

Radiology Administrator's

Compliance & Reimbursement Insider

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CMS Warns About Exploiting New Reassignment Rule

In its *draft Medicare physician fee schedule*, published in the Aug. 5, 2004, issue of the *Federal Register*, CMS not only lists proposed physician fees for 2005, including fees for the new preventive services covered under the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA); it also cautions providers who are taking advantage of recent changes to the Medicare reassignment rule that they'll come under scrutiny for doing so unless their arrangements comply with all other relevant laws and regulations. We'll explain this development in detail and tell you what it may mean for your radiology practice. When the final fee schedule is published in November, we'll discuss the changes to the fee schedule itself, which may include a proposed 1.5 percent average increase in payments for physician services.

MMA Eases Reassignment Restrictions in Certain Cases

As we first reported in the March 2004 issue of the *Insider* ("New Medicare Law Changes Key Part of Reassignment Rules," p. 1), the MMA eases some of the rules restricting Medicare reassignment that had been in place. Specifically, the law made two big changes that have particular significance for radiology practices:

1) It eliminates on-site requirement. The MMA allows a provider to reassign his right to bill Medicare for professional services to a clinic or facility, regardless of where the professional services were performed. Before the MMA, if a provider reassigned his Medicare billing rights to a clinic or facility, the professional service had to have been performed on the premises of the clinic or facility.

2) It lets independent contractors reassign billing rights. The MMA permits independent contractor providers to reassign their right to bill Medicare to the party with whom they're under contract. Before the MMA, only a W-2 employee could reassign his Medicare billing rights to an employer.

Insider Says: For Model Language you can use in your practice's contracts with independent contractors, see "In the News: CMS Issues Transmittal on New Reassignment Rule," *Insider*, May 2004, p. 6.

Changes Seemed to Offer Opportunities

Many people believed that the new reassignment rule opened up a wealth of business opportunities for radiologists. Health care attorney Thomas W. Greeson anticipated that radiologists could enter into "reading arrangements" with other medical practices that have their own imaging equipment, like orthopedic groups. The radiologist could perform the professional services through teleradiology and reassign the right to bill to the other practice, in return for a fair

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NEW REASSIGNMENT RULE (continued from p. 1)

market value fee. Greeson also anticipated that the radiology practice could even hire an independent contractor to do those readings.

And other recent developments seemed to indicate an easing of the restrictions on reassignment that many radiologists find burdensome. For example, when the CMS transmittal was read in conjunction with certain provisions of the Phase II Stark regulations, it seemed that the rules on purchasing diagnostic tests had become more flexible, too, Greeson points out. But in the preamble to the draft fee schedule, CMS seems to warn providers against a liberal interpretation of its recent transmittal and the Phase II Stark regulations.

CMS Expresses Concern About Program Integrity

The changes to the reassignment rules caused quite a stir, as attorneys and others analyzed them and recognized the opportunities the changes may offer radiologists. Greeson believes that CMS may be having trouble reconciling these increased opportunities, which are required by the MMA, with its need to protect the integrity of the Medicare program. So in the draft fee schedule, CMS is trying to "pull on the reins" a bit, Greeson suggests, to give itself time to figure out how to police these new ventures the MMA made possible.

So, for example, CMS pointed out that global billing won't be possible in an off-site reading arrangement between two medical practices. Here's why, in a nutshell: The professional component of a radiology service is a designated health service (DHS) under Stark, Greeson explains. And in order for a physician to self-refer for a DHS, the arrangement must come within one of the enumerated exceptions to Stark. Medical practices must rely on the in-office ancillary services exception, which permits a "self-referral" for a DHS if the DHS is provided or performed in the physician's office by the physician or a member of the physician's group practice. Independent contractors can be considered a member "in the group practice" for the purposes of this exception, but *only if they perform the professional services at the location where the group practice provides professional services.*

CMS emphasized this point: It mentioned in the preamble to the draft fee schedule that if a physician practice uses an independent contractor to perform professional services and that independent contractor reassigns her right to bill for the services to the practice, the practice must also comply with Stark. This effectively removes the opportunity for radiologists to enter into off-site reading arrangements using independent contractors, Greeson says. Significantly, CMS says in the preamble that it's "...aware that the changes in the reassignment rules based on section 952 of the MMA may create new fraud and abuse vulnerabilities...Parties should be mindful that contractual arrangements involving reassignment may not be used to camouflage inappropriate fee-splitting arrangements or payments for referrals...We intend to monitor reassignment arrangements for potential program abuse."

What Does This Mean to You?

You should be especially cautious when you reassign Medicare and Medicaid billing for professional services to other practices. Greeson says that if you reassign Medicare or Medicaid billing rights for professional services to any practice or facility (except an independent diagnostic testing facility (IDTF), as discussed, below), you should make sure that you perform the services:

- On-site—that is, not providing services through teleradiology or PACS systems; and
- In a manner that conforms to the Stark in-office ancillary services exception.

“CMS seems to be debating whether the benefits to beneficiaries of lifting certain restrictions on the provision of professional services outweigh the perceived threat to program integrity and increased potential for fraud and abuse,” says Greeson. “Until that internal debate is resolved, I’m advising my clients to either bill off-site services separately or perform the services on-site if they wish to reassign the right to bill Medicare or Medicaid,” he remarks.

Insider Says: You don’t have to worry about this aspect of the reassignment rule if you own or operate an

independent imaging facility or are hospital based. The independent contractors you hire to provide night coverage, overflow coverage, and so on, need not perform their professional services on-site in order to reassign their billing rights to your facility. Also, this reassignment rule doesn’t apply to services performed for IDTFs—there’s no on-site requirement for professional services provided for an IDTF, Greeson notes. ■

Insider Source

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HIPAA COMPLIANCE

Test Your Staff’s HIPAA Knowledge with *Insider Quiz*

How well do your staff members understand their HIPAA compliance responsibilities? By now you’ve probably invested time and money to train your staff on patient privacy issues. Your next step is to monitor how well they know their responsibilities under HIPAA. A low-cost and effective way of doing this is to give your staff a HIPAA quiz that covers the main compliance areas, says health care consultant Sandra Jones, who chairs a HIPAA task force for ambulatory surgery centers. “You can use a quiz to pinpoint educational needs, close compliance gaps, document that your staff is trained, and emphasize that compliance is everyone’s responsibility,” she explains. The benefits far outweigh the minimal costs, Jones says.

We’ll fill you in on the benefits and how-to basics of giving your employees a HIPAA quiz. We’ll tell

you what the quiz should cover and give you a Model Quiz (see p. 5), created by Jones, which you can adapt to start testing your staff’s HIPAA knowledge right away. The answer key appears on p. 6.

Why Give Quiz

Having staff members complete a HIPAA quiz will allow you to assess how well they know HIPAA and how well they’re complying with it. Your practice or facility may be able to satisfy its legal obligations to train staff by simply requiring all staff members to read your HIPAA policies. But you can promote meaningful compliance and reduce the risk of violations by testing staff members’ HIPAA knowledge. “A quiz will allow you to assess whether your staff understands your HIPAA policies and knows how to put them into action,” says health care attorney Abby Pendleton. “If

your staff is up to snuff on HIPAA, you should have fewer patient complaints and fewer HIPAA violations,” she adds.

Giving a quiz will also allow you to pinpoint problem areas where staff members need more training. “This is key to staying in compliance,” says Jones. For example, you may find that staff members read your HIPAA policies, but didn’t understand certain requirements. Or it may turn out that the policies or your initial training sessions weren’t as complete as they should have been, adds Pendleton. In these cases, you’ll want to retrain staff or tighten up your policies to make them more complete and easier to understand.

There are also other benefits of giving a quiz. Having a written quiz allows you to have written proof of your training efforts. “Having written

(continued on p. 4)

HIPAA COMPLIANCE (continued from p. 3)

documentation is important if the government should ever question you about your HIPAA compliance," says Jones. And having staff take a quiz can also serve as a morale booster—especially if they've been trained well. "Having every staff member take the quiz emphasizes that compliance is everyone's responsibility," Jones adds.

Who Gets Quiz

Give the quiz to all staff members. "HIPAA requires you to train all staff members. Quizzing them after their training will allow you to assess what they understood from the training," says Jones.

When to Give Quiz

You should administer the quiz to all staff members shortly after they've been trained, and then at least annually. "Even though HIPAA only requires initial training of your employees, it makes sense to do an annual review of your staff's HIPAA knowledge. This quiz could be used as an annual refresher," says Jones. Since you conduct other compliance training annually for all employees, it would be easy to give a HIPAA quiz and review it at that time. And from a liability perspective, annual quizzing is a good idea. "This will give you an annual checkup on what, if any, HIPAA compliance gaps you need to fill," says Pendleton. If HIPAA compliance problems come up frequently at your practice or facility, you may want to give staff members a refresher quiz more than once a year, she adds.

What Quiz Should Cover

Like our Model Quiz, your quiz should ask questions that require staff members to apply their HIPAA knowledge. Because HIPAA privacy

regulations focus on keeping patients' information confidential, the quiz should focus on patients' rights vis-à-vis their protected health information (PHI). "It's particularly important to make sure that staff members understand the basics of patients' privacy rights and know the protocol to follow when a patient tries to exercise those rights," says Pendleton. For this reason, it's best to ask questions that require staff members to apply HIPAA requirements in realistic situations. The quiz should also include any additional rights beyond HIPAA that you have in your privacy policy and give to patients. Like our Model Quiz, your quiz might include questions about:

1) Signing authorizations. Find out if your staff knows when a patient doesn't need to sign a HIPAA authorization. For example, our Model Quiz asks whether a patient needs to sign an authorization before you can schedule the patient's procedure or call the patient with preprocedure instructions. Neither would be necessary in this example because HIPAA doesn't require that you get patient authorization for use of PHI that pertains to "treatment, payment or operations" relating to that patient.

2) Sharing PHI. Find out if staff members know whom they can share PHI with and how that information should be shared. For example, our Model Quiz asks whether staff can fax a radiologist's interpretation to the patient's surgeon. The answer is yes, as long as the sender is sure that the office will receive the fax in a secure manner, says Jones. You would call ahead to be sure that someone appropriate would be available to receive the fax. "Also, with every fax sent you want to be sure your staff members double-check that they dialed the correct fax number," she adds.

Insider Says: For more information on faxing PHI, see "Set Fax Policy to Help Prevent Patient Privacy Violations," *Insider*, Feb. 2000, p. 5.

3) Giving privacy notices. Find out if staff members know who gets a privacy notice. Radiology practices with an indirect treatment relationship with a patient need give a notice only to a patient who requests one. But if the relationship is direct, as it is for interventional radiologists and radiation oncologists, you must give each patient a copy of the privacy notice. And your staff needs to ask each patient to sign an acknowledgment of the receipt of a privacy notice.

4) Registering patients. Ask your staff about patient registration protocols. Like our Model Quiz, your quiz might ask if it's okay for staff to post a patient's name and procedure at the registration desk to facilitate registration. Your staff mustn't do this because a patient's name and procedure is PHI that can't be available for anyone coming to the registration desk to read, explains Jones. It's okay to use a sign-in sheet if patients don't write down what procedure they're having, she adds.

5) Addressing patients by name. Ask your staff about how they should address patients when they speak to them. Ask staff members whether it's appropriate to address a patient by her name while in the waiting room, registration area, or elsewhere in the facility where other people are present. Some staffers may think they can't use the patient's name and must instead address the patient with a different designation. "It's not necessary to use a pseudonym or assign a patient a number for this purpose," says Jones. "Simply saying a patient's name in public or anywhere in the facility isn't violating that patient's privacy rights under HIPAA," she adds.

6) Failing to get patient's privacy notice acknowledgment. On the quiz, include a question about failing to get a patient's privacy notice acknowledgment. "Although HIPAA requires you to use your best efforts to get a patient to acknowledge that he got your privacy notice, it's not a prerequisite to treating him," says Pendleton. Even if the patient doesn't want to or can't sign an acknowledgment, you still need to treat him. But because HIPAA requires you to give a privacy notice to all patients, be sure to document the efforts you made to get a signed acknowledgment.

7) Signing business associate agreements. Like our Model Quiz, your quiz should include a question about who must sign a business associate agreement. The business associate agreement rules are tricky, so you'll want to check that your staff members have a handle on them. "Business associate agreements aren't needed for every person or organization that works with the practice or facility—just those that perform services for the practice or facility and have access to patient information," explains Jones. So, for example, you would want signed business associate agreements from transcription services providers, pharmacy consultants who review narcotics logs or medical records, and risk management or quality improvement consultants. But you wouldn't need one for maintenance personnel, biomedical engineers, or lawn care providers. "And you wouldn't need an agreement signed by any provider or payor involved in the treatment, payment, or operational tasks of the practice or facility," explains Jones.

8) Handling patient complaints. You'll want to quiz staff on handling patient complaints, a key compliance element under HIPAA. "HIPAA requires you to establish a

patient complaint process so that complaints can be investigated and resolved," says Pendleton. "Staff members need to be trained on your specific patient complaint process, which, for example, may require patient complaints to be directed to the privacy officer," she adds. And HIPAA requires that every health care organization have a privacy officer to handle complaints. "Having your staff get this information to

the privacy officer quickly can also help you prevent other privacy breaches and potentially more serious problems," Pendleton explains.

9) Handling staff questions.

Your staff should know where to go with any questions or concerns about how PHI is being handled. For example, our Model Quiz tests staff members on whether they know to go to

(continued on p. 6)

MODEL QUIZ

Find Out How Well Staff Understands Its HIPAA Responsibilities

Here's a quiz that you can adapt and give your staff to make sure it's up to speed on HIPAA requirements. Consultant Sandra Jones developed it as a low-cost, easy-to-use, and effective

HIPAA compliance tool. The quiz consists of 10 true-or-false questions that will test your staff's understanding of HIPAA requirements. The answer key appears on p. 6. **RACRI0019**

HIPAA COMPLIANCE QUIZ

NAME: _____ DATE: _____

This is a test of your HIPAA compliance knowledge. Circle True or False.

1. A patient must sign an authorization that allows us to use health information before the imaging center can schedule the procedure or call about preprocedure instructions. True False
2. You can fax the next day's surgery schedule to the anesthesiologist's office to plan coverage. True False
3. The patient must ask for a copy of the privacy notice before we will give him one. True False
4. I can post the patient's name and procedure at the registration desk for the patient to check when she signs in. True False
5. At registration, the patient will receive a number, and from that point forward, all employees have to refer to the patient by number only. True False
6. If a patient refuses to sign an acknowledgment of receipt of the privacy notice, we must deny the patient service. True False
7. Every nonemployee who does any work in the facility must sign a business associate agreement. True False
8. If a patient complains that her health information was given to someone who shouldn't have it, I should immediately refer the patient's complaint to the Privacy Officer. True False
9. When I have a question about how information is being handled, I should talk to the Privacy Officer to clarify issues or report possible problems. True False
10. I can give my computer password to others who do many of the same tasks I do. True False

HIPAA COMPLIANCE (continued from p. 5)

the privacy officer whenever they need to clarify issues or report possible problems. "Having staff ask questions and report concerns is your first line of defense against HIPAA violations. For this reason, you should strongly encourage staff members to ask questions and report any concerns they might have to the privacy officer to help you *prevent* problems," says Jones.

10) Sharing computer passwords. Make sure your staff members know not to share computer passwords. "Staffers who perform many of the same tasks may think it's okay to share passwords, but it's not," explains Jones. Employees, no matter what tasks they're doing, shouldn't share passwords.

Insider Says: Make sure you tailor your quiz to your needs. For example, if you noticed that your staff is weak in certain areas or staff members have asked specific HIPAA questions, you may want to include those topics in your quiz, says Pendleton.

Discuss Correct Answers with Staff

Use the review of the quiz as an opportunity to educate your staff further about HIPAA. "After you give the quiz, go over the answers and discuss each question. This will allow staff members who got answers wrong to learn the right answers. And it will reemphasize HIPAA policy for those who got the answers right," says Jones.

You should use the quiz results as a guide for future training and education. "The quiz is intended to help measure your staff's understanding of what was covered in your HIPAA training and identify where staff need more training," says Jones "If the quiz reveals weaknesses in your staff's understanding of HIPAA requirements, you should spend more time training staff in these areas," says Pendleton. "It may be that your HIPAA policies aren't clear enough or that your initial HIPAA training wasn't sufficient," she adds.

Have each staff member turn in the quiz at the end of the session, and then file the quiz along with that staff member's other educational

papers—such as OSHA, fire, and disaster training, says Jones. "This way, if you ever need to refer to the staffer's quiz, you'll be able to locate it easily," she adds.

Insider Says: To get ongoing, in-depth HIPAA training for your staff—including a monthly quiz—consider subscribing to our sister publication, *HIPAA Security & Privacy Staff Trainer*. For more information and a free sample issue, call 1-800-643-8095. Or visit www.brownstone.com and click on "health care management." ■

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Quiz Answers

- | | |
|--|-------------|
| 1. False | 7. False |
| 2. True | 8. True |
| 3. False (if the relationship is direct) | 9. True |
| 4. False | 10. False |
| 5. False | Score _____ |
| 6. False | |

ASK THE INSIDER

The INSIDER welcomes questions from subscribers. You can: 1) e-mail jgormley@brownstone.com; 2) send your questions to Brownstone Publishers, Inc., "Ask the Insider," 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 3) fax (845) 331-0861; or 4) call (845) 331-0817, and speak with the editor.

Reconstruction Without Orders

Q Recently, my radiologists heard about a radiology group that had to pay more than \$2 million to settle charges with the federal government. One of the charges was that the radiology group did CT reconstructions without specific orders from referring physicians. We've always thought that the radiologist had the right to make a clinical judgment to do a CT reconstruction, even without an order specifying reconstruction. We've done reconstructions without orders often—it sounds as if we're in serious trouble. What should we do?

A "There's no need to panic," says Virginia health care attorney Thomas W. Greeson. "I can't speak to the specifics of the case you're referring to, but I can say that, in general, radiologists have the discretion of performing a reconstruction, provided the situation warrants it," he adds.

That's because the *Medicare Carriers Manual*, as well as accepted standards of medical practice according to the American College of Radiology (ACR), permit a radiologist to "design" an ordered test in the manner that's most

likely to achieve the desired diagnostic or therapeutic result. The ACR has posted guidance to its members on its Web site, www.acr.org. The guidance explains that CT reconstruction may fall under the test design exception to Medicare's ordering test rules, Greeson notes. According to these ordering test rules, the radiologist may decide, among other things, whether contrast should be administered or how thick a CT slice should be. The same Medicare rules are relevant to post-processing images (reconstruction), Greeson says.

Practices may run into problems if they habitually or routinely perform and bill for "add-ons" to simple studies—like contrast or reconstruction—without adequately analyzing or documenting the medical necessity of the add-on, Greeson says. Reconstruction is sometimes, but not universally, appropriate, and your practice protocols should reflect that fact.

You can avoid trouble by making sure your radiologists always clearly document the reason for their test design, Greeson notes. If your radiologist decides to do a reconstruction without a specific order for one, the record should clearly indicate why reconstruction was appropriate. And the interpretation should describe the additional information the radiologist gleaned from the reconstruction, Greeson suggests. If you don't have the appropriate documentation supporting medical necessity, don't bill for the add-on service, he cautions. Greeson advises every practice to consult its attorney when establishing policies or procedures to implement this—or any other—Medicare rule. ■

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Be Prepared as Private Insurers Step Up Antifraud Efforts

You may have noticed that Medicare is no longer the only payor encouraging its insureds to report health care fraud. For example, the Blue Cross/Blue Shield plans (the Blues)—which offer a number of indemnity and managed care health insurance plans, in addition to serving as third-party administrator for Medicare in several localities—recently announced that they're forming an "antifraud strike force" to coordinate antifraud efforts nationwide. These efforts will include information sharing among several private and government agencies, as well as "consumer education efforts" designed to encourage patients to report suspected fraud.

We'll tell you what you need to know about the Blues' antifraud strike force, and similar efforts by other private payors. We'll explain why you should be aware of what these plans are doing, even if you're sure that your practice bills and codes properly. And we'll give you some pointers about dealing with antifraud

investigators, should they turn their attention your way.

Reasons for Increased Antifraud Initiatives

The Blues' antifraud strike force and similar efforts by other insurers are the result of several factors, notes New York health care attorney Jay Silverman:

- "No-fault or workers' compensation programs are so frequently and grievously abused, the private insurers that have contracts to provide them are just fed up," he says. So they're cracking down on fraud because they're sick of getting burned.

- Many states are requiring insurers to engage in aggressive antifraud activities as a condition of getting or retaining a license to do business in the state. As states feel a budget pinch, they are, in essence, deputizing private insurers to investigate health care fraud and report the most egregious abusers, Silverman explains.

- Some insurers are publicly traded companies that must answer to their stockholders. Antifraud activities that result in money coming back into the company's coffers help boost the bottom line and make the company look good to shareholders, he says.

- Health care fraud is perceived as a drain on national resources and a major reason for the high cost of health insurance coverage. So cracking down on fraud, loudly and publicly, is a savvy public relations move for any insurer, Silverman remarks.

Don't Underestimate Strike Force Investigators

Practices tend to concentrate their compliance efforts on Medicare reimbursement issues, Silverman says. But this focus on Medicare compliance may mean that cases of upcoding, providing "unnecessary" services, or other compliance problems go unnoticed if the patient has private insurance. And some practices try to use private insurance

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ANTIFRAUD EFFORTS (continued from p. 7)

plans to take up the shortfall caused by declining Medicare reimbursement. These practices may not realize that defrauding private insurers can have consequences every bit as severe as defrauding Medicare, he remarks.

Physicians have cause for concern as these antifraud strike forces gear up and become more active, Silverman says. That's because the private insurers' antifraud investigators differ from the government's investigators in several important ways:

They're more experienced. The investigators the private insurers hire for their fraud investigations are often retired law enforcement personnel like ex-FBI agents and police detectives and former prosecutors. They may have a medical background in addition to their law enforcement background. And they frequently have far more professional experience than the typical investigator for a local Medicare carrier, so they know what to look for—and they've seen it all before. That makes them tough to fool, Silverman says.

They're well-funded. Unlike the government, private insurers can "write their own check" when it comes to funding antifraud efforts. So they don't need to concentrate just on the biggest fish—in fact, they often pick a midsize fish to make an example of, Silverman says. For example, he says that he's been seeing a number of insurers send letters to physicians disputing all their claims for a certain procedure over a certain period of time and demanding back sums of \$25,000 to \$100,000. The private insurers have the resources to aggressively pursue these relatively small demands for repayment, and they do so—although the claims are often settled for less than the amount originally demanded, Silverman says.

They share information. The private insurers share information with

each other, Silverman says. This can help them work as a team to focus their antifraud efforts to combat a particular problem in a particular locality. For example, several years ago there was a crackdown on dermatologists in the New York City area who had staff members give facials to patients and billed the encounter as acne surgery. The crackdown began when one insurer reported the widespread practice to other local insurers.

They can use hardball tactics. Private insurers can engage in some activities that the government may not engage in. For example, to induce a settlement, a private insurer may threaten to report a physician to a state insurance department or state medical board or threaten to throw the physician out of its program. An administrative law judge must find sufficient reason to throw a physician out of the Medicare program, but a private insurer can choose not to renew a physician's managed care contract without any findings of wrongdoing and without consequence, Silverman notes.

As you can see, the strike force investigators have significant enforcement options at their disposal. They can not only demand money back from your practice, but they also can affect your practice's status with the insurance plan. If they believe you've intentionally defrauded their plan, they can kick you out of the plan. Even if you don't want to stay in the plan, getting kicked out is an event that you must report on any applications or renewal forms for a medical license, insurance plan participation, and hospital privileges, Silverman cautions. More important, strike force investigators who think they've detected a pattern of improper billing can share the information with state Medicaid fraud control units, investigators from other insurance plans, the OIG, and state medical licensing boards. In short, "Messing with a strike

force investigation can, for all intents and purposes, end a physician's career," Silverman warns.

How Strike Forces Select Targets

The best way to avert a strike force investigation is to avoid attracting the attention of the strike force in the first place. Unfortunately, that's more easily said than done, Silverman remarks. Strike force investigators cast a wide net, and inevitably they look into some practices that are doing nothing wrong—and those practices must spend time and money to prove that they've been treating patients appropriately and billing for their services properly. It's helpful to know how these strike forces operate so that you can be prepared. Here are the major ways that strike forces select physician practices for investigation:

Claims tracking. The private insurers' antifraud strike forces track the claims histories of their physicians, and they look for outliers or unusual claims patterns. If they're already aware of an abusive situation, like the dermatologists described above, they'll focus on that specialty or procedure code and target physicians who seem to be participating, Silverman explains. The strike forces also look at information like the number of procedures claimed per day or per week, and they may target practices that seem to submit an inordinate number of claims.

Subsidized insurance plans. Physicians who do a lot of work for workers' compensation, no-fault, state disability claims, and the like can expect to receive attention, Silverman says. There has been so much fraud in these plans that close scrutiny is almost inevitable for their participants, Silverman says.

Reports to fraud hotline. Every strike force has a method for con-

sumers who suspect fraud to report it—usually a hotline number to call. And every strike force is publicizing this method. So even if you're certain that your practice isn't an outlier and has no compliance problems, a competitor, disgruntled employee, or unhappy patient may report you to the strike force as a way to get back at you for some perceived wrong that may have had nothing to do with your billing practices. And once a report is received, the rules governing these strike forces generally require them to initiate an investigation, Silverman says.

What to Do if You're Investigated

Practices need to understand that a fraud investigation by a private insurer's antifraud strike force is a serious matter, Silverman says. First contact is usually made by letter, asserting that a certain number of claims of a certain dollar amount were improperly billed and paid, and demanding the money back by a certain time—say, within 10 days from the date of the letter. If you receive such a letter, don't panic—but do get to work crafting your response right away, Silverman suggests. Here are some important tips for responding:

Contact your attorney. Get your health care attorney involved from the beginning to help you figure out whether your claims are defensible and to develop a negotiating strategy. In Silverman's experience, the investigator's original demands, in cases where the physician's claims can't be completely defended, can generally be settled for a portion of the initial demand.

Collect records. Collect the records the insurer is questioning and go through them to try to find a pattern. As always, a well-documented record is your best defense. If your documentation is sparse, or if the

documentation for every record flagged is identical, then it's more likely that you'll have trouble convincing the investigator that your claims are legitimate.

Silverman has had cases where the demands were dismissed entirely because he was able to show that the care was appropriate, given the circumstances, and that it was billed correctly. These cases typically involved subspecialists with an unusual patient mix that caused the practice to be an outlier. So if your documentation is clear and thorough and you can explain why your claims history differs from the norm, Silverman says the investigators will sometimes accept the explanation and the matter will close without action.

Insider Says: In some cases, the justification for your recent treatment of a patient may be found way back in the patient's history, says Silverman. In those cases, the investigator may not have requested the records that will explain your treatment. Your attorney can raise this issue and get the investigator to focus on the reasons underlying the treatment you provided.

Get in touch with your specialty society. If your initial explanation doesn't satisfy the investigators, but

you and your attorney believe that the claims are defensible, your specialty society may be able to help. The specialty society sometimes can provide references and documentation showing that certain treatments are effective and appropriate for certain patients. "Specialty societies can't always help, but when they can, it's great to have that prestigious ally behind you," Silverman says. Plus, even if the society can't help you, at least you'll have brought your problem to its attention, and it may be able to focus its efforts on helping others avoid a similar situation.

Get written settlement. If you agree on a settlement, your attorney will draft a settlement document that states that the repayment is a settlement of all claims and that your payment isn't an admission of inappropriate care or improper billing. And Silverman tries to insert a confidentiality clause to ensure that the payor doesn't report the settlement to a state agency or other regulator. All these points are negotiable, he says, and should be handled by your attorney. ■

Insider Source

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FROM OUR READERS

Make at Least One Attempt to Return All Overpayments

In our July 2004 issue, we told you about a system your practice can implement to make it easier to “work”—that is, aggressively follow up—overpayment refunds that your payor is rejecting. In that article (“Establish System for Handling Payors Who Refuse Overpayment Refunds,” *Insider*, July 2004, p. 1), we reported that some states define *de minimus* as amounts that aren’t worth collecting—and, by implication, aren’t worth bothering to refund. We advised you to decline to work those small overpayments to get the payor to accept them and, instead, to return them to the patient or apply them to the patient’s balance (if the patient gives you permission to do so).

After reading the article, one radiology administrator contacted our

source, saying she believed that she didn’t have to return small overpayments that came within her state’s definition of *de minimus*. Instead, she believed that her practice could keep such small overpayments without making any attempt to return them to the payor or credit them to the patient.

According to radiology compliance expert Claudia A. Murray, practices must make at least one attempt to return *all* overpayments to the payor—regardless of their amount. It’s not always necessary to remit small overpayments, you may notify the payor and wait for its response. If the payor acknowledges the money is owed, send a check. On the other hand, if the payor doesn’t recognize the overpayment and the amount is *de minimus*, you may forward the overpayment to the patient or, if the

patient agrees, apply it to his balance. But you may not treat even very small overpayments as “found money,” Murray emphasizes. ■

Insider Source

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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.

- Draft Medicare physician fee schedule: Fed. Reg., 8/5/04, Vol. 69, No. 150, p. 47524.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Pub. L. 108-173 §1842(b)(6) (12/8/03).