

# Radiology Administrator's

## Compliance & Reimbursement Insider

AUGUST 2003

### Boost Your Bottom Line by Challenging Medical Necessity Denials . . . . . 1

If the carrier doesn't have an applicable LMRP, sometimes challenging these denials is worthwhile.

- ▶ Model Letter: Send Challenge Letter to Your Carrier (p. 3)

### Hospital Relations: Consider Getting CMS Determination for Provider-Based Facilities . . . . . 4

Now that CMS has released a sample attestation form, getting this determination may be well-worth the effort.

- ▶ How to Know Whether Your Facility Is Provider Based (p. 5)

### In the News . . . . . 6

- ▶ OIG Announces New Source for Enforcement Information

### Be Careful When Donating Your Medical Services . . . . . 7

Donating your services at clinics is great for the community—but make sure you know the risks involved before you volunteer.

- ▶ Model Letter: Verify Malpractice Coverage for Volunteer Services (p. 7)

### Patient Privacy: Permanently Delete Health Information Before Selling or Discarding Computer Equipment . . . . . 8

We'll tell you how to do this.

### Dos & Don'ts . . . . . 9

- ▶ Clarify Confusing Contract Language Before You Ask for Changes
- ▶ Don't Set Bad Precedent by Writing Off Plan's Bad Debt
- ▶ Don't Bill Medicare Allowable Charge

### Show Your Lawyer . . . . . 10

## Boost Your Bottom Line by Challenging Medical Necessity Denials

Denials of claims for services are a fact of life in radiology practices. Sometimes the denial is due to a clerical error on your part—for example, using the wrong place of service, date of service, or code. But sometimes a claim is denied for a reason that you dispute—for example, you disagree with the payor's assessment that the service wasn't medically necessary. If you strongly disagree with the payor's determination, you may want to challenge the denial.

Challenging every questionable denial can be time-consuming and expensive—especially if not done properly. But if you pick your battles and prepare thoroughly, you can challenge denials efficiently and successfully.

In this article, we'll discuss how to challenge denials based on medical necessity when the carrier has no LMRP covering the treatment in question. And we'll give you a Model Letter you can adapt and send to your carrier (see p. 3). In future issues of the *Insider*, we'll tell you how to challenge denials based on insufficient documentation, and how to challenge denials of claims for new technology services.

### No LMRP Means Carrier Can Be Convinced

If your carrier has no LMRP for a given treatment, it hasn't made a decision yet about whether and when that treatment should be covered, explains Washington, D.C., health care attorney Alison Weber Shuren. So if your carrier denies your claim based on the medical necessity of a service for which it has no LMRP, you can challenge that denial if you think the service *was* medically necessary, she says.

A carrier may be willing to reconsider its denial if you can show that the patient's condition warranted the service and that the service is recognized as appropriate for a person with your patient's condition.

### Gather Data to Support Your Case

Before challenging the denial, Shuren advises that you gather the following evidence:

- The patient's history, which should indicate the patient's diagnosis or, in the case of a diagnostic procedure, the patient's suspected diagnosis and/or signs and symptoms;
- Information to support your contention that the service is indicated and effective for the patient's condition—this would include peer-reviewed scholarly and scientific articles, FDA findings, ACR publications, or other carriers' LMRPs that cover the service for patients with the condition your patient has; and

(continued on p. 2)

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## CHALLENGING MEDICAL NECESSITY DENIALS (continued from p. 1)

■ Any indication that other alternative services have failed or are contraindicated for the particular patient.

### Evaluate Whether Data Supports Your Decision

Once you've assembled all this evidence, consider whether it supports your contention that the service was medically necessary for the patient. If it doesn't present a persuasive case, you might want to reconsider disputing the denial. After having already denied the claim once, the carrier isn't likely to give you the benefit of the doubt—it will have to be convinced.

### Confer with Your Radiologist

If, after you review the documents you've assembled, you still think that the service should have been paid for the particular patient, schedule a meeting with your radiologist, says radiology reimbursement expert Jackie Miller. Make sure the radiologist agrees with your assessment. If so, ask the radiologist what documents he believes are most persuasive and what specific circumstances most strongly support the need for the service for the particular patient, Miller suggests.

### Challenge Denial in Writing

Once you've assembled all this information, you can use it to draft a letter to the carrier. The letter should be from the radiologist who performed the disputed service and should be addressed to the carrier's medical director. With this letter, you'll also send all the documentation you have to support your case.

Your letter, like our Model Letter, should include the following components:

**Claim ID.** Above the body of the letter, right below the recipient's address, state the claim number, date of the denial, and reason for the denial.

**History.** In the first paragraph, briefly summarize the patient's history and diagnosis, and/or signs and symptoms. Then, state the service the radiologist provided, and explain why the treating physician performed the particular service—for example, because other treatments failed or were contraindicated.

**Supporting information.** In the second paragraph, describe the supporting information you're including with your letter. List the most persuasive evidence first. For example:

■ First, list any indication that government regulators approve the service in cases similar to the patient's, says Shuren. This would include FDA findings and other Medicare carriers' LMRPs.

■ Next, list any ACR position papers that support the use of the service for the particular patient.

■ Then, Miller suggests listing references in textbooks because they indicate that a particular use is well established. She says you may also cite articles in medical journals but should do so sparingly—you don't want to give the impression that the service is experimental or brand new. And limit such

articles to well-known, respected, peer-reviewed journals, she advises.

■ Finally, list information from the manufacturer of the technology or pharmaceutical company if it seems extremely helpful—but given their

obvious bias, these materials aren't as persuasive, Shuren says.

**Explanation.** In the third paragraph, explain why the documentation you've enclosed supports your claim

that the denied service was medically necessary for the particular patient. This paragraph shouldn't be a rant, Miller cautions, but it should be a strong statement in favor of your radiologist's decision.

(continued on p. 4)

## MODEL LETTER

### Send Challenge Letter to Your Carrier

If you decide to challenge a denial that the carrier based on lack of medical necessity in the absence of an LMRP, compile persuasive evidence of the service's effectiveness and send it to the carrier's medical director along with a letter. As in the Model Letter below, drafted with the help of radiology reimbursement expert Jackie Miller, your letter should outline the patient's particular circumstances and refer to the evidence you're including.

Keep in mind that this letter is just an example, and the circumstances and evidence included in it are hypothetical. They're included just to show you how to support medical necessity in your letter. Be sure to consult your radiologist before you draft the letter so he can help guide you toward the most persuasive medical arguments and evidence supporting his decision.

John Smith, MD, Medical Director  
Local Medicare Carrier  
1234 Main Street  
Anytown, USA 00000

**Re: Claim # 5678, denied 6/10/03, not medically necessary**

Dear Dr. Smith:

I am writing regarding the above-referenced claim denied by your claims examiner and am asking you to reconsider the denial. I believe the service I provided was medically necessary and appropriate for the patient in question.

Patient Dana Jones is a 65-year-old woman who was seen by her physician, Susan Smith, MD, for sudden onset of mental status changes, on May 1, 2003. Dr. Smith referred her to me for an MRI scan of her brain to rule out brain tumor. According to Dr. Smith, the patient's family stated that the patient has difficulty finding words, and has memory loss and mood swings. MRI is recognized by many experts as a low-risk and non-invasive method of diagnosing intra-cranial processes such as tumors in the brain. I performed the MRI for which I submitted the above-referenced claim. The scan revealed no evidence of a tumor or other organic process.

In support of my contention that the MRI scan was medically necessary, I have included the following for your review. At tab 1 you will find a copy of the LMRP from Other State carrier, which supports my use of MRI as a covered service for patients with Ms. Jones's symptoms. The FDA has approved the use of MRI scans as safe and effective for patients with suspected brain tumors. I have included the FDA statement at tab 2. The ACR statement that supports the use of MRI scans as an efficacious diagnostic tool for patients with Ms. Jones's symptoms follows at tab 3. Finally, I have attached several articles from peer-reviewed medical journals, at tab 4.

As described in the enclosed JAMA article, when patients present with sudden onset of altered mental state and brain tumors are suspected, MRIs have produced fewer false-positives than CT scans, located the tumors more precisely, and reduced the time patients have had to wait to begin effective treatment.

Early treatment has been key in long-term survival rates. In the study, patients whose brain tumors were diagnosed with, and whose subsequent treatment was based on, MRI results had significantly better outcomes than patients whose tumors were diagnosed with CT scans. Since this article was published, 12 state carriers have added MRI coverage for sudden onset of altered mental state to their LMRPs.

Thank you for your reconsideration of the denial of coverage of this service for Ms. Jones. If you wish further information or would like to discuss this matter, I am available to speak to you Monday through Thursday, between 8:00 A.M. and 5:00 P.M., at (555) 555-5000. I will appreciate receiving your decision or request for further information by Aug. 30, 2003.

With best regards,  
Ralph Radiologist, MD

### CHALLENGING MEDICAL NECESSITY DENIALS (continued from p. 3)

**Conclusion.** Your letter should wrap up by thanking the medical director for his attention, inviting him to contact the radiologist for more information, and requesting a response within a given period of time—60 days is reasonable, Shuren says.

**Insider Says:** Binding the letter and the supporting documentation together makes a good impression, shows you're serious, and will help the reader follow your arguments. You can buy inexpensive plastic binders with tabs for attachments at any office supply store and most drug stores. It's well

worth the minimal expense and effort to make a professional presentation. ■

#### Insider Source

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## HOSPITAL RELATIONS

### Consider Getting CMS Determination for Provider-Based Facilities

Hospital-owned or managed off-site or off-campus diagnostic imaging facilities finally have a standardized method for confirming their status as provider-based facilities. In an April 2003 Program Memorandum to Intermediaries, CMS published instructions for facilities to attest that they're entitled to provider-based status. This is good news because until then, there had been no set method for getting a determination that a facility is provider based.

We'll tell you how CMS determines whether a facility should be considered provider based. And we'll explain how to weigh the risks and benefits of submitting an attestation if you're a provider-based facility.

#### Advantages of Provider-Based Designation

Provider-based facilities are departments, locations, or facilities that are part of a hospital complex but that may be located apart from the main hospital, says Washington, D.C., health care attorney Eric Zimmerman.

Services performed at a provider-based facility are billed as hospital outpatient services, and the hospital can claim the costs associated with

operating the facility on its quarterly cost reports. Plus, CMS reimburses the services under the Hospital Outpatient Prospective Payment System (HOPPS). This is important because reimbursement for some procedures, including some radiology procedures, is higher under HOPPS than under the Part B fee schedule—the fee schedule that's used for IDTFs and physician offices.

#### Lack of Application Process Caused Difficulties

According to a proposed rule issued in April 2000, facilities that were operating as provider based before Oct. 1, 2000, were "grandfathered"—that is, they could continue to operate and bill as provider-based facilities until the start of the hospital's first cost-reporting period on or after July 1, 2003. Other facilities had to affirmatively apply for provider-based status right away, although facilities that came into existence between Oct. 1, 2000, and Oct. 1, 2002, could bill as provider based until CMS had made a determination of their status.

But Zimmerman says it has been difficult for facilities that operate as provider-based entities—even long-

established ones—to get confirmation of their provider-based status, because CMS never developed an application process for those seeking provider-based status. Sometimes a provider's attorneys would try to put together a package of material that proved the facility was provider based, only to have the CMS office reject the package or ask for more material. The lack of a clear process wasted time and money.

This problem was exacerbated by the fact that grandfathered facilities needed to get a determination in time for the beginning of their July 1, 2003, cost-reporting period. So the CMS regional offices were dealing with many more requests for determinations than they could handle, with no standardization in either the requests or the approval process.

#### CMS Establishes Voluntary Attestation Process

In a final rule that became effective in October 2002, CMS decided not to require facilities to get an affirmative determination of their provider-based status. Instead, CMS substituted a voluntary attestation process: A facility can choose to submit an attestation, and CMS will either approve or dis-

approve it. Since then, CMS published a Sample Attestation Format in a Program Memo, so the process of securing a determination of provider-based status should be a lot simpler now, Zimmerman points out.

### Know Risks and Benefits of Voluntary Attestation

Although the attestation process is now voluntary, CMS may review the attestation and determine that a facility doesn't merit provider-based status. (For a simple explanation of how CMS decides whether a facility is provider based, see box at right.) So there's some risk to using the attestation process, Zimmerman says. Plus, there are administrative costs involved in completing the attestation, he adds.

So who should complete the attestation process? For facilities that are clearly provider based—that is, they are operating within the four walls of the main provider, and the main provider handles the administration of the facility—submitting an attestation may not be worth the effort involved.

But if you're not 100 percent sure of your provider-based status, the act of submitting an attestation offers you some protection, says Zimmerman. So he advises most of his clients to take advantage of the voluntary attestation process and seek a provider-based determination. That's because if a facility doesn't submit an attestation and continues to bill as a provider-based facility, and CMS ever decides that the facility doesn't meet the provider-based requirements, then CMS can collect overpayments from Oct. 1, 2002, Zimmerman notes.

But if a facility submits an attestation and CMS disapproves it, then CMS may recover only any overpayments the facility received from the date the attestation was submitted. And if a facility submits an attestation

and CMS approves it, and later CMS decides its decision was incorrect, CMS can seek repayment of only the difference between the amount paid to the facility since the submission of the attestation, and the amount it would have received as a facility that doesn't meet the provider-based requirements.

### Completing the Voluntary Attestation

The voluntary attestation process is simplest for provider-owned, on-campus facilities—joint ventures and off-campus facilities must submit a bit more paperwork, Zimmerman

points out. Although CMS has provided a sample attestation format (you can find it at [www.brownstone.com/jump/racri.cfm](http://www.brownstone.com/jump/racri.cfm)), using it isn't mandatory. You can submit your voluntary attestation in any form you choose, as long as it contains all the information CMS requires to make its determination. Here's a rundown on what you'll need to complete your attestation:

**On-campus facilities.** On-campus facilities that choose to submit an attestation must submit the following:

- Identifies the main provider and the facility seeking the determination;

(continued on p. 6)

### ► How to Know Whether Your Facility Is Provider Based

In the past, CMS didn't have any criteria to determine which facilities were provider based, says Washington, D.C., health care attorney Eric Zimmerman. CMS just relied on the hospitals to bill for these satellite facilities properly. But in 2000, CMS published its intention to more closely scrutinize provider-based facilities, because the reimbursement differential between the Hospital Outpatient Prospective Payment System (HOPPS) and Part B fee schedule offered a potential incentive for overpayments and fraud. CMS was going to start requiring facilities that wished to bill as provider based to get a CMS determination of provider-based status.

But in an August 2002 notice in the *Federal Register*, CMS announced that instead of requiring facilities to get a provider-based determination, it was establishing a voluntary attestation process that would allow facilities that chose to make the attestation to get a CMS determination of provider-based status. But that announcement didn't change the CMS requirements that a facility must meet in order to be considered provider based. The following is a simple summary of the requirements that applies to all provider-based facilities:

- The main provider (such as a hospital) and the facility must operate under the same license, unless state law requires separate licenses;
- The clinical services the facility offers must be integrated with the clinical services the main provider offers; and
- The financial operations of the facility must be integrated with the financial operations of the main provider.

There are other, more specific requirements that a facility must meet in order to be considered provider based. These vary depending on whether the facility is a hospital outpatient department or hospital-based entity, whether it's located on-campus or off-campus, and/or whether it's a joint venture, Zimmerman explains. For example, a joint venture must be at least partially owned by the main provider and must be located on the main provider's campus. And except in certain circumstances, an off-campus facility must be located within 35 miles of the main provider.

CMS's April 14 program memo explains the specific provider-based requirements, and the proof CMS will accept to show that a facility meets these requirements. You can find the program memo at [www.cms.hhs.gov/](http://www.cms.hhs.gov/). On the left side of the page, look for the heading "Programs" and click on "Medicare." Look at the bottom right side of the page for "Professional and Technical Publications" and click on "Program Memoranda." Then scroll down to AB-03-030, dated April 18, 2003.

**HOSPITAL RELATIONS** (continued from p. 5)

- Lists the facility seeking the determination by name and street address;
- If the main provider is a hospital, affirms that the facility will fulfill the obligations of a hospital outpatient department—for example, by complying with EMTALA;
- Reveals the date on which the facility became provider based;
- Identifies the person CMS should contact for more information, along with contact information;
- States explicitly that the facility is located on-campus; and
- Affirms that the facility meets the requirements for provider-based facilities as set out in the *provider-based regulations*.

**Insider Says:** An on-campus facility need not submit information verifying that it conforms to the

requirements of the provider-based regulations, notes Zimmerman, but it does need to have the information available should CMS ask for it. Since the facility needs to gather the information when submitting the attestation, anyway, he advises his clients to submit the proof along with the attestation.

**Off-campus facilities.** The attestation for an off-campus facility must include all the elements described in the attestation for an on-campus facility except, of course, that it won't claim to be an on-campus facility. Plus, the facility must submit proof that it meets the following requirements:

- The main provider owns and controls the facility;
- The main facility administers the facility and exerts the same amount of supervision there as it would if the facility were an outpatient department;

■ The facility is located within 35 miles of the main provider (with certain rare exceptions);

■ If the main provider is a hospital, the facility informs Medicare patients in writing of their financial liability before treatment (a copy of this notice, as well as the hospital's EMTALA policy, should be included with the attestation);

■ If the facility is operated under a management contract, the main provider is a party to the contract; directly employs all staff who perform patient care services; has significant control over facility operations; and integrates the administrative functions of the facility into its own. ■

**Insider Source**

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**IN THE NEWS****► OIG Announces New Source for Enforcement Information**

The OIG has added an enforcement section to the "Fraud Prevention and Detection" page of its Web site. The new section is intended to make it easier for providers and the public to monitor the OIG's enforcement efforts and learn from others' mistakes. It will provide summaries of recent cases and background information about the types of enforcement actions the OIG is conducting in two categories—administrative and criminal.

**Administrative actions.** In this category, the OIG provides background information about its authority to seek civil monetary penalties. It then provides summaries of recent cases dealing with the following issues:

- False and fraudulent claims;
- Kickback and physician self-referral;
- Managed care; and
- Patient dumping.

**Criminal actions.** In this category, the OIG provides summaries of criminal actions grouped chronologically by month (starting with February 2003) in the following categories:

- Physicians and other health care professionals;
- Home health agencies;
- Ambulance companies;
- Misuse of grant funds;
- Durable medical equipment;
- Psychiatric services;
- Prescription drug fraud;
- Mental and social services;
- Child support enforcement; and
- Other cases of interest.

**Insider Says:** You can find the enforcement section of the OIG's Web site at [www.oig.hhs.gov/fraud/enforcementactions.html](http://www.oig.hhs.gov/fraud/enforcementactions.html). ■

## Be Careful When Donating Your Medical Services

From time to time, radiologists are asked to donate their medical services—say, to interpret films at a mammography screening event, or to staff a public clinic. Volunteer activity like this is good both for the patients served and for your reputation—plus, it probably makes you feel good.

But if you're not careful, donating medical services can lead to problems. We'll tell you about the pitfalls of donating medical services, and show you how to avoid them. And we've included a Model Letter (at right) that you can send to your malpractice insurer so you can be sure you're covered for your donated medical services.

### Be Sure Your Service Can't Be Called a Kickback

In certain situations, donating your medical services could be considered a kickback, warns New York health care attorney Jay Silverman.

*Example:* A family practice that sends your practice a lot of patients has a health fair at a retirement home and offers osteoporosis screening at the fair. Your radiologist attends the fair to assist in interpreting these screening tests. Neither you nor the family practice will bill Medicare or any other payor for the services performed at the fair, and the family practice won't be compensating your practice or the radiologist for her time. If there's an indication that your radiologist's participation at the fair is part of a quid pro quo—that is, the participation is in exchange for the family practice's referral of Medicare patients to your practice—then both your practice and the family practice could be charged with violating the *antikickback law*.

So if you encounter a situation where someone wants you to donate free services in return for the referral

of paying patients—especially Medicare and Medicaid patients—you should decline, warns Silverman.

### Make Sure Malpractice Insurance Covers You

Physicians are often shocked when, after donating free medical services to a needy patient, that patient turns around and sues them for malpractice. But it happens—you owe every patient you treat the same duty of care and the benefit of your best medical judgment. And the patient you treated for free has the same right to sue you as any other patient, Silverman remarks. So before you agree to donate your medical services, make sure that you have the time and inclination to give these nonpaying

patients exactly the same care that you give to your regular patients. And most important, make sure that your malpractice insurance covers these donated medical services.

If you'll be performing the donated medical services in your office or the hospital where you normally work, and the services are typical of those you perform in your regular practice, then malpractice coverage shouldn't be an issue. But your insurance may not cover your services in certain situations. For example:

- If you plan to perform the services off-site—like at the retirement home; or

(continued on p. 8)

### MODEL LETTER

#### Verify Malpractice Coverage for Volunteer Services

When you decide to donate your medical services, especially if you'll be performing the donated services outside your office or hospital, it's best to get your malpractice insurer's written verification that you'll be covered, says New York health care attorney Jay Silverman. To do this, send a let-

ter to the insurer, requesting this verification. Direct the letter to your practice representative—that helps ensure that your letter won't get "lost." Here's a letter that you can adapt and send to your malpractice insurer asking it to verify coverage for your proposed volunteer activity.

[Insert date]

**Re: Policy # A7890**

Dear Practice Representative:

Main Street Family Practice is sponsoring a health fair for the residents of the Anytown Retirement Home on Thursday, December 12, 2002. The fair will take place at the retirement home at 123 Willow St. I plan to offer my professional services on-site at the health fair to provide interpretation of osteoporosis screenings and other radiological services.

Kindly send me written verification that my malpractice insurance policy referenced above will cover me in the event of a lawsuit arising out of my activities at the health fair. Please include an explanation of any limitation on my coverage.

Thank you for your prompt attention to this matter.

Yours truly,  
Roger Rad, MD  
ABC Radiology

**DONATING YOUR MEDICAL SERVICES**

(continued from p. 7)

■ If the services aren't typical of the services you perform in your practice.

Check your policy before you agree to donate medical services to see if there are limitations that might affect your coverage for them, Silverman suggests.

**Write to Your Malpractice Insurer**

If you think your policy might not cover your services, Silverman recommends that you write your malpractice insurer a letter. Direct it to your practice representative so that you can be sure it will get attention.

We've given you a Model Letter that you can adapt and use in your practice. Like our Model Letter, the letter you send to your malpractice insurer should:

- Identify the sponsor of the volunteer activity;
- Explain exactly what medical services you plan to provide;
- Disclose where and when you'll be performing the medical services; and
- Ask the insurer to give you a written verification of coverage and an explanation of any limitations on coverage.

Keep a copy of the letter you send the insurer in your files. And if you don't get a response within ten days or so, follow up—that is, call the representative to let him know you're waiting for a response, and send another letter, this time by certified mail, return receipt requested. You want to be sure to have the insurer's written verification of coverage before you perform any donated medical services, Silverman emphasizes. ■

**Insider Source**

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**PATIENT PRIVACY****Permanently Delete Health Information Before Selling or Discarding Computer Equipment**

If you're upgrading your computer equipment or replacing it with newer systems, you'll have to get rid of the old equipment (for example, workstations, computer hard drives, floppy disks, and magnetic tapes). You may decide to sell the equipment, reuse it in another area, or throw it out altogether. Or, if you've leased the equipment, you may have to return it to the vendor. No matter what you do with it, there's a risk that the next person handling the equipment could get access to the confidential health information contained in it, warns health care consultant Gwen Hughes. By inadvertently disclosing confidential health information to a third party, you're violating the patient's privacy, the HIPAA privacy regulations and, most likely, state law.

To avoid this risk, you'll need to take steps to make sure that confidential health information is permanently

deleted from the equipment. There are several methods you can use. We'll give you a rundown on those methods and tell you where you can get more detailed information about them.

**What to Delete**

It's good practice to permanently remove all information of any type from your equipment before selling or discarding it, suggests health information consultant Tom Hanks. But it's especially critical to remove any confidential health information, particularly if it could be used to identify an individual. The current HIPAA privacy regulations contain a laundry list of information types that must be removed from equipment. Some examples of identifying information are the individual's name, address, employer, biometrics (for example, fingerprints), all date information, Social Security number, vehicle identifica-

tion numbers, telephone/fax numbers, e-mail address, and photograph.

**How to Permanently Delete Information**

You've got to take the right steps to permanently delete information. If you think that you've already removed information by pressing the "delete" key on the computer, moving it to the "trash" file, or reformatting the disk, think again, says Hughes. The delete function is misnamed, she explains. Even when information appears to be gone, most of it can easily be restored or reconstructed, she says.

There are a number of ways to permanently delete information. They are:

**Magnetic "degaussing," or demagnetizing.** This is the preferred method for erasing data from magnetic storage devices, such as magnetic tapes, floppy disks, and even hard

drives. You can buy a “degausser,” or demagnetizing device, from a technical supply store. You simply insert the disk, tape, or drive containing the information into the degausser, and it does the rest.

**Using hand-held magnet.** You can use a hand-held magnet to erase floppy disks, disk platters, magnetic drum surfaces, bubble memory chips, and thin-film memory modules. But this method isn't suited to all devices, and it can be unreliable. For example, if you turn the magnet on unintentionally, you could damage nearby equipment. And if you don't demagnetize properly, you run the risk of leaving confidential information on the storage device, warns Hanks.

**Overwriting.** Overwriting relies on special computer software that's used to cover data with a pattern. For example, data is covered with a 0011,

followed by 1100, and then 1000. But there's a risk that data that's been overwritten even several times can be restored, cautions Hughes.

**Destroying the computer storage media.** This is an option for write once read many (WORM) laser disks, for example, that you can't reuse. Two common destruction methods are pulverization and incineration. Destruction is highly recommended for disks and platters because there's no way to reconstruct them once they've been physically destroyed, says Hanks.

### Where to Get More Information

For more information about degaussing, overwriting, and other methods of data destruction, look at *A Guide to Understanding Data Remanence in Automated Information Systems*, published by the U.S. Department of

Defense. You can view a copy of this document at [www.radium.ncsc.mil/tpep/library/rainbow/NCSC-TG-025.2.html](http://www.radium.ncsc.mil/tpep/library/rainbow/NCSC-TG-025.2.html).

**Insider Says:** Don't forget about removing confidential health information from diagnostic medical equipment that you're about to sell or discard, warns Hanks. For example, images taken by ultrasounds and MRIs also include patient identifying information and may be stored on this equipment. You may need to contact the equipment's manufacturer to determine the best way to permanently remove patient information from this equipment. ■

### Insider Sources

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**Gwen Hughes:** Care Communications, 205 W. Wacker Dr., Ste. 1900, Chicago, IL 60606-12141.

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

### ✓ Clarify Confusing Contract Language Before You Ask for Changes

When you get a contract for review from a plan, ask the plan to answer any questions you have about the contract and clarify any ambiguities before you begin to negotiate any changes to the contract. In many cases, the plan's explanation or clarification will be acceptable to you—and you won't have to make any demands of the plan on that issue or give up anything to get what you want. “A provider can get 10 percent of the easier concessions just by getting confusing contract language clarified, without having to give up anything in return,” notes Marvin Fairbank, director of managed care for a Kansas provider. Fairbank routinely uses this tactic when negotiating contracts on behalf of his provider organization.

Getting the contract explained or clarified before you begin to negotiate changes is also practical, says managed care consultant Maria K. Todd. “It may seem more efficient and faster to ask for changes right away, but that doesn't finalize the contract any faster,” she notes. “And plans seem to take a harder line if you pressure them for changes right at the start. It's inflammatory.”

Protect yourself by flagging all language that you're not sure about and by asking the plan representative to clarify each item in writing. This includes seemingly straightforward words like “adequately,” “appropriate,” “insufficient,” or “other,” that people may interpret differently. If the plan representative fails to put the clarifications in writing or says she doesn't have the time, write down what you believe the ambiguous language means and ask the representative to confirm that your interpretation is correct. Then you can start to negotiate the more contentious parts of the contract, without having to worry that you've lost bargaining chips just getting the clarifications or the easier concessions, says Todd.

### ✗ Don't Set Bad Precedent by Writing Off Plan's Bad Debt

Don't be too quick to write off a plan's debt if it doesn't pay you or pays you less than it's supposed to. If you're too willing to settle for less, you may be setting a bad precedent and making it much more likely that in the future, the

(continued on p. 10)

**DOS & DON'TS** (continued from p. 9)

plan will underpay you or won't pay you at all on valid claims, warns California attorney Glenn Solomon.

Some providers are just glad to be participating with a plan and will take whatever reimbursement they can get. But that's a mistake, says Solomon. "It's bad business for the provider, and the provider ends up with a reputation for being easily taken advantage of," he points out. For instance, many providers will back down when plans don't pay their claims for service because they failed to follow a technical requirement (by doing something like billing the wrong office or using the wrong form).

To protect yourself, keep after a plan if it owes you money. "You've treated the member, and quickly settling won't improve your business relationship with the plan," says Solomon. If, after your reasonable efforts, you're not getting anywhere, you may need to make a business decision about whether a write-off is appropriate. But at least you're in a better position with the plan for future claims. "You've shown that you won't roll over simply because the plan tells you to," says Solomon.

### **X Don't Bill Medicare Allowable Charge**

Don't set up a special fee schedule for Medicare patients to bill at Medicare's allowable charge. Instead, bill Medicare your practice's usual and customary charge for covered services.

According to Atlanta health care consultant Jackie Miller, Medicare doesn't require you to bill at the Medicare allowable charge. And your carrier or intermediary will pay you based on the Medicare allowable charge, regardless of the amount you bill for a particular service. So establishing a separate fee schedule for Medicare patients every year is a waste of time and resources. It also presents the chance of error every time you redo your fee schedule, Miller points out. Most important, if a patient turns out to be covered by a payor other than Medicare, you could find yourself billing the payor for less than it allows for that service. ■

#### **Insider Sources**

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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).
- Provider-based regulations: 42 CFR 413.65.