Consider Offering Your Radiologists’ Services as Medical Experts

Radiology practices often get calls from attorneys looking for a radiologist to offer an opinion on a case the attorney is handling. Many practices refuse these requests out of hand. But there are several good reasons to encourage any of your radiologists who might make good expert witnesses to try it. It can bring recognition and prestige to your practice. Plus, serving as an expert for one side in a trial or administrative action is well paying, doesn’t have to take up a lot of time, and involves virtually no extra overhead or start-up costs.

But serving as an expert can have drawbacks, so your practice should carefully consider the pros and cons. You should make sure that your practice has a policy regarding service as a medical expert and that all the radiologists in your practice support it.

We’ll tell you when experts are needed and define the characteristics attorneys look for in an expert witness. We’ll explain what’s typically involved in an assignment to provide an expert medical opinion. We’ll also point out some potential pitfalls that can bedevil an expert witness. And we’ll give you a Model Clause that sets forth the practice’s policy about its radiologists serving as experts (see p. 3). You can adapt it to use in your employee manual, partnership agreement, employment contracts, or other legal documents.

Who Needs Medical Experts?
The radiologists in your practice may shy away from being experts because they feel that by doing so they’re supporting a litigious environment that’s bad for physicians and patients. But physicians who are uncomfortable acting as experts for one side or the other in malpractice suits have many other opportunities to be paid for their review and analysis of a given physician’s treatment, says New Jersey health care attorney John D. Fanburg. Or they can elect not to judge other physicians at all and merely provide information regarding the condition of a particular patient. Besides giving evidence for the plaintiff or the defense in a medical malpractice case, medical experts may be needed to:

- Assist a hospital in reviewing a physician’s medical staff privileges;
- Provide an objective analysis of a complaint about a physician to a state medical board;
- Advise a malpractice insurer about the viability of a patient’s malpractice case from a medical perspective;
- Help a malpractice insurer decide whether to insure or continue the coverage of a physician who has been sued;
- Inform an employer whether an employee is or was disabled and/or entitled to workers’ compensation; and
- Provide evidence about a patient’s condition in no-fault auto cases and other accident cases.

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What Makes a Good Medical Expert?

How do you know if one of the radiologists in your practice would make a good expert witness? When Fanburg seeks to engage a medical expert, he generally looks for the following:

Excellent credentials. The expert should have verifiable degrees from an accredited college and medical school, board certification in at least one specialty, and a license to practice medicine in at least one state.

Clean history. The expert’s background should be free of events that are damaging to his credibility. For example, all else being equal, a radiologist is a less effective witness if:

- Any state in which he has ever been licensed has investigated him for alleged unprofessional conduct—regardless of the eventual outcome of the investigation;
- Any hospital or facility at which he has worked has ever limited, restricted, suspended, or revoked his privileges or denied his application for medical staff privileges; or
- He has ever been found liable in a medical malpractice lawsuit.

Good communicator. Whether serving as a witness in court or merely providing advice to an insurer or other third party, a good medical expert must have the ability to get ideas and information across in a manner that’s believable and understandable to a lay person, Fanburg says. The radiologist should be able to write and speak clearly and concisely. And if the radiologist will be appearing in court or before an administrative body, like a Workers’ Compensation Review Board, the radiologist should have an acceptable appearance and demeanor. A witness who appears unkempt or sloppy makes a poor impression, Fanburg notes. And an arrogant or abrasive witness isn’t likely to be as persuasive as one who’s engaging—or at least inoffensive, he adds.

Experience. A credible medical expert is one with recent experience treating patients. Some physicians essentially retire and become professional witnesses, Fanburg points out. He prefers to use physicians currently in practice as witnesses. That’s because their viewpoint is more likely to reflect the current reality of practicing medicine. But he also likes to use witnesses who have spent significant time in practice—experience is the best teacher, and the opinion of an experienced witness is likely to carry more weight with a jury or other administrative body.

What Does a Medical Expert Do in a Legal Proceeding?

When an attorney hires a medical expert, there are several tasks that the attorney typically assigns. The tasks may be divided into two categories: preproceeding consulting and appearing as a witness at a deposition, hearing, and/or trial.

Preproceeding consulting. The attorney who hires the medical expert for preproceeding consulting will ask the expert witness to review the medical records at issue in the proceeding and give an opinion about the crux of the case. For example, in a medical malpractice case, the expert witness will be asked to determine whether the defendant’s care and treatment met the
standard of care. If the expert witness decides he can work on behalf of the attorney’s client, the expert may contribute in other ways besides merely rendering a medical opinion. For example, the attorney may want the expert to teach her what sorts of questions to ask the other side to elicit the medical information she needs to best present her client’s case. Or the attorney may want the expert to point out every potential problem with her client’s case so that she can be prepared to counter the other side’s assertions. And the attorney may ask the expert to research the clinical literature to provide support for the case she’ll present on behalf of her client.

Preproceeding consulting is usually paid on an hourly basis, although there are exceptions, Fanburg notes. For example, if an attorney often hires a particular physician to serve as an expert, the physician may be willing to do an initial review of records at no charge—just to see whether he can offer an opinion in support of the attorney’s client. That way, the client isn’t out-of-pocket if the expert can’t help him. But in the absence of such a relationship, physicians can and should be compensated on an hourly basis for the work they do to help an attorney prepare a case, Fanburg says.

The attorney may ask for a written report of the expert witness’s findings if they support the position of the attorney’s client. But in litigation, a written report issued by one side’s expert is “discoverable” by the other side—that is, the other side may get a copy of the report and may use it to support its side of the case. So the attorney may prefer that the expert report his findings orally, instead, to protect the expert’s findings from discovery.

Insider Says: In some jurisdictions, even oral findings are discoverable by the other side in a lawsuit, says Fanburg. In those jurisdictions, the expert may be asked to review the records, then orally inform the hiring attorney whether he’s willing to serve as an expert in support of the attorney’s client. In that way, an expert who makes findings unfavorable to the side that hired him can express that opinion obliquely without uttering a medical opinion that may be discoverable, Fanburg explains.

Appearances. Expert witnesses who present themselves well and are willing to make the time commitment may be asked to appear as a witness at a deposition, hearing, or trial. Testifying as an expert witness isn’t for everyone, Fanburg stresses. Some radiologists with sparkling credentials and sterling reputations make poor experts or falter as witnesses. But an expert who’s confident, comfortable presenting information to people, and who can explain complex information in understandable terms may find appearing as an expert lucrative and even enjoyable.

In addition to the time spent actually testifying, significant time is spent preparing for the testimony, Fanburg says. This is to ensure that the expert knows exactly what to expect, has thought about the answers to the questions he’s most likely to be asked, and can be coached on responding appropriately to pointed or hostile questioning. Experts who make court

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appearances usually charge by the half-day for the appearance, but the fee they charge includes any preparation time. So if an expert spends 12 hours preparing for a three-hour deposition, the expert should be sure to factor prep time into his calculations when setting the fee, Fanburg remarks.

What Are the Risks of Being a Medical Expert?
There are some risks involved in being a medical expert in legal disputes, and these risks can affect not only the physician who’s serving as the expert but other members of his practice, as well. So you should consider these risks before permitting a physician in your practice to accept an engagement as an expert. How serious the various risks are depends on the circumstances of the physician who’s hiring himself out as an expert, Fanburg says. In general, the risks can be characterized as harm to referral relationships, risk of sanction by a professional organization, and possible licensure actions.

Harm to referral relationships. Your practice should be concerned about whether the engagement of one of your physicians as a medical expert in medical malpractice trials may offend your referral sources. If so, that physician could choose to accept work for the defense in malpractice trials and decline any plaintiff’s work he’s offered. Or the physician may confine his expert activities to cases that don’t involve any adverse consequences to another physician—such as appearing on behalf of an employer or employee in a workers’ compensation case.

Violating professional organization guidelines. The American College of Radiology has guidelines for expert witnesses. And it can sanction any member who violates those guidelines. The guidelines require any radiologist who offers his services as an expert to:

■ Have significant experience in the area in which he’s giving an opinion;
■ Have expertise in the area; and
■ Be honest and fair in his analysis.

Other professional organizations may have stricter requirements for experts. For instance, the Society of Breast Imaging has issued guidelines that require any expert in a mammography case to, among other things:

■ Meet FDA certification and criteria for interpreting mammograms for at least five years;
■ Have read at least 2,000 mammograms in each of the two years prior to his work as a witness; and
■ Have been involved in breast imaging at the time of the alleged malpractice.

Being sanctioned by a professional organization has no direct consequences on a physician’s license to practice medicine, but it can be damaging to the physician’s reputation, Fanburg says. So physicians should check with the professional societies of which they’re members to find out about any guidelines for expert witnesses and consider those guidelines when deciding whether to be a witness.

Possible licensure actions. There’s a concern among medical licensing boards and state legislatures about unqualified persons offering their services as expert medical witnesses and fueling the “malpractice crisis,” says Fanburg. So some states are considering laws that would make an expert witness liable if he espouses an opinion in a legal matter that deviates from the accepted standards of the medical community. Although Fanburg isn’t aware of a state that has passed such a law, he believes that several are considering such measures. Even if no law is passed, it’s crucial that any physician purporting to be an expert have a firm basis in the accepted medical standards of the community for any opinion that he gives in a legal matter.

Clearly Define Expectations Regarding Expert Service

Usually, members of a practice are happy to have one of their own serve as an expert because of the prestige and recognition it brings to the practice as a whole. But trouble can arise if the expert radiologist is perceived as neglecting his duty to the practice or if his activities interfere with or harm the practice, Fanburg says.

These situations can be avoided by having a policy about serving as an expert, and making sure all your radiologists are aware of it. You can have an actual policy that goes in the practice policy and procedures manual, but more often it’s incorporated into a practice’s partnership or employment agreements, Fanburg says. However you choose to formalize it, it should clearly set forth the practice’s expectations regarding service as an expert.

You can adapt our Model Clause to include in your employee policy manual, partnership agreements, or employment agreements. Like our Model Clause, yours should set forth the practice’s policy on the following issues:

Cases accepted. Many practices want some control over the types of cases their member physicians will accept because of the issues described above. If you want that kind of control in your practice, you must make it clear that all proposals for expert work are subject to the approval of the practice [Clause, par. 1].

Time spent. Most practices Fanburg deals with permit their radiologists to pursue work as an expert only during their time off. Limiting expert service to vacation or other personal time makes sense because it eas...
scheduling problems. But some practices do permit work as an expert during regular working time, with the permission of the practice, he notes [Clause, par. 2].

Disposition of fees. Typically, the fees the radiologist earns as an expert are his to keep, says Fanburg, but sometimes they’re shared among the partnership—especially if the service is occurring during the radiologist’s regular working hours. Fees that are shared among the partnership should be distributed to the individual partners, the same way as fees for professional services are distributed, he advises [Clause, par. 3].

Limit Audit Risk by Considering Alternatives to Modifier 59

In its 2004 Work Plan, the OIG mentioned that it’s concerned about physicians misusing the 59 modifier. The OIG suspects that many physician practices are appending this modifier to circumvent Correct Coding Initiative (CCI) edits and to get paid for services that are normally bundled. So the OIG has instructed Medicare carriers to be on the lookout for the 59 modifier, and to flag practices that seem to overuse it for audit.

To help limit your audit risk, investigate whether other modifiers may be appropriate in a given situation, and use those alternative modifiers whenever possible, suggests radiology compliance consultant Jackie Miller. We’ll explain how CCI edits are meant to curb overbilling, and tell you the two types of edits you’re likely to encounter. Plus, we’ll explain what modifiers are meant to do, and why the OIG is particularly concerned about modifier 59. And we’ll point out some situations where you can avoid using the 59 modifier, and append another modifier instead.

CCI Edits Meant to Curb Unnecessary Billing

CCI was implemented in 1996 to “promote national correct coding methodologies and to control improper coding leading to inappropriate payment in part B claims,” according to the Medicare Carrier’s Manual. The CCI accomplishes this primarily by bundling the components of a service together and paying for the service as a whole, rather than as separate parts, Miller explains.

There are two bundling scenarios radiologists frequently encounter:

Comprehensive component edits. The CCI bundles components of a comprehensive procedure into the payment for the comprehensive procedure, even though the components may be performed separately. These are called “comprehensive procedure edits,” or, more familiarly, “column 1/column 2” edits. When both codes in the code pair are billed by the same physician for the same patient on the same day, only the comprehensive (column 1) code will be paid. For some code pairs, the physician is permitted to use a modifier to show that the two procedures are separate and distinct—then both will be paid.

For example, the administration of intravenous contrast material is bundled into the payment for an MRI with contrast. So if a physician performs an MRI (column 1) on a patient and later the same day administers a medication by IV infusion (column 2), the physician will be paid only for the MRI. But in this scenario the bundling wouldn’t be appropriate, says Miller, because the intravenous drug infusion was unrelated to the contrast administration. So the physician can append a modifier to the infusion code to indicate that it’s a separate and distinct procedure and should be paid separately.

For some other code pairs, no separate payment will be made. For example, an esophagogram (CPT* code 74220) is defined as a component of an upper GI series (74240). If both are billed together, only the upper GI will be paid. The esophagogram is never paid separately under these circumstances, even if a modifier is appended, because the esophagogram is always considered a bundled service, Miller reports.

Mutually exclusive edits. Many procedure codes can’t be billed together because the CCI recognizes them as mutually exclusive. For example, if similar procedures can be accomplished using either of two methods, the CCI will “bounce” any claim that indicates both methods were performed. But in fact this does sometimes happen. For example, say a patient has a lumbar puncture under fluoroscopic guidance (76005) and a needle biopsy of a lung mass under CT guidance (76360) by the same physician on the same day. Unless you use a modifier to indicate that these were separate services for different purposes, only 76005 will be paid, Miller says.

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Insider Says: Remember that when both codes of a mutually exclusive code pair are billed without a modifier, only the lower value code will be paid, Miller says. This differs from the column 1/column 2 (comprehensive component) edits, when the higher value code is paid if a modifier isn’t used. So when circumstances warrant using a modifier, always append it to the lower valued code, she says. In the case of comprehensive code edits, the column 2 code is the lower valued of the two codes. But in the case of mutually exclusive edits, the column 1 code is the lower-valued code—and is therefore the code that should get the modifier, she says. If the modifier is erroneously appended to the column 2 code of a mutually exclusive code pair, the physician will be paid only for the lower valued service.

59 Modifier Bypasses Edits
The 59 modifier denotes a “distinct procedural service,” and permits a practice to get paid for a service that would normally be bundled under the CCI edits. Depending on the circumstance, several other modifiers could serve the same purpose. But the 59 modifier is most likely to be used on a “default” basis by an unscrupulous provider seeking to bypass the CCI edits entirely. That’s why the OIG is concerned about its overuse, Miller explains.

When Is It Appropriate to Use 59 Modifier?
In general, it’s appropriate to use the 59 modifier only when a procedure performed on the same day was distinct and separate because:

■ It was performed at a separate patient encounter (typically this would occur only in a hospital); or
■ It was performed on a separate injury, or a separate area of injury in extensive injuries; and
■ No other modifiers adequately describe the circumstances.

Select Modifiers Carefully to Get Paid Appropriately
Frequently another modifier will produce the same end result as the 59 modifier—that is, it will inform the payor why a procedure should be paid separately rather than bundled. Often, says Miller, an anatomic modifier will suffice, so you need not resort to 59. It behooves you to investigate using other modifiers before choosing the “red flag” modifier 59. Here are other options Miller suggests you consider before choosing 59:

LT or RT. Miller says she’s surprised at the frequency with which practices use the 59 modifier, when simply denoting that a unilateral procedure was done on each side would have made the claims payable. For example, when performing selective contrast injection in the right common carotid and the left common carotid, simply report the right common carotid catheter placement with the RT modifier (36216-RT) and the left common carotid catheter placement with the LT modifier (36215-LT). This makes it clear to the carrier what happened and why you should be paid for two catheter placements, without using the red flag modifier.

Global surgical modifiers. There are several modifiers that interventional radiologists may use to prevent inappropriate bundling of unrelated procedures that are performed during the global period of the original procedure, Miller notes. These modifiers can also be useful if a patient under-
New Code Grace Period Eliminated

Q When the new CPT codes go into effect every year in January, providers have had a 90-day grace period in which they could use either the new code or the old code. This grace period has given both providers and carriers a chance to get used to the new codes. But now I’m hearing that there will no longer be a grace period when new codes are introduced next January. Is this correct?

A Yes, it is, says Georgia radiology compliance expert Jackie Miller. The HIPAA Transaction and Code Set (TCS) standards require you to use the codes that are in effect at the time the service is provided. And this requirement doesn’t apply just to CPT codes, but to HCPCS and diagnosis codes, too, Miller points out.

So even though you’ve traditionally had a grace period when you could use either the old codes or the new ones, you’ll no longer have one now that the TCS standards have taken effect, Miller explains. This is important because the new ICD-9 diagnosis codes take effect on Oct. 1, 2004. So you need to get your staff ready now on using the new diagnosis codes, she warns. For services provided on or after Oct. 1, they’ll need to start using them right away, she explains. And you’ll need to start training your staff on the 2005 CPT codes as soon as the book comes out in the fall because they’ll need to use those new CPT codes for all services provided on or after Jan. 1, 2005, Miller says.

You can find the transmittals announcing the change at the CMS Web site, www.cms.hhs.gov/manuals. Click on “2004 transmittals,” then scroll down to R95CP (the notice for the ICD-9 codes) and R89CP (the notice for the HCPCS/CPT codes). They were published on Feb. 6, 2004.

Insider Source

Eight Ways Medicare Reform Affects Your Relationships with Plans and Plan Members

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, passed at the end of 2003, is the biggest revision ever to the Medicare program. We’ve been telling you about some of those changes. Among the many changes to the program are provisions that encourage managed care enrollment, increase Medicare managed care reimbursement, and give plans incentives to offer new products. These and other changes will have a big effect on physicians’ dealings with plans and plan members. Some of these changes are positive developments for physicians.

To help you prepare for these changes to the managed care environment, we’ll tell you about some of the most important ones and what they mean to you.

Change #1: Incentives to Promote Medicare Managed Care

One goal of the new law is to revitalize the Medicare + Choice program, now known as the Medicare Advantage program. So the law encourages plans to join (or return to) the Medicare program, by greatly increasing the amount the Centers for Medicare and Medicaid Services (CMS) will pay for having Medicare managed care products. This means that more plans are likely to set up new Medicare managed care products, expand existing ones, and resurrect discontinued ones. The law also creates new regional Medicare PPOs, which will let plans offer Medicare managed care in locations, including rural areas, that weren’t attractive to them before, says Washington, D.C., attorney Jeffrey Micklos.

What this change means to you. Expect this change to create new sources of business for physicians, says New York City attorney Anne Maltz. There should be more Medicare managed care products for providers to participate in, as well as more plans offering these products. Also, some of these products will be in geographic areas that previously didn’t have Medicare managed care products, opening contracting opportunities for physicians in those areas.

If you have an existing plan contract with a clause requiring you to (continued on p. 8)
participate in all the plan’s products, you may have no choice but to participate in that plan’s new Medicare managed care products. Otherwise, if some of the new products appeal to you, you may be negotiating and signing new managed care contracts and joining their networks. If you don’t join these networks, you may lose out on some new business. Plus, some of your existing Medicare patients may join a Medicare HMO or PPO and leave traditional fee-for-service Medicare.

**Change #2: Higher Payments to Plans**

As mentioned above, CMS will try to increase the number of Medicare managed care products by raising its payments to plans for them. The new law also earmarks money to encourage certain providers to join Medicare managed care networks. For instance, CMS will pay plans to contract with providers that meet CMS’s definition of a “federally qualified health center.” Many rural centers that previously didn’t participate in Medicare managed care should meet that definition.

Likewise, CMS will entice “essential hospitals”—that is, certain rural hospitals—to join Medicare managed care networks. CMS will do so by paying a supplement to essential hospitals in a Medicare managed care network. This would be in addition to whatever a plan would pay the essential hospital if it showed that it had high operating costs.

**What this change means to you.**

Because plans will be getting more money from CMS, you may be able to better the reimbursement you get for Medicare managed care in your existing and new contracts, says Micklos. “Providers should try to negotiate or renegotiate better rates for these products,” he recommends. If you’re a generally qualified health center or essential hospital, you should have additional leverage to negotiate a good deal with plans, says Micklos.

**Change #3: Payment for Previously Uncovered Services/Products**

The new law expands what Medicare will cover. For instance, Medicare will now pay for a one-time physical for new Medicare enrollees and for some preventive health services it didn’t pay for before, says Jennifer Miller of the Medical Group Management Association. This means that plans that offer Medicare managed care products will also have to cover and pay for these benefits. While several plans did cover some of these services voluntarily, now all plans offering Medicare managed care products will have to cover and pay for all of those services for their Medicare managed care members.

**What this change means to you.**

Physicians will now be able to collect payment for these services directly from the plans instead of trying to collect from patients. Another potential benefit for providers is that there may be a “trickle-down” effect for a plan’s commercial business. For ease of administration or good public relations, plans often will have their commercial products cover the same services as Medicare. So if Medicare expands its coverage, plans probably will decide to also cover the added services in their private, non-Medicare products, says Miller. That means that you may be able to get paid by plans for these services, even when given to non-Medicare members.

**Change #4: Higher Medicare Fees for Many Providers**

The reimbursement rates in traditional fee-for-service Medicare are going up for many providers. For instance, the rates in the physician fee schedule will rise at least 1.5 percent, says Miller.

**What this change means to you.**

Many plans base or tie their payments to providers on the Medicare fee schedule, even for their commercial products. Depending on how your contracts are worded, your reimbursement may go up as a result. For instance, if you have a plan contract that says you’ll be paid 10 percent above the “current” Medicare fee schedule, your payments under that contract should automatically increase (you should monitor that contract to make sure that happens). If you have contracts that are tied to older, less generous Medicare fee schedules, you may want to try to negotiate with the plan to change that, says Miller.

**Change #5: Health Savings Accounts Established**

Health savings accounts (HSAs) are tax-exempt accounts through which individuals can pay certain qualified medical expenses. HSAs are similar to already-existing medical savings accounts (MSAs). But unlike MSAs, which are restricted to small business employees and the self-employed, HSAs are open to everyone covered by a high deductible health insurance plan. HSA funds can be used to pay deductibles, copayments, and certain other items not covered by plans, says Micklos. It’s expected that the existence of HSAs will encourage plans to offer lower-cost, high-deductible products both to individuals and to employers who previously couldn’t afford to provide health insurance to their employees.

**What this change means to you.**

This change affects physicians in several ways. First, physicians will be collecting more payments from members through HSAs—either directly, by use of debit cards, or by submitting claims through HSAs.
to the HSA—as members (or their employers) move from lower-deductible managed care plans to high-deductible ones. So you’ll want to make sure that you have adequate collection systems and procedures to deal with this. The change also means that members will be more likely to scrutinize and possibly complain about your rates, because more of the payment may come directly from their accounts rather than from the plan.

Physicians also can expect to deal with more HSAs than MSAs. Plans and third-party administrators will set up more HSAs to meet the increased interest in them, now that they’re available to more people. You may also find you’re submitting claims to, and otherwise dealing with, HSAs administered by entities new to health care, such as banks, says Micklos.

Collections from members may also get more confusing because different HSAs will use different methods to pay you. Another complication is that an HSA doesn’t have to be opened at the same institution that provides the high deductible health plan. So you may be submitting claims for the covered and noncovered portions of a member’ s services to two different entities.

Change #6: New Clinical Standards
The new law sets out or requires CMS to establish new clinical standards in particular categories. For instance, the law requires the Medicare program to create a formulary for prescription drugs, which, among other things, will have guidelines to coordinate medication therapy, says Maltz. The law also sets standards for how providers transmit electronic drug prescriptions, says Miller. And the law requires CMS to conduct studies on whether to set standards in other clinical areas.

What this change means to you.
Physicians will have to comply with the new standards for both traditional fee-for-service Medicare and Medicare managed care. Because setting new clinical standards will also change what’s acceptable clinical practice, it’s likely that plans will adapt the same clinical standards for their commercial plan products, says Maltz. So you’ll probably have to comply with the new standards in your non-Medicare business, as well.

Change #7: New Payment Methods and Levels
The new law changes the way certain products are paid for. For instance, physician-administered drugs, such as injectibles, will be paid under an average sales price, not an average wholesale price, beginning in 2005, says Miller. The law also calls for several studies and evaluations of the accuracy of the reimbursement levels for certain services. For instance, the law requires CMS to study whether the fee schedules for covered outpatient chemotherapy drugs need to be adjusted, notes Maltz.

What this change means to you.
If you deal with services or products that will be affected by the fee changes set out in the law, your payments from a Medicare managed care plan may change, depending on how your contract is worded. If a plan’s reimbursement to you for its commercial business is based on or tied to the Medicare fee schedules, your payment for these particular products also should change.

You can also expect payment changes if CMS’s studies indicate that some fee schedules need to be adjusted. If CMS makes those adjustments, plans will incorporate them into their own fee schedules for Medicare managed care—and may do so for their commercial products, as well.

Change #8: New Diagnostic Code System
CMS will adopt and use the new diagnostic code system, ICD-10, created by the Centers for Disease Control and Prevention (CDC) in 2000 to replace the ICD-9 codes.

What this change means to you.
Once CMS officially adopts the new
Radiology Group Settles for Millions, Whistleblower Gets $443K

A former billing manager for a Florida radiology practice filed a civil lawsuit against the practice for knowingly submitting false claims to Medicare. The federal government intervened to prosecute the former billing manager’s claim, and the radiology practice settled the case. According to the settlement documents the Department of Justice (DOJ) released, the billing manager claimed that the practice billed for some procedures without orders from treating physicians and billed separately for some studies that were part of more comprehensive procedures, resulting in double billing.

The practice didn’t have sufficient documentation to support its contention that it had oral orders for the procedures in question, and it admits that billing errors led to some double billing. So it settled with the DOJ by agreeing to pay $2.5 million. And as a condition of maintaining its eligibility to bill Medicare, the practice entered into a five-year corporate integrity agreement with the OIG. The “bounty” the billing manager gets for bringing the whistleblower suit is $443,000 [U.S. ex rel. Walker v. Radiology Regional Ctr.].

Insider Says: You’ll have to educate your patients about these sweeping changes, many of them complicated and confusing. The government plans to spend money on consumer education, and plans will also educate their Medicare managed care members about the changes. But providers will end up with the frontline responsibility to explain the new benefits to patients under both traditional fee-for-service Medicare and managed Medicare, says Miller. So you should be prepared to answer questions from patients about the new law, she recommends.

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