

# Radiology Administrator's

## Compliance & Reimbursement Insider

JUNE 2003

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## Get Familiar with New OB Ultrasound Codes

One of the biggest changes in radiology in 2003 involves coding for obstetrical ultrasound. This is helpful for radiology practices because now there are several new codes that describe the different types of ultrasounds and their complexities. So now you can code these procedures more accurately—and that may possibly increase your reimbursements.

But correctly using these new, more specific codes requires much more detailed documentation than was required in the past, says radiology reimbursement expert Jackie Miller. And many radiologists haven't adjusted their dictation style accordingly, so coders often have to try to apply the correct code without the documentation to support it.

We'll explain why these new OB ultrasound codes are helpful and give you a brief description of them. We'll also describe what your documentation must include to support them. And we'll give you a Model Memo (see p. 3) you can distribute to your radiologists, telling them what information their dictation must include to ensure that their OB ultrasound claims are coded and reimbursed correctly.

### New Codes More Descriptive, Accurate

The new OB ultrasound codes are much more specific—so practices can code more accurately, says Miller. For example, the new codes differentiate between ultrasounds performed early in pregnancy and ultrasounds performed later in pregnancy.

They also distinguish between ultrasounds meant to evaluate specific abnormalities and ultrasounds meant only to monitor fetal growth and verify fetal heartbeat. Plus, new add-on codes permit reporting of multiple fetuses—so that if a patient is carrying twins, for example, you can now get paid for assessing each fetus.

More descriptive codes mean less guesswork for a coder. Plus, now when your radiologists perform these more complicated exams, there are codes for them—so you don't have to add a narrative, search for an adequate code, or use a modifier.

### Description of the New Codes

Here's a brief description of the new codes:

**Fetal and maternal examination.** There are two codes that describe this common transabdominal ultrasound examination, and two add-on codes that you use for each additional fetus. The code you select will depend on the gestational age of the fetus(es), Miller says.

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**Subscriptions:** *Radiology Administrator's Compliance & Reimbursement Insider* (ISSN 1527-2338) is published monthly. Subscription rate: \$357 for 12 monthly issues. Address all correspondence to: Brownstone Publishers, Inc., 149 Fifth Ave., New York, NY 10010-6801. Tel.: 1-800-643-8095 or (212) 473-8200; fax: (212) 473-8786; e-mail: jgormley@brownstone.com

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## NEW OB ULTRASOUND CODES (continued from p. 1)

► **76801.** This code is used for a first trimester examination that includes determination of the number of gestational sacs and fetuses, measurements appropriate for gestational age, survey of visible fetal and placental anatomic structure, assessment of amniotic fluid volume/gestational sac shape, and examination of maternal uterus and adnexa.

► **+76802.** This add-on code is used with the 76801 exam, described above, for each additional gestation.

► **76805.** This code is used for a second or third trimester examination that includes determination of the number of fetuses and amniotic/chorionic sacs; measurements appropriate for gestational age; survey of intracranial/spinal/abdominal anatomy, four-chambered heart, umbilical cord, and placenta location; amniotic fluid assessment; and assessment of maternal adnexa (when visible).

► **+76810.** This add-on code is used with the 76805 exam, described above, for each additional gestation.

**Fetal and maternal exam plus detailed fetal anatomic exam.** This transabdominal exam requires specialized equipment and will most often be performed in referral centers with neonatology services, Miller explains. It's aimed at patients with a high risk of birth defects. Use of this code doesn't depend on fetal age, she notes.

► **76811.** This examination includes the fetal and maternal evaluation described above in 76801 and 76805, plus detailed anatomic evaluation of fetal brain/ventricles, face, heart/outflow tracts and chest anatomy; number/length/architecture of limbs; and detailed evaluation of placenta, umbilical cord, and other fetal anatomy as clinically indicated.

► **+76812.** This add-on code is used with 76811 for each additional gestation.

**Limited exam.** For a limited transabdominal ultrasound exam, use the following code regardless of fetal age and number of fetuses, Miller says. It represents a "quick look"—for example, to check on fetal position.

► **76815.** This code is used when the exam includes one or more of the following elements: fetal heartbeat, placental location, fetal position, and/or qualitative amniotic fluid volume.

**Follow-up exam.** The following code is used for subsequent transabdominal exams, regardless of gestational age. But you can code this exam once for each fetus, so if the patient is carrying twins, you can report two exams, Miller says.

► **76816.** Use this code for an exam used to reassess fetal size and interval growth, or to re-evaluate one or more suspected or confirmed anatomic abnormalities found on previous ultrasound.

**Transvaginal exam.** If a transvaginal ultrasound is performed, you can report it in addition to any transabdominal ultrasound. Use the following new code for obstetrical transvaginal ultrasound. (Non-obstetric transvaginal exams are still reported with code 76830.)

► **76817.** Use this code for a transvaginal ultrasound of pregnant uterus.

## Send Memo About Dictating OB Ultrasound Exams

To ensure that you get the specific information you now need, your radiologists must provide a detailed dictation of the ultrasound exam. But many radiologists aren't used to giving a detailed dictation of OB ultrasound exams. So Miller suggests that you send them a memo explaining the new, more descriptive OB ultrasound codes that, if used properly, may result in an increase in overall reimbursement for these procedures.

Your memo, like our Model Memo, should ask the radiologist to include certain information in every dictation regarding an obstetric ultrasound, such as:

- Gestational age;
- Number of fetuses or gestational sacs; and
- Whether the exam is being performed to follow up on findings from a previous exam.

The dictation should also include all those elements required for the code in question, as listed in the CPT manual. Although radiologists typically do all these evaluations when conducting an ultrasound, they don't always describe everything they see. By encouraging them to include all this information in every dictation, your coders will be able to make the right code choices.

Your memo should also describe the elements needed to code a detailed fetal examination. This will help ensure that your reports can withstand a payor audit. And because these exams will be priced higher, the reports will be more likely to be audited, Miller explains. Inappropriate use of the detailed fetal anatomy codes is likely to attract the attention of payors, she points out. ■

## MODEL MEMO

### Use Memo to Inform Radiologists of New Ultrasound Codes

The new ultrasound codes are much more descriptive than the old ones, and using them properly can increase your reimbursement. But to optimize the use of the descriptive codes, you must have descriptive dictation from your radiologists, says radiology reim-

bursement expert Jackie Miller.

Here's a Model Memo that you can give to your radiologists, explaining the new codes and listing what information radiologists must include in their dictation for your staff to select the proper code.

#### NEW CPT CODES FOR OBSTETRICAL ULTRASOUND

To: All Radiologists  
From: Office Manager

The 2003 CPT codes contain several new codes describing obstetrical ultrasound procedures. To ensure that our practice is receiving the maximum allowable reimbursement for the OB ultrasounds we perform, kindly include the following information:

#### OB ULTRASOUND DICTATIONS

Include the following in all your OB ultrasound dictations:

- Transabdominal or transvaginal examination.
- Initial or follow-up examination.
- Gestational age.
- Number of gestational sacs or fetuses.
- Fetal measurements as appropriate for gestational age.
- Assessment of amniotic fluid volume, placenta, and fetal heartbeat.
- If a follow-up exam, interval growth and re-evaluation of any confirmed or suspected anatomical abnormalities.

#### DETAILED ULTRASOUND EXAM OF FETUS

When conducting a detailed ultrasound exam of the fetus, please dictate your evaluation of the following in addition to the information above:

- Fetal brain/ventricles.
- Face.
- Heart/outflow tracts and chest anatomy.
- Abdominal organ specific anatomy.
- Number/length/architecture of limbs.
- Umbilical cord and placenta.
- Other fetal anatomy as clinically indicated.

Thank you for your cooperation with this request. Your detailed dictation will allow us to bill promptly and accurately, and optimize our reimbursement.

#### Insider Source

**Jackie Miller:** Per-Se Technologies Consulting Group, 2840 Mt. Wilkinson Pkwy., Atlanta, GA 30339.

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## IN THE NEWS

### CMS Revamps Physician Web Page

CMS recently revamped the physician page, called the "Physicians Information Resource for Medicare," on its Web site. You can find it at [www.cms.hhs.gov/physicians](http://www.cms.hhs.gov/physicians). Like the old page, the new page will provide updates of news and policies that affect Medicare-participating physicians. You'll still find the most recent news relevant to physicians, as well as an alphabetical list of topics of interest, with links to CMS documents and news releases, laws, and regulations. But it also has two new features that physicians and their staffs may find helpful. We'll introduce you to the two new features and explain how you might use them in your practice.

#### Medicare Physician Fee Schedule Look-Up

This significant new feature lets you look up fee schedule amounts and geographic practice cost indexes for every carrier and locality. It also allows you to look up payment policy information by procedure code, without having to download the entire fee schedule. So you can limit your research to only those codes you're interested in, and save a lot of time.

*Example:* Say you want to find out what your carrier will pay for an interventional procedure that was aborted before completion. Here's how to use the Web page to get the information:

- Go to the Web page and click on "fee schedule look-up." An introductory page will appear. Click on the word "start," at the bottom of the page.

- The next screen will ask you whether you want to search a single code, a list of codes, or a range of codes. It also will ask you to select "pricing information," "payment policy indications," "relative value units," or "geographic practice cost information." Select "single code" and "pricing information."

- The next screen will ask you to select a carrier: You can choose "nation" (which will allow you to make comparisons among all carriers), a specific carrier, or a specific locality.

This screen will also ask you to select the information you want to review: You can select "all fields," which will give you policy information and RVUs, or "default fields." The default field provides pricing information that will show you only what the carrier(s) pay for the procedure. Choose "specific carrier" and "default fields."

- The next screen will ask you to enter the code you're interested in. You have a choice of a single code, a list of codes, or a range of codes. It will also ask you to select a modifier. You may select from four choices: "global," "professional component," "procedures physician terminated before comple-

tion," or "technical component." Enter the procedure code and select the modifier for "procedures physician terminated before completion."

Since you're looking for a specific carrier's policies, it will also ask you to select the carrier. Once you've made your choices, click "submit" and the information you requested will appear.

#### Get Up-to-the-Minute Information with Physician Listserve

The new Web page also offers you an opportunity to join the physician listserve. Members of the listserve will get e-mail notification of all policy changes and developments direct from CMS, as soon as they're released. These notices will frequently contain links to program memoranda, *Federal Register* notices, and other resources.

Members also may post questions or comments on the listserve. Plus, members can review questions, comments, and responses posted by others. Although the listserve will deal with physician Medicare issues, membership isn't limited to physicians, so administrators, techs, and other staff may join the listserve if they wish. ■

## PATIENT PRIVACY

### Get Set to Comply with Final HIPAA Security Regs

After much delay, HHS published the final *HIPAA security regulations* on Feb. 20, 2003. These regulations apply to health care organizations, such as physician practices and IDTFs, that store and transmit health information electronically (such as information regarding claims status, eligibility, and referrals). The regulations require you to implement administrative, physical, and technical safeguards to protect electronic protected health information (EPHI) in its custody from potential security threats and hazards. Although the final security regulations aren't drastically different from the proposed regulations, they've been reorganized and revised to be more consistent with the HIPAA privacy regulations. And like the privacy regulations, the final security regulations require you to adopt a host of policies and procedures to safeguard EPHI and to train your entire workforce on security.

Although you'll have two years to comply with the final security regulations, the time will go fast—it's essential that you begin your compliance efforts now. To help you get started, we've prepared a two-part article that will explain the regulations and what you need to do to comply. In this issue, we'll answer some key questions about the final security regulations. Next month we'll describe in more detail the safeguards that the regulations require you to implement.

#### What Information Is Covered?

The final security regulations cover EPHI—that is, protected health information (PHI) that's maintained or transmitted in electronic form. Exam-

ples include PHI stored on a computer disk, magnetic tape, or computer hard drive, or PHI that's transmitted over the Internet. Although the privacy regulations require safeguards for all PHI, the security regulations are more limited in scope and set standards to safeguard only EPHI, explains health information consultant Tom Hanks. Unlike the privacy regulations, the final security regulations don't cover PHI that's on paper or in oral form.

The security regulations are also clear that EPHI doesn't include PHI on paper sent by fax or oral PHI transmitted by phone, since neither existed in electronic form before transmission. But the commentary to the final security regulations notes that, in a change from the proposed security regulations, telephone voice response and "faxback" systems are now covered.

**Insider Says:** Because there's overlap in the information that the privacy regulations and security regulations cover, you may have already addressed some of the security regulations' standards when implementing the privacy regulations. In the preamble to the security regulations, HHS says that it expects that many of the security requirements will already have been implemented by organizations as part of their privacy compliance efforts, notes Hanks.

#### When Must I Comply?

The final security regulations were published in the *Federal Register* on Feb. 20, 2003, and go into effect on April 21, 2005 (after a 60-day public comment period). Covered entities have two years to comply—until

April 21, 2005. There's an exception for small health plans (those with annual receipts of \$5 million or less). They have an extra year to comply—until April 21, 2006. But there's no exception for physician practices, regardless of size—so you should be preparing to be in compliance by April 2005.

#### What Do the Security Regs Require?

The final security regulations start with a general requirement that a covered organization protect the confidentiality, integrity, and availability of EPHI that it creates, stores, maintains, or transmits, explains Hanks. By "confidentiality" the regulations mean ensuring the information's privacy; by "integrity" ensuring that the information isn't improperly altered or destroyed; and by "availability" ensuring that it's accessible and usable to authorized persons. HHS stressed the importance of "availability" throughout the security regulations, Hanks notes, because it's especially important to health care providers, who need the EPHI to make patient care decisions.

Next, the final security regulations describe safeguards, organizational requirements, and documentation requirements as follows:

**Safeguards.** There are three categories of safeguards:

- Administrative safeguards;
- Physical safeguards; and
- Technical safeguards.

The three safeguard categories are broken down into 18 security standards that explain what must be done.

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**PATIENT PRIVACY** (continued from p. 5)

Many of these security standards are accompanied by specifications that describe the policies, procedures, and steps that must be implemented to achieve a particular standard.

**Organizational requirements.**

The regulations set one standard for business associate contracts and other arrangements, and another standard for documents of group health plans.

**Documentation requirements.**

Like the privacy regulations, the security regulations require you to adopt formal policies and procedures to comply with their requirements. These policies and procedures must be in written or electronic form and be maintained and updated. You must also document any action, activity, or assessment that's required by the regulations.

In next month's issue of the *Insider* we'll give you a detailed description of the standards for the safeguards, and organizational and documentation requirements.

**Are the Security Regs Flexible?**

Like the HIPAA privacy regulations, the final security regulations are designed to be flexible, says Hanks. They say that you should take a flexible approach to meeting the security standards. They also say that when determining which security measures to use, a practice or facility *must* take into account the following four factors:

- Its size, complexity, and capabilities;
- Its technical infrastructure, hardware, and software security capabilities;
- The costs of the security measures; and
- The probability and criticality of potential risks to EPHI.

So how you meet a particular security standard will depend, in part,

on your practice's unique characteristics and technical environment, Hanks explains. And documenting these decisions is extremely important, he adds. You should have a documented risk analysis to support your implementation decisions. For each area, the analysis should identify the likelihood of a particular security incident's occurring, its potential effects, and the cost of preventing or reducing the likelihood, he suggests.

**Insider Says:** The final security regulations' flexibility extends to your technology decisions. Like the privacy regulations, the final security regulations are technology neutral, notes Hanks. That means that you're not required to use a particular technology to meet a particular security standard. So you may make your own technology decisions by determining what's reasonable and appropriate given your business environment, he explains.

**What's an 'Addressable' Implementation Specification?**

The final security regulations include more than 40 implementation specifications. Each one is labeled either "required" or "addressable"; 22 of the implementation specifications are addressable.

What's the difference between required and addressable? When an implementation specification is labeled required, then you *must* implement it, explains Hanks. But even a required implementation specification can be scaled up or down depending on the your risk analysis, he explains.

When an implementation specification is labeled addressable, you must determine whether the addressable implementation specification is a "reasonable and appropriate safeguard" for you to adopt, he says. In

other words, you must determine whether the particular specification will help you protect your EPHI. Once you've determined that, you must do one of the following:

**Reasonable and appropriate.** If the implementation specification is reasonable and appropriate, then you must implement it.

**Not reasonable and appropriate.** If the implementation specification isn't reasonable and appropriate, then you must document why it's not, and then either:

- 1) Implement an alternative measure that's reasonable and appropriate, which will fulfill the security standard; or
- 2) Not implement any alternative measure—but only if the security standard can be met without implementing an alternative measure. In this case, you must document how the security standard will be met.

Regardless of whether an implementation specification is required or addressable, documentation is key. You must document its decisions regarding the level of implementation (or lack of implementation, if appropriate), advises Hanks.

**What Are the Penalties for Noncompliance?**

HHS has the authority to impose penalties for failure to comply with the security regulations. Although regulations to enforce the security regulations aren't yet drafted, HIPAA (the law) sets the penalty amount for a violation of those regulations, Hanks points out. It's a maximum of \$100 per violation per person or organization. The total penalty imposed on any one person or organization for multiple violations of the same HIPAA requirement or prohibition in a calendar year may not exceed \$25,000.

Another factor to consider is that many of the provisions in the security regulations are inextricably linked with the privacy regulations, Hanks notes. Although a security violation on its own isn't punishable by larger fines and penalties, it's likely to have

been uncovered due to unauthorized disclosure, which is a privacy violation. And privacy violations are subject to substantial criminal penalties, including fines up to \$250,000, jail time of up to 10 years, or both. ■

#### Insider Source

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## D O S & D O N ' T S

### ✓ **Check Plan Contracts Sent Electronically for 'Hidden' Information**

When a plan sends a contract by e-mail or computer disc for your review, use your computer's word-processing program to see if the contract contains hidden comments or other information. You may find that the plan mistakenly left information in the contract that you were never supposed to see. If it did, you may be able to use that information to your advantage during your negotiations, suggests managed care consultant Maria Todd.

This happened to one of Todd's clients, an Ohio hospital. The hospital was negotiating a contract with a national HMO. The hospital's representative typed questions and suggested changes into the draft contract sent by the HMO, then e-mailed the annotated contract back to the HMO's representative. The HMO's representative and her supervisor reviewed the hospital's questions and suggested changes, and e-mailed a revised contract to the hospital.

While reading the revised contract on the computer screen, the hospital's representative inadvertently jostled her computer mouse, causing the computer cursor to move across the screen and highlight the text. By doing so, she discovered hidden comments inserted in the contract by the HMO representative's supervisor. "Evidently, the HMO's representative and her supervisor had conferred via e-mail about the hospital's questions and requested changes, and then neglected to remove the internal discussion before sending the contract back to the hospital," explains Todd.

The hidden comments contained the supervisor's positions on the contract changes the hospital had requested, the HMO's negotiating strategies, and its fall-back positions. (There was also one insert where the supervisor used insulting language.) Armed with this confidential information, the hospital was able to take a much stronger stance when negotiating the contract.

To see if a contract sent to you by e-mail or computer disc has any hidden information, don't just print it out to review it, says Todd. "Right click" on your computer

mouse and run the cursor over the contract. Some of the words on the contract may have "dropdown" menus—just as on many Web sites—that contain information you wouldn't otherwise see. You may also uncover hidden information by clicking on "insert" on your word processing program's toolbar, and then clicking on "comments."

And check with your information system department or consultant to see if there are additional ways to check for hidden information in a contract. "It takes only a few minutes to check for hidden information, but if you find any, it can be a real bonanza," says Todd.

### X **Don't Undercode Claims to 'Play It Safe'**

Don't undercode claims for reimbursement just to "play it safe." Sometimes you may want to submit a claim under a lower-paying code—in effect, charge less than you're entitled to—because you don't know whether Medicare or another insurer will reimburse you for a higher-paying claim and you want to avoid possible upcoding violations. You might think that because you'll be getting paid less than you may be entitled to, you're not violating the law. But that's wrong, says health care attorney and compliance expert Robbi-Lynn Watnik.

"Undercoding can be as dangerous as upcoding because when a provider undercodes, it's still presenting an inaccurate claim," warns Watnik. And because undercoding a claim to avoid charges of upcoding is intentional miscoding, it could be considered an intentional submission of a false claim, putting you at risk of being charged with violating the False Claims Act, she adds. The bottom line: Any claim that intentionally misstates the service provided, is fraudulent. Period.

Besides the risk of False Claims Act charges, undercoding can involve other legal pitfalls, Watnik adds. For example, CMS's Office of Inspector General (OIG) could view your undercoded claims as an improper inducement to Medicare patients, in violation of the federal antikickback

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**DOS & DON'TS** (continued from p. 7)

law. This is because when you undercode a procedure, your patient is charged a reduced copayment. The discounted copayment could be construed as an improper inducement to get the patient to use your services.

On top of this, you're almost certainly violating your state's licensing laws when you intentionally miscode claims, says health care attorney Matthew Kupferberg. Submitting false insurance claims constitutes professional misconduct in most states, he adds. Moreover, an insurer that gets an undercoded claim from you could decide to deny reimbursement altogether for that particular service, sue you for violating the terms of your agreement, or terminate your agreement entirely.

So it's best to code all claims for service accurately, advises Watnik. And always document why a particular code was used. Even if Medicare, an insurer, or the OIG ultimately determines that the code you used was incorrect, you'll face lower penalties—and in some cases may avoid penalties—if your documentation shows that you made a good-faith effort to do the right thing, says Watnik. ■

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**HOSPITAL RELATIONS****Get Key Protections if You Delegate Billing Function to Hospital**

Sometimes a hospital-based radiology practice is asked to allow its hospital to bill radiology services on behalf of the practice. In fact, some hospitals may insist on handling the billing function for the radiology department. Although some hospital-based practices are happy to hand over the billing hassle to the hospital, there are risks associated with letting someone else submit your claims on your behalf, warns Virginia health care attorney Thomas Greeson.

We'll tell you when you shouldn't give the hospital the right to bill and collect your claims. And we'll explain when it's okay to allow the hospital to take over this function. We'll explain the risks and give you some pointers on how to limit them if you decide to let the hospital handle your coding and billing duties.

Plus we'll give you some Model Language you can put in your contract with your hospital. This language will help protect you if there's a problem with the way your hospital codes and bills your claims.

**Avoid Kickback Problems**

Allowing the hospital to code and collect your claims can be a violation of the federal *antikickback law*, says Greeson, if your practice:

- Is an independent contractor;
- Assigns its rights to collect professional fees to the hospital; and
- Gets payment from the hospital that's lower than the amount of professional fees, minus fair market value for billing costs and bad debt.

The government could consider the amount of your practice's professional fees that the hospital keeps to be a kickback in return for the contract to provide radiology services, Greeson warns. You can avoid this problem by requiring the hospital to turn over all your professional fees to your practice. Then you pay the hospital fair market value for its billing services, rather than allow the hospital to keep your professional fees and pay you a portion of them, he advises.

It's important to understand that this problem arises only when the practice is an independent contractor of the hos-

pital. If the hospital and the practice have an employment relationship, there's no concern about antikickback violations because the antikickback law has an exception for bona fide employment relationships, Greeson explains.

**Your Provider Number, Your Problem**

Sometimes practices fail to understand that they can be held responsible for claims submitted with their provider number even when someone other than the practice submitted the claims, Greeson notes. If you turn the coding and billing function over to your hospital, you must be aware that any errors the hospital makes will come back to haunt you.

For example, if the hospital is routinely upcoding claims for your professional services and the hospital gets caught, your practice is likely to be investigated. You'll have to show that you had no input into the way your claims were coded, and didn't know of or benefit from the upcoding, Greeson says. Even if you manage to do that and avoid sanctions, the

cost of defending the investigation will be high, he adds.

### **Include Protections in Your Hospital Contract**

If your hospital will be handling the billing function for your practice, there are a few steps you can take that will help protect you should the hospital bill improperly for the radiology services you provide.

Greeson suggests that you try to get the following assurances and protections from your hospital if the hospital will be coding and submitting claims for your radiology services. Keep in mind that your hospital may not be willing to give you all of these assurances and protections. But Greeson warns that you should be unwilling to sign a contract with a hospital that refuses to adopt the less protective provisions listed here.

**Get indemnification from hospital.** Ideally, you want the hospital to give you a broad indemnification. An indemnification clause is useful, Greeson says, because it typically makes the indemnifying party—in this case, the hospital—liable for any problem it causes. So the hospital would be on the hook for any requests for repayment you received—or other costs you might have incurred—that resulted from the hospital's improper coding of your services. And an indemnification clause may encourage the hospital to consult you as any coding questions or problems arise, Greeson notes.

#### **Model Language**

Hospital agrees to indemnify and hold harmless Practice, its officers, directors, and employees from and against any claims, losses, damages, causes of action, attorney's fees, and all other costs associated with and arising directly or indirectly from Hospital's actions in coding and submitting claims for services provided by Practice pursuant to this Contract.

### **Get right to audit periodically.**

The right to audit the hospital's records of the claims it submits on your behalf can be an effective tool. It ensures you that the hospital isn't submitting incorrect claims for services you provide, Greeson says.

Try to get the hospital to agree to let you audit at least annually—and more often if you reasonably suspect a billing problem. Also, your audit right should survive your contract with the hospital. So if allegations of billing improprieties arise after your contract with the hospital has ended, you can still investigate and defend yourself if necessary.

#### **Model Language**

Hospital shall permit Practice or its authorized representative to audit claims for radiology services submitted under this Contract. Such audits shall be permitted annually or more frequently should Practice, in good faith, deem more frequent audits necessary to investigate allegations or evidence of improper or erroneous billing or other wrongdoing in Hospital's coding and submission of claims for radiology services. These audit rights shall survive the expiration or earlier termination of this Contract.

**Insider Says:** If you get this audit right, you must take advantage of it, cautions Greeson. That is, hire an independent firm to conduct a thorough audit as often as the contract allows. Otherwise, the government or a third-party payor could accuse your practice of complicity in billing errors because you failed to exercise your audit rights under the contract, he warns.

**Get access to data.** If you can't get a broad audit right, demand the right of access to the hospital's billing data, Greeson says. You must be able to find out what the hospital has done with claims for your services, he emphasizes. This information will be crucial if there's ever a problem with claims for radiology services your practice provided at the hospital and

someone—like the OIG—wants to know how it happened.

You can't properly defend yourself without access to the hospital's billing data, Greeson explains. If a hospital won't agree to this right, you shouldn't sign a contract allowing it to handle the billing function, he says. Also, just like the right to audit, the right of access must survive the end of your contract, he adds.

#### **Model Language**

Hospital shall provide all claims records, data, and software that Practice or its authorized representative requests upon reasonable notice, as Practice requires to conduct internal audits or to respond to any inquiry from a government agency, regulatory body, or third-party payor, or to defend itself in any proceeding in a court of law. This right of access shall survive the expiration or earlier termination of this Contract.

**Get compliance warranty.** Your hospital should have an effective compliance plan in place. Greeson suggests that your contract with the hospital reference this compliance plan and obligate the hospital to perform its coding and billing functions in accordance with the compliance plan and with all other legal requirements. That way, if the hospital improperly bills claims for your services, the hospital will have breached its contract with you and you can terminate the contract—and maybe even sue the hospital.

#### **Model Language**

Hospital warrants that it has a compliance plan, that such plan is effective and consistent with the Office of Inspector General's Compliance Program Guidance for Hospitals, and that it shall perform all coding and billing functions under this Contract in accordance with the compliance plan and all applicable laws and regulations. ■

#### **Insider Source**

**Thomas W. Greeson:** Reed Smith LLP, 3110 Fairview Park Dr., Ste. 1400, Falls Church, VA 22042.

## Find ABN Info in CMS's ABN Quick Reference Guide

In late January, CMS posted the ABN Quick Reference Guide on its Web site at [www.cms.hhs.gov/medlearn/refabn.asp](http://www.cms.hhs.gov/medlearn/refabn.asp). The guide contains links to information necessary to help physicians and other providers use the new advance beneficiary notice (ABN) form correctly. It also covers some frequently asked questions (FAQs). According to the CMS press release announcing the new guide, it will be updated frequently and is supposed to serve as a "one-stop shop" for all the most current information relating to noncovered services for Medicare beneficiaries.

We'll walk you through this new guide so that you can start making it work for you.

### Section #1: ABN Form CMS-R-131

The first section of the guide gives general information about ABNs. It explains the purpose of an ABN—that is, to let a Medicare beneficiary know that Medicare won't pay for an item or service before he receives it, so that when making decisions about treatment, he's aware that he'll be responsible for the cost of the item or service.

This section also contains several important links. For example, you can click on a link that will take you to the Beneficiary Notices Initiative Web page. There you can review the notices that Medicare sends to beneficiaries about their treatment rights. You can also click on a link that will take you to the CMS Program Memorandum that explains how and when to use ABNs.

This section also lets you download the general use ABN, in either English or Spanish. Just click on the appropriate links.

### Section #2: References

This section provides many important links that are helpful in understanding how ABNs are supposed to work and how to put them to work in your practice. There are several subheadings under this section:

#### Laws, regulations, and rulings.

You can click on links under this subheading to read the law that exempts certain items or treatments from Medicare coverage, the beneficiaries' rights concerning noncovered items or services, and the regulations implementing this law. This subsection also provides links to Administrator's rulings, which are decisions the administrator of CMS (then HCFA) has made regarding ABNs, their use, and misuse. This section will be updated as laws and regulations change and rulings are issued.

**Instructions.** In this subsection, there are links to various program memoranda (PMs) and transmittals. As the *Insider* went to press, four such links were posted under this heading:

- Sept. 25, 2001, PM on coding for noncovered services;
- Oct. 22, 2001, PM on DMERCS—ABNs for upgrades;
- Oct. 31, 2001, PM on providing upgrades of DMEPOS without any extra charge; and
- July 31, 2002, PM on instructions for the new ABN.

New links will be added as new program memoranda are released.

**Exhibits.** At press time, this subsection contained links to several other useful documents. For example, there's a link to a chart that explains when to use the various modifiers that denote a noncovered service. There's also a link to a working paper that analyzes the applicability of ABNs to certain claim denials, which is helpful for people who want to learn more about the proper use of ABNs to avoid claim denials for improper use or failure to use an ABN. And there's a link to Excluded Services Notices, a customizable form that practices can use to inform their patients about services that Medicare never covers.

### Section #3: Most Frequently Asked Questions

The last page of the guide includes links to categories of FAQs on topics related to ABNs. Currently there are FAQs posted about four different categories, one of which is "Answering Beneficiaries' Questions About ABNs." The other three categories are less likely to concern radiology practices. ■

#### 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).
- HIPAA security regulations: Fed. Reg., 2/20/03, Vol. 68, No. 34, p. 8374.