

# Radiology Administrator's

## Compliance & Reimbursement Insider

SEPTEMBER 2004

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## Important Changes to Medicare Appeals Process on Horizon

Over the past few months we've been telling you about some changes in the new Medicare Reform Act that haven't been getting as much attention as the prescription drug card. One big change that the Medicare Reform Act requires is a major overhaul of the Medicare appeals system. If your practice has ever attempted to appeal a Medicare denial of a claim you think should have been paid, you know that the current Medicare appeals process is unwieldy and slow. In fact, it's so tedious and such a hassle that many practices never bother to appeal denied claims because they feel that the chance for financial recovery isn't worth the time and effort required to mount a successful appeal.

But whether your practice often appeals Medicare denials or never does, you may want to rethink your position. The changes the Medicare Reform Act requires are likely to have an impact on the time frame for appeals and on the likelihood of success. The changes aren't in place yet, but will become partially effective later this year—and the new appeals process may be in place within two years.

We'll explain how the current appeals process works. Plus, we'll tell you about the upcoming changes and show you how the changes will affect medical practices. And we'll let you know what you should be doing now to be prepared when Medicare gets its new appeals process up and running.

### How Current Medicare Appeals Process Works

At the present time, appealing a Medicare denial can be a long and arduous process, says Washington, D.C., health care attorney Alan Reider, who has represented physicians in this situation. The appeals process currently consists of the following levels:

**Level #1: Internal review.** This is a request for reconsideration of the denial by the carrier—although not by the same individual who originally denied your claim. You may submit documentation to support your request for internal review, but you may not argue your position in person. It might be up to six months from the time you submit a request for reconsideration until you get the internal reviewer's determination. If the internal review doesn't resolve the matter to your satisfaction, you can request the following:

**Level #2: Fair hearing.** The hearing is before a "fair hearing officer" who's also an employee of the carrier. (Under the Benefits and Improvement Act of 2000, or BIPA, hearing officers were supposed to be replaced by qualified independent contractors, starting in April 2002. But Reider points out that this aspect of BIPA hasn't yet been implemented.) You can present live testimony and provide supporting documents at this hearing, and there may be some dialogue between you and the hearing officer. The fair hearing gives you a chance

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## MEDICARE APPEALS PROCESS (continued from p. 1)

to answer any questions the carrier has about the service you provided. It can take nine to 18 months from the date you request the fair hearing until the receipt of the officer's decision. If the results of the fair hearing aren't satisfactory, you could request the following:

**Level #3: Formal hearing with ALJ.** Although it may take 18 months or more before you have your hearing with an Administrative Law Judge (ALJ), depending on the case, having a hearing before an ALJ can be worth the wait, Reider says. ALJs often overturn the decision of the carriers' internal reviewers and fair hearing officers, he reports. ALJs work for the Social Security Administration and aren't bound by the carrier's LMRPs or even CMS's instructions to carriers. So with this broad discretion, they can right wrongs they perceive in CMS and carrier policies. And the hearing process itself permits physicians to introduce expert testimony and engage the ALJ in a persuasive dialogue that can be beneficial to the physicians, Reider explains. But if the ALJ's decision isn't what you hoped for, you can request the following:

**Level #4: Medicare Appeals Council (MAC) review.** Most appeals don't go this far. But for physicians who have a point to make, a MAC appeal is a possibility. The MAC reviews the record of the lower proceedings and may consider any new evidence and legal briefs, at the appellant's request. The main reason to request a MAC review is to "exhaust administrative remedies," Reider explains—a legal term that means you must try every other option to resolve your problem before taking the government to court. If the MAC appeal doesn't come out in your favor, you may sue in federal court.

## Problems with Current Appeals Process

The problems with the current appeals process are twofold from the physician's perspective, Reider says:

- You must go through two levels of appeal before you get to an "independent" reviewer who's more likely to be sympathetic to your case; and
- The process is too slow.

The government, specifically the OIG, doesn't like the current appeals process either, but it has a different concern. It feels that the appeals process is unworkable because the ALJs overturn the carriers' denials too often. The OIG's position is that this tendency weakens its ability to fight fraud and abuse in the Medicare program.

## New Process May Be Good and Bad for Physicians

Congress attempted to remedy all these concerns with the new appeals process it included in the Medicare Reform Act. Although we won't know how it will truly play out until the new process is up and running, it's likely to be a mixed bag for physicians, Reider remarks.

**The good news.** Several aspects of the new appeals process are likely to benefit physicians:

■ All denials now must specifically explain the reason for the denial, including whether the carrier used an LMRP or local coverage determination in making the denial. Appeals that are denied must include a summary of the clinical or scientific evidence considered when making the denial. Currently the carrier or fiscal intermediary (FI) has to give only a vague reason for the denial—such as “not medically necessary”—and that’s often difficult for the physicians to counter. Having the specific reason for the denial will be a huge boon, Reider says, because it will help physicians choose which claims to appeal and focus their appeals more specifically.

■ The Medicare Reform Act includes standards for “qualified independent contractors” (QICs), who will employ professionals to handle the second level of appeal—thus replacing the “fair hearing.” (As mentioned above, BIPA established a QIC system in 2000, but it was never implemented.) The Medicare Reform Act says QICs must utilize either a physician “with medical expertise in the field of practice that is appropriate for the items or services at issue” or a health care professional “who is legally authorized to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.” Individuals with medical expertise will be a welcome change, Reider says, because they may be more receptive to, and persuaded by, clinical and patient care considerations that led to the decision to provide the denied item or service.

■ The new appeals process sets time frames for decision making for every level of appeal. Although statutory time frames are often ignored, Reider says having them

means that physicians can expect a more speedy process.

**The bad news.** Some aspects of the new appeals process are meant to streamline it and make it a more effective weapon in the war against fraud and abuse. But these aspects are likely to have an adverse impact on physicians, Reider says. For example:

■ The ALJ hearing is no longer a “de novo” review. That means that unless you can show good cause why some supporting evidence wasn’t introduced at an earlier review stage, you may not introduce it later, Reider explains. So the beginning of the appeals process is likely to be more expensive and time consuming for the physicians because they must assemble all relevant evidence that they want considered at an early stage of the process, Reider notes.

In addition, the QIC appeal level is “on-the-record,” which means that there’s no longer an opportunity for an in-person hearing. Reider feels an in-person hearing allows the physician to engage in a dialogue that may be beneficial. He feels that the lack of opportunity for an in-person hearing will be an overall negative for the physician community.

■ ALJs, who have been employed by the Social Security Administration, will be moved to the employ of the Department of Health and Human Services (HHS). An ALJ still is supposed to be independent. But under the new process, the ALJs will answer to the Director of HHS (not to CMS). Still, the reason behind the move is concern that ALJs overturn carrier and FI decisions too frequently, Reider points out. So it’s natural to be concerned that once the ALJs move to HHS, they’ll be less likely to overturn the decisions of their own agency, he says.

## Prepare for New Process

There’s no telling when the new appeals process will be fully implemented, and the current process remains in effect in the meantime. You’ll probably receive a notice from your carrier once it’s prepared to implement the new process. But in the meantime, you should be taking certain steps to make sure that you’ll be in a position to benefit from the new process should you wish to appeal a denial.

### Step up documentation audits.

This is especially important now that appeals are on-the-record, Reider explains, because there’s less opportunity for you to supplement poor documentation with other evidence. So you should be regularly auditing a random sample of patient medical charts—not just denied claims—to make sure that your documentation is up to par. Good documentation is the key to appropriate reimbursement, and you can’t mount a successful appeal without it. Physicians and techs who consistently document poorly should be counseled, trained, and, if they don’t improve, sanctioned.

**Collect clinical and other supporting evidence.** If you ever decide to appeal a denial, having timely, relevant clinical material at hand will help you to put together a persuasive case from the beginning—which is crucial now that there are restrictions on offering new evidence at later stages of the process, Reider points out. You should have files that contain clinical studies, articles, and other material that support the services you provide, Reider suggests. Assign one of the radiologists in your practice to review the peer-reviewed medical literature regularly and clip relevant articles for your file.

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**MEDICARE APPEALS PROCESS**

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**Insider Says:** As you consider whether to pursue appeals under the new system, you need to have a good idea of the types of claims that are being denied and try to figure out

why. A well-run practice should regularly be asking and answering the following questions, Reider notes: Are your protocols consistent with your local LMRPs? Is your documentation adequate? Are your claims coded correctly? If you can answer yes to all of

these questions, but you're still receiving denials, you may want to consider an appeal. ■

**Insider Source**

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## Check Law and Notify Plan When Giving Waiver or Discount to Out-of-Network Patient

Radiology practices that don't belong to a managed care plan's provider network sometimes offer to waive or discount plan members' copayments or deductibles to help the patients keep their costs down. That's because plans usually require patients to pay a lot more when getting services from out-of-network providers, and the waiver or discount of the copayment or deductible can help.

Waiving or discounting charges for out-of-network patients may be a good way to get business and help out patients. But if you don't do it properly, you can get into legal trouble, says health care attorney William A. Sarraille. Waiving a copayment or deductible for an out-of-network patient may violate state law. And if you don't disclose the waiver to the plan, the plan can accuse you of submitting a false claim, in violation of insurance law, Sarraille adds.

To help you avoid these legal pitfalls, we've listed seven states that bar waivers (see box at right). You can use our list as a starting point in finding out whether your state law affects your ability to give waivers and discounts. And we've given you a Model Letter (see p. 5), which you can adapt to tell a plan that you're giving out-of-network waivers or discounts to its members.

### Find Out Whether Waivers Violate State Law

Check your state law before waiving or discounting copayments and deductibles for out-of-network patients. Some state insurance laws make it illegal to waive copayments or deductibles. The penalties for violating these laws vary by state, but generally include fines and suspension of your operating license. So if your practice is located in a state that bars waivers, you shouldn't waive any copayments or deductibles, including those for patients who use your facility out of network.

#### ► States that Prohibit Waivers of Copayments

Here are seven states that have adopted some form of prohibition on waiving copayments. Waiving a copayment or deductible in these states may violate state law and lead the state medical board to take severe action against you, warns ASC attorney Scott Becker. Other states may have adopted similar restrictions, he adds, so be sure you review your own state's law with an attorney.

- Colorado
- Georgia
- Idaho
- Nevada
- Ohio
- South Dakota
- Texas

Some states that bar waivers may not specifically bar discounts. In that case, you can give an out-of-network discount. But make sure your discounts aren't too steep. "Plans have successfully sued providers and withheld payments to them, claiming that discounting and other efforts violate insurance benefits contracts and state laws," says Illinois health care attorney Scott Becker.

**Insider Says:** Ask your attorney to check your state's antikickback laws, too, and help you structure your arrangement to avoid violating them, advises Sarraille. Many states have antikickback laws that make routinely waiving copayments and deductibles illegal because waivers can be a way to induce referrals.

### Tell Plan About Waiver or Discount

If, after checking state law, you decide to give out-of-network waivers or discounts, be sure to notify the patient's plan, advises Sarraille. If you don't tell a plan you're waiving or discounting copayments or deductibles for an out-of-network patient, it could accuse you of submitting a false claim and refuse to pay you because, it could argue, you misstated the amount you actually charged for the services.

For example, say a patient gets a procedure at your out-of-network facility, for which you normally charge \$1,000. The patient's managed care plan requires a 40 percent copayment for out-of-network providers. So you're supposed to collect \$400 from the patient (40 percent of \$1,000) and the remaining \$600 from the plan (60 percent of \$1,000). To encourage the patient to go out of network and come to your facility, you agree to waive half the patient's copayment and collect only \$200 from him. Since the copayment you collect is supposed to be 40 percent of your billed charges, the plan could say that your billed charges should be \$500 (\$200 being 40 percent of \$500). By this logic, the plan owes you only \$300 (60 percent of \$500). If you bill the plan for \$600 and accept reimbursement, while collecting only \$200 from the patient, it can claim that you've overbilled it and committed insurance fraud by not disclosing the discount.

### What Letter to Plan Should Say

If you tell the plan before you bill it that you're waiving or discounting copayments or deductibles for an out-of-network patient, it will be harder for it to accuse you of submitting a false claim or attempting to conceal information.

Your letter, like our Model Letter, should start by identifying the patient and her claim number. It should then explain that you've given the patient an out-of-network discount or a waiver. Next, explain what services the patient received and when she received them. Then, say what the charges were for the services, and how much of a discount you gave the patient. Let the plan know that your claim for reimbursement will note the discount or waiver. Conclude by

saying that you'll assume that the plan has agreed to the discount or waiver unless you hear otherwise.

"This puts the ball in the plan's court to take further action if it objects to your handling of the claim," says Sarraille.

### If Plan Objects

If, after receiving your notification, the plan objects to the waiver or discount, you have two choices: Either ask the patient to pay in full the copayment or deductible that you waived or discounted *or* reduce the amount you charge the plan by the same percentage that you reduced the patient's charges, advises Becker. In other words, if you reduce a patient's copayment by 50 percent, you need to reduce the charge to the plan by

50 percent. If you waive the copayment or deductible completely, you shouldn't bill the plan at all, Becker says.

**Insider Says:** Have your attorney look at your contract with the plan to see if waiving or discounting the patient's out-of-network copayment or deductible may violate it, says Becker. Some courts have ruled that a provider who violates the no-waiver clause of a plan's contract waives its right to collect anything for that procedure from the plan, explains Becker. ■

### Insider Sources

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## MODEL LETTER

### Tell Plan Up Front About Out-of-Network Waivers or Discounts

Here's a letter you can use to notify a plan that you're giving a patient an out-of-network discount. You can also adapt the letter if you waive the copayment or deductible entirely. The letter explains that you've given the discount

Sept. 2, 2004

**Re: Alan Smith, Member, Claim # [insert #]**

Dear Mr. Roe:

This letter is to inform you that we provided the above-referenced patient with a discount on his out-of-network copayment. We performed [insert description and CPT code of procedure performed] on [insert date]. The patient received services at a total cost of \$1,000. His out-of-network copayment charges were 40 percent of the total charges, or \$400. We discounted the copayment by half and charged him \$200. We will note this discount on the claim form we submit to you, as well.

If we do not hear from you within 14 days, we will interpret your silence as acknowledgment and approval of this discount. If there is a problem, or if you object to the discount, please feel free to contact me at (888) 444-4444.

Yours truly,  
Anne Doe, Billing Coordinator  
XYZ Imaging Center

and specifies the amount. It also gives the plan a time frame in which to object to the discount. The letter was developed with the help of health care attorney William A. Sarraille. **RACR10016**

## I N T H E N E W S

### ► **CMS Proposes Expanded Coverage of PET for Suspected Alzheimer's**

On June 15, 2004, CMS proposed offering Medicare coverage of PET scans to aid in the diagnosis of elderly patients with mild cognitive impairment whose condition has remained undiagnosed despite a thorough clinical evaluation. According to a press release, CMS determined that PET scans for such patients may aid in providing a definitive diagnosis of Alzheimer's Disease (AD). CMS had previously considered and rejected Medicare coverage of PET to help diagnose AD, but reconsidered its decision. We'll summarize CMS's decision. Plus, we'll tell you when you can expect it to become effective.

#### **Thorough Workup Required**

According to the Draft Decision Memo issued on June 15, Medicare won't cover PET scans to diagnose AD in every elderly patient. But Medicare may cover a PET scan if a patient has:

- Received a recent diagnosis of dementia;
- Experienced a documented decline in cognitive function for at least six months; and
- Undergone other diagnostic tests that have failed to yield a definitive diagnosis.

To be eligible for coverage, the patient already must have undergone a thorough evaluation by a physician experienced in diagnosing and assessing dementia, and that physician must have performed a specified battery of tests in an attempt to diagnose the patient's dementia. Also, Medicare will cover the PET scan only if the treating physician has complied with significant documentation requirements.

**Insider Says:** You can get a copy of the CMS Draft Decision Memo at [www.cms.hhs.gov/coverage](http://www.cms.hhs.gov/coverage). Under "Medicare Coverage Database" click on "National Coverage Analyses" and then look in the box labeled "Pending." You'll find it under "Reconsiderations."

#### **PET Won't Be Covered Until Instructions Issued**

CMS accepted comments on its decision for 30 days, until July 15. CMS will consider these comments and will release instructions to carriers by Oct. 15 about how to handle claims for PET to diagnose AD, according to the June 15 press release. We'll tell you about CMS's final decision and the instructions in future issues of the *Insider*. ■

## **Obey Stark Rules if You Extend Professional Courtesy**

Professional courtesy—that is, offering free or discounted service to colleagues and their family members—was once standard practice in physician offices. It has fallen by the wayside in recent years, largely because the OIG has voiced concern that it could be a violation of the antikickback and Stark laws. Private insurers also have voiced concern that waiving copayment for colleagues under the guise of professional courtesy, then billing the insurer without disclosing the waiver, is fraud.

But in Stark's recent Phase II regulations, CMS published an

exception for professional courtesy. So now, many practices may decide to begin offering professional courtesy again. If you're one of those practices, we'll explain why you should proceed cautiously. We'll tell you what you need to do to make sure that your professional courtesy policy satisfies Stark—and explain how following Stark to the letter will minimize the risks that you're violating other laws. And we'll give you a Stark-compliant Model Policy on p. 7 that you can adapt and use in your practice, as well as a Model Letter on p. 8 that you can send to insurers if you want to waive a colleague's copayment.

#### **Professional Courtesy OK if Not Abused**

Many practices stopped offering professional courtesy because they thought it violated:

- The antikickback law, which bars the payment of any consideration in return for referral of services reimbursable under one of the federal health insurance programs; and/or
- The Stark law, which bars physicians from making referrals of federally reimbursed items or services to an entity in which the physician or a family member has a financial interest.

But that was never really true, says New York health care attorney

Jay S. Silverman, because there's no legal prohibition against offering a colleague discounted or free services simply because she's a colleague.

The trouble is that many practices would discount the amount they charged the colleague by, for example, reducing or waiving the copayment—but still bill the insurer the full amount for the service without disclosing the copayment reduction. Or practices would extend professional courtesy to only certain colleagues as a reward or inducement for referrals, and not offer it to colleagues who weren't in a position to make referrals. Courtesy policies like these are legally questionable, Silverman says, because the physician expects a gain for extending the professional courtesy. It's this aspect of professional courtesy that insurers and the OIG find objectionable, he explains.

### **Stark Phase II Permits but Limits Professional Courtesy**

These concerns don't change just because Stark has included an exception, says Silverman. The OIG and private insurers are still on the lookout for professional courtesy abuses, he warns. That's why the Stark exception allowing professional courtesy is drawn to severely limit its potential for abuse, Silverman points out. So if your practice chooses to extend professional courtesy, you should be sure that your professional courtesy policy complies with Stark.

The professional courtesy exception in the Stark Phase II regulations requires that your professional courtesy policy be in writing and that it be approved in advance by the "governing body"—that's the administration of your hospital if you're a hospital-based practice or the owners

or executive board of your private practice or imaging center. Like our Model Policy, your professional courtesy policy should:

**Be available to all.** Your professional courtesy policy must apply to every colleague, without regard to the volume or value of referrals or other business generated between the parties. So, for example, if you want to offer professional courtesy to employees at your hospital, you must offer it to all employees, without discrimination, Silverman explains. Similarly, if you would like to offer professional courtesy to local orthopedic surgeons and their families, you must offer it to all local physicians and their fami-

lies—not just those who send you business [Pol., par. 1].

**Cover your practice's typical services only.** Stark requires that you offer professional courtesy solely on items or services that your practice routinely offers to other patients. So your radiology practice certainly may offer professional courtesy on X-rays, MRIs, and other imaging services you routinely perform. But you shouldn't offer it on services you don't routinely perform for other patients, Silverman cautions [Pol., par. 2].

**Exclude Medicare patients absent financial need.** The Stark exception doesn't permit professional

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## MODEL POLICY

### **Adopt Written Policy if You Offer Professional Courtesy**

Here's a Model Policy that we developed with the help of health care attorney Jay S. Silverman. This policy complies with the exception that CMS recently published in Phase II of the Stark regulations. You can adapt it

to suit the needs of your practice. Remember that to fully comply with Stark, the policy must be approved in advance by the governing body of the entity (that is, your hospital, practice, or imaging center). **RACRI0017**

#### PROFESSIONAL COURTESY POLICY

1. XYZ Radiology will offer professional courtesy to all physicians who live or practice within the city limits of Anytown, USA, and their immediate family members. Patients receiving professional courtesy will receive services at half our usual and customary fee, and any copayment will likewise be reduced by half.
2. Professional courtesy will be offered only on items and services XYZ Radiology typically provides to its patients.
3. Paragraph 1, above, notwithstanding, professional courtesy may not be offered to any patient who has Medicare, Medicaid, or TRICARE coverage. However, any patient who would otherwise be eligible for professional courtesy and who claims financial hardship may request a copayment waiver under XYZ Radiology's financial hardship policy.
4. In the event that a patient's copayment is reduced, pursuant to this professional courtesy policy, the patient's insurer must be notified by letter of the reduction. Please notify the office manager whenever a patient's copayment is reduced by professional courtesy.
5. XYZ Radiology's Compliance Officer will audit all professional courtesy claims on a regular basis. Any employee who fails to adhere to the above policy will be subject to discipline, including termination.

**PROFESSIONAL COURTESY**

(continued from p. 7)

courtesy for beneficiaries of the federal health insurance programs. So you must collect a copayment and submit a claim for colleagues who are covered by Medicare, Medicaid, or TRICARE. The only exception is that in verified cases of financial need, you may waive or reduce the copayment on the same terms as you would offer other patients in similar circumstances, Silverman explains [Pol., par. 3].

**Insider Says:** For more information on verifying financial hardship and waiving copayments, see "Certify Financial Need Before You Waive Copayments or Deductibles," *Insider*, Dec. 2001, p. 1.

**Require disclosure of copayment waivers.** If your offer of professional courtesy involves a whole or partial waiver of the patient's copayment, the patient's insurer must be informed in writing of the waiver [Pol., par. 4]. You can adapt our Model Letter for this purpose. Your letter, like our Model Letter, should inform the insurer that in accordance with your professional courtesy policy, the patient has received discounted services and a reduced copayment. Plus, it must inform the insurer that the claim you'll submit for the service you provided to the patient will be discounted, as well.

Note that if you waive the patient's entire copay (under managed care) or share of the bill (under indemnity insurance), you must also waive the fee to the insurer. In other words, you can bill the insurer only the same percentage you bill the patient. But even if you choose to waive the patient's entire copay, you should still write to inform the insurer that the service was performed and your fee was waived, so that the insurer has a record that the service was performed.

**Be compliant with antikickback law.** If your policy is Stark compliant, you won't be offering professional cour-

tesy in return for referrals or other business, Silverman notes. But it's crucial that your policy reflect this in actual practice, not just in theory. So if you decide to offer professional courtesy, the practice's compliance officer should periodically audit the professional courtesy cases to make sure your professional courtesy policy is being implemented in a compliant manner, Silverman advises [Pol., par. 5]. ■

**Insider Source**

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**MODEL LETTER****Send Letter When Waiving Copayment**

Compliance with the Stark professional courtesy exception requires that you send a patient's insurer a letter if you're going to waive or reduce

the patient's copayment. Here's a Model Letter that you can adapt and use when you reduce or waive a colleague's copayment. **RACRI0018**

Acme Health Insurance Co.  
456 Main St.  
Anytown, USA

**Re: Your Insured Sally Smith, MD, Policy #98765**

Dear Sir or Madam:

Recently, we provided imaging services to Dr. Sally Smith, who has health insurance with your plan. In accordance with our professional courtesy policy, we reduced Dr. Smith's copayment by one-half. The reduced copayment collected is reflected in our claim for the service. Kindly contact me if you have any questions.

Yours truly,  
Office Manager

**It's Not Too Early to Start ICD-10 Preparation**

Many of you already know that the diagnosis coding system will be undergoing a change in the not-too-distant future—the U.S. Department of Health and Human Services (HHS) could introduce the ICD-10 system as early as 2007. ICD-10 is the diagnosis coding system that's already in effect in many parts of the world. It's far

more detailed than ICD-9, says Atlanta compliance expert Jackie Miller, so it will make diagnosis coding more accurate.

But changing from ICD-9 will be a huge amount of work, and it will affect several of your practice's operations—not just coding. "One of the

really important things to consider now is whether your software company, billing service, and other vendors are aware of—and preparing for—the introduction of ICD-10," Miller says.

We'll give you some questions to ask your vendors so that you can make business decisions now that

will ease your practice's implementation of ICD-10 later. Plus, we'll give you some pointers on how to start preparing to implement ICD-10 within your practice.

### Are Your Vendors Prepared?

Miller encourages her clients to start thinking about the change in diagnosis coding now because the impact on providers will be so pervasive. For example, changes to the diagnosis coding system could affect not only billing but also patient registration, scheduling, order entry, transcription, and other aspects of your radiology information system, Miller points out. So she says you should keep the upcoming transition to ICD-10 in mind when making all your business decisions over the next several years.

For example, when selecting vendors that provide systems for patient registration, scheduling, billing, or order entry, you need to know how the vendor plans to implement ICD-10. Any compliance consultants or training providers your practice uses must be up to speed, as well.

**Software vendors.** Miller suggests you ask the following questions of your software vendors:

- Will an ICD-10 update be included in the price of the software, or is it an additional expense?
- Are you beta testing an ICD-10 compatible system now?
- When will an ICD-10 compatible system be available—months prior to the official implementation date or days prior?
- What are the credentials of the staff developing the ICD-10 update? You'll want to hear that there's a certified coder among the IT personnel putting together the new system, Miller says.

**Consultants.** You should ask the following questions of your compli-

ance consultants and anyone else who may be providing you with services that relate to billing and coding to determine whether they've been thinking about the challenges that ICD-10 will present:

- Have you attended any seminars or programs about ICD-10? Or better yet, have you spoken or written on the topic?
- When do you suggest we begin planning for ICD-10 compatible systems? "If they're not overly concerned about prompt implementation, that's a bad sign," Miller says.
- What type of support do you plan to give your clients during the transition period to ICD-10? A consultant who has already thought out a support program is likely to be on the ball, Miller says.

### Employee Training

Training is one area that should get particular attention, Miller says. You should start thinking about which of your staff members should be trained in ICD-10 and investigate training programs that you hear about. Seminars and reference materials on the new coding system are already available from a variety of vendors. If you outsource training, you should make sure that any entity offering training is competent and up to speed on ICD-10, Miller cautions. National organizations, like the American Health Information Management Association and the American Association of Professional Coders, are good places to start. And many specialty-specific organizations, like the American College of Radiology, are likely to offer programs on ICD-10.

### Ease Transition by Starting List of Tasks Now

"This transition will be like HIPAA, in that it will affect nearly every aspect of the business of medicine,"

Miller says. "And like HIPAA, there will probably be a degree of unnecessary hysteria and lots of misinformation floating around," she adds. But Miller also points out that the codes themselves (in draft format) are already available through the National Center for Health Statistics ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)), so providers can see for themselves what the system will look like. Furthermore, HHS must provide two years' advance notice before the ICD-10 implementation date, so there will be ample time to prepare. Your job is to learn as much as you can as soon as you can so that you can implement ICD-10 with a minimum amount of trouble and with maximum efficiency.

Since you're not likely to think of everything you'll need to do to accomplish the transition right away, Miller suggests you begin creating a checklist of tasks and issues now. As tasks or issues occur to you, add them to the list. Then when HHS sets a firm implementation date, you'll have your own checklist, tailored for your practice.

For example, here are a few tasks Miller says every practice will need to accomplish before the changeover occurs:

**Educate key personnel.** The decision makers in the practice or facility need to understand the nature and scope of the ICD-10 changes so that they can budget appropriately for time and expenses associated with the transition.

**Create a training plan.** Management should identify the extent of ICD-10 training that's required for each position. Obviously, billing personnel will need in-depth training, but registration staff and techs will probably also need at least a "nodding acquaintance" with the new system, Miller says. Depending on the size of

(continued on p. 10)

**START ICD-10 PREPARATION**

(continued from p. 9)

your practice or facility, it may be most cost-effective to send a key employee for in-depth training and then make that person responsible for training other personnel.

**Identify all computer systems that use diagnosis codes.** Everyone realizes that billing systems will need

to change, says Miller, but other software may need to be updated, too. For example, you'll need to update software that you use to identify non-covered exams and issue advance beneficiary notices. Do this in time to install the update, and test it in advance of the implementation date.

**Do a forms inventory.** Many of your forms, including requisitions,

may use diagnosis codes. Making a laundry list of forms that need to be updated with ICD-10 codes will help ensure that nothing is overlooked. ■

**Insider Source**

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**D O S & D O N ' T S****✓ Report Souvenir, Keepsake Ultrasounds to FDA**

If you're aware of a provider or facility that's doing fetal ultrasounds for nonmedical reasons—sometimes called “souvenir” or “keepsake” ultrasounds—you should report the facility to the FDA, according to a resolution passed at the American College of Radiology's (ACR) 2004 Annual Meeting.

In 1994 the FDA expressed concern about unnecessary exposure to radiation due to the use of diagnostic ultrasound equipment for nonmedical purposes. Citing the continuing proliferation of facilities that provide souvenir or keepsake ultrasound images to prospective parents, the ACR's resolution encourages ACR members to report any facility that provides those ultrasounds to the FDA's Office of Compliance, Diagnostic Devices Branch. You can report by telephone to (301) 594-4591, or fax a written report to (301) 594-4636.

**X Don't Bill for Film Comparisons Done for QA or Risk Management**

As a general rule, if your radiologist interprets a film and later compares it to an earlier film, don't bill for the comparison. Comparisons that radiologists do to cover themselves in case the patient has a bad outcome and then sues, or comparisons done for general quality assurance, aren't reimbursable, says radiology compliance expert Claudia Murray. And if you bill them as if they are, your practice or facility could get into trouble with your carrier.

Sometimes, taking and interpreting comparison films is reimbursable—when looking for evidence of degenerative joint disease, for example. But in general, a radiologist compares a current film with an earlier film just to make sure that the interpretation was correct, and to document

that the comparison was made. These are quality assurance or risk management comparisons—the ACR's “Standard for Communication: Diagnostic Radiology” says that “comparison with relevant previous examinations and reports should be part of the radiologic consultation and report when appropriate and available.”

So although it's always a good practice to do these comparisons, they aren't ordered by the treating physician and may not have a direct effect on the care and treatment of the patient. So they're not considered “medically necessary” and aren't reimbursable, Murray says. ■

**Insider Source**

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