

Radiology Administrator's

Compliance & Reimbursement Insider

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Review Your Joint Ventures to Prepare for Greater OIG Scrutiny

Many radiology practices have arrangements with other providers that are considered "joint ventures"—that is, the radiology practice and the other providers establish a new joint business entity to provide certain services or they sign an agreement for one party to provide services for the other. In a 1989 Special Fraud Alert, the OIG expressed concern that joint ventures among health care providers can serve as an opportunity for a referral source to generate a fee—in short, a way to reward referrals for medical services.

The OIG's main concern about joint ventures seems to be that they can be used to mask illegal kickbacks under the guise of a legitimate business arrangement, says Washington, D.C., health care attorney Thomas W. Greeson. Recently, the OIG issued a Special Advisory Bulletin, "Contractual Joint Ventures," in which it reemphasized and clarified this concern. This bulletin could mean a greater chance that the OIG will scrutinize your joint ventures, Greeson cautions.

We'll tell you what this bulletin says and explain how it can apply to some arrangements that radiology practices and facilities commonly use. Plus we'll give you some pointers to help you to determine whether your joint venture arrangement is likely to attract OIG scrutiny.

Joint Ventures Raise Antikickback Concerns

The federal *antikickback law* bars the payment or receipt of any remuneration in return for, or to induce, referrals for services that are reimbursable under federally supported health care programs. The OIG warns that a business arrangement between health care providers that's intended to lock up a referral stream for one provider or compensate one provider for referrals is a violation of the antikickback law.

What the OIG Is Looking For

The OIG released its recent Special Advisory Bulletin on contractual joint ventures because it "is concerned that [these] arrangements are proliferating."

Key characteristics. According to the bulletin, the OIG will carefully scrutinize joint ventures with the following characteristics:

- One party (called the owner, in the bulletin) is expanding into a new line of business;
- The owner contracts out substantially all the new operations to a contract partner (called the manager/supplier);
- The manager/supplier is an established provider of the same service and so would otherwise be a competitor;
- The owner and the manager/supplier each receive compensation from the new business; and

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JOINT VENTURES (continued from p. 1)

- Aggregate payments to the manager/supplier vary based on the volume or value of referrals from the owner.

Other characteristics. Of course, not all joint ventures set up this way necessarily violate the antikickback law, Greeson says. The bulletin also explains that the OIG will look for certain other indicators that may indicate that a given joint venture may be improper. Some of the indicators the OIG mentioned are:

- The owner provides a captive referral base and assumes little or no bona fide business risk. That is, the owner doesn't invest in the venture; instead, the owner's primary contribution is a referral stream; and
- The practical effect of the arrangement is to allow the owner to bill for services that might otherwise be supplied by the manager/supplier.

The OIG is likely to scrutinize arrangements with these characteristics very carefully, Greeson suggests.

Safe Harbor May Not Offer Protection

One of the most significant aspects of the bulletin is also the most controversial, Greeson says. In the bulletin, the OIG warned that a joint venture that's structured to fit within one or more of the safe harbors still may be problematic—and the joint venture as a whole may violate the antikickback law.

This is worrisome, Greeson reports, because many joint ventures are structured as a combination of several subagreements, each of them carefully designed to fit within a specific safe harbor. But the bulletin says that if the overall context of a joint venture arrangement indicates that it's meant to induce or compensate referrals, safe harbor protection may not be available for the joint venture, even though its parts are technically in compliance. If the OIG intends to enforce this interpretation of the law, it would affect many joint ventures that had been considered compliant, not just the type of joint venture described in the bulletin, Greeson explains.

It's debatable whether the OIG has the authority to enforce its position that a contractual joint venture arrangement is out of compliance if its components fit within the safe harbors and there's no evidence of intent to defraud, Greeson notes. But even if the OIG's position turns out to be wrong, all parties to contractual joint ventures should be aware that the OIG is proposing such an interpretation, and proceed cautiously, Greeson advises.

All Joint Ventures May Undergo Scrutiny

Even if a joint venture doesn't look at all like the joint ventures the OIG discusses in its recent bulletin, radiologists still need to be very careful and should review their joint venture arrangements with a fresh eye, Greeson says. If the OIG thinks the topic is important enough to release a Special Advisory Bulletin about it, it's likely to look closely at *all* joint venture agreements, he warns.

Example: Radiology practice sells the technical component of its MRI on a per click basis to an orthopedic group that refers patients to the radiology practice. Orthopedic group then bills the technical component at a marked up rate to payors, including Medicare. In the past, many of these arrangements were

thought to pass regulatory muster, as long as the orthopedic group paid the radiology practice fair market value for the technical component, Greeson reports. But the OIG bulletin implies that this sort of arrangement may be suspect, even though it doesn't have all of the characteristics identified as suspect arrangements in the bulletin.

That's because the arrangement allows the orthopedic group an opportunity to bill the technical component and receive compensation at a profit, so the orthopedic group is rewarded for its referrals, he explains.

The OIG bulletin emphasizes that compensation based on the volume or value of referrals that pass between the parties indicates an improper arrangement, Greeson notes. That, combined with the OIG's assertion that safe harbor protection may not be available, means that per click arrangements—even those based on fair market value—will pose a problem if the price varies with the volume or value of referrals. Greeson suggests that any practice or facility that has a per click arrangement settle

on a fair market value price per click, and charge that price to all parties it contracts with. "If you offer the technical component at \$200 per click to the orthopedic group that sends you lots of referrals, you should offer the same price to the dermatologist who sends you very few patients," he says.

Review Your Agreements for Compliance

The OIG's enforcement priorities as set forth in the recent bulletin don't necessarily reflect a correct interpretation of the law, Greeson emphasizes. A joint venture agreement that's structured to fit within safe harbors should enjoy safe harbor protection unless the arrangement is clearly a sham and a fraud, Greeson believes. But given the OIG's interest in this topic, it's prudent to review your joint venture arrangements and perhaps rework them if they have some of the characteristics the OIG mentioned as especially suspect.

Greeson suggests you carefully review any joint venture arrangement in which:

- You and your contract partner would otherwise be competing to provide the service you provide in your joint venture;

- One contract partner has little day-to-day responsibility for the joint venture's operations;

- One contract partner gets revenue based on the volume or value of his referrals to the joint venture; or

- The contract partner without responsibility for daily operations assumes little or no business risk.

Insider Says: You can get the OIG Special Advisory Bulletin at the OIG Web site, www.oig.hhs.gov. Click on "Fraud Prevention and Detection," then click on "Fraud Alerts, Bulletins and Other Guidance." Next, click on "Bulletins" and scroll down to "Special Advisory Bulletin: Contractual Joint Ventures," which is dated April 23, 2003. ■

Insider Source

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IN THE NEWS

CMS Announces New Coverage for MRA and PET

In mid-April, CMS announced several changes in reimbursement policy, which are of interest to radiology practices and facilities. In three National Coverage Analysis (NCA) decision memos—one dated April 15, 2003, and two dated April 16, 2003—CMS announced its decision to expand Medicare coverage of Magnetic Resonance Angiography (MRA) and Positron Emission Tomography (PET) for patients with certain conditions.

We'll tell you which of these technologies CMS has decided it will cover. And we'll tell you why it may

be a while before CMS's decision to expand coverage of MRA and PET is reflected in your reimbursement.

MRA of Abdomen and Pelvis Covered in More Circumstances

Medicare currently covers MRA for patients with vascular disease of the abdomen and pelvis only when the patient has damage to the aorta. But with this limited coverage, Medicare patients with unexplained hypertension and possible renal artery stenosis must endure catheter angiography (CA)—

an invasive procedure with a significant rate of complications—to get a firm diagnosis of their condition. MRA, on the other hand, is non-invasive and quite effective in diagnosing this condition, says Atlanta radiology reimbursement expert Jackie Miller.

In its NCA decision memo, CMS pointed out that although MRA is somewhat less sensitive than CA at diagnosing vascular disease in the abdomen and pelvis, the low risk associated with MRA makes it a rea-

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sonable and medically necessary diagnostic tool. So CMS announced it will cover MRA in the following additional circumstances:

- To evaluate renal arteries in patients without a damaged aorta;
- To evaluate pelvic arteries in patients without a damaged aorta; or
- In addition to CA when clinically warranted.

The NCA decision memo says Medicare won't always cover MRAs for patients in these circumstances, Miller points out. The procedure must be reasonable and medically necessary for the particular patient. That is, the ordering physician must have conducted a thorough physical examination, including appropriate laboratory tests, and ordered the MRA only after more standard diagnostic tools have failed to reveal or confirm the patient's condition.

Insider Says: You can find the NCA decision memo on CMS's Web site at www.cms.hhs.gov/ncdr/memo.asp?id=51.

New Coverage for PET

CMS released two NCA decision memos on PET scans. The NCA decision memos expand PET (FDG) coverage to patients with thyroid cancer, and cover myocardial perfusion imaging with PET (N-13 ammonia). Any decision to expand coverage is welcome news, says William Uffelman of the Society of Nuclear Medicine.

PET (FDG) for patients with thyroid cancer. CMS elected to expand PET (FDG) coverage for only one small group of thyroid cancer patients. CMS reviewed several studies of PET (FDG) for use in the staging and restaging of thyroid cancer and in the identification of patients at greatest risk of death from thyroid cancer.

According to the NCA decision memo, CMS found that these studies didn't prove that using PET (FDG) would affect the management of the patient's disease or alter the patient's eventual outcome in most cases.

In the decision memo, CMS also said that Medicare will now cover PET (FDG) for restaging or recurrent residual thyroid cancer originating in the follicular cells if:

- The patient has Tg levels >10ng/ml; and
- Standard imaging tests have failed to localize metastatic or recurrent disease.

CMS pointed out that some studies show that using PET in these cases has led providers to modify a patient's therapy in response to the PET results and that there are no other options for identifying disease in this group of patients.

Insider Says: You can find this National Coverage Analysis decision memo at www.cms.hhs.gov/ncdr/memo.asp?id=70.

PET (N-13 Ammonia) for myocardial perfusion. The NCA decision memo on this application says that results of myocardial perfusion imaging to assess the amount of viable and functioning myocardium are an important factor in making treatment decisions for patients in congestive heart failure.

Medicare has covered myocardial perfusion using PET (Rb-82) since 1995, and PET (FDG) or SPECT for evaluation of myocardial viability since 1998. In its NCA decision memo, CMS compared the use of PET (Rb-82) and PET (N-13 ammonia) in myocardial perfusion imaging and determined that they're equally accurate and reliable.

But the NCA decision memo notes that N-13 ammonia nucleotide

is easier to maintain and less expensive to acquire. So CMS is expanding Medicare coverage to allow myocardial perfusion imaging by PET with either Rb-82 or N-13 ammonia, but with the following limitations:

- A PET scan may be conducted at rest alone or at rest with stress, but not in addition to SPECT used to evaluate myocardial viability.
- But a PET scan may be used after an inconclusive SPECT if necessary to determine what medical or surgical intervention the patient requires.

Insider Says: The coverage analysis is available at www.cms.hhs.gov/ncdr/memo.asp?id=66.

No Reimbursement Until NCDs Set Rules

Before you can get your Medicare carrier to pay for any of these newly covered procedures, CMS must release a National Coverage Determination (NCD). After that, it may take a while for local carriers to program their systems to recognize these procedures, Miller says. But you'll eventually get paid for the procedures you perform on or after the NCD's effective date, she notes.

On May 14, CMS released an NCD for the newly covered MRA applications; it goes into effect on July 1. As the *Insider* went to press, CMS hadn't yet issued an NCD for the newly covered PET applications. So it may be some time before these PET applications will be reimbursed, Uffelman says.

Insider Says: The NDC is available at www.cms.hhs.gov/manuals/pm_trans/R170CIM.pdf. ■

Insider Sources

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PATIENT PRIVACY

Understand the Security Standards for the Final HIPAA Security Regs

Last month, we answered some key questions about the final *HIPAA Security regulations*. These regulations require that you implement standards to protect electronic protected health information (EPHI) in your custody from potential security threats and hazards. As we promised, this month we'll give you a detailed description of the security standards listed in the regulations.

What Are the Security Standards?

There are 22 security standards listed in the final security regulations. Fifteen of these security standards are accompanied by implementation specifications that detail how a particular security standard may be met. Here's a brief description of each security standard, including whether or not it has implementation specifications and how many. We've prepared a list of the standards under the category to which the security regulations assign them.

Administrative Safeguards

Nine of the security standards fall into this category. They require policies and procedures to manage the selection, development, and use of security measures to protect EPHI and to manage the conduct of employees with access to EPHI. They are:

1) Security management process. An organization—including a medical practice or facility—must implement policies and procedures to prevent, detect, contain, punish, and correct security violations (4 implementation specifications).

2) Assigned security responsibility. An organization must designate a person responsible for developing and

implementing the organization's security policies and procedures (no implementation specifications).

3) Workforce security. An organization must implement policies and procedures to ensure that its employees have appropriate access to EPHI (3 implementation specifications).

4) Information access management. An organization must implement policies and procedures for authorizing access to EPHI (3 implementation specifications).

5) Security awareness and training. An organization must implement a security awareness and training program for its entire workforce (4 implementation specifications).

6) Security incident procedures. An organization must implement policies and procedures on reporting and responding to known security incidents (1 implementation specification).

7) Contingency plan. An organization must implement policies and procedures for responding to an emergency or other occurrence that damages the organization's equipment or systems containing EPHI (5 implementation specifications).

8) Evaluation. An organization must perform a periodic technical and non-technical evaluation to determine the extent to which the organization's security policies and procedures meet the requirements of the security regulations (no implementation specifications).

9) Business associate contracts and other arrangements. An organization must get satisfactory assurances from its business associates who create, receive, maintain, or

transmit the organization's EPHI that the business associate will appropriately safeguard the information (1 implementation specification).

Physical Safeguards

There are four security standards aimed at ensuring that physical safeguards are implemented to protect an organization's electronic information systems, buildings, and equipment from natural and environmental hazards, and unauthorized intrusion. They are:

1) Facility access controls. An organization must implement policies and procedures that limit physical access to electronic information systems and their locations to authorized individuals only (4 implementation specifications).

2) Workstation use. An organization must implement policies and procedures that describe what tasks can be performed at a particular workstation, how those tasks are to be performed, and the physical surroundings of workstations that can access EPHI (no implementation specifications).

3) Workstation security. An organization must implement physical safeguards for workstations that can access EPHI to protect them from unauthorized users (no implementation specifications).

4) Device and media controls. An organization must implement policies and procedures governing the transport (receipt and removal) of hardware and electronic media that contain EPHI into, out of, and within the organization (4 implementation specifications).

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Technical Safeguards

This category includes five security standards that specify how to use technology to protect EPHI and control access to it. They are:

1) Access control. An organization must implement policies and procedures to limit access to electronic information systems that contain EPHI only to persons or software programs with access rights (4 implementation specifications).

2) Audit controls. An organization must install hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use EPHI (no implementation specifications).

3) Integrity. An organization must implement policies and procedures to protect EPHI from being improperly changed or destroyed (1 implementation specification).

4) Person or entity authentication. An organization must implement procedures to make sure that persons or organizations seeking access to

EPHI are who they claim to be (no implementation specifications).

5) Transmission security. An organization must implement security measures to prevent unauthorized access to EPHI that's being transmitted over an electronic communications network (2 implementation specifications).

Organizational Requirements

This section covers two standards, one addressing business associates and the second addressing group health plans.

1) Business associate contracts or other arrangements. An organization must ensure that its contracts or other arrangements (such as a memorandum of agreement or understanding) with its business associates are amended to address the security regulations (2 implementation specifications).

2) Requirements for group health plans. Group health plans must ensure that their plan documents provide that the plan sponsor will safeguard EPHI created, received, maintained, or transmitted by the plan

sponsor on behalf of the group health plan (except when EPHI is disclosed with a patient authorization) (4 implementation specifications).

Documentation Requirements

This section includes two standards, the first requiring organizations to implement policies and procedures to comply with the security standards, and the second requiring that such policies and procedures be documented.

1) Policies and procedures. An organization must adopt policies and procedures as reasonable and appropriate for the organization to meet the standards, implementation specifications, and other requirements of the security regulations (no implementation specifications).

2) Documentation. An organization must maintain in written or electronic form the policies and procedures that it has implemented to comply with the regulations. It must also document in written or electronic form any action, activity, or assessment that's required by the regulations (3 implementation specifications). ■

Use Temporary Agencies to Help Ease Tech Shortage

Consider contacting a temporary agency the next time you need to hire a technologist. Temporary agencies can be a great resource for practices and facilities that are suffering from the current shortage of qualified radiology techs. Using temporary techs can be a boon to your practice by helping it allocate resources more effectively, says health care attorney Joan Roediger. You can use temporary techs to cover for permanent employees who are on vacation or on leave, and not have to invest a lot of time verifying the tech's credentials. Using temporary techs can also help you avoid the has-

sles, like arranging for their health coverage, that are inevitable when you bring someone new into your practice on a permanent basis. And you can hire a tech on a temporary basis to see if he works out, without making a commitment beforehand.

We'll tell you why hiring techs on a temporary basis can be more convenient than hiring permanent employees. Plus we'll explain what to look for in a temporary agency so that you hire an agency that works well for you. And we'll give you some Model Language that you can adapt and use

to protect yourself in your agreements with a temporary agency.

Temporary Techs Can Help Your Practice

Radiology practices and facilities sometimes resist hiring temporary techs because they're afraid the temp may not be as competent as someone who's looking for a full-time job. But that's not always the case, Roediger says. Many competent professionals choose to work on a temporary basis because of the greater flexibility it provides. And some people just like

moving from place to place—that way, they can concentrate on doing their job and avoid getting involved in office politics.

Hiring a tech on a temporary basis helps you, too. You're spared the time and effort of advertising the position, screening candidates, negotiating salary and benefits, and training the tech—often just to see the tech leave as soon as a better offer comes along. If you use a reputable agency to find you a tech, the agency will handle most of this for you.

Choose Agency that Gives You Certain Protections

If you choose to use a temporary agency to find you a tech, make sure it's a reputable agency that screens its candidates, Roediger advises. Ask for recommendations from colleagues, your hospital, or your local radiology society. But the best way to tell if an agency has its act together is to ask whether it will give you certain assurances. The agency should, at a minimum, verify the candidate's credentials and ensure that the candidate is covered by adequate malpractice insurance, doesn't have a criminal record, and hasn't been excluded from Medicare.

Sign Agreement with Agency

Often, temporary agencies don't have formal contracts to govern their relationships with their clients. But all good agencies should be willing to give you a written agreement of some sort—often called a "letter agreement." We'll give you some Model Language, below, that offers you certain assurances—make sure your letter agreement with the temporary agency contains similar language. And get your attorney to review the agreement to make sure all bases are covered.

No Medicare sanctions or exclusions. It's crucial that both the agency you use and the tech the agency assigns to you have clean records with Medicare. Otherwise, you might be endangering your own Medicare status, because Medicare rules bar providers from paying Medicare dollars to an excluded person or entity, Roediger explains. So make the agency acknowledge in the agreement that neither it, its owners, nor the techs it assigns to your practice are in trouble with Medicare. And make the agency agree to check the Medicare status of the tech periodically and notify you immediately of any changes. Plus, you need the right to terminate your relationship with the tech and the agency immediately if either the agency or the tech is sanctioned or excluded. Your agreement with the agency should include the following language:

Model Language

Neither the Agency, its owners, principals, nor any technologist it assigns to the Practice have been sanctioned by or excluded from the Medicare program or any other government-funded health insurance program. The Agency will verify on a quarterly basis the Medicare status of any technologist it assigns to the Practice. The Agency will notify the Practice within one business day of learning of any change in the Medicare status of either the technologist or the Agency, its owners, or principals; and the Practice shall have the right to terminate this Agreement immediately upon receipt of such notice.

Credentials verification. Running a background check on every new employee eats up a lot of time, so one advantage of using a temp agency is that the agency will do the background check on the temp for you, Roediger notes. But make sure that the agency promises in writing to do the check. And add that you can terminate the tech immediately without penalty if you discover something negative in the tech's background. Your agreement

with the agency should contain language like the following:

Model Language

The Agency has investigated and verified the education, licensure status, malpractice coverage, employment history, and criminal background of all technologists it assigns to the Practice. The Agency agrees that if the Practice should independently learn of any error, omission, discrepancy, or relevant change in the technologist's credentials, malpractice coverage, licensure status, or criminal history, the Practice may immediately terminate the services of the technologist without prior notice or penalty, provided it notifies the Agency of such error, omission, discrepancy, or change.

Right to fire tech. Sometimes, employees just don't work out. You need to recognize that, and so does the agency. Don't enter into an agreement that forces you to accept whom-ever the agency sends you or that locks you into a relationship with a tech you don't like. Make sure your agreement with the agency says something like this:

Model Language

The Practice will have the right to deny employment to any candidate the Agency provides, without exception, but will make a reasonable effort to assist the Agency in selecting appropriate candidates. The Practice may terminate the services of any technologist the Agency provides for any reason.

Right to hire. Sometimes a temporary tech works out so well that you want to hire the tech on a permanent basis. In that case, some agencies may demand that you pay them a fee that's as much as the tech's annual salary if you decide to hire the agency's "temporary" employee permanently, Roediger says. Usually the agreement with the agency says the employee can't work in your practice except through the agency for some period of time. If you think there's any possibility that you eventually may want to hire a temporary tech on a permanent

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USE TEMPORARY AGENCIES

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basis, try to negotiate a more reasonable fee up front—perhaps a few months' salary, rather than a full year's, or a specific dollar amount for a finder's fee. Many agencies will

agree to this, she notes. Your agreement could say something like this:

Model Language

In the event that the Practice decides to hire any technologist that the Agency introduced to the Practice, whether or not the Agency ever assigned the technologist to work in the Practice, the

Practice agrees to pay a finder's fee of \$[insert amount] to the Agency prior to the technologist's first day of permanent employment with the Practice. ■

Insider Source

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How and When to Use E&M Codes with Mammography

When a patient is referred to a radiology practice or facility for a mammogram, it's not unusual for the radiologist to perform a physical exam before doing the mammogram to try to palpate a mass. And sometimes the radiologist will discuss the mammogram results with the patient, instead of leaving that discussion to the referring physician. Or the patient may have self-referred, so the radiologist is, in essence, the treating physician. In any of those situations, some practices will bill an office visit or consultation—an evaluation and management (E&M) service.

But it's not always appropriate to bill an E&M code for the physical exam or follow-up discussion associated with a mammogram, explains radiology compliance expert Claudia Murray. Improper use of E&M codes will attract the attention of auditors and could subject you to demands for repayment or even false claims or fraud charges, she warns.

We'll explain what needs to occur—and what needs to be documented—to bill an E&M code. If you understand these rules, you can avoid compliance trouble and still get all the reimbursement that you're entitled to.

E&M Coding Complex, Confusing

CMS has been trying to formulate workable guidelines for E&M coding for years, Murray points out. The

agency released guidelines in 1995 and 1997 that emphasized counting the elements of service the physician provided and tracking the amount of time spent with the patient. CMS then permitted physicians to code for E&M services using whichever set of guidelines was most advantageous under the particular circumstances.

In 1999, CMS published another set of draft guidelines—this one assigned codes based on the thoroughness of the history that was taken and the complexity of the physician's decision making. This set of guidelines has never gone into effect.

Obviously, the lack of firm direction from the agency that oversees the Medicare program has made proper E&M coding a challenge. "It's tough for a physician or coder to know what code to assign when CMS seems confused about how best to define E&M services," Murray points out.

OIG Work Plan Targets E&M Billing

Despite the fact that CMS hasn't presented clear guidance about coding for E&M services—or perhaps because of the lack of guidance—the OIG has focused on E&M coding as a potential source of overpayments to providers, and even fraud. For the past several years the OIG has mentioned in its annual work plan that it's concerned about physician use of E&M codes. The OIG's 2003 Work Plan reiterated

that concern. The OIG is looking into whether physicians overuse the E&M codes, and whether they code at a level higher than the visit merits, in order to secure more reimbursement.

Radiology practices and facilities may be particularly vulnerable to OIG scrutiny on this point, says Murray, because they typically don't use E&M codes often. A radiology practice or facility that bills a lot of E&M codes may be an outlier, which makes it a target for extra scrutiny, like audits. Plus, radiologists and radiology coders may have less experience using E&M codes, so their error rate may be somewhat higher than more experienced coders' error rates.

So if your practice or facility uses E&M codes, it's important that the radiologist's interaction with the patient is adequate to merit an E&M code, and that the documentation of the visit supports it.

Exam Must Be a Medically Necessary Separate Service

In order to bill a physical exam and/or discussion as a separate E&M service, it must be both:

- A service distinct and separate from the interpretation of the mammogram that requires the radiologist's time and expertise in evaluating the patient's condition, designing a treatment plan, or managing the patient's care; and

- Medically necessary.

Which Services Might Be Separately Billable

"Some radiologists conduct a breast exam before every diagnostic mammogram—it's part of their protocol," Murray says. In that case, the exam isn't likely to meet the "medically necessary separate service" standard that merits E&M billing, she explains.

But sometimes radiologists do provide services with a mammogram that are separately billable as E&M services. For example, say a patient arrives for a screening mammogram, which a radiologist "converts" to a diagnostic mammogram because of an anomalous finding. The radiologist may conduct a physical exam to try to appreciate the mass that appeared on the mammogram, and may talk to the patient in detail about the findings. In that case, the exam and the discussion are separately billable as a "medically necessary" E&M service, Murray says. The key is that the exam and the discussion were motivated by the results of the screening examination.

Exams conducted in conjunction with a diagnostic mammogram may be separately billable as E&M services, too. Say that a patient with a history of cancer presents for a diagnostic mammogram of the left breast, and complains of a new symptom—like pain in the left armpit. The radiologist decides to do a physical exam to try to find the cause of the pain, and discusses the findings in detail with the patient. This too is an interaction with a patient that's specific to the patient's particular history, diagnosis, signs, and symptoms, so it's separately billable as an E&M service, Murray says.

Insider Says: Even when a service is separately identifiable and medically necessary, it will usually merit a low-level E&M code, Murray explains. Typically, radiology practices will use level 2 or level 3 codes to report their E&M services, she says.

Documentation Is Key

Because CMS's guidelines for billing E&M services are fuzzy, documenting an encounter thoroughly is especially important, Murray emphasizes. She advises you to make sure that your radiologists, coders, and billers know not to use an E&M code unless the following elements are documented in the patient record:

Patient history. Murray notes that to justify an E&M code, the radiologist's documentation should refer to some specific aspect of the patient's history that shows that the radiologist specifically considered the patient's history—even if the note is just "patient claimed no history of x." If the radiologist discussed the patient's history with her, the documentation should say so. For example, "Pt claims hx of cystic breasts, claimed two episodes, '90(L), '97(R) in response to questioning."

Description of service. The radiologist's documentation should clearly describe the reason for the referral for the mammogram and the reason for the E&M service provided. It needn't be a long description, but it should be complete, Murray says. For example, the radiologist's note should indicate a referral for diagnostic or screening mammogram, explain why a diagnostic mammogram was done if the referral was for a screening mammogram, include the number of views, and if any view needed to be repeated, include that information, too. And if the patient's complaint or the radiologist's findings prompted a physical exam, make sure that the radiologist's note describes what prompted the physical exam and clearly reports the results of the exam. For example, "Pt. referred for scr. mammo, complains of pain in left armpit, appreciated palpable mass in left upper quadrant app. 1cm, Dx mammo, 2 view/bl."

Findings. The radiologist should report his diagnosis, or his inability to

make a definitive diagnosis. The radiologist also should note any recommendations for further tests, follow-up care, or treatment, Murray says.

Patient interaction. Sometimes, even when there has been an anomalous finding and a physical exam, the radiologist doesn't report to the patient but instead leaves it to the referring physician to discuss the findings with the patient. The radiologist needn't discuss findings with the patient in order to bill an E&M code, as long as the physical examination rises to the level of a separately billable E&M service, Murray explains. But often the radiologist will discuss findings with the patient, and doing so is probably better for the patient because the patient won't have to wait and worry about the results. Plus, a thoroughly documented conversation with the patient about results may permit you to bill a higher level E&M code, Murray points out.

The discussion should include the radiologist's diagnosis, and the documentation should include any questions the patient asked and the radiologist's answers. If the discussion includes treatment options, that should be noted. And if the radiologist suggests that the patient discuss options with the referring physician instead, the radiologist's note should reflect that. If the radiologist makes any recommendations regarding further tests or follow-up care, the radiologist's note must so indicate.

"The radiologist should document enough so that a reviewer can assess the comprehensiveness of the conversation," Murray says. That's the only way that the coder can assign the proper E&M code and get your practice all the reimbursement it's entitled to get for the encounter. ■

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