

# Radiology Administrator's

## Compliance & Reimbursement Insider

FEBRUARY 2003

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## Use EOBs to Maximize Reimbursement and Compliance

A Medicare Explanation of Benefits (EOB)—which some carriers are starting to call Medicare Summary Notice (MSN)—is more than just a piece of paper that accompanies your reimbursement check from a payor. You can get lots of valuable information from your EOBs that can help improve your practice's or facility's reimbursement and compliance, says accountant and health care consultant Reed Tinsley. Consultant Cynthia Thompson agrees, saying that reviewing your EOBs is essential to the financial and operational success of your practice or facility.

Tinsley suggests that your practice or facility review EOBs every other month, if possible. But at the very least, review of denied claims, in particular, should be an ongoing process. By carefully reviewing your EOBs, you'll be better able to spot problems and inefficiencies, and reduce claims denials, advises Tinsley. For example, EOBs can tell you:

- How good your billing practices are;
- How quickly certain payors reimburse you;
- How efficiently you manage billing and collections; and
- Whether your fee schedule is adequate.

To help you learn more from your EOBs, we'll tell you how to organize them so they're easy to access. We'll also give you five tips for getting the most out of your EOBs. Plus there's a Model Worksheet (see p. 3) that you can adapt and use to chart your claims denials and spot patterns.

### Organize EOBs to Maximize Usability

To get the most out of your EOBs, Tinsley suggests that you organize them so they're easy to retrieve and review. Some practices just file EOBs in the relevant patient charts. But it's hard to spot trends in your EOBs if they're scattered throughout your patient files. Instead, Tinsley suggests, put all the EOBs together in one place so you can review them and find trends more easily. To do this, he recommends that you file your EOBs in notebooks, organized according to payor. That way, you can track denials, delayed or incorrect reimbursement, and other payor-specific problems, he says.

You'll still be able to find information from a specific patient's EOB, even if the EOB isn't in that patient's chart. The patient's chart will tell you when the service was rendered and who the payor is. And if you keep your EOBs organized in each notebook by date of service, you can easily find the EOB you need by checking that date range, says Tinsley.

**Insider Says:** Another option is to enter the data from the EOBs into your computer. Find out whether your software can capture reasons for denials and

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## USE EOBs (continued from p. 1)

generate reports for use in operational decisions, performance evaluations, and other management studies, advises Thompson.

## FIVE TIPS TO FOLLOW WHEN REVIEWING EOBs

Once your EOBs are organized so you can easily access and review them, follow these tips to spot patterns that indicate problems with your operations or policies.

### Tip #1: Pay Attention to Denials

If you spot a zero in the "Amount Allowed" column of the EOB, it means that the claim was denied. Note the reason for the denial. Tinsley recommends having the practice or facility administrator or another designated individual review every denial. Monitor denials by creating a worksheet like our Model Worksheet to keep track of the reasons for denials. Your worksheet, like ours, should list:

- Patient's name;
- Date of service;
- Amount billed; and
- Reason for denial.

Using this worksheet will help you see patterns that may indicate problems in your practice's or facility's operations or billing practices, Tinsley points out. Once you know where the problems are, you can correct them. For example, you may need to revise or update information on encounter forms or on your computer system, or train physicians and coders about common coding errors, suggests Thompson.

If your computer system will allow, Thompson recommends that you create a worksheet or report, using your computer software. Some software programs are capable of generating management reports that can track the reasons for denials if you input the appropriate information, she says. She advises that you contact your software vendor if you aren't sure whether your software is capable of doing this.

Here are some common problems to look for:

**Failure to verify coverage.** One of the most common problems you can detect by reviewing reasons for denials on EOBs is failure to verify your patients' insurance coverage. For example, frequent denials for "coverage not in effect at the time of service" or "client covered by other insurance" may mean your staff isn't doing a good enough job confirming patients' insurance information. If you're getting a number of EOBs denying claims for these or similar reasons, review your policies and procedures on updating and verifying patient information.

**Missing information.** If the EOB says your denied claim "lacks information," it means that the claim didn't give the payor enough information to process and pay for the service, says Tinsley. If you repeatedly see this type of denial, you may have a problem with sloppy billing practices or incomplete patient files, he advises.

**Untimely filing.** Your EOB may say that the payor denied the claim because it was filed after the deadline. That means your practice either

failed to file the claim promptly, or first filed a claim that wasn't clean, then failed to refile the corrected claim within the required time, says Tinsley. If you see this type of denial occurring repeatedly, you probably need to improve your billing and collection processes, he recommends.

**Coding problems.** If a payor denies a number of claims that have the same CPT code or diagnosis code, you may need to do further research to find out why these denials are occurring. The denials may indicate that your staff is billing or coding improperly and needs additional training. For example, if you repeatedly see denials for "visit part of global surgical fee," your billing and coding

staff may need training on the use of modifiers or on the concept of global fees, Tinsley suggests.

**Insider Says:** Repeated denials could also mean that the payor is improperly denying your claims. If so, you need to challenge those denials. Many practices don't check denials to see if the payor denied the claim appropriately and so may be losing out on reimbursement they're entitled to, says Thompson.

**Tip #2: Monitor Payor's Accuracy in Payment**

Review EOBs and compare the payments listed on them to the payor's contracted rates. This tells you whether your payors are paying you

properly. Payors often make mistakes—usually in their favor. If you aren't reviewing the payment amounts on your EOBs, you may be missing reimbursement you're entitled to, says Thompson. She adds that you may be able to use your computer to help you track this. She explains that you could set parameters in your computer system to generate "exception reports," which flag any payments you get that are less than the contract rate.

**Tip #3: Measure Timeliness of Payments**

Timely payment can be critical to a practice's cash flow and financial solvency. You can use your EOBs to find

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**MODEL WORKSHEET**

**Use Worksheet to Detect Patterns in Claims Denials**

Tracking the reasons a payor denied your claims can reveal problems with your practice's operations, as well as payor errors. Here's a Model Worksheet we prepared with the help of consultant Reed Tinsley that you can use to monitor your denied claims.

Prepare a separate chart for each payor so that it's easy to spot problems specific to that payor, suggests Tinsley. Your worksheet, like ours, should include the patient's name, the date of service, the amount billed, and the reason for the denial.

LISTING OF DENIED CLAIMS			
Worksheet preparation date: _____			
Payor name: _____			
Worksheet preparer: _____			
PATIENT NAME	DATE OF SERVICE	AMOUNT BILLED	REASON FOR DENIAL OF CLAIM

**USE EOBs** (continued from p. 3)

out the average length of time it's taking you to get paid for services billed to each payor. Each EOB should have a "control date," says Tinsley. The control date is the date the payor printed the EOB and the related reimbursement check. Compare this control date to the last date of service on the EOB, instructs Tinsley. This will give you an estimate of how long it took to get paid. If you take a sampling of numerous EOBs from the same payor, you can calculate an average payment time for that payor, he says. Your computer software may also be able to help you do this analysis, says Thompson.

You should be getting paid 30 to 45 days, on average, from the date services were rendered, advises Tinsley. If payment is taking longer than 45 days on average, it's a sign that you have a problem in your collection process, he says. But before you assume that the problem is with the payor, look at how long your staff is taking to send out claims; make sure they're filing them promptly.

**Insider Says:** Don't include secondary insurance claims in determining average payment times, says

Tinsley. These claims typically take longer to get paid and could skew your results, he points out.

**Tip #4: Assess Adequacy of Fee Schedule**

One challenge for a medical practice is to establish a fee schedule that's in line with the fees customary in its particular service area. You can use EOBs to check whether your fee schedule is up to par, says Tinsley. For example, if you're getting reduced payments, along with messages on the EOB saying "billed charge exceeds usual, customary, and reasonable level," it could be a sign that your fees are too high, notes Tinsley.

On the other hand, all payors may be paying your charge for a particular service in full. Why? You may be charging less than the usual, customary, and reasonable charge for that service. Managed care plans generally pay a *discounted* charge. So if all your payors are paying you in full, your full charges may be equal to or below their discounted charges. If so, you're probably charging less than most other providers, says Thompson. You may need to research your market and

change your fees, possibly with the help of a consultant.

**Insider Says:** Don't consult other physician practices in your area about what they charge because that could violate antitrust law.

**Tip #5: Evaluate Specific Managed Care Contracts**

You can also use EOBs to help you determine whether you should renegotiate or terminate certain contracts with managed care plans. Many plans keep cutting back on what they pay physicians. But some practices or facilities don't notice this because they don't closely monitor changes in their managed care reimbursement. You can review EOBs from plans to find what they're paying for your most commonly performed services. And that can tell you if certain plans are paying unreasonably low rates or rates that are below your cost to provide the service, says Tinsley. ■

**Insider Sources**

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## Use Attorney-Client Privilege to Protect Sensitive Information

There may come a time when your medical practice could benefit from an independent review, such as a financial audit or a compliance audit. Such reviews focus on whether the practice is coding correctly and following all the applicable rules and regulations that govern it. For example, your practice should have an independent review to investigate an unusual pattern of claim denials, or whenever you have reason to suspect there may be a compliance problem.

At a minimum, a well-designed review will turn up lots of useful information that will help you run your practice better—and sometimes it will unmask situations that need immediate attention.

The problem with initiating a review is that it might reveal sensitive information about your practice. And, depending on who conducts the review, the results can be "discovered"—that is, turned over to your

adversary—if you're ever involved in a lawsuit.

But don't let fear of eventual exposure deprive you of the benefits of independent review, says New Jersey health care attorney Lisa D. Taylor. If you believe there might be a problem, it's crucial to discover the source of the problem immediately, and an independent reviewer can do that a lot more effectively than your own staff can. And if you follow certain steps, you can get around the possibility of

having results discovered, by using the privilege that protects information your attorney uses to represent you. This privilege can protect information the reviewer turns up from discovery in civil court, and may protect the information from disclosure in criminal proceedings. We'll explain how the privilege works and how you can use it. We'll also discuss when you might want to waive—or forgo—the protections of the privilege.

### **Attorney Must Coordinate Review to Get the Privilege**

The law prevents adversaries in civil court—and in many cases even the government in criminal proceedings—from gaining access to the confidential conversations, written exchanges between a client and his attorney, or “work product” the attorney uses in the course of representing you. “The legal system wants to encourage clients to fully confide in their attorneys, so that the attorneys can offer guidance and counsel based on a full understanding of the facts,” Taylor explains. So information the attorney gains and uses in representing you, including review results, should be protected from discovery.

If you hire an auditing or consulting firm to perform the review, or if you have the work done in-house, it's much tougher to keep the results out of the hands of your adversary or the government. That's because business documents produced in the normal course of business are generally subject to subpoena and disclosure in the courts—and to government investigators, including Medicare carriers. But if your attorney hires the reviewer on your behalf and coordinates the reviewer's work and analysis for the purpose of helping you to solve a particular problem, the results then become part of the attorney's work product and are protected by a privilege.

The attorney should determine the scope of the reviewer's work and set it out in writing, Taylor suggests. The scope of the work the attorney hires the reviewer for should be as specific as possible, she says. For example, your attorney could ask the reviewer to “analyze particular charts to confirm compliance with Medicare rules” or direct an auditor to “ascertain the cause of a pattern of denials with respect to certain specified codes.”

It's important that the auditor report results directly to the hiring attorney, rather than to you or someone else in your practice, in order to preserve the privilege, Taylor points out. That means that your attorney must act as the sole conduit of information between the reviewer and the practice, and the reviewer and the practice shouldn't communicate orally or in writing about any aspect of the review while it's underway or after it's completed. And Taylor recommends further precautions to minimize the likelihood of discovery:

- The reviewer should orally discuss findings with the attorney before putting anything in writing;
- The reviewer should submit an unsigned draft statement to the attorney for review before submitting a signed statement of findings; and
- In certain cases where the findings indicate major problems, the attorney should ask that the reviewer not submit any findings in writing.

Although doing it this way will be more expensive than hiring the auditor yourself, Taylor believes it's worth the extra expense to gain the insights of an impartial reviewer without fear that the findings may someday be used against you. Any problems the review reveals will be known only to you and your attorney, and communications between your attorney and you will be protected by the attorney-client privilege. So

you can go about fixing the problems without fear that some third party—or the government—will find out about what the reviewer discovered.

**Insider Says:** Take care not to disclose the results of the review to any third party—like a friend or colleague. If you do, you will have waived the attorney-client privilege and the information will be subject to discovery, Taylor cautions.

### **Sometimes Disclosure Is Recommended**

It's important to remember that if your auditor finds problems, it's probably just a matter of time before a third party—like Medicare—notices that something's wrong, too. Wrapping audit results in the attorney-client privilege isn't a way to commit fraud without fear of detection, Taylor warns. Even if the audit results are protected by the privilege, that doesn't protect you from the consequences of fraudulent or abusive billing practices or other compliance violations.

#### **Attorney's ethical obligations.**

Attorneys have ethical obligations that prevent them from perpetuating a fraud on the court or participating in crimes. So if the audit turns up serious violations and you don't try to fix them, your attorney may have an ethical duty to quit representing you. And in the wake of recent corporate scandals, many states are considering changing attorney licensing laws to require attorneys to report fraud, regardless of privilege. Some states have already begun this process, Taylor reports.

**Self-disclosure.** Also, some types of violations come under the OIG's “self-disclosure” protocol. This is a program in which the OIG agrees to deal less harshly with providers who self-disclose violations of Medicare

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**USE ATTORNEY-CLIENT PRIVILEGE**

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rules. Depending on the audit findings, your attorney may recommend that you self-disclose violations that the audit found and enter into a plan of corrective action with the OIG.

**CIA requirement.** Sometimes the OIG requires that the plan of corrective action be part of a corporate integrity agreement (CIA). CIAs usually have stringent reporting requirements. They may even require that certain information, which might nor-

mally be considered attorney work product and protected from discovery, be turned over to the government, Taylor explains. The OIG may offer a CIA if the practice's violations are serious enough to merit exclusion from the Medicare program, but the OIG believes the practice can operate in a compliant manner and should be given the opportunity to prove its ability to do so. In that case, the OIG may insist that the practice agree to give up some of the confidentiality that it's entitled to in exchange for

being allowed to continue to operate under the CIA.

**Insider Says:** For more information about CIAs, see "Understanding Corporate Integrity Agreements," *Insider*, June 2001, p. 8. For more information about the OIG's self-disclosure protocol, see "Seek Attorney's Advice Before Using OIG's Self-Disclosure Protocol," *Insider*, Dec. 1999, p. 5. ■

**Insider Source**

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## Take Four Steps to Deal with Bounced Checks

From time to time every practice gets a patient's check returned to it because of, say, insufficient or unavailable funds. In other words, the check bounces. If this happens a lot, it can lead to disruptions in your cash flow. But the more serious issue is the administrative burden of collecting the money the patient owes, without alienating him.

Dealing with bounced checks effectively but tactfully can be difficult, but it's easier if you take four simple steps. We'll tell you those steps and give you a Model Policy (see box, at right) that you can post to tell your patients what you'll charge them for a bad check. Plus we'll give you a Model Letter (see p. 7) that you can adapt and send to patients who pass you bad checks.

### Step #1: Learn Your State's Law

Your state law governs how you may handle bounced checks, says New York City health care attorney Matthew Kupferberg. Some states allow you to collect a certain amount more than the value of the check if it bounces. Some states require you to give the writer of the check a set amount of time to make the check

good before you can charge any penalty. But all states allow you to collect the face value of the check plus any fees your bank charged you, Kupferberg says. And many states allow you to charge an additional penalty for your inconvenience.

### Step #2: Set Policy and Post It

Establish a policy about how much you're going to charge patients who write you bad checks, Kupferberg advises. You definitely want to recoup your costs, and you may also want to impose a penalty consistent with your state's law. But for the sake of good patient relations, it's probably a bad

idea to charge the maximum penalty the law allows for bad checks—assuming that your state lets you charge a penalty. You want to discourage patients from writing bad checks, but you don't want to lose their business entirely.

Many practices redeposit a returned check once, and will contact a patient only if the check bounces a second time. But since your bank may charge you each time a check you deposited is returned unpaid, you may not want to do this. Patients may ask you to redeposit a returned check, so if you decide not to redeposit checks

### MODEL POLICY

#### Post Notice to Patients About Bad Check Policy

Collecting on a bad check is easier if the patient knows ahead of time what will happen to him if his check is returned to you unpaid. The simplest method of notifying patients about your policy is to post the policy in the reception area and print it on patient

receipts. But be sure to find out what your rights are under state law before you develop your policy, Kupferberg suggests. Then make a sign, similar to the one below, stating your practice's policy regarding personal checks.

#### XYZ RADIOLOGY CHECK POLICY

We are happy to accept your payment by personal check, but please note that there will be a charge of \$30 for all returned checks.

that bounced once, make this clear up front in your office policy.

Your policy needn't be a long, involved document. A simple one- or two-sentence statement like our Model Policy will do. Be sure to post it prominently in your reception area so that any patient who writes you a check can see it. You might also want to print your policy along the bottom of the receipts you give your patients, Kupferberg suggests. This lets patients know that your office has a method of dealing with bad checks. So they're less likely to feel that you're singling them out if you pursue them for extra fees and penalties. Plus letting patients know the consequences of writing a bad check may discourage them from doing it in the first place.

### Step #3: Send Letter

When your practice gets a check that bounces, deal with it immediately and in writing. This helps protect your rights, since you can prove that you tried to collect the check. Plus many patients will get defensive or embarrassed if confronted about a bounced check in person or on the phone, so a letter is also more tactful.

Send the patient a polite but firm letter, letting him know that his check bounced and he needs to make it good immediately. Like our Model Letter, your letter should:

- Include information identifying the check—such as the date of the check, the check number, and the amount of the check;
- Inform your patient that the check he wrote your practice has been returned, and give the reason for its return (such as insufficient funds);
- Explain your practice's returned check policy;
- Demand the full amount that your practice's policy entitles you to demand;

- Set a reasonable amount of time for the patient to respond to the demand—say, 10 business days from the date of the letter;

- Ask for the payment in cash, money order, or certified check so that you don't just get another worthless check; and

- Explain the consequences if the patient doesn't respond within the time set. For example, in our Model Letter we let the patient know that we'll turn the matter over to a collection agency if we don't get full payment immediately. And we let the patient know that it will cost him more if he allows the check to be turned over to a collection agency.

### Step #4: Follow Up

Once you've sent the letter, someone on your office staff should keep track of the patient's account. After the time frame set in the letter has elapsed, follow up in accordance with the letter, Kupferberg says. Empty threats won't do you any good and won't relieve your staff of the administrative burden of dealing with bad checks. So if the letter says you'll send the check to a collection agency, do it, Kupferberg urges. And make a note in the patient's chart not to accept checks from him in the future. ■

#### Insider Source

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## MODEL LETTER

### Send Letter to Patient Who Bounces Check

Here's a Model Letter that you can adapt to reflect your office's bounced check policy and send to a patient who bounces a check to you. Be sure to make a note of the date you sent the

letter so that you can follow up at the appropriate time. And you may want to make a note in the patient's file so that you don't accept checks from him in the future.

[Insert date]

Paul Jones  
123 Fourth Ave.  
Megalopolis, USA 98765

Dear Mr. Jones:

Your check number [insert #] dated [insert date] in the amount of \$[insert amount] was returned to us unpaid for [insert reason, e.g., insufficient funds].

In accordance with state law, and pursuant to our policy posted in our office, our practice charges a returned check fee of \$[insert amount] for each returned check.

Accordingly, kindly remit to this office \$[insert amount of check plus fee] by [insert date, e.g., within 10 days of the date of this letter]. Payment must be made in cash, by money order, or by certified check.

If we do not receive payment by [insert the date stated immediately above], we will forward your account to our collection agency. Please be advised that should your account be sent to collection, you will be charged an additional fee to cover our collection costs.

Thank you for your immediate attention to this matter.

Yours truly,  
Betty Smith  
Accounts Receivable Manager

## Protect Your Radiology Practice by Setting Nonretaliation Policy

If your radiology practice is like most, you invest a lot of time, energy, and money trying to stay abreast of the many laws and regulations that govern your practice. You probably have a compliance plan that requires your employees to obey all laws and regulations and report any noncompliance to you. But does your compliance plan protect employees and others who report noncompliance? If not, there's a hole in your compliance efforts that can lead to trouble down the road.

That's because many state and federal laws that govern medical practices bar you from retaliating against employees and others who report your practice's noncompliance. Even HIPAA bars every "covered entity"—which includes medical practices—from retaliating against employees and others who report HIPAA violations. So you need a mechanism to ensure that people who report noncompliance in your practice are protected.

We'll explain the nonretaliation requirements that HIPAA and some other laws impose on medical practices. And we'll give you a Model Policy (p. 9) that you can adapt and use in your practice.

### 'Whistleblowers' Are Protected Under Federal, State Law

The government has been concerned for years about protecting whistleblowers from retaliation, says New York health care attorney Matthew Kupferberg. In fact, there's a specific whistleblower protection in the Civil Rights Act that permits an employee who has reported wrongdoing to sue for violation of her civil rights if she encounters retaliation. Similarly, the False Claims Act has provisions pro-

tecting people who report suspected Medicare fraud from retaliation. And many state laws have similar provisions, Kupferberg reports.

The OIG emphasized the importance of protecting employees from retaliation for reporting wrongdoing, in its Compliance Guidance for Small Physician Practices, notes Virginia health care consultant Nisha Shajahan. This guidance says that an effective compliance plan will allow employees to report suspected violations without fear of retaliation, and even suggests that practices consider permitting anonymous or confidential reporting mechanisms to protect against retaliation, Shajahan says.

### HIPAA Bars Retaliation for Reporting Violations

Even though most practices realize that they can't retaliate against persons who report their suspected wrongdoing, many practices haven't adopted a formal policy yet. But you might as well start formulating a non-retaliation policy now because the *HIPAA privacy regulations* bar covered entities from retaliating against people who disclose HIPAA violations or who oppose practices that may lead to HIPAA violations. So while you're implementing other HIPAA requirements, it makes sense to adopt a nonretaliation policy, too.

### Adopt Nonretaliation Policy for Your Practice

Formulating a coherent nonretaliation policy that your employees can understand and you can follow is tough. But Shajahan's company has developed a policy that you can adapt and use in your practice. Your nonretaliation policy, like our Model

Policy, should contain the following provisions:

**Obligation to report.** Your policy should contain a statement that it's your employees' obligation to report suspected wrongdoing or noncompliance [Policy, par. 1]. Depending on the size and structure of your practice, you may want to designate a specific person, like the compliance manager, to receive these reports. Or you may want your policy to suggest that employees report suspected wrongdoing or noncompliance to their supervisor, the practice manager, or one of the owners of the practice. And you may want to note that employees can make reports about noncompliance through whatever confidential reporting mechanism your practice's compliance plan established—such as a hotline or a drop box.

**Open-door policy.** Your policy should state that your practice's management will maintain an open-door policy regarding the receipt of and response to reports of noncompliance [Policy, par. 2]. Your policy should state that management will also receive and respond to reports from patients, vendors, and others—not just employees, Kupferberg adds.

**Good faith, reasonableness standard.** Your policy should state that employees and others are protected from retaliation provided that their reports or their objections to any of the practice's procedures are made in good faith and that the manner of their expression is reasonable and doesn't violate any laws [Policy, par. 3]. This is important because you don't want to be hamstrung by your nonretaliation policy when dealing with troublemakers or bad apples, Kupferberg points out.

**Nonretaliation statement.** Your policy should say that your practice won't retaliate against anyone for making a report or participating in any process to investigate or correct compliance violations [Policy, par. 4]. Because this is the heart of your policy, it should be quite specific, Shajahan says. It should protect people from any sort of retaliation if they exercise their

rights under law, participate in any internal or external investigations, make reports to government agencies, or testify or provide evidence in any proceeding, she explains.

**Retaliatory behavior subject to discipline.** The policy should make it clear that anyone who engages in retaliatory behavior is subject to disci-

pline, including termination of employment [Policy, par. 5]. ■

#### Insider Sources

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**Nisha Shajahan, MPH:** Associate Consultant, Strategic Management Systems, Inc., 112 S. West St., Ste. 200, Alexandria, VA 22314.

## MODEL POLICY

### Set Nonretaliation Policy for Your Practice

A specific nonretaliation policy shows your employees that compliance is serious business at your practice, says Virginia health care consultant Nisha Shajahan. An effective nonretaliation policy will make reporting mandatory, require management to receive and respond to reports, and will protect all

appropriate reports of noncompliance. Here's a nonretaliation policy that's based on one developed by Shajahan's company. You can adapt it for use in your practice, and distribute it your employees—or put it in your employee manual.

## NONRETALIATION POLICY

ABC Radiology is committed to compliance with all laws and regulations that govern medical practices, and wishes to foster an environment in which all employees and others feel free to report possible instances of noncompliance. Accordingly, ABC Radiology adopts the following policy to protect employees and others from intimidation, threats, coercion, discrimination, or other retaliatory action.

1. **Employees Obligated to Report.** It is the responsibility of all employees of ABC Radiology to report perceived misconduct, including actual or potential violations of laws, regulations, procedures, the ABC Radiology Code of Employee Conduct, and the ABC Radiology Compliance Plan. Employees may report misconduct to their supervisor, the compliance officer, or the practice owners, or use the confidential reporting mechanism as set forth in ABC Radiology's compliance plan or as described in the ABC Radiology Employee Handbook.
2. **Management Has Open-Door Policy.** All management employees, including supervisors, compliance officers, and practice owners, must maintain an "open-door policy" to encourage employees, vendors, patients, and others to report problems and concerns. Any person who receives a report of perceived wrongdoing or violation is obligated to investigate personally or forward the report to a person charged with investigating reports of misconduct, as appropriate.
3. **Reports Must Be Good Faith, Reasonable.** This nonretaliation policy applies to all reports or expressions of opposition to the practice's procedures that are held in good faith and that are expressed in a manner that is reasonable and that does not violate the law.
4. **Practice Will Not Retaliate.** ABC Radiology will not retaliate through harassment, intimidation, denial of promotion or raises, or loss of employment or business opportunities, or in any other manner, against employees, individuals, and others for:
  - a. Exercising any right under, or participating in any process established by federal, state, or local law or regulations or ABC Radiology policies; or
  - b. Making a complaint with ABC Radiology, any third-party payor, or any state or federal regulatory or law enforcement agency including the Office of Inspector General and the Department of Health and Human Services; or
  - c. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or
  - d. Opposing in good faith any act, practice, or procedure that is unlawful by federal, state, or local law or regulation or that is improper according to ABC Radiology policies.
5. **Violators Subject to Discipline.** Any employee of ABC Radiology who violates this nonretaliation policy is subject to discipline, up to and including immediate termination of employment with ABC Radiology for cause.

## ASK THE INSIDER

RACRI welcomes questions from subscribers. You can 1) send your questions to Brownstone Publishers, Inc., "Ask the Insider," 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 2) fax (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail [jgormley@brownstone.com](mailto:jgormley@brownstone.com)

### Small Providers Don't Get HIPAA Exemption or Delay

**Q** I'm the office manager of a radiology practice with just four physicians. I've been trying to get the office HIPAA compliant, but one of the physicians insists that he heard at a conference that small practices are exempt from HIPAA. Another physician says that HIPAA applies to us, but that we have a longer time to comply with the regulations.

I think they're both wrong, and I'm afraid we'll be in trouble if we don't get started on HIPAA compliance right away. Does HIPAA have any special exemptions or delays for small medical practices?

**A** Small medical practices aren't entitled to any special treatment under the HIPAA privacy regulations or under the proposed HIPAA security regulations (as they now stand), says Florida health care attorney Susan Wilson. Small health *plans* get extra time to comply with the HIPAA privacy regulations, but small medical practices aren't entitled to this delay, she says.

Chances are your practice is covered under HIPAA. HIPAA says that all "covered entities" will be required to comply with all aspects of HIPAA. And a medical practice is a covered entity, regardless of size, if it bills electronically or transmits any health information in electronic form to another party to carry out financial or administrative activities related to health care, Wilson explains.

But if the practice doesn't bill electronically or engage in any other electronic transmission of information related to health care, then the practice isn't a covered entity, and it needn't comply with HIPAA. Only a very small group of practices will be in this situation, because Medicare requires almost all providers to bill electronically, Wilson explains. The only providers that are exempt from this Medicare requirement are small medical practices with fewer than 10 full-time equivalent employees.

But many small medical practices covered by this exemption, and those that don't treat Medicare patients, still bill electronically even though they're not required to do so. And many health plans require all their enrolled providers to bill electronically.

The bottom line, says Wilson: You're not a covered entity and HIPAA doesn't apply to your practice *if* your medical practice is small enough to be exempt from Medicare's electronic billing requirement (or you don't treat any Medicare patients) *and* you don't bill Medicare or any other payor electronically or engage in any other electronic transmission to carry out financial or administrative activities related to health care. But, Wilson emphasizes, it's crucial to have your practice's attorney review your situation and advise you about what HIPAA means to your practice.

**Insider Says:** If you're a covered entity under HIPAA, then you've been required to comply with the HIPAA transactions standards since October 2002 (unless you filed for an extension) and will be required to comply with the privacy rule starting April 14, 2003. ■

#### 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.

- HIPAA privacy regulations non-retaliation standard: 45 CFR §164.530(g).