

Radiology Administrator's

Compliance & Reimbursement Insider

MAY 2003

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Guard Against Sexual Harassment in Your Radiology Practice

Are you devoting enough attention to protecting your practice's employees against sexual harassment in the workplace? It's an oversight most practices can ill afford. That's because if you create or permit a work environment that an employee claims is a "hostile environment" or in which the employee is subject to unwanted sexual attention, you may be subject to penalties under federal or state laws. And even if your practice isn't covered by a state or federal antidiscrimination statute, an uncomfortable workplace may lead to difficulty in attracting and keeping employees. It can also lead to poor employee morale and decreased productivity.

You shouldn't tolerate any kind of harassing behavior in your practice, whether it's directed toward a person's age, race, religion, gender, national origin, physical disability, or sexual orientation, says Elaine Herskowitz, an attorney who conducts training on employment discrimination issues. She stresses that every practice should have a policy barring all forms of discrimination, and we'll give you a general antidiscrimination policy in a future issue of the *Insider*. But in this issue, we'll limit our discussion to how to create a policy that helps you prevent sexual harassment and respond to allegations of sexual harassment in your practice. We'll discuss the state and federal laws governing this issue. And we'll explain why a policy against sexual harassment is a good idea, even if the law doesn't require your practice to have one. Plus we'll give you a Model Policy (see p. 3) that you can adapt and use in your practice, as well as a Model Form (see p. 4) you can adapt and distribute to your employees to have them acknowledge that they understand the policy.

Law Bars Sexual Harassment

If there are 15 or more employees in your practice, it's governed by Title VII of the Civil Rights Act of 1964. That law bars discrimination on the basis of race, religion, national origin, or gender, Herskowitz says. And creating or permitting a work environment in which an employee feels that the environment is hostile or offensive based on his or her sex is gender-based discrimination, she explains.

Even if your practice has fewer than 15 employees, you're not off the hook—you may be subject to state antidiscrimination laws, Herskowitz cautions. Many states have laws that apply to smaller employers than the federal statute applies to, and some state laws apply to every employer, regardless of size. Plus some state laws bar discrimination on bases not covered by the federal law—sexual orientation, for example.

Insider Says: Even in the absence of a state or federal law that bars your practice from engaging in sexual harassment or discrimination of any kind, it's still a good idea to have an antidiscrimination policy and to enforce it, says Herskowitz. "Any employer in this day and age should recognize the importance of maintain-

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SEXUAL HARASSMENT (continued from p. 1)

ing a work environment that's free of discrimination and harassing behavior—if not because it's the right thing to do, then because no one can afford to lose good employees, who move on to more supportive environments," she says.

Practice Is Responsible for the Acts of Its Employees

Some physicians mistakenly believe that as long as they don't sexually harass anyone, they can't be liable if one of their employees harasses someone—like another employee. That's wrong, says New York health care attorney Jay Silverman. As an employer, you may be held responsible for your employees' harassing behavior if you're aware of the harassment and do nothing to stop it. Plus you may be held responsible even if you have no direct knowledge of the specific situation but, through your actions or inaction—like permitting off-color jokes or pranks in your office—you've permitted a hostile environment to exist.

By creating a sexual harassment policy for your practice—and enforcing it—you can demonstrate that you took steps to prevent the creation of a hostile environment. And Herskowitz points out that your practice is more likely to win a sexual harassment suit if you can show that you have a policy that:

- Gives employees an opportunity to complain about sexual harassment, without fear of retaliation;
- Ensures a prompt and thorough investigation of all complaints; and
- Ensures prompt and appropriate corrective action, including discipline of harassers.

Take Four Steps to Prevent, Respond to Sexual Harassment in Your Practice

Here are four steps you should take to prevent sexual harassment in your practice. Implementing these steps won't guarantee that sexual harassment won't happen. But taking these steps may reduce the likelihood of sexual harassment happening and limit your liability if it does.

Step #1: Adopt a written policy barring harassment. Creating a policy barring harassment is key. Like our Model Policy, your policy should:

▶ Refer Allegations of Sexual Misconduct with Patients to Attorney

Sexual harassment of employees in your office can lead to a lot of headaches, but an allegation of sexual misconduct with patients is even more serious. Any allegations of sexual misconduct with a patient shouldn't be handled internally, says Jay Silverman, an attorney who specializes in representing physicians and other health care providers. In some states a mere accusation that a physician committed sexual misconduct or engaged in improper conduct with sexual overtones with patients can lead to immediate suspension of the physician's medical license—before the allegations are even presented in a formal hearing. And a physician risks loss of his license in every state if found guilty of inappropriate behavior with patients. Because of the very serious implications, any allegation of sexual harassment or misconduct with patients should send you to your attorney's office immediately—whether the allegations are credible or not.

■ State that your practice won't tolerate discrimination, including sexual harassment, by any of its employees [Policy, par. 1].

■ Bar sexual harassment by any employee, and state that employees who engage in harassing behavior are subject to discipline, up to and including immediate termination for cause [Policy, par. 2].

■ Define sexual harassment in plain English, not legalese, so that it's clear to all your employees [Policy, par. 3]. Include examples of barred behavior that constitutes sexual harassment, says Herskowitz. Some people mistakenly still believe that only a quid pro quo situation—sleep with me or you'll lose your job or chance of promotion—is sexual harassment. But there are many other ways to engage in illegal harassment, and you should spell them out so that your employees are clear on this point, Herskowitz advises.

■ Establish a mechanism for employees to report sexual harassment without fear of retaliation, and encourage them to report any incidents immediately [Policy, par. 4]. Ideally, your policy should designate a particular person to receive reports of alleged sexual harassment. That person should be someone with substantial authority within your practice who's accessible to others within the practice—for example, the compliance officer or a senior physician shareholder, provided that the physician is accessible to all employees and takes a hands-on approach to managing the practice.

But designating a senior physician who's cutting back his hours and leaving most management decisions to others will be ineffective, Silverman remarks. It doesn't demonstrate a commitment to preventing sexual harassment, and employees are less likely to come forward if they perceive that your sexual harassment policy is

just window dressing. You should also designate at least one alternate person to receive complaints, just in case the other individual is the subject of a harassment allegation.

■ Ensure a prompt and fair investigation of any harassment complaint and corrective action if the complaint is found to be justified [Policy, par. 5]. "Take corrective action, even if you're

not sure whether the harassment occurred often enough or was severe enough to violate federal law. The threshold for a federal violation is high, but you should try to prevent unlawful harassment by stopping the misconduct *before* it escalates to the point of a statutory violation," Herskowitz advises.

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MODEL POLICY

Adopt Policy Barring Sexual Harassment in Your Practice

Here's a Model Policy banning sexual harassment, which you can adapt and use in your practice. Insert this policy in your employee handbook, make sure that every employee has a copy of the policy, and make sure that all employees understand what the poli-

cy means. You may also want to post this policy in the employee break room or other area where employees, but not patients, will see it. Show this policy to your attorney before adapting it for use in your practice.

XYZ RADIOLOGY POLICY ON SEXUAL HARASSMENT

1. XYZ Radiology condemns discrimination in all forms and is committed to providing a working environment that is comfortable for all employees and free from all forms of discrimination, including sexual harassment.
2. Sexual harassment is specifically prohibited. Such conduct will bring prompt and certain disciplinary action, including immediate termination, if warranted.
3. Sexual harassment is a form of misconduct that subjects the victim to unwanted sexual attention, interferes with the victim's ability to perform his or her job, and causes the victim to feel uncomfortable or insecure in the workplace, such that the employee regards the workplace as a hostile environment. Sexual harassment does not refer to conversation or compliments of a socially acceptable nature. Sexual harassment includes, but is not limited to: repeated offensive sexual flirtations, advances, or propositions; continued or repeated verbal abuse of a sexual nature; graphic or degrading sex-based comments about an individual's appearance; offensive or abusive physical contact targeted at an individual because of his or her sex; and any statement or implication that a person's employment or opportunity for job advancement or benefits is in any way conditioned upon or related to submission to sexual advances.
4. All employees are strongly encouraged to immediately report any instance of sexual harassment to *[insert name and/or title of designated person and contact number and at least one alternate official]*.
5. *[Insert name and/or title of designated person]* will promptly investigate all complaints and take immediate corrective action, including disciplinary action against an offending employee, if warranted.
6. Employees who report perceived sexual harassment in good faith will be protected from retaliatory action. Employees who report sexual harassment in bad faith—that is, in an attempt to intimidate or discredit another without reasonable belief that the allegations reported are true—will themselves be subject to disciplinary action, including termination, if warranted.

SEXUAL HARASSMENT (continued from p. 3)

■ Make clear that any harassment complaint that's made in bad faith will be subject to discipline. Define bad faith as making a false allegation in an attempt to discredit or harass someone [Policy, par. 6]. Assure employees that those who report perceived sexual harassment in good faith will be protected from retaliatory action. This will encourage people who truly believe they were victims of harassing behavior to report it, even though an investigation may not find enough evidence to support or refute the allegation or may find that the behavior doesn't rise to the level of illegal harassment. Exercise a good deal of caution before disciplining someone for what appears to be a bad faith complaint, Herskowitz suggests. Otherwise, you could be found liable for retaliating against an employee who was simply mistaken in his or her belief that harassment occurred. And the Equal Employment Opportunity Commission (EEOC) takes the position that if an employee has filed a formal EEOC charge, that employee is absolutely protected against retaliation of any sort, even if it turns out that the charge was undertaken in bad faith.

Step #2: Inform employees.

Once you've adopted a written policy, distribute it to all your employees. If you have an employee handbook, make sure that the policy is added to it. If your employees have their own copies of the handbook, instruct them to insert the sexual harassment policy in their copies. Also, it's a good idea to have a staff meeting to explain the policy and answer any of your employees' questions about it. You may even want to hire a consultant or other expert to come in and speak to your staff about the policy. Training can sensitize employees to the potential offensiveness of their own remarks or behavior, and training managers can help ensure that they address these

matters appropriately. Ask each employee to sign an acknowledgment, like our Model Form, that he has received the policy, has read it, understands it, and agrees to abide by it, Herskowitz says. And put that acknowledgment in the employee's personnel file.

Step #3: Take complaints seriously. The toughest policy won't help you avoid liability if you do a poor job of investigating and responding to complaints. That's why it's so important to take care when designating a person to receive and follow up on complaints. And make sure you instruct the person you designate to take the following steps if someone complains about sexual harassment in your practice:

- Get a detailed written statement from the person complaining, and ask if there are any witnesses to support the complaint;
- Interview any witnesses, and write down what they say;
- Confront the alleged offending employee, give him or her an opportunity to respond to the complaint, and write down what he or she says; and
- Evaluate all the evidence to determine whether the report was made in good faith and, if so, whether the conduct complained of occurred

and whether it constitutes barred harassing behavior. If the results of the investigation are unclear, disciplinary action would not be appropriate. But if you're confident the complaint was made in good faith, you should try to juggle staff duties so that the complaining employee has limited contact with, and doesn't report to, the alleged offender, Silverman suggests.

Step #4: Discipline offenders. If your investigation determines that the complaint was well founded, you must discipline the offending employee. The degree of discipline to impose will depend on several factors, including the offending employee's work history and the severity of the conduct. If you decide not to terminate the employee, make sure he knows that he may not retaliate against the person who reported the offending behavior, Herskowitz suggests. Although the reporting person may not be happy if you don't fire the offender, at least she'll have the comfort of knowing that she won't be subject to retaliation. ■

Insider Sources

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MODEL FORM**Have Employees Sign Acknowledgment**

When you meet with your employees to explain the sexual harassment policy, have each employee sign an acknowledgment, like this Model Form, that says the employee is aware of your sexual harassment policy,

understands it, and will obey it. Place this signed form in the employee's personnel file. Give new employees the policy when they start work, and have them sign the acknowledgment, too.

ACKNOWLEDGMENT OF SEXUAL HARASSMENT POLICY

I hereby certify that I have read and understand XYZ Radiology's policy on sexual harassment, and I agree to abide by the policy.

Employee's signature _____ Date _____

ASK THE INSIDER

Global Billing at IDTFs

Q Our radiology practice has a contract with a local independent diagnostic testing facility (IDTF) to provide interpretations of tests performed at the IDTF. The IDTF bills globally and pays us a rate that's less than our usual and customary rate for the service. The IDTF's new billing manager says that the IDTF must disclose our provider number and the contracted amount for our radiologist's services in box 20 of the claim form it submits to Medicare. We've had this arrangement for a year, and as far as I'm aware, our contracted amount and our provider number have never been included on the IDTF's claims in the past. Should they have been? If not, should this information be included now?

A The billing manager of the IDTF is mistaken, says Virginia health care attorney Thomas Greeson. She's confusing the rules about global billing for purchased *technical* components, which is handled with the appropriate disclosures in box 20 of the claim form. But in the scenario you describe, the IDTF is furnishing the technical component and buying the professional component (the interpretation) from you, and then billing globally. Box 20 isn't used to disclose purchased interpretations—only purchased tests, he explains. So the IDTF shouldn't submit your prac-

tice's provider number in box 20. And the IDTF shouldn't include the amount it paid you for the interpretation on its claim form either—in fact, there's no place on the form to do so, Greeson points out.

Her confusion probably results from the fact that section 3060.4 of the *Medicare Carriers Manual* (MCM) bars a provider from marking up the cost of a technical component. But MCM section 3060.5—which deals with purchased professional components—doesn't bar markups on the professional component, Greeson explains. So the IDTF needn't disclose on its claim form the amount that it paid a radiologist for the interpretation because it's not relevant under Medicare rules.

Insider Says: Make sure that the amount you charge the IDTF for interpretations is consistent with fair market value in your area, advises Greeson. If the rate your practice is paid is out of line with the fair market value of the services, the arrangement could be seen as an inducement to attract referrals—a violation of the antikickback law, he says. ■

Insider Source

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Consider Getting Pre-Authorizations Yourself

Radiology practices often run into a problem when a patient shows up for a test without pre-authorization from his insurer. Performing the test without the pre-authorization can lead to payment delays or even denials. But if you send the patient away and reschedule the test until you get the pre-authorization, you create scheduling disruptions. Neither scenario is good for the radiology practice or the patients.

Because the referring physician ordered the test, it's her obligation to get the pre-authorization. But it's the radiology practice—and the patient—who suffer if the referring physician doesn't do it. So some radiology prac-

tices are taking matters into their own hands and getting the pre-authorizations themselves. We'll describe how these practices are doing it. And we'll tell you some of the benefits of getting a pre-authorization when the referring physician doesn't get one.

Check Insurer's Requirement

Insurers' rules about pre-authorizations vary. Some insurers require the referring physician to get the pre-authorization. This is unfair to you because if the primary care physician doesn't get the pre-authorization, you're the one faced with explaining the situation to an angry patient—and

you're the one who won't get paid. When dealing with such an insurer, you should educate the primary care physicians and their office staffs about what you require in order to serve their patients. Or you can try to get the insurer to change its policy and permit you to get the pre-authorization.

But many insurers don't say who must get the pre-authorization—they just care that somebody gets one. In that case, you may be doing yourself and your patients a favor if you get pre-authorizations when patients' referring physicians haven't gotten them for the tests they've ordered.

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GETTING PRE-AUTHORIZATIONS

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Scheduler Can Get Pre-Authorization

One way to get these pre-authorizations is to have your schedulers get them, says Linda Wilgus, Chief Financial Officer of a Midwest radiology network. In her office, when a referring physician or a patient requests an appointment, the scheduling staff immediately contacts the patient's insurer and does the following:

- Verifies coverage for the test;
- Gets information about copays and deductibles; and
- Asks if the test has been pre-authorized, and if it hasn't, gets the pre-authorization.

If there's a problem—say, the insurer is denying coverage—the scheduler contacts the patient and the treating physician, if necessary, to try to resolve the problem before the patient's scheduled appointment. Wilgus reports that this system has worked well in her practice and doesn't require a lot of extra time or work, as her scheduling staff typically contacts the insurer anyway to get coverage information on the patient.

How This Can Help Your Practice

Radiology practices that have begun getting pre-authorizations report many benefits.

Referral sources appreciate it.

Referring physicians—and their office staffs—generally appreciate being relieved of the burden of getting the pre-authorization, which involves explaining to the insurer the medical necessity of the test. So as long as the referring physician gives you adequate information about the patient's history and condition, you can do this as well as—maybe better than—the referring physician's staff can. That's because you're more familiar with radiological tests and what they can be expected to reveal. And if your referral sources know they need only give you the test order and patient's history and you'll do the rest, they may be more likely to refer patients to you. It's a way to help your referral sources while helping yourself.

Patients appreciate it. Many radiology practices feel they have no choice but to turn a patient away if she arrives without pre-authorization.

Patients then leave, angry at the radiology practice, even though the referring physician is at fault, Wilgus remarks. If the radiology practice can secure pre-authorization before even scheduling the patient's appointment, it can avoid that messy situation. Plus, it allows the scheduler to get information about the patient's copay or out-of-pocket costs at the time of scheduling, and let the patient know what he'll be expected to pay at the time of service. That way, the patient doesn't get any surprises. Patients appreciate knowing what to expect, and it helps your front office staff, too.

Your bottom line will benefit. If there's no pre-authorization for the service, the radiology practice doesn't get paid. So getting the pre-authorization will help cut down on the number of denials you get for “not pre-authorized services.” In Wilgus's practice, the amount collected far exceeds the small increase in overhead that getting the pre-authorizations represents. “It has been a positive process,” she says ■.

Insider Sources

Linda Wilgus, CPA: Chief Financial Officer, Northwest Radiology Network, PC, Indianapolis, IN 46278.

H I P A A**HIPAA Privacy Regs Set Major 'Administrative Requirements'**

The HIPAA privacy regulations set a wide array of major “administrative requirements” that your practice must meet. Many of these HIPAA administrative requirements will be new to you. Depending on the size and structure of your practice, the task of complying with these requirements could be significant.

With the help of health information consultant Tom Hanks, we explain, below, what these requirements are. In

future issues we'll give you specific tools you can use and incorporate into your HIPAA compliance efforts to meet these requirements.

Requirement #1: Appoint Privacy Official and Privacy Contact

The privacy regulations require you to appoint a privacy official who's responsible for developing, implementing, and overseeing your privacy

policies and procedures. Depending on your practice's size and complexity, the position could be full- or part-time.

The regulations also require you to designate a privacy contact—someone to receive privacy complaints from patients who believe your practice has violated their privacy rights. That person will have to be able to answer questions from patients and others about the notice of privacy practices that your practice must distribute to patients.

Can you appoint one person to serve as both your privacy official and your privacy contact? The proposed regulations had allowed it, but the final regulations are silent on this issue, so you'll have to make a determination based on your practice's size and structure, Hanks points out. Most small- to medium-sized practices will be allowed to appoint the same person, but many larger practices won't, unless they fit an exception, he says. The regulations are complicated on this issue, and you'll have to make a careful determination, in conjunction with your attorney, of what you can do.

Requirement #2: Develop, Implement, and Document Privacy Policies and Procedures

In the section of the regulations that deals with administrative requirements, there's a general requirement to develop, implement, and document privacy policies and procedures. For most practices, this requirement will be the single largest component of their HIPAA privacy compliance efforts, says Hanks. Although you may already have some of these policies and procedures in place, you'll need to update them to meet HIPAA requirements. And you'll have to create many others from scratch.

This administrative requirements section of the regulations also lists some of the specific policies and procedures that are required—for instance, policies and procedures that impose sanctions on workforce members who use or disclose protected health information (PHI) in violation of the privacy regulations. But for the most part, the policies and procedures you'll be required to put into place are listed elsewhere in the regulations (for example, the requirement that you have a policy and procedures on a patient's right to access and copy his

PHI is set out in the section of the regulations dealing with patients' rights).

All privacy policies and procedures must be in written or electronic form. And you must keep a copy of each policy and procedure for at least six years from the date it was last in effect. The regulations also say that you'll have to change your privacy policies and procedures to accommodate any changes in law or in the HIPAA regulations and document and implement the changes promptly. And if a change to any of your policies and procedures significantly affects your practice's notice of privacy practices, you'll need to immediately incorporate the appropriate changes into your notice.

Requirement #3: Train Your Workforce on Privacy

You should have given privacy training to your entire workforce on the policies and procedures required by the regulations to protect PHI by April 13, 2003, says Hanks. The privacy training must be appropriate to the job function of each workforce member.

After the compliance deadline, you must train all new workforce members within a reasonable time after they're hired. And if you make any significant changes to your privacy policies or procedures, all workforce members affected by those changes must be retrained within a reasonable time.

To meet the HIPAA training requirement, says Hanks, you'll need to implement policies and procedures that address:

- Providing privacy training to your workforce;
- Providing retraining, as needed; and
- Documenting that the training has taken place.

Requirement #4: Adopt Privacy Safeguards to Protect PHI

You need to adopt administrative, technical, and physical safeguards to protect PHI against unauthorized uses and disclosures. But the regulations don't tell you what safeguards to use. Instead, they allow you to choose safeguards that make sense for your practice and that take into account your size, structure, and business and operational needs, says Hanks. Examples of safeguards given in the commentary to the regulations include locking the rooms and file cabinets used for storing PHI and requiring paper documents that include PHI to be shredded before disposal.

Insider Says: Don't confuse these safeguards with those required by the proposed security regulations, says Hanks. Although the proposed security regulations may be brought into line when they're finalized, the privacy regulations cover PHI whether maintained electronically, on paper, or orally, but the proposed security regulations cover only electronically maintained PHI. Also, the focus of the privacy regulations is on maintaining the confidentiality of PHI, but the security regulations are aimed at safeguarding the integrity of PHI that's stored or transmitted electronically, he explains.

Requirement #5: Establish a Complaint Process for Privacy Violations

You need to create a process for receiving complaints from patients concerning possible violations of your privacy practices. Although the regulations don't tell you how to handle or respond to such complaints, they require you to document all complaints received and the action taken, if any. Keep that documentation for at least six years from the date you got the complaint or took any action on it.

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HIPAA (continued from p. 7)

Requirement #6: No Retaliation Allowed Against Individuals for Privacy Complaints

Your practice is prohibited from retaliating against any person who exercises the privacy rights granted to him or her by the regulations, such as filing a privacy complaint with the government or your practice. This requirement also applies to protect someone who reasonably opposes your practice's actions, if that person has a good-faith belief that the actions are illegal. And it applies whether the person is a patient, a patient's relative, a member of your workforce, or your business associate.

Requirement #7: Set Sanctions for Privacy Violations

You need to have procedures in place to measure compliance with your privacy policies and to develop policy and procedures to impose appropriate sanctions for privacy violations by members of your workforce or your business associates. And you must document the sanctions you impose for violations, if any. There's one exception to this requirement: You may not impose sanctions on, or otherwise retaliate against, a member of your workforce who

engages in whistleblower activities (that is, reports allegedly illegal conduct by your organization to law enforcement or other agencies) or who opposes your privacy practices (for example, states a belief that some of your practices may violate the HIPAA privacy regulations).

Requirement #8: Lessen Harmful Effects of Damage from Known Privacy Violations

You must have procedures in place to mitigate—that is, lessen—the harmful effects of any known use or disclosure of PHI made in violation of your privacy policies or procedures. This requirement applies to any privacy violation that you're aware of, whether it's committed by a member of your workforce or a business associate. For example, if one of your employees is inappropriately e-mailing PHI, once the violation becomes known, you'll need to take steps to reduce the damage caused by any unauthorized disclosure.

Mitigating actions may include notifying the affected individuals of the disclosure, its extent, and to whom it was disclosed. Steps should also be taken to prevent a future occurrence. Depending on the circumstances, that could mean modifying your policy and procedures, applying sanctions to the employee or business associate, or

further limiting access to PHI. The regulations say that mitigating actions must be practical and may depend, for example, on whether it's possible to minimize the harm.

Requirement #9: No Waiver of Individual Right to Complain Allowed

You may not require as a condition of treatment that a patient waive his or her right to file a complaint with HHS or waive any other individual privacy right granted by the privacy regulations. This requirement was added to ensure that health care facilities couldn't take away any of the privacy rights the regulations give to individuals, explains Hanks.

Insider Says: For a detailed run-down on the final privacy regulations, see *Guide to Understanding and Complying with HIPAA Security and Privacy Regulations*, written by Hanks. You can download a copy onto your computer at www.hipaacomply.com/downloads.htm. Note that it's in pdf format and is a zipped file. ■

Insider Source

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HOSPITAL RELATIONS

Beware of Hospital Demands for Fee Concessions

Often a hospital will staff its radiology department by entering into an exclusive arrangement with a radiology practice. The practice agrees to provide radiology services for the hospital's patients, and all the hospital's patients are sent to the practice for radiology services. Under an arrangement like this, the hospital

effectively controls the flow of patients to the radiology practice.

But this arrangement raises a host of legal and compliance issues, warns Virginia health care attorney Thomas Greeson, because the hospital may attempt to demand concessions in return for access to the patients it controls. For example, the hospital may

ask the radiology practice to provide discounted or free care to certain people—like employees or others who are injured in the hospital. Or the hospital may ask the practice to interpret hospital employees' annual tuberculosis screenings free of charge. But what seem like minor concessions, worth

making for business reasons, can get you into trouble, Greeson says.

We'll explain why it's a bad idea to agree to concessions like these, even if they seem reasonable from a business perspective. This knowledge may come in handy if your hospital ever asks you to offer free or discounted services as part of an exclusive agreement for radiology services. And we'll show you how you may be able to accommodate the hospital's request for a break on some services without violating the law.

Reduced-Fee or No-Fee Arrangements May Violate Law

A radiology practice's agreement to perform certain services free of charge or at a discount in return for the opportunity to treat the hospital's patients is a problematic arrangement, according to Greeson. It could be interpreted that one party is being compensated for the referral of medical services. And that may violate one or more of several laws:

Federal antikickback law. The federal *antikickback law* bars anyone from asking for, paying, or receiving remuneration in return for the referral of an item or service that may be reimbursed under one of the federally sponsored health insurance programs. Greeson explains that this law is very broad and that it covers indirect and covert forms of remuneration, not just straight fee-splitting or referral fee arrangements. And courts have interpreted it to bar any arrangement that might otherwise be reasonable, if one of the purposes of the arrangement is to obtain a benefit for the referral of services or to induce further referrals, he warns. So giving free or discounted care to hospital employees as part of a contract to provide radiology services to the hospital's patients could be construed as a violation of

the antikickback law. That's because at least one purpose of such an arrangement is to secure referrals of the hospital's patients.

State antikickback laws. Many states have laws that are similar to the federal antikickback law, but some state's laws are even broader, covering all medical services, regardless of who pays. These state laws are meant to bar anyone from paying or receiving compensation in return for the referral of medical services. So you won't necessarily steer clear of legal violations by limiting your free or discounted care arrangements to patients who aren't covered by Medicare or Medicaid, Greeson points out.

HIPAA. Although most practices are aware of HIPAA's patient privacy requirements, there's an antifraud section of HIPAA, too, Greeson notes. And under that section, barred "remuneration" includes "the transfer of items or services for free or for other than fair market value." So if you provide free or discounted services to the hospital as a condition of getting the hospital's referrals, you may be violating HIPAA, too.

OIG Concerned About Abuses in Physician/Hospital Relationships

The OIG has been raising questions about the relationships between hospitals and hospital-based physicians for years, Greeson notes. He explains that the OIG doesn't view these arrangements as it does other business arrangements because the hospital holds all the cards. The hospital can control access to its patients through the credentialing process and through exclusive contracts for services like radiology. So the OIG will scrutinize these arrangements more closely because it wants to prevent hospitals from exercising control, to the detriment of Medicare patients.

In fact, the OIG has published its concerns several times:

■ In 1991 the OIG issued a report about financial arrangements between hospitals and hospital-based physicians. It said that the antikickback law is violated when a hospital knowingly solicits or receives remuneration from a provider who's dependent upon the hospital's referrals—like the hospital's radiology practice—in return for the right to practice at the hospital and have access to the hospital's patients.

■ In 1998 the OIG's Compliance Program Guidance for Hospitals expressed concern about "arrangements with hospital-based physicians that compensate physicians for less than the fair market value of services they provide to hospitals or require physicians to pay more than market value for services provided by the hospital." It specifically described such arrangements as "risk areas" for hospitals.

■ The OIG's 2000 Compliance Guidance for Small Physician Practices recommended that all business relationships between physicians and entities (like a hospital) in a position to obtain or generate referrals be on a fair market value basis.

Insider Says: You can get copies of all these documents on the OIG's Web site at <http://oig.hhs.gov>. To get the 1991 report, go to the OIG's Web site and click on "Reports" on the right side of the page. Then click on "Office of Evaluation and Inspection Reports." Choose search method 3, then click on "E-H" on the index page. Scroll down, and under the heading "Financial Relations" you'll find the report entitled "Financial Arrangements Between Hospitals and Hospital-Based Physicians." To get the OIG compliance plan guidance documents, go back to the OIG home page, click on "Fraud Detection and Prevention," then click on "Compliance Guidance." Scroll down to 2000 for the "Final Compli-

ance Guidance for Individual and Small Physician Practices,” and to 1998 for the “Compliance Program Guidance for Hospitals.”

Coercion Is No Excuse

The OIG has the authority to impose civil money penalties for violations of the antikickback law. And in the past it has been as willing to impose sanctions on the “coerced” party as on the soliciting party, Greeson cautions. So you won’t get off the hook by saying that the hospital forced you to agree to the provision that the OIG considers a violation, he explains. As far as the OIG is concerned, the person who pays the kickback is just as guilty as the person who accepts it.

Keep in mind that unless the OIG unmasks massive fraud, the hospital will most likely only be fined—and that will be the end of it for the hospital. But any sanction imposed on a physician for antikickback violations will be reported to all the states that have given the physician a medical license. And each state is likely to initiate its own inquiry into the circum-

stances, putting the physician’s license—and ability to practice his profession—at risk.

Solution: Always Charge Fair Market Value

Greeson always advises his clients not to give anything away to a hospital with which they have a referral relationship, and that’s good advice for all health care providers. That doesn’t mean you must refuse to give the hospital a break for certain patients. You can provide care at discounted rates to hospital employees or to others the hospital specifies, as long as you get fair market value for the services.

Determining fair market value for medical services is tricky, and it’s not an exact science. But if you’re ever asked to explain why you agreed to provide certain services to a hospital at a discounted rate, it’s crucial to be able to show that you made an effort to determine the going rate for the services and charged the hospital accordingly. To do this, Greeson advises that you consider and document the following:

- What Medicare and Medicaid pay for the service; and
- What the larger third-party payors in your area (both traditional indemnity plans and managed care organizations, if possible) pay for the service.

Ideally, the rate you offer the hospital won’t be the highest or the lowest of these rates, but instead will fall right in the middle. But even if the rate you offer the hospital is on the low side, if you can show that the rate you’re offering is within the same range, you’re likely to pass the fair market value test. ■

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.

- Antikickback law: 42 USC §§1320a-7b(b).