so. Accordingly, we cancelled Mr. Smith’s test and requested that he secure a more recent order for the test. We also counseled him on the importance of securing the order and rescheduling the test promptly.

We apologize for any inconvenience this policy causes you or your patients, but be assured that this policy is designed to assist us in providing your patients with the best possible care.

Yours truly,
Rhoda Radiologist, MD
XYZ Radiology

Important Changes in CPT 2004

The new CPT and HCPCS codes for 2004 are in effect, and you can start using them now—although you’re not required to use them until April 1. This year sees many new and revised codes, particularly for interventional radiology, says Atlanta radiology coding and compliance expert Jackie Miller.

Unfortunately, this year there is a lot of confusion surrounding how to use some of the new codes, as well as how to reimburse for them. “It seems like every week we’re getting new and different information about how we’re supposed to use some of these new codes,” says Miller. For example, there are new codes for procedures related to vascular access devices, but the rules for using and getting reimbursed for them are still evolving.

So we’ll take up discussion of the vascular access codes—as well as new codes for ultrasonic and fluoroscopic guidance—in future issues of the Insider as the rules become more settled. In this article, we’ll introduce some of the less controversial new codes and definitions.
CAD with Mammography
The CPT* code for computer-aided detection (CAD) with mammography (76085) has been deleted and replaced with two new codes—one for CAD in conjunction with screening mammograms, and one for CAD in conjunction with diagnostic mammograms. The old code did not indicate whether the CAD was being used for screening or for diagnostic purposes, so Medicare restricted its use to screening mammography and required providers to report HCPCS code G0236 when CAD was performed for diagnostic mammography. Code G0236 has now been deleted, too.
- +76082—Computer-aided detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography.
- +76083—Computer-aided detection with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography.

Biodistribution Studies
There are several significant changes in coding for diagnosis and treatment of non-Hodgkin’s lymphoma with radiolabeled monoclonal antibodies. First, the tumor localization codes (CPT codes 78800–78804) have been expanded to include exam for biodistribution of radiopharmaceutical agents such as Zevalin. A new code has also been added for whole body exams that require two or more days. The CPT code that was previously used for whole body exams, 78802, will now be used only for single-day exams, Miller explains. The new code 78804 replaces HCPCS code G0273, which was previously used for the biodistribution exam.
- 78804—Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s), whole body, requiring two or more days’ imaging.

There are also new rules for billing for diagnostic use of radiopharmaceutical agents and how to bill them, and what codes to use depends on whether you’re a hospital or an imaging center.

Hospitals. Hospitals should bill for the supply of diagnostic Zevalin with HCPCS code C1082, and if Bexxar is used, rather than Zevalin, the hospital would report code C1080:
- C1082—Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose.
- C1080—Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose.

Imaging centers. Imaging centers should report the supply of diagnostic Zevalin with HCPCS code A9522 and the supply of diagnostic Bexxar with code A9533:
- A9522—Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per mci.
- A9533—Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per mci.

Monoclonal Antibody Therapy
If the biodistribution exam is satisfactory and the patient receives treatment with Zevalin or Bexxar, new CPT code 79403 should be reported:
- 79403—Radiopharmaceutical therapy, radiolabeled monoclonal antibodies by intravenous infusion.

Miller notes that there is a huge difference in reimbursement between the diagnostic agent and the therapeutic agent. For this reason, it’s crucial that the facility’s charge codes be set up appropriately and that staff understand which charge to select. For example, the Medicare APC payment to a hospital for code C1082 (diagnostic Zevalin) is approximately $2,260, while payment for code C1083 (therapeutic Zevalin) is approximately $19,565. (Note: Payment amounts are national averages and do not include patient copay.)

Hospitals. Hospitals should use the following codes to bill for therapeutic doses of radiopharmaceuticals.
- vC1083—Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose.

If Bexxar is used, rather than Zevalin, the hospital should report code C1081:
- C1081—Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose.

Imaging centers. Imaging centers use different codes for the therapeutic supply of radiopharmaceuticals than hospitals use. Imaging centers should bill for the supply of therapeutic Zevalin with code A9523:
- A9523—Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per mci.

Imaging centers should report the supply of therapeutic Bexxar with code A9534:
- A9534—Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per mci.

Myelography
The definition of a complete myelogram has been changed so that it is consistent with the way Medicare pays for these services. In other words,
HIPAA Issues Related to Film Jacket Summaries

We’re a hospital-based radiology practice. Frequently, hospital inpatients need multiple tests and interpretations over the course of a hospital stay. And often, the patient must get the next test before the previous test’s dictation is transcribed.

To keep on top of things and better serve the patients, the radiologists typically will write a brief summary of their findings directly on the film jacket, using abbreviations. That way, if the patient has another test before the prior test’s interpretation is transcribed, at least a summary of the prior test’s findings is available.

The hospital’s HIPAA compliance officer says that we’re violating HIPAA by putting this information on the outside of a film jacket, where anyone in the reading room or at the nursing station can see it. The radiologists say that this is the only way to make sure the patient’s progress is followed properly and that there’s no HIPAA violation anyway. Do these summaries on film jackets violate HIPAA?

No, the scenario you describe probably isn’t a HIPAA violation, for a number of reasons, says Washington, D.C., health care attorney Anna Spencer.

HIPAA allows the disclosure of PHI for the purposes of providing treatment. As long as the only people who will see the PHI are radiologists, technologists, nurses, and others involved in treating the patient, the PHI disclosure is permitted under the HIPAA privacy regulations, Spencer says.

A different issue arises—the question of incidental disclosure—if someone who isn’t involved in the care and treatment of the patient (say, another patient or a custodian) happens to see the film jacket. But it still probably isn’t a HIPAA violation as long as certain conditions are met, Spencer says. Incidental disclosures don’t violate HIPAA as long as:

- They’re “incident to” a permitted disclosure;
- Reasonable steps have been taken to prevent unauthorized disclosures; and
- “Minimum necessary standards” are in place—that is, the minimum amount of PHI necessary is being disclosed.

In this case, the summaries are contained on a film jacket that’s available only in the radiology reading room, where it’s likely to be seen only by people involved in the patient’s treatment. So any disclosure here is incident to a permitted disclosure. And as long as access to the reading room is restricted and the film jackets don’t leave the reading room or other restricted areas of the hospital—like the medical records room—in Spencer’s opinion, the incidental disclosure tests are met.

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A HIPAA violation might occur if the film jacket with the patient’s name and interpretation summary were to fall into the hands of someone not involved in the patient’s care—say, if it were given to a relative of the patient, or carelessly discarded so that “Dumpster divers” could find it. So the hospital should have procedures and safeguards to prevent this sort of disclosure, Spencer asserts.

**Independent Contractors Supervising Diagnostic Tests**

**Q** Our imaging center recently hired a part-time physician on an independent contractor basis. We would like him to take over supervising diagnostic tests when he’s in the office, but one of our radiologists insists that only physician employees of the group practice—as opposed to independent contractors—can supervise tests. Can we use our independent contractor physician to supervise diagnostic tests performed in our imaging center?

**A** At one time your radiologist was correct in that belief, because the proposed Stark regulations said that independent contractors couldn’t supervise diagnostic tests, says Philadelphia health care attorney Alice G. Gosfield. But the final Stark regulations published in January 2001 didn’t contain that restriction, and the 2002 physician fee schedule stated that 1099 employees—known as independent contractors—may supervise diagnostic tests if they are otherwise qualified to do so.

Who’s qualified? In general, an independent contractor must be:
- A physician;
- Available by telephone for tests requiring general supervision;
- Present in the office suite for tests requiring direct supervision; and
- Present in the room during tests requiring personal supervision.

If your independent imaging center is an independent diagnostic testing facility (IDTF), the independent contractor must also have demonstrated expertise in each of the tests he supervises and be capable of performing and interpreting the test, Gosfield adds. That means, in essence, that in an imaging center that’s an IDTF, the supervising physician, whether employee or independent contractor, must be a radiologist, nuclear medicine specialist, or have some specific additional training in radiology procedures, she explains.

**Don’t Assume Plan’s Claim About NCQA Requirements Is True**

Sometimes a plan will tell you that the National Committee for Quality Assurance (NCQA)—the leading organization accrediting plans—requires a particular clause in the plan’s contract. For instance, the plan’s representative may tell you that NCQA requires the plan’s contract to say that the plan must be deemed the owner of all members’ medical records. Or the plan won’t include ancillary providers in the contract because it claims that NCQA says it can’t.

Should you accept these arguments from the plan? Not necessarily, according to NCQA spokesperson Brian Schilling. Sometimes a plan misinterprets NCQA’s standards or invokes NCQA’s name to bully a provider into agreeing to a “requirement” that NCQA doesn’t actually have. If you don’t challenge the plan’s arguments, you may end up with onerous provisions in your contract that you didn’t have to agree to.

**Plan Caught in Lie About NCQA’s ‘Requirement’**

For example, a large, powerful plan told its contracted physicians that the plan needed their personal medical records because, “NCQA required it.” Several physicians didn’t want to give their personal medical records to the plan and asked their local medical association to help them. The association contacted NCQA to ask whether this was truly a requirement, according to Schilling, who’s familiar with the situation. NCQA told the association, the physicians, and the plan that it had no such requirement. When the plan realized that it had been caught lying to the physicians, it backed down and dropped the requirement.

**Check Requirements with NCQA**

Whenever a plan tells you that NCQA requires you to agree to something
TRAPS TO AVOID (continued from p. 7) that seems overly burdensome, unusu-
al, or otherwise suspicious, contact NCQA, either directly or through your professional association. Find out if it’s really an NCQA require-
ment, and if so, whether the plan is applying it correctly. “NCQA doesn’t want providers to think that it’s intrusive or to blame for every unfair con-
tract clause,” Schilling says.

To raise your concern directly, call NCQA’s customer service center at 1-888-275-7585. If it turns out that the plan is misinterpreting an NCQA require-
ment or claiming that NCQA has a requirement that it doesn’t actu-
ally have, NCQA will call the plan on the provider’s behalf or even issue a formal corrective action against the plan, says Schilling.

Going to NCQA (or any other or-
ganization whose name the plan is invoking to force you to accept a suspicious requirement) can give you a double benefit. Not only will a plan generally drop a supposed
requirement once it’s clear that it’s not a requirement, but you get more negotiating leverage on the rest of the contract because you’ve caught the plan trying to pull a fast one on you. It hurts the plan’s credibility and shows that you’re not afraid to chal-
lenge the plan when something seems wrong or unfair, so you can usually get more concessions.

Insider Source
Brian Schilling: Spokesperson, National Committee for Quality Assurance, 2000 L St. NW, Ste. 500, Washington, DC 20036; schilling@ncqa.org.

Keep Your Reimbursement Up-to-Date with Coding Changes

Does your reimbursement from plans take into account coding changes rela-
ting to new technologies and clinical procedures you use? Plans typically don’t automatically update the reimbursement amounts in their contracts with providers whenever coding is changed to reflect clinical developments. Unless you habitually alert the plan to these coding changes, you’re probably getting shortchanged on reimbursement.

You can get your reimbursement updated to reflect the most recent codes, experts say, by keeping on top of the coding changes that affect you and working with the plan to keep your reimbursement current with those changes. We’ll tell you how. And we’ll give you a Model Letter that shows you how to notify a plan about a coding change that affects your reimbursement (see p. 9).

What’s the Problem?
The CPT and diagnostic related group (DRG) codes, which describe medical procedures and diagnoses, are updated every year, according to Illinois consultant Pam Waymack. “But plans and a provider’s managed care negoti-
ators often aren’t aware of clinical changes that may have caused codes to be added, deleted, or modified. So the reimbursement becomes outdat-
ed,” she explains.

The problem is compounded by the shift of more and more contracts from percentage discounts off billed charges to fixed price reimbursement methods, such as fee schedules and per diem reimbursement. With no set reimbursement for them, new or modified codes can fall through the cracks. “A percentage discount ar-
rangement allowed providers to keep the reimbursement and codes up-to-
date themselves because all they did was apply the discount to the new technology or procedure. But you can’t unilaterally do that with other reimbursement methods,” notes Wis-
consin attorney John Hintz. Also, most plan contracts are “evergreen” and automatically renew, so many plans and providers don’t periodically review the contract and make sure that they reflect current coding. “This is especially a problem where the con-
tract carves out reimbursement for certain services or procedures at a higher rate,” notes Waymack.

How to Protect Yourself
You can take the following three steps to help keep your fees up-to-date with coding changes:

Step #1: Keep current with cod-
ing changes. Stay abreast of how clinical changes have affected your practice or facility and whether any codes have been added, deleted, or modified to reflect these changes. “The contracting people need to understand technologi-
cal changes in the practice or facility,” says Waymack. Don’t expect the plan to do this for you. Periodically ask your clinical and reimbursement depart-
ments if there are any coding changes related to clinical advances that you may need to raise with the plan.

You can also stay on top of coding changes by checking with the organi-
izations that issue the codes. CMS and the American Medical Association (which establishes the CPT codes that physicians use to identify the proce-
dures they provide to patients) typi-
early announce coding changes for the next year by the preceding October, says Waymack. You can visit their Web sites at www.cms.gov and www.ama-assn.org, respectively. Plus specialty societies like the American College of Radiology (ACR) usually announce significant changes to their membership. CMS announces which procedures are under review for coverage and payment changes one or two years ahead of time, so savvy providers can track possible changes early on.

**Step #2: Review contract.** Check if your contract gives you any protections that support an update of your reimbursement to reflect coding changes made to match clinical advancements. For instance, some contracts say that the provider will be reimbursed based on Medicare’s “then current” fee schedule. In that case, if Medicare adds a new code for a new procedure to its fee schedule, it would automatically be incorporated into your fee schedule with the plan, says Hintz. Or during contract negotiations, you may have added catchall language that requires the plan to pay you for covered services that aren’t listed on the fee schedule.

You may have some ammunition even if the contract doesn’t address coding changes. For instance, your contract’s miscellaneous section may say that “the parties will work cooperatively in furtherance of this Contract” or other similar language. You can use that language to approach the plan and work out how to handle a clinical change and your reimbursement for it.

The plan’s past behavior may even help. For instance, the plan may have previously updated the fee schedule to take into account new procedures, drugs, or technologies. Or it may have selectively updated reimbursement for codes when doing so lets it pay you at lower rates. You may be able to use that prior conduct as leverage to get the plan to make the changes you want, suggests Hintz.

**Step #3: Send letter to plan.** Send a letter to the plan to notify it about any coding changes that would increase your reimbursement and to ask it to update your contract accordingly. Most plans are willing to make these changes if you ask for them, an insider told us. “If Medicare has made a coding change, plans tend to follow its lead. And the change gives the provider the opening to go back to the plan and say why payment needs to change,” the insider explains.

Send the letter to the person with whom you would negotiate contract changes. Since you’re also pointing out a clinical change that you want the plan to be aware of, send a copy of your letter to the plan’s medical director, recommends Waymack.

**What Letter Should Say**

Like our Model Letter, your letter should:

(continued on p. 10)
Inform plan about the change.
Tell the plan about the clinical advance or procedure change and how it has affected coding. “It’s possible that the plan doesn’t even know about the change,” says Waymack. Be specific. Our letter addresses DRGs in the specialty of cardiology. You should adapt your letter to code changes that affect your facility or practice [Ltr., par. 1].

Refer to contract. If your contract helps you in any way, include that information. Our letter reminds the plan that the contract says it will be amended from time to time to be consistent with laws, regulations, and government policies. “In that case, if the plan doesn’t update the coding and reimbursement to be consistent with Medicare, it may be violating the contract,” says Hintz [Ltr., par. 2].

Ask plan for action. Ask the plan to change the coding and corresponding reimbursement for it. What you ask for may vary. For instance, if your contract says you’ll get paid at the Medicare rate for codes, ask for the plan to add the code and pay it at that rate. If your contract has a negotiated fee schedule or per diem rate, you may want to suggest a particular reimbursement rate. “The plan may want to negotiate the rate, but at least it will be included,” says Waymack [Ltr., par. 3].

Our Model Letter discusses a coding change that has just been announced. But if you’re pointing out a change that was made months ago, the plan should have updated your reimbursement rate at that time. So also ask the plan for the balance owed on past claims.

Offer to meet/be available. Give your telephone number so it’s easy for the plan to contact you. And offer to meet or otherwise be available so the matter can be resolved. “This generally isn’t a controversial area for plans,” says Waymack. “They want their providers to be using new technologies and advancements and understand that they should pay appropriately,” she notes. Although you don’t have to say so in the letter, be prepared to follow up, she adds [Ltr., par. 4].

If Plan Refuses
Most plans will agree to make these types of coding and reimbursement changes. But if the plan refuses or doesn’t respond, talk to your attorney about what to do next. If the plan is clearly violating your contract or a lot of money is at stake, you may want to press hard for the changes. Look at this issue in the context of other issues you have with the plan before deciding on a strategy, says Hintz.

Insider Sources
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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.


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(continued from p. 9)

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