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Inventory Your Business Associate Contracts to See if You Get Extra Time to Comply

The August 2002 changes to the HIPAA privacy regulations included a major change to the compliance deadline for the business associate contract requirements. The privacy regulations previously required health care organizations (except small health plans) to have contracts in place with their existing business associates no later than April 14, 2003. But after the recent changes, the regulations now allow organizations subject to that deadline up to one extra year to get some of these contracts in place. (The compliance deadline for small health plans, April 14, 2004, is unaffected by the changes.)

This extra time may be just what you need to complete some of your other HIPAA compliance projects. But it's available only for certain business associate contracts. So how do you know which contracts must comply sooner rather than later?

With the help of our legal experts, we'll explain what the HIPAA privacy regulations now require. And we'll provide a Model Form (see p. 3) that you can use to inventory your business associate contracts and determine when each one must be HIPAA compliant. We've filled in some examples on the Model Form to show you how to use it.

New Deadline Applies Under Two Conditions

The privacy regulations require you to have a written contract with each business associate to set out how it will safeguard the protected health information (PHI) you share with it. Generally, except for small health plans, you must have your business associate contracts with your existing business associates in place by April 14, 2003. But changes to the privacy regulations added a new exception to this deadline for certain contracts and other written arrangements with business associates. This exception allows a practice to continue to operate under an existing contract with a business associate for *up to* one additional year—that is, up until April 14, 2004, explains health care attorney Todd C. Brower.

The extra time is automatically available if two conditions are met: 1) The contract must be signed and in operation before Oct. 15, 2002, and 2) it must *not* be renewed or modified in the period starting on Oct. 15, 2002, and ending before April 14, 2003.

Condition #1: Contract Signed and in Operation

The changes to the regulations say an organization must have "entered into" and "been operating pursuant to" the contract before Oct. 15, 2002, as one condition for getting extra time on the business associate deadline. "Entered into" before Oct. 15, 2002, means that the parties must have signed the contract before that date, explains health information attorney Michael C. Roach.

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BUSINESS ASSOCIATE CONTRACTS (continued from p. 1)

The regulations don't specify what "operating pursuant to" the contract before Oct. 15, 2002, is. But generally, this means that the contract is in effect and the parties are performing their duties under the contract, Roach says.

It's not uncommon for a contract's signature date and effective date to be different. If either date occurs on or after Oct. 15, 2002, you could have a problem, Roach suggests. "Taking a cautious approach, I would advise covered entities to consider only those written agreements that have been signed *and* have an effective date prior to Oct. 15, 2002, to be eligible for the extension," says Roach.

Insider Says: Don't backdate your contracts, warns health information attorney Edward Shay. It could put you at risk of a HIPAA violation, he says. Someone may know about it or a dispute may arise and the other party could blow the whistle on you. "A disclosure of protected health information under these circumstances could be construed as 'knowingly' violating the business associate requirement for a disclosure made post-April 14, 2003," he suggests.

Condition #2: No Interim Renewal or Modification

The other condition to be eligible for the deadline extension is that the existing contract mustn't be renewed or modified at any time on or after Oct. 15, 2002, until, but not including, April 14, 2003. This could apply, for instance, if the contract has a clause that specifies the date it's up for renewal. Or the contract may not include a renewal clause, but simply end after a specified period (for example, one year), and the parties may decide to renew it. Or the parties may want to make changes to the contract during its term. If this renewal or change occurs during the above time period, the contract generally isn't eligible for the deadline extension.

According to the preamble to the changes to the privacy regulations, this condition is triggered only if the renewal or modification involves some action by the parties. In other words, an evergreen contract—one that automatically renews, say, every six months, without any action by the parties or changes to its terms—would be eligible for the deadline extension. In an example given by HHS, an automatically renewing contract that includes an inflation adjustment but no other changes to any terms of the contract would still be eligible for the extension.

Insider Says: For more information on what to include in a business associate contract, see "How to Create a Business Associate Contract," *Insider*, Nov. 2002, p. 7.

Inventory Your Contracts

To take advantage of this extra time, you'll need to determine which contracts, if any, meet the new exception. To do this, you can create an inventory showing the relevant details of each of your business associate contracts, suggests Brower. You may already have a list of your business associate contracts that you can adapt for this purpose, he notes.

Our Model Form can help you organize your inventory. It consists of eight columns in which you would enter the following information for each business associate contract:

- The business associate's name;
- The services it provides;
- The date the contract was signed (and effective date, if different);
- Whether the contract was signed and in effect before Oct. 15, 2002;
- The contract's renewal or modification date;
- Whether the contract was or will be renewed or modified on or after Oct. 15, 2002, but before April 14, 2003;
- Whether the exception applies; and
- The HIPAA compliance date for the contract.

Place Contracts in Three Categories

Once you've completed the inventory, you'll be able to place each of your business associate contracts into one of three categories, suggests Brower:

Category I: Compliance deadline extended. This first category should include contracts that were in place before Oct. 15, 2002, and *won't* be renewed or modified on or after Oct. 15, 2002, and before April 14, 2003. Since the exception applies to these contracts, the compliance date for these contracts is the *earlier* of:

- The contract renewal or modification date after April 14, 2003 [Form, company A]; or
- April 14, 2004 [Form, company B].

► *What to do.* You can put these contracts aside for now, says Brower. But don't forget about them, he warns. Make them your first priority after your other business associate contracts are in place.

Category II: Compliance deadline unchanged. This second category should include contracts that were in place before Oct. 15 but *will* be—or have been—renewed or modified on or after Oct. 15, 2002, and before April 14, 2003. The exception *doesn't* apply to these contracts, so the compliance date for them remains unchanged—April 14, 2003 [Form, company C].

► *What to do.* These contracts must be amended or renegotiated

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MODEL FORM

Determine if New Deadline Exception Affects Your Business Associate Contracts

Use the Model Form below to create an inventory of all your contracts with business associates. It can help you determine which of the contracts fall within the new exception to the compliance deadline for business associate requirements. For those that do, you'll have extra time to get the required business associate language in place. (This Model Form doesn't apply to small

health plans, which have until April 14, 2004, to comply with the business associate requirements.)

The Model Form was developed with the help of health care attorney Todd C. Brower. We've included examples—listed as company A through E—to help illustrate how the new exception works.

BUSINESS ASSOCIATE CONTRACT INVENTORY

INSTRUCTIONS: For each contract, give the following information:

- Col. 1:** Name of the business associate
- Col. 2:** Services provided
- Col. 3:** Date contract signed (and its effective date, if different)
- Col. 4:** Whether either of those dates falls before Oct. 15, 2002 (say "yes" or "no")
- Col. 5:** Contract's renewal or modification date
- Col. 6:** Whether that date is on or after Oct. 15, 2002, and before April 14, 2003 (say "yes" or "no")

Col. 7: Whether the exception applies (say "yes" if the answer in column 4 is "yes" and in column 6 is "no"; in all other cases, say "no")

Col. 8: Applicable HIPAA compliance date for each contract (if the answer in column 7 is "yes," this is the earlier of the date in column 5 or April 14, 2004; if the answer in column 7 is "no," it's April 14, 2003)

Bus. Assoc. Name	Services Provided	Date Signed (& Eff. date, if diff.)	Before 10/15/02? (Y/N)	Renewal/Modif. Date	10/15/02-bef. 04/14/03? (Y/N)	Exception Applies? (Y/N)	Compliance Date
Company A	Billing Svcs.	9/1/02	Yes	9/1/03	No	Yes	9/1/03
Company B	Document Destruction	8/15/02	Yes	8/15/04	No	Yes	4/14/04
Company C	Software Svcs.	2/1/02	Yes	2/1/03	Yes	No	4/14/03
Company D	Medical Record Storage	3/31/03	No	3/31/04	No	No	4/14/03
Company E	Managerial Svcs.	6/01/03	No	6/01/04	No	No	6/01/03

BUSINESS ASSOCIATE CONTRACTS

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to add the required business associate language by April 14, 2003, advises Brower.

Type III: New contracts. This third category includes new contracts—that is, any contract signed or in effect for the first time on or after Oct. 15, 2002. The exception doesn't apply to these contracts. The compliance date for these contracts is April 14, 2003 [Form, company D]—*unless* the contract is signed and goes into effect after April 14, 2003. If the contract is signed and goes into effect after April 14, 2003, the contract must comply with the business associate requirements

when signed, or effective, whichever is earlier [Form, company E].

► *What to do.* If you're signing any new business associate contracts after Oct. 15, 2002, you should automatically include the required business associate language in each one, reminds Brower. Although, technically, the business associate language isn't required until April 14, 2003, including it sooner means you won't have to revise the contract later, he points out.

Insider Says: Don't avoid making contract amendments just to qualify for the compliance extension, cautions Shay. "You need to continue to manage your contractual relationships in accordance with your current business needs

and not let the business associate extension become a driver in those relationships," he says. For example, suppose a practice needs to amend a contract with a vendor, but amending the contract would make the practice ineligible for the extension. "I would counsel the practice to address that situation now rather than defer it to avoid the business associate amendment," he says. ■

Insider Sources

Todd C. Brower, Esq.: Shareholder, Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone, PC, 101 Eisenhower Pkwy., Roseland, NJ 07068.

Michael C. Roach, Esq.: Partner, Michael Best & Friedrich LLC, 401 N. Michigan Ave., Ste. 1900, Chicago, IL 60611.

Edward Shay, Esq.: Partner, Post & Schell, PC, 1800 JFK Blvd., 19th Fl., Philadelphia, PA 19103.

CMS Relaxes Requirements for LOCM Payment Under OPSS

On Nov. 22, 2002, CMS published a program memo that eases the requirements for payment to hospitals for low osmolar contrast media (LOCM) under the Outpatient Prospective Payment System (OPSS). Previously, hospitals needed to distinguish between LOCM and high osmolar contrast media when submitting claims. And CMS would reimburse for LOCM only for patients with certain diagnoses, says Virginia health care attorney Thomas Greeson.

But now, the OPSS system doesn't distinguish between the different types of contrast media. Instead, payment for a particular procedure is the same regardless of the type of contrast media used—that is, there's no longer a difference in payment rate between a procedure using LOCM and a procedure using high osmolar contrast media or any other contrast media. So CMS has lifted the requirements that restrict the payment for LOCM to patients with particular diagnoses.

What Does the Program Memo Say?

The program memo says the following:

No edit of claims. It instructs intermediaries *not* to edit a claim for LOCM if the claim doesn't reflect a designated diagnosis. But there's an exception to this instruction: Hospitals that don't bill under the OPSS system must still use the old system, and for them, payment will still be restricted based on the patient's diagnosis.

Billing for LOCM. The program memo describes how all procedures using LOCM performed on or after Jan. 1, 2003, at a hospital under the OPSS system should be billed. Hospitals billing under the OPSS system must either:

- Include the charge for the LOCM in the charge for the diagnostic procedure; or
- Bill it separately as a "drug incident to radiology services" or

as a "drug incident to other diagnostic services."

The amount of the payment will depend on the procedure performed, Greeson explains.

Return claims. The program memo instructs intermediaries to return any claim they receive for services performed on or after Jan. 1, 2003, using HCPCS codes A4644, A4645, or A4646. If a claim of yours is returned, you should resubmit it using the new instructions, Greeson says.

Insider Says: You can find the program memo on the CMS Web site at <http://cms.hhs.gov>. Click on "manuals" in the left-hand column. Scroll down to "Program Memoranda," click on "2002 Program Memos," and look for program memo A-02-120, Nov. 22, 2002. ■

Insider Source

Thomas W. Greeson, Esq.: Reed Smith LLP, 2880 Fairview Park Dr., Ste. 1400, Falls Church, VA 22042.

IN THE NEWS

Senate Passes Bill to Freeze 2003 Physician Fee Schedule at 2002 Levels

On Jan. 24, the U.S. Senate passed an FY 2003 omnibus appropriations bill that includes an amendment that would freeze Medicare payments to physicians under the Part B fee schedule at 2002 levels until Sept. 30, 2003. Although this may seem like bad news, it's not—assuming that the bill becomes law. The 2003 physician fee schedule that CMS published in the Dec. 31, 2002, *Federal Register* would result in an overall reduction in Medicare program payments to physicians below the 2002 levels—and would reduce physicians' payments overall for the second year in a row.

We'll explain why even CMS thinks the 2003 CMS fee schedule and the payment reductions in it are inappropriate and supports a legislative change. And we'll tell you how implementation of the 2003 fee schedule may be averted if the House of Representatives passes the same version of the bill as the Senate and President Bush signs it by March 1, 2003.

Flawed Formula Causes Reduction

According to a Dec. 20, 2002, CMS press release, which accompanied the release of the 2003 fee schedule, the 2003 fee schedule would result in a 4.4 percent reduction in payments to physicians. This reduction would come on top of last year's reduction of almost 5.6 percent.

To calculate the physician fee schedule, CMS uses a "conversion factor," which is supposed to reflect the overall rate of inflation and fluctuations in the cost of providing health care services. This conversion factor is used to adjust the base fee calcula-

tion for all physician services. But in its press release, CMS attributes both the 2002 and the 2003 payment reductions to a flaw in the formula that the law requires CMS to use to determine the physician fee conversion factor.

CMS has known about this problem and delayed publishing the 2003 fee schedule while it refined its method for calculating the rate of inflation. As a result, CMS was able to limit the reduction to 4.4 percent rather than the 5.1 percent reduction that would have occurred without the refinement.

"CMS has done everything it can to shore up physician payments for 2003, but only Congress has the authority to fix the formula," noted CMS administrator Tom Scully in the press release. "We want doctors, and patients, to see Medicare as a trustworthy partner in providing quality services. Fixing the formula to provide an accurate update (which we think should be 1.6 percent for...2003) is essential to restoring that trust," he continued.

Physician Groups Protest, and Congress Reacts

The American College of Radiology, the American Medical Association, the Medical Group Management Association, and many other physician organizations protested the 2003 CMS fee schedule. Congress tried last year to pass a bill that would correct the flawed formula. Although the House passed it, Congress adjourned before the Senate passed the bill. So on Jan. 7, in an attempt to enact a temporary fix while negotiating a revision to the flawed formula, a joint resolution of Congress was introduced that

would halt implementation of the 2003 fee schedule and freeze Medicare payments at their 2002 levels for one year. The amendment that the Senate has now passed is, in essence, buying time for Congress to enact a permanent fix. Because Congress hasn't agreed on other portions of the appropriations bill, no vote on it had yet been scheduled in the House as the *Insider* went to press. If Congress doesn't pass the bill in time for President Bush to sign it by March 1, CMS's proposed 2003 physician fee schedule based on the flawed formula will go into effect.

Professional associations of health care providers continue to lobby to secure passage of the bill before the deadline. In a press release dated Jan. 24 and posted on the media section of the AMA Web site (www.ama-assn.org), AMA president, Dr. Yank D. Coble, said, "This Senate action, if signed into law by March 1, will stop the hemorrhaging in the Medicare program and prevent an access meltdown for Medicare patients."

Dr. William M. Jessee, president and CEO of the Medical Group Management Association (MGMA), also emphasized the importance of the bill to secure continued access to treatment for seniors. In a statement posted in the pressroom section of the MGMA's Web site (www.mgma.com), he said, "Physician groups are struggling to subsidize the Medicare segment of their practices. To offset rising costs and declining reimbursement, they must treat fewer Medicare patients, eliminate staff, close rural offices and postpone investments in

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IN THE NEWS (continued from p. 5)

new technology. Each of these actions directly affects the integrity of the Medicare program.”

Be Prepared for Cuts if House, President Don't Act

Because CMS delayed issuing the 2003 fee schedule, it didn't go into effect on Jan. 1, as it normally would have. Instead, physician services will be reimbursed at the 2002 rates until March 1, 2003. After that date, unless

the House of Representatives and the president act, the new fee schedule will take effect and physicians will see an overall decrease in payments of about 4.4 percent.

Radiologists who share in technical component fees for services like MR and CT may be less affected because adjustments in the RVUs associated with the technical components of these procedures will result in higher payments. But radiologists who depend on professional fees for the bulk of their revenue will take a hit.

Insider Says: You can find the press release announcing the 2003 physician fee schedule at <http://cms.hhs.gov>. Point to Public Affairs at the top of the page, then click on “current press releases,” and scroll down to “Dec. 20, 2002—Medicare Announces Physician Pay Changes for 2003.” To get more information on the 2003 fee schedule final rule, return to the CMS home page and scroll down to the headline “CMS Announces 2003 Medicare Physician Fee Schedule Final Rule Published 12/31/02.” ■

Protect Your Radiology Practice with Disaster Recovery Planning

If you're like many private radiology practices, you probably spend a lot of time, energy, and money protecting your physicians and practice against the risk of medical malpractice lawsuits. But there are a lot of other risks—like fires, earthquakes, or other disasters—that can damage your office space or make it unsafe to occupy. This damage can disrupt your business operations just as badly as a large malpractice judgment can. And, according to the experts we spoke to, many practices skimp on protecting themselves against these risks.

We'll describe some of these risks that private radiology practices need to think about. And we'll show you how to help protect yourself against those risks. Plus we'll tell you about insurance that's available to protect you against the risks from those disasters and give you some advice about how to shop for an insurance policy.

Evaluate Your Practice's Risk Factors

The first step to making sure your practice is protected is to find out what risks your practice is exposed to, says

South Carolina health care consultant Peter Lucash. Consider the following:

- What's the weather like in your locale? If hurricanes, tornadoes, or blizzards are likely, you should formulate a plan to help you get through any weather event that may disrupt your operations. If your practice is located in an earthquake zone, factor that into your planning.

- How do you protect your practice's records? If you still keep paper records, a hurricane or an earthquake that scatters your records could devastate your practice. If your records are electronic, a fire or flood could destroy all your data if you don't have recent backup at another location.

- Does your practice have one indispensable employee who knows all about the practice's billing and collection system, as well as its business relationships with vendors and others? If so, you're leaving yourself vulnerable should something happen to that employee—or if your trust in that employee turns out to be misplaced.

“The important point is to think through all these scenarios ahead of

time and prepare for them as much as you can. Insurance will pay you money for a loss, but it can't reconstruct lost records for you,” says Lucash.

Minimize Exposure Through Prior Planning

Once you've identified and weighed the risks that your practice is exposed to, think hard about how to prevent or minimize losses. Lucash says that most practices can benefit from taking the following steps:

Distribute current contact list.

You should have an up-to-date contact list with the address, phone number, cell phone number, and/or pager number of everyone on your staff, Lucash says. All the practice's physicians, supervisors, and managers should have a copy of that list.

Arrange for off-site storage. All practices should have off-site storage for copies of certain records so that information that's crucial to your practice will be available in case of a fire, flood, or other catastrophic event at your office location. Copies of the patient list, the last few months of

accounts receivable (A/R) records, and patient records should be kept at a secure off-site facility, Lucash suggests. Be sure to update these records regularly so that current information is always available.

If you keep records electronically, make backup tapes at least monthly, and store those backup tapes at a secure facility. And make sure that the off-site facility is truly secure. For example, don't rely on fireproof safes for storing diskettes and electronic tapes because in the event of a fire, the information on the diskettes and tapes can be corrupted. Instead, invest in a "media safe" that's designed to protect the integrity of electronic media, Lucash suggests.

Insider Says: If your practice is in an earthquake or flood zone, Lucash recommends that the storage facility be located at least 50 miles away from your practice location.

Make a video. If there's ever an event that destroys your office or its contents, you'll need a good record of what you lost. A dated, narrated video is one of the best ways to validate your losses, says Lucash. Go through the office slowly and describe the furnishings, equipment, and other items as you film them. Make a note of the price of each item and the date that you bought it or the rental charge if the item is leased. Don't forget to make at least one copy (preferably two) of the video and to keep each copy in a separate, secure location.

Have a contingency plan. Think about what would happen if your office or facility were destroyed or couldn't be used for a period of time. How long a period of interruption could your practice survive? If, like most practices, yours would need to be back in business within a couple of weeks to remain viable, you should have some alternative sites in mind

before disaster strikes. Do you have a satellite office that you could move into temporarily? Is there space you could use in your hospital or a nearby office building? Would a mobile facility suffice temporarily?

Considering these options ahead of time can make a big difference should you ever need to relocate your practice suddenly, Lucash says. Having a plan in mind can help your practice recover as fast as possible.

Share responsibilities among employees. Make sure that more than one employee is familiar with every system, Lucash emphasizes. If only one employee knows the billing and collections system and that employee is away on vacation when some catastrophe occurs, you could be hamstrung until the employee returns. That's a bad business practice, Lucash says, because it hampers your efficiency. Plus it makes you susceptible to dishonest employees, he notes.

Insure Against Business Losses

Even the best planning can't protect you against all risks. But there are insurance products that can provide you with a comfortable cushion if a catastrophic event affects your practice's ability to operate. These are commonly called "box policies," and they typically have three components:

1) A general property insurance component that insures your office or facility against loss due to a casualty such as a fire, hurricane, or building collapse. *Note:* In flood zones, earthquake zones, and other susceptible areas, you may need to buy an additional rider to protect you against those specific risks;

2) A general liability component that insures your practice against losses for injuries to third parties—for

example, if a patient slips and falls in your office; and

3) A business interruption component that reimburses your practice for certain costs you may incur if you must cease operations for a period of time and/or move operations to another location.

Make Sure Business Interruption Component Meets Your Needs

The business interruption component of the major insurers' box policies varies significantly in price and in what's covered. But it may be the most important part if something happens and it takes you a while to get the practice going again. A good business interruption policy will help you pay your employees, secure temporary space if necessary, and keep your business going despite the disruption.

So Lucash suggests that when considering buying a box policy, read it carefully to find out whether the business interruption component will do the following:

Pay your A/Rs. If you're unable to see patients because your office was destroyed, a good policy will pay you an amount similar to the amount you would have collected under normal circumstances.

Insider Says: Always maintain good A/R records: The better your records of what you've been collecting in the recent past, the more likely that the insurer will pay you a comparable amount, Lucash says.

Provide virus protection. Many good policies offer you protection against computer viruses and will reimburse you for the cost of professional data recovery services if a virus destroys your data. But keep in mind that data recovery doesn't always work, so there's no substitute for maintaining

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DISASTER RECOVERY PLANNING

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up-to-date virus protection and using it religiously, Lucash points out.

Pay expenses associated with temporary operations. If your office isn't usable for some period of time and you must reestablish your practice elsewhere, a good policy will cover things like rent at your alternative location, cell phones, furniture, computer and medical equipment rental, and so on. The best policies will advance you cash for these purposes—you could find yourself strapped if you must pay for these items out-of-pocket and wait for reimbursement, Lucash points out.

Insider Says: Some companies may offer only some of the coverage described above as a rider that will cost extra, Lucash warns. But you should carefully consider the potential losses if you don't have the coverage, before you reject the additional rider, he adds.

Protect Yourself Against Dishonest Employees

Although not generally part of a box policy, your insurance broker can also

help you get an employee dishonesty bond. If an employee steals from you, this type of policy protects you by reimbursing you for the amount stolen. Lucash suggests that you buy one of these bonds for each of your employees who handles money for your practice. The insurer generally does a brief background check on each employee you want to be bonded and may refuse to bond an employee with, for example, a poor credit history, says Lucash. The insurer also may reserve the right to audit your practice periodically or require you to conduct independent audits, in order to maintain the bond.

Look for Terrorism Insurance in the Future

Although it's not readily available now, you may soon be able to get a policy that insures you against losses due to terrorism, biohazard exposure, and so on. At this time such policies are difficult to find, but in the current climate, demand for this type of coverage is increasing. Over time, insurers will get a better sense of exactly how much risk is involved in writing these policies, and they may become

more readily available and affordable, Lucash says.

Use a Reputable Insurance Broker

When shopping for a box policy or any insurance product, it's important to deal with reputable people. Your accountant and your attorney can help steer you toward a reputable insurance broker, says Lucash. He also notes that both these professionals may be able to help you decide specifically what risks you should insure against and give you good advice about what insurance products may be best for your practice. Other physicians in your area may be able to steer you toward insurance professionals who understand the needs of medical practices. Above all, Lucash recommends, consult two or three brokers, ask a lot of questions, and read all the fine print before you decide to buy a particular policy. ■

Insider Source

Peter Lucash: Lucash & Co., 4 Carriage Ln., Ste. 406C, Charleston, SC 29407; (843) 402-0900; peter@lucash.com.

MANAGED CARE**Catch Underpayments from Payors**

Times are tough, and radiology practices, like most businesses, are feeling the pinch. So it's more important than ever to make sure you're getting all the money you're entitled to. But if your practice is like most radiology practices, you may be losing money you're entitled to every

day. That's because many payors probably aren't paying you what they should.

We'll tell you about how payors can underpay you, whether intentionally or not. And we'll show you how you can track your payments and compare them to your fee

schedule so you can find out if you're being underpaid. If you don't have copies of a payor's fee schedule, we'll demonstrate, step-by-step, how to analyze your explanation of benefits (EOBs) to catch payors that are shortchanging you. Plus if you use a billing service, we'll explain

how you can help it to track discrepancies between what you're supposed to be getting and what you actually get. If you follow our advice, you should see an increase—maybe a substantial increase—in your revenues, says New Jersey billing expert Barbara Cobuzzi.

How Payors Typically Underpay Providers

Cobuzzi says it's very common for a payor to pay a provider less than it's entitled to under the fee schedule agreed to in the payor contract. There are many ways this can happen to your practice. For example:

- You and the payor may have agreed in the contract to upwardly adjust your fee schedule periodically, but the payor didn't make these adjustments;
- The payor may offer several different plans with different fee schedules and may pay you in accordance with the lowest paying plan's fee schedule, even though you're entitled to get more; and
- The plan may have agreed in the contract to pay you the higher of two rates—say, the greater of 120 percent of the Medicare allowable rate or an amount the plan sets forth in its fee schedule. But, instead, it pays you the lower amount.

Use Fee Schedule to Catch Underpayment

In a perfect world, you would have copies of the fee schedules that you agreed to with all your major payors and you would be able to tell easily if you were being underpaid. Although many practices don't have fee schedules for all their major payors, you probably have some. For payors that give you their fee schedules, Cobuzzi suggests that you do

one of two things to check for underpayments:

- Use your billing software to compare "expected" payment versus actual payment or the percent variance between the expected payment and the actual payment. If your software has that capability, just plug in the payor fee schedule as your expected payment. Enter the payments you receive as the actual payment. The software will be able to tell you if you're being underpaid.
- If your billing software can't track and compare expected payments, you'll have to make the comparison manually. Put together a book or a binder that contains your payors' fee schedules, and from time to time—say, every couple of weeks, monthly, or every six months, depending on how big a problem you think you have—sit down and make the comparison. If you're finding more than occasional, random underpayments by a payor, sit down with your provider rep and ask what's going on, Cobuzzi suggests.

Take Five Steps if You Don't Have Fee Schedules

Many plans never give you a fee schedule—and the payor might give you a hard time when you ask for it, or say "It's in the mail," but it never comes (see box below). If you don't have a fee schedule—for whatever reason—tracking down underpayments becomes more difficult. But it's not impossible, and it's well worth the effort, says Cobuzzi. Here's what to do:

Step #1: Identify your biggest payors. If you're like most practices, two or three payors probably provide the bulk of your practice's revenues. To keep the comparison process from being overwhelming, it's best to start with just these payors, Cobuzzi suggests. You'll see the biggest payoff for your efforts if you select your practice's biggest payors.

Insider Says: Cobuzzi points out that it's a lot easier to identify payor patterns if you file EOBs chronologically *by payor*, rather than just by date.

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► Get Copies of Fee Schedules to Track Payments More Easily

Ideally, your practice won't sign up with a payor until it has seen and been given a copy of the plan's fee schedule, says New Jersey billing expert Barbara Cobuzzi. But in managed care, circumstances are rarely ideal, and many practices sign contracts with payors without seeing the fee schedule first.

Contracts between plans and providers almost always say that the plan's fee schedule is a part of the contract, but the fee schedule often isn't included in the documents the plan sends the provider. So to be able to properly track your payments, you must get the information some other way.

Sometimes, just bugging your provider rep frequently enough will get you a copy of the fee schedule. But many plans that don't provide the fee schedule up front have rules about how you can get it. For example, Cobuzzi has heard of plans that will give you the fee schedule for only 10 procedures at a time. In that case, Cobuzzi suggests that one month, you request the fee schedule for 10 procedures. The next month, ask for the schedule for another 10. Keep asking every month until you get the fee schedule for every service and procedure you typically perform for patients covered by that plan.

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Step #2: Identify the most common and highest reimbursement amount procedures. Cobuzzi advises that you select the 25 or 30 services or procedures that make up about 80 percent of your practice's revenue. Generally, they'll be the services or procedures that your practice performs most frequently and the services and procedures that give the highest reimbursement.

Step #3: Create a spreadsheet of payor patterns. Next, use your EOBs to follow the payments received from each of the payors you identified in Step #1 for the services and procedures you identified in Step #2. Track these payments for three to six months, depending on the volume of your practice. (Busier practices will probably get sufficient data to track payments after the shorter period of time). Compile all the information you collect on a

spreadsheet. This spreadsheet will give you an idea of what you're getting paid for each service and procedure you're tracking. And when you get a payment that's out of line with what you've typically been receiving, you'll notice it.

Step #4: Ask provider rep about discrepancies. If your spreadsheet shows inconsistencies in the payments you receive, Cobuzzi suggests you ask for a meeting with your provider rep to go over your results. Don't call the rep until you're armed with a few months' worth of data that show these inconsistencies. Ask the provider rep to explain the inconsistencies you've found. And if you don't get a satisfactory explanation, take your concerns to the next level—even have your radiologist contact the plan's medical director, if necessary. Keep bugging people until you have an idea of the plan's fee schedule, if not an actual hard copy of it.

Step #5: Follow up periodically. Your spreadsheet and your meeting with your provider rep should have cleared up exactly what you should be getting for your list of services. To keep the plans on the straight and narrow, sit down with your spreadsheets and your EOBs every few months to make sure the problem isn't recurring, Cobuzzi advises.

Insider Says: If you use a billing service, you can pay it to do the spreadsheet for you. Or if you make the spreadsheet yourself and let the service know what your payment patterns are, the billing service should be able to track discrepancies for you. ■

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Barbara J. Cobuzzi, MBA, CPC, CPCH, CHBME: Cash Flow Solutions, 1255 Rte. 70, Lakewood, NJ 08701.