Radiology Administrator's
Compliance & Reimbursement Insider

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# Be Prepared to Notify Patients of Privacy Practices Even if You're an Indirect Provider

HIPAA compliance is on the minds of most health care providers because the April 15, 2003, compliance date is upon us. One key requirement under the *HIPAA privacy regulations* is that each provider in a direct treatment relationship with a patient must give that patient a "notice of privacy practices" at the first patient encounter. This notice spells out how the provider might use or disclose the patient's protected health information (PHI).

Some radiology practices don't seem to feel the same urgency about preparing to comply with this HIPAA requirement as their colleagues in other specialties do. And that may be due to confusion about what HIPAA requires of providers in indirect treatment relationships versus direct treatment relationships, says Virginia health care attorney Thomas Greeson.

We'll review what the HIPAA privacy regulations require health care providers—including radiology practices that may be considered indirect treatment providers—to do with regard to giving patients the notice of privacy practices. We'll explain what an "indirect provider" is, and we'll give you some advice about how to prepare to comply with the HIPAA privacy regulations. We'll also give you a Model Notice (see pp. 3–4) that you can adapt and give to your patients, when necessary.

## Providers Must Give Patients Notice of Privacy Practices

Among other obligations, the HIPAA privacy regulations require providers—including physician practices—to give each of their patients at his or her first visit a notice of privacy practices that explains how the provider will use the patient's PHI. But according to the privacy regulations, providers must give patients the notice at the first encounter only if the practice is in a "direct treatment relationship" with the patients, Greeson points out.

But that doesn't mean that providers whose relationships with patients are indirect needn't prepare a notice of privacy practices. The privacy regulations also say that a provider in an "indirect treatment relationship" with a patient must give the patient a notice of privacy practices at the patient's request. So although the HIPAA privacy regulations relieve an indirect provider of the responsibility of giving a patient a notice of privacy practices at the first encounter, the practice still must have a notice of privacy practices available for those patients who ask to see one.

To determine if your practice must give its patients the notice of privacy practices at the first encounter with the patient, you must determine whether your practice's relationships with patients are direct or indirect. The privacy reg-

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**PRIVACY PRACTICES** (continued from p. 1)

ulations say that a health care provider has an indirect treatment relationship with a patient when:

■ The provider delivers a health care service based on the orders of another health care provider; and

■ The health care provider reports the results of his service to the health care provider who ordered the service, rather than to the patient.

Greeson notes that a relationship with a patient must satisfy both parts of this test in order to be considered an indirect treatment relationship. Radiologists often have only an indirect treatment relationship with their patients because, typically, they don't perform tests on their own initiative but, instead, perform services in accordance with a treating physician's orders. And they generally report the results of their tests directly to the treating physician, rather than to the patient.

## Radiologist/Patient Relationship May Be Direct

Some radiologists' interactions with patients may constitute a direct treatment relationship in certain circumstances, notes Greeson. To cite several common examples:

■ In a hospital setting, a radiologist may perform tests without an order from a treating physician, which fails the first part of the test;

■ A radiologist may inform a patient of the results of her mammogram or other diagnostic test, in a letter or in a face-to-face discussion, which fails the second part of the test; and

■ Interventional radiologists and radiation oncologists devise their own treatment plans, have extensive face-to-face interactions with patients, and are considered treating physicians, just as a surgeon or a pediatrician would be. So radiation oncologists and interventional radiologists fail both parts of the test.

## Prepare Notice of Privacy Practices

Because of the potential for these direct relationships to arise, and because even patients with an indirect treatment relationship may request the notice of privacy practices, Greeson thinks radiology practices should prepare a notice of privacy practices now if they haven't done so already. Hospital-based radiology practices may be able to avoid this by entering into an organized health care arrangement (OHCA) with their hospital (see box on p. 5). But practices that operate independent imaging centers should err on the side of caution and have a notice of privacy practices, Greeson suggests.

The HIPAA privacy regulations say what needs to be in the notice of privacy practices but, with one exception, leave the exact wording up to you. To get started, you can adapt our Model Notice for use in your practice. Like our Model Notice, your notice should do the following:

**Include required language.** The HIPAA privacy regulations require you to prominently include the following language:

(continued on p. 5)

MODEL NOTICE

# Give Notice of Privacy Practices to Patients with Whom You Have Direct Relationship

Here's a Model Notice of privacy practices that you can adapt and use in your radiology practice. If you have a traditional diagnostic radiology practice, you won't need it for most of your patients. But you should have it available to give to patients who request it or with whom the radiologist personally discusses results. Or if you typically report certain test results—such as mammogram results or DEXA scores—in a letter to the patient, you should give those patients your notice of privacy practices. And if you have a screening center or perform self-referred tests, like full-body scans, you should give those patients a notice of privacy practices at the first patient encounter, Greeson says.

## NOTICE OF PRIVACY PRACTICES

### I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information protected health information, or PHI for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in [*insert location where notice will be posted, e.g., main reception area*]. You can also request a copy of this notice from the contact person listed in Section VI, below, at any time and can view a copy of the notice on our Web site at [*insert Web site address, e.g., www.XYZRadiology.org*].

### III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.** We may use and disclose your PHI for the following reasons:

1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical rehabilitation facility in order to coordinate your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.
3. **For health care operations.** We may disclose your PHI in order to operate this facility. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

**B. Certain Uses and Disclosures Do Not Require Your Authorization.** We may use and disclose your PHI without your authorization for the following reasons:

1. **When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

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## NOTICE OF PRIVACY PRACTICES (continued)

6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
8. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer.

**C. Uses and Disclosures Require You to Have the Opportunity to Object.**

**Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**D. All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, B, and C, above, we will ask for your written authorization before using or disclosing any of your PHI. [*Optional: A sample authorization form is attached to this notice for you to look at.*] If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

### IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**B. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (*for example, sending information to your work address rather than your home address*) or by alternate means (*for example, e-mail instead of regular mail*). We must agree to your request so long as we can easily provide it in the format you requested.

**C. The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $[*insert fee*] for each page. Instead of providing the PHI you requested, we may provide you with a summary or an explanation of the PHI as long as you agree to that and to the cost in advance.

**D. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before [*insert your organization's HIPAA compliance date*].

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $[*insert fee*] for each additional request.

**E. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

### V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: [*insert name or title of contact person, address, phone #, and e-mail*].

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed above. You also may send a written complaint to the Secretary of the Department of Health and Human Services [*insert HHS's address*]. We will take no retaliatory action against you if you file a complaint about our privacy practices.

### VI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on [*insert date*].

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**PRIVACY PRACTICES** (continued from p. 2)

> This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Greeson suggests that you include this language, set off in all capital letters and/or in boldface, at the top of your notice, as in our Model Notice [Notice, par. I].

**Explain your duty to protect PHI.** The privacy regulations require the notice to explain that you're required to maintain the confidentiality of the patient's PHI, to disclose to patients through the notice of privacy practices how you'll use their PHI, to give patients a copy of your notice of privacy practices, and to comply with the terms of that notice. Greeson suggests that you define PHI here, too. And keep in mind that at some point you may want to revise your notice of privacy practices, so say in your notice that you reserve the right to change it in the future, he says [Notice, par. II].

**Give examples of how you may use PHI without the patient's consent.** The privacy regulations permit you to use and disclose PHI as necessary to treat the patient, receive payment for health care services, or conduct health care operations. The regulations also permit disclosure without a patient's authorization for certain other reasons, such as when the law requires it and for organ donation purposes. Our Model Notice includes a list of the permitted uses for which patient authorization isn't required and gives an example of each [Notice, par. III, A & B].

**Explain uses that require the patient's authorization.** The notice should say that uses of PHI that aren't described in the previous sections require the patient's authorization. Greeson says it's a good idea to specifically mention certain other disclosures that come up frequently in your practice. For instance, in our Model Notice, we use an example of disclosing PHI to a patient's friend or family member [Notice, par. III, C & D].

**Describe patient's rights concerning PHI.** The HIPAA privacy regulations give patients certain rights concerning their PHI, like the right to request limits on its use and disclosure and the right to get copies of their PHI. Our Model Notice lists these patients' rights concerning PHI [Notice, par. IV].

**Explain how to get more information or how to complain about privacy violations.** This section should contain the contact information for your practice's privacy officer—the person you've designated to oversee HIPAA privacy regulation compliance issues. This section should also let patients know that they may file a complaint with the Department of Health and Human Services and include the address of where to send complaints [Notice, par. V].

**Give the effective date of the notice.** Your notice of privacy practices should include the date that the notice became effective [Notice, par. VI]. ■

***Insider Source***

**Thomas W. Greeson, Esq.:** Reed Smith LLP, 3110 Fairview Park Dr., Falls Church, VA; (703) 641-4242; tgreeson@reedsmith.com.

### ▶ *OHCA Participation Makes Compliance Easier for Hospital-Based Practices*

The good news for radiology practices is that the HIPAA privacy regulations allow members of an organized health care arrangement (OHCA) to share PHI for treatment and payment purposes. Typically, a hospital, its outpatient departments, and associated entities, like skilled nursing facilities and ambulances, may set themselves up as an OHCA and share PHI for treatment and payment purposes. In effect, this means that if one member of the OHCA—for example, the hospital—gives each of its patients a notice of privacy practices, all the other members—which would include, in this example, the radiology department—can "piggyback" on that notice. So a radiologist providing services at a hospital or an independent diagnostic testing facility (IDTF) under an OHCA won't need to give the patient a notice of privacy practices, as long as the hospital or IDTF gives the patient one. Of course, the radiologist must comply with information in the notice, says Virginia health care attorney Thomas Greeson.

Greeson thinks all hospital-based radiology practices should enter into an OHCA agreement if they can. That way, the practice can delegate the administrative requirements of HIPAA compliance to the organization—similar to the way it delegates responsibility for storing medical records, for example. Greeson says that it isn't even necessary for the parties to enter into a written agreement to establish themselves as an OHCA, although he believes it's a good idea, just to make sure that everyone's in sync.

A radiologist providing services under contract to an IDTF can enter into an OHCA with an IDTF and be relieved of the responsibility of providing a notice of privacy practices to IDTF patients. Greeson notes that although it's less likely that services provided in an IDTF setting will be considered direct services, he advises IDTFs and their contracted physicians, including radiologists, to enter into an OHCA, just in case.

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IN THE NEWS

# Medicare Physician Fee Schedule Fix Becomes Law

Congress gave physicians a nice valentine this year. On Feb. 13, both houses of Congress passed an amendment to the 2003 Omnibus Appropriations Bill that will eliminate the 4.4 percent reduction in payments to physicians that was called for under CMS's 2003 physician fee schedule. President Bush signed the bill on Feb. 21. CMS admitted that the reduction in its 2003 fee schedule was inappropriate, but it claimed that its hands were tied because of flaws in the formula that the law requires it to use when calculating the fee schedule.

The bill the president signed gives CMS the authority to correct the flawed formula, so the 4.4 percent reduction won't take effect. And this "should result in modestly positive Medicare physician payment updates for the next several years," said William F. Jessee, MD, president and CEO of the Medical Group Management Association (MGMA), in a Feb. 13 press release. In fact, physicians will see an average increase in payments of 1.6 percent, according to CMS's calculations.

## Amendment Offers Hope for Long-Term Solution

In an AMA press release, Yank Coble, MD, president of the American Medical Association, said, "This bill comes just in the nick of time for Medicare patients and the physicians who care for them." The press release goes on to call the bill a "dramatic improvement for physicians overall. Elimination of the projection errors [the flaw in the CMS formula that led to the inappropriate decrease] lifts physicians out of a significant budget hole and increases organized medicine's ability to pursue other policy objectives." The payment crisis that led to the bill may spur continued efforts to find a long-term solution to the problem of fairly compensating physicians for the actual costs of providing care to Medicare patients.

***Insider* Says:** You can get a copy of the MGMA press release at the "press room" section of the MGMA's Web site, www.MGMA.org. The AMA press release is available on the AMA home page, www.ama-assn.org. ■

MANAGED CARE

# Don't Promise to Provide a Specific Standard of Care

Plan contracts typically set a standard of care that physicians must meet when treating plan members. For instance, the contract may say that the physician's care must meet the "applicable standard of care" or the "prevailing standard of care" for your specialty or geographic region. Although language like this looks harmless, it can be disastrous for you if a plan member sues you for injuries caused by your treatment. The standard of care language allows the member to sue you not only for malpractice but also for violating the contract—what attorneys call breach of contract. That may allow the jury to ignore state laws that limit malpractice awards and give the member much higher damages, cautions Missouri attorney Susan J. Cooper.

## How Standard of Care Language Hurts Providers

In malpractice lawsuits, physicians aren't expected to be perfect or even better than their colleagues. They only must be as good as their peers, according to New York attorney Dr. Barry B. Cepelewicz. "Physicians can be liable for committing malpractice if they fail to meet this standard," he explains.

But when the plan makes the standard a part of the contract, it inadvertently exposes the physician to much greater risk in lawsuits brought by members, warns Cooper. It does so because it allows members two separate legal reasons to sue: malpractice and breach of contract. If a member can sue you for violating your plan contract, the member may not be constrained by the laws that most states have adopted to limit the amount of money a patient can recover from you in a malpractice lawsuit, according to Pennsylvania attorney James Saxton. The member could be able to win much higher damage awards that way, he says.

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### Physician Group Pays Millions to Member

A physician group learned firsthand the impact of promising to provide a specific standard of care in a contract. The group signed a plan contract that obligated it to "provide care of good medical quality," according to Cooper, who's familiar with the case. A plan member who was treated by a physician in the group sued the group for injuries supposedly caused by the physician, claiming that the group not only committed malpractice but also violated its contractual obligation to provide care of good medical quality. The member's attorney even enlarged the contract language and displayed it to the jury on a poster. The jury decided that the group committed malpractice and breached the contract. Because there was a breach of contract, the jury didn't have to abide by the cap on malpractice damages set by Missouri law, and awarded the member a seven-figure damage award.

### Soften Obligation in Contract

To avoid being sued by a member for both malpractice and a contract violation, change the contract language so that quality care is a goal, not an obligation, recommends Cooper, who frequently negotiates this change on behalf of providers. "Plans often drop this contract obligation. They know physicians are human and can't guarantee performance," she says.

To do this if, for example, the contract reads, "Provider shall at all times provide care of the quality prevailing in the community," add the words "endeavor to":

> Provider shall at all times *endeavor to* provide care of the quality prevailing in the community (emphasis supplied).

If a plan is reluctant to soften the language, point out that you're not asking it to remove the obligation entirely, says Cooper. "You're just toning it down enough so that if you do get sued for hurting a plan member, the member can sue you only for malpractice," she notes. Plans are also more likely to soften the language once you tell them that the change also protects the plan from being sued by the member for a contract violation, according to Saxton.

***Insider* Says:** If the plan refuses to make this change, then at least make sure that the contract requires you to provide care only at the same standard as your peers, not better.

### Check for Beneficiary Language

Also review the contract for language that says that members are third-party beneficiaries to the contract. If your contract has this language, ask the plan to remove it. Juries are much more likely to find that you violated the contract as well as committed malpractice if your contract has this language, says Cepelewicz. In effect it means that you agree that the member has a right to sue you for a violation of the contract. If the language is deleted, the member will have a tougher time claiming that she's entitled to sue you for a contract violation, and must prove she has that right. And not all courts will agree that she has, he says. ■

***Insider Sources***

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# Avoid Liability When Accepting Assignment of Provider Agreement

Radiology practices looking to expand their market share may consider buying another practice or existing freestanding facility. Buying an already existing practice or facility is, in some ways, a lot easier than trying to either expand incrementally or develop a new facility yourself. But in some situations the buyer can be held liable for the wrongdoing of the seller. One common situation arises when a seller sells stock or an LLC membership interest and assigns its Medicare provider number and/or provider agreement to the buyer, and the buyer inherits a host of problems due to the seller's noncompliance.

We'll explain how accepting assignment of an existing entity's Medicare provider number and/or provider agreement can cause problems. We'll go over the pros and cons of not accepting assignment of an acquired entity's provider number or agreement. Then we'll suggest ways to minimize your risks through a process called a "due diligence investigation."

### Accepting Assignment Can Lead to Liability

Like many things in life, you have to take the bad with the good, says New Jersey health care attorney Michael Schaff. When you buy an existing practice or facility, you can build certain protections into the purchase agree-

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ment. But if you accept assignment of the seller's Medicare provider number or agreement, you can't "contract away" any liability incurred by the seller before the sale. Medicare isn't a party to the transaction between you and the seller so, as far as Medicare is concerned, the seller's bad acts become your bad acts when you take over the seller's provider number or agreement.

Here are some of the common ways a practice can get into trouble when buying another practice by purchasing stock or LLC membership interest and accepting assignment of its Medicare provider number and/or provider agreement:

**Violations of state licensing rules.** If a facility—like an imaging center—isn't properly licensed, you could end up paying the price later, Schaff warns. When the state finds out that the proper licenses were never in place, it can kick the facility out of the state Medicaid program. And it can report the facility to the federal authorities, endangering the facility's status with Medicare. So even if you tried to get the license in order as soon you took over the facility, you could still find that you're unable to bill Medicare or Medicaid as a result of the previous owner's wrongdoing. Plus Medicare may want money back from the time when the facility wasn't properly licensed—and you'll have to pay.

**Billing irregularities.** If the facility or practice you buy didn't bill properly or didn't document claims properly, you can be on the hook for any consequences, Schaff points out. Because you have stepped into the seller's shoes and are using the seller's provider number or agreement, you'll now be responsible for all of its overpayments or false claims—even though you didn't submit the false claims or benefit from the overpayments. Even if Medicare doesn't ask you to pay back any money, you may be audited because of the seller's history of billing irregularities, Schaff notes.

## Why Accept Assignment of Medicare Provider Agreement?

If accepting assignment of a provider number and/or provider agreement can lead to all these problems, why not just buy the assets of the practice or facility—rather than its stock or an LLC membership interest? Then the provider agreement and/or number doesn't transfer automatically, and you can refuse assignment.

The answer is basic economics, Schaff explains. Medical practices, even large ones, are still small businesses that don't have large cash reserves. So when a practice makes the decision to buy another practice or facility, it's important to be able to bill Medicare immediately. Not only are Medicare revenues important, but many other payors won't accept a practice or facility into their plans unless the practice or facility is eligible to bill Medicare.

Applying for a new Medicare provider number—or in the case of a facility, certification—can take weeks or even months. Although Medicare has recently made efforts to speed up the process, there's still a significant waiting period between application and approval, Schaff notes. This wait tends to be even longer for facilities because state licenses must often be obtained before Medicare will consider the facility's application for provider status, he explains. So if you don't acquire the stock or membership interest of the facility and accept assignment of the seller's provider number or agreement, you're likely to have cash flow issues until the new Medicare provider number comes through.

## What to Do if You Don't Want to Accept Assignment

You may decide that accepting assignment of the seller's Medicare provider number or agreement isn't worth the risk. In fact, Schaff advises his clients to avoid acquiring stock or membership interest of the seller, and so not accepting assignment, if possible. In that case, there are a couple of ways to work around the cash flow problem, he says.

**Lease practice or facility temporarily.** Schaff says sometimes the seller will lease the practice or facility to the prospective buyer for a short period, like a year, if your state's law allows it (some states don't permit this type of arrangement). While leasing the facility, the lessee/prospective buyer can apply for and receive its own Medicare provider number or agreement, and then arrange to buy the practice or facility without accepting assignment of the seller's provider number or agreement. This is a less attractive option for a prospective buyer because the seller may want major concessions in return for agreeing to delay a sale and lease the practice or facility instead, Schaff says.

**Delay closing.** An easier way to avoid accepting assignment of a seller's provider number or agreement is to execute the purchase agreement and apply for a new provider number and/or agreement, but delay closing the sale until the new number and/or agreement arrives. The seller may still want concessions in return for delaying closing. But because the delay is likely to be a matter of several months at most, the seller's demands are likely to be less onerous than they would be if the prospective buyer were requesting a short-term lease before the sale, and there's less likelihood of violating state law, Schaff says.

***Insider* Says:** If you refuse assignment of the seller's provider number or

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agreement, notify CMS of your intention to terminate an existing provider number and/or agreement at least 45 days before the change in ownership is effective, Schaff cautions. And if you're buying a state licensed facility, you must notify the state licensing agency, too. Otherwise, Medicare assumes that the existing provider agreement has been assigned. It isn't enough to refuse assignment in your purchase agreement or other transaction document, Schaff says, because that doesn't let Medicare know what's up.

### Perform Due Diligence to Protect Your Investment

If you decide to accept assignment of the seller's Medicare provider number and/or agreement, it doesn't make any sense to invest a lot of money to buy a practice or facility and then have to pay more to fix someone else's mistakes. So to protect yourself, you should take a careful look at the practice or facility you're planning on buying. This process, called due diligence, really means making sure you're buying what you think you're buying—that is, a compliant business in good standing with all relevant regulatory agencies.

You should hire an attorney, accountant, or consultant to help you conduct the due diligence investigation. The professional you hire should take a close look at the following:

**Licenses.** If you're buying a facility like an imaging center or ASC, you need proof that the facility has all the licenses it needs to operate. The requirements vary from state to state, so it's important that the professional you hire be familiar with the requirements in your area. Besides making sure that the facility is properly licensed to operate, you should also make sure that:

- All the staff who will remain to work at your practice have appropriate licenses;
- All the staff who will remain are up-to-date on any licensing fees and continuing education requirements; and
- The facility has any ancillary permits or certifications it requires, like medical waste and/or radioactive waste permits and OSHA certifications.

**Medicare status.** The professional you hire should check to make sure that the facility or practice you plan to buy has an unsullied record with Medicare and Medicaid, and that all employees who will be staying on after your acquisition also have clean records. If the due diligence investigation turns up a problem, you should reconsider going forward with the purchase, Schaff says. If you decide to go forward, at least be sure to put some sort of indemnification language in your purchase agreement and don't accept assignment of a provider agreement or provider number under those circumstances, he advises.

**Billing history.** The most expensive part of the due diligence investigation is a thorough audit of the prospective seller's billing—but it's also the most important part. The professional you hire should take a large sample of the prospective seller's claims and review them for documentation, medical necessity, and appropriate coding. Because Medicare can impose sanctions for six years after the claim was submitted, the audit should cover claims going back at least six years. If the audit turns up anything that might lead to problems down the road—like inadequate documentation or systematic upcoding—talk to your attorney and the professional you hired to conduct the due diligence about whether you should reconsider going forward with the acquisition, Schaff suggests.

***Insider* Says:** Proof of a problem gives you leverage—which you should use—to reduce the purchase price, says Schaff, because the seller's problems are likely to cost you money later. ■

***Insider Source***

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# Proper Coding in Absence of Definitive Diagnosis

In September 2001, CMS published a program memorandum on ICD-9 coding of diagnostic tests. The program memo, which went into effect in January 2002, explained how the *Official ICD-9-CM Guidelines for Coding and Reporting* should be applied in submitting claims for diagnostic tests. These guidelines require that when the exam reveals a definitive diagnosis that explains the patient's symptoms, that diagnosis should be coded to the greatest possible level of specificity, and the patient's signs and symptoms needn't be coded.

But what happens if the test yields no definitive diagnosis? Although that scenario was explained in the program memo, there still seems to be some confusion about it. So we'll go over four situations you may encounter where the proper diagnosis coding isn't obvious, and we'll show you how to handle them.

### Diagnostic Test Is Normal or Inconclusive

If the diagnostic test you perform is normal or inconclusive, then you

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should report the patient's signs and symptoms. The referral from the patient's physician should include the patient's signs and symptoms that prompted the physician to order the test, says Atlanta health care consultant Jackie Miller. Use those signs and symptoms, she explains. But if the referral doesn't include the signs and symptoms, then you should ask the patient what her symptoms are, and report them based on the patient's answer, Miller says.

***Insider* Says:** If the referring physician provides only a "rule out diagnosis," and the test results are normal or inconclusive, you should report the patient's signs and symptoms, she explains. Do not code the unconfirmed diagnosis.

### Diagnostic Test Doesn't Show Referring Physician's Diagnosis

Sometimes a referring physician will indicate a confirmed diagnosis (for example, congestive heart failure), but the diagnostic test you perform doesn't confirm this diagnosis. In this case, you should use the referring physician's diagnosis, Miller says, because the condition may, in the referring physician's judgment, be clinically present even though it doesn't show up on the test you performed.

### Diagnostic Test Shows Abnormality but Doesn't Yield Definitive Diagnosis

This is the most common scenario. For example, suppose a patient presents with chest pain and the chest X-ray shows an infiltrate, but it's not clear whether the cause is pneumonia or some other condition. You should code the signs and symptoms as the diagnosis—in this case, chest pain.

### Follow-Up Test Shows Abnormality but Doesn't Yield Definitive Diagnosis

Let's say that the patient in the example above had a follow-up chest X-ray a few days later, and the second X-ray still didn't clarify the nature of the infiltrate. When a follow-up test still doesn't yield a definitive diagnosis, you should use an "abnormal findings" diagnosis code, in this case 793.1 ("findings, abnormal, lung field"). In another example, say a patient has a mammogram that shows a microcalcification, and that result leads the radiologist to do a breast ultrasound. If the ultrasound reveals no condition of concern, then the ultrasound should be reported with the abnormal findings code—793.81 ("mammographic microcalcifications").

***Insider* Says:** You can get the program memorandum on the CMS Web site, http://cms.hhs.gov. Click on "Professionals" at the top of the page and then "Medicare" in the left column. Then click on "Medicare Program Memoranda" on the lower right, under "Medicare Technical Publications." Scroll down to the bottom of the page to click on "2001 Program Memos," and then look for AB-01-144. ■

***Insider Source***

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

- HIPAA Privacy Regulations: Fed. Reg., Vol. 67, No. 59, 3/27/02, pp. 14776–14815.

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