

Radiology Administrator's

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CMS Issues Integrity Manual Revisions that Clarify IDTF Rules

In July 2003, CMS issued revisions to the *Medicare Program Integrity Manual* regarding independent diagnostic testing facilities (IDTFs). These revisions mark CMS's first major change to the IDTF rules since 1999, when CMS (then called HCFA) first recognized IDTFs as independent providers of diagnostic services, separate from physician offices.

We'll tell you why these recent revisions came about and what they say. And we'll point out how they may affect the way your IDTF operates.

Revisions Clarify Confusion

According to Virginia health care attorney Thomas W. Greeson, the recent revisions reflect the experience that carriers have acquired regulating IDTFs—specifically, what they've learned while inspecting IDTFs at site visits before assigning them a Medicare provider number and while regulating IDTFs thereafter.

Many of the revisions attempt to clarify some operational issues that have been confusing to both carriers and IDTFs, Greeson says. The major clarifications contained in the revisions are:

A facility that isn't "provider based" but is partially owned by a hospital or located on campus must enroll as an IDTF. Some facilities are partially owned by a hospital or located on a hospital campus but don't qualify for provider-based status under CMS rules. The revisions confirm that these facilities must enroll as IDTFs if they provide diagnostic tests to patients who aren't patients of the hospital under their own billing number, Greeson says. But the revisions don't affect the existing exception for a facility, owned in whole or in part by radiologists, that's primarily used to provide professional radiological services. These facilities may be considered physician offices and needn't enroll as IDTFs, Greeson notes.

Certification for new services. A facility must list the CPT and/or HCPCS code for each test, service, or procedure it intends to offer on its IDTF application. But before the recent revisions, there had been some confusion about how an IDTF should proceed if it wanted to offer a test, service, or procedure that wasn't listed on its initial IDTF application. The revisions explain that the requirements for adding a new test, service, or procedure will differ depending on how similar the new test, service, or procedure is to those the IDTF is already performing.

▶ *No new certification required.* According to the revisions, no new certification is required if the test, service, or procedure the IDTF wants to add:

- Is similar to a test, service, or procedure the IDTF is already certified to perform; *and*
- Requires the same level of supervision as a test, service, or procedure the IDTF already performs.

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INTEGRITY MANUAL REVISIONS (continued from p. 1)

In that case, the IDTF needs to just submit a new form CMS855 identifying the test, service, or procedure it wants to add. And once it has notified CMS, the IDTF may immediately go ahead and perform the new test and bill for it without waiting for CMS's okay.

► *New certification required.* But if the new test, service, or procedure the IDTF wants to perform:

■ Isn't similar to a test, service, or procedure the IDTF is certified to perform; *or*

■ It requires different supervision levels,

then the IDTF must notify CMS that it wants to offer the new test, service, or procedure by submitting an amended form CMS855. And the carrier must then conduct a new site visit to certify that the IDTF may offer the new test. Meanwhile, the carrier will suspend payment for the new test until the site visit has been completed and CMS has certified the IDTF to perform the new test, Greeson says.

Here's an example of the certification rules from the revision: If an IDTF certified to perform MRIs of the shoulder wants to offer MRIs of the hip, it need only complete a new form CMS855 notifying CMS that it will be offering MRIs of the hip. But if an IDTF that's certified to perform sleep studies wants to begin offering MRIs, the carrier must inspect the facility and certify that it may offer MRIs before it will get paid for MRI services.

Billing for nondiagnostic, related services. IDTFs may perform and bill for diagnostic tests only, but there has been debate about whether IDTFs may bill for services that aren't purely diagnostic but are related to a diagnostic test—for example, some injections needed for certain diagnostic tests are separately billable if performed in a physician's office. The revisions confirm that IDTFs *may* bill for these additional, nondiagnostic services, provided they are:

- Related to or required to perform a diagnostic test; and
- Performed by a qualified practitioner in accordance with all other Medicare billing rules, Greeson says.

Revisions Reflect CMS's Fraud and Abuse Concerns

Some of the revisions seem designed to combat fraud and abuse, Greeson remarks. They may indicate scenarios that CMS finds troubling, and IDTFs should take heed and make sure that their facilities won't attract unwanted regulatory attention, he advises. For example:

Physician supervising at multiple IDTFs subject to scrutiny. Some radiologists supplement their incomes by acting as the supervising physician at one or more IDTFs. Apparently the practice of acting as supervising physician at more than one IDTF is causing concern at CMS, Greeson says. The revisions instruct carriers to contact physicians who are listed as the supervising physician at more than one IDTF and confirm that the physician is still providing supervision at each IDTF that names him as the supervising physician. And significantly, the revisions instruct carriers to contact their benefit integrity unit whenever a physician is listed as the supervising

physician at five or more IDTFs. This may indicate that CMS has substantial concerns about the effectiveness of the IDTF supervision rules and may be suspicious that physicians are being paid to provide supervision but aren't actually performing their duties, Greeson says.

Mobile units performing tests requiring physician presence. If a facility performs diagnostic tests that require direct or personal supervision, the physician must be on-site to provide the supervision. CMS seems to question whether a physician would actually be on-site at a mobile IDTF and has instructed carriers to give both mobile IDTFs and their supervising physicians special attention. Specifically, the revisions instruct carriers to contact the IDTF owner/manager and the supervising physician and discuss how the physician will

provide direct or personal supervision in the mobile facility.

Mobile units improperly compensating physicians. The revisions also indicate that CMS is concerned about illegal compensation to the supervising physician from the mobile IDTF. In other words, CMS is worried that a mobile IDTF may hire a supervising physician who refers patients to the IDTF. The job may seem to be a quid pro quo for the referral of patients, Greeson remarks. CMS also seems suspicious that a mobile IDTF may permit a physician to perform and supervise a diagnostic test on his own patient, he says. That would violate the Medicare reassignment rules, which bar the IDTF from billing an interpretation if the physician who ordered the test is the same physician who supervised the test. It may also violate IDTF supervision rules, which require a supervising physician to be

qualified to perform and interpret each test the IDTF offers. It's unlikely that a patient's treating physician would be appropriately trained and qualified to be a supervising physician at an IDTF that performs radiological procedures, Greeson points out.

Mobile unit compliance with other laws. The revisions also instruct carriers to look for and report violations of other laws at mobile IDTFs—for example, lack of wheelchair access that violates the Americans with Disabilities Act or health and safety violations. This directive may indicate a heightened level of concern about the quality of the services provided at mobile IDTFs overall, Greeson says. ■

Insider Source

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H I P A A

Take Four Steps Now to Prepare for Claims Payment Problems After Oct. 16

Like many providers, you may be in for a shock on Oct. 16, the date you expect to start filing your claims electronically, in compliance with the HIPAA transactions and code sets (TCS) standards. You may find that you or your payors aren't ready to process and accept claims using the new electronic formats, warns Robert Tennant, senior policy advisor for the Medical Group Management Association. This could result in your experiencing serious payment delays and potentially severe cash flow problems. According to Tennant, even if you've upgraded your billing system software and sent test claims to your payors, you should still expect and plan for a

cash flow delay. We'll tell you why, and we'll give you four steps you can take now to make sure your facility stays afloat if the worst happens.

Expect Payment Disruption

The Workgroup for Electronic Data Interchange (WEDI), the consortium named as an advisor to the Department of Health and Human Services (HHS) on the TCS standards, recently advised HHS, in a letter, that the health care industry has made a lot of progress toward compliance with the standards. But there are still three big problems that could affect payment of your claims:

■ Despite their efforts, a substantial number of private payors and several states don't expect to be fully compliant and ready to process electronic claims by Oct. 16.

■ Even if payors are ready to process electronic claims, you may not be able to submit electronic claims forms the way you do now, either because of a connection problem with the payor or because you've failed to include the additional information that the new, electronic claims form requires.

■ Some practice management software vendors won't have software upgrades that comply with the TCS standards available by Oct. 16, and

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HIPAA (continued from p. 3)

some vendors have even decided not to develop and offer HIPAA-compliant software to their provider customers. That means that even if the plan is ready and you have the additional information to submit, your own software won't let you.

Providers shouldn't discount the potential for disruptions as yet another computer scare, like Y2K, Tennant warns. This is a far more comprehensive problem, involving both format and content of the data. If any system in the chain of claims payments is impaired, whether it belongs to a provider, a vendor, a payor, or the government, everyone will be hurt, he warns. "Providers have been so focused on HIPAA privacy that they've neglected the TCS standards. They need to be nudged to deal with this aspect of HIPAA, as well," says Tennant.

Insider Says: You can view the WEDI letter at www.wedi.org. Click on the link for "Resources/Archives," and then click on "WEDI Comment Letters to DHHS." Next, click on the link to "WEDI Letter of April 15 to HHS Secretary Thompson on Contingency Planning for October, 2003."

Submitting Paper Claims Is No Solution

You can't avert this problem by submitting paper claims instead—even though the TCS standards allow providers to file paper claims after Oct. 16. Filing paper claims would cause huge problems, says Tennant. "Payors just aren't going to be able to handle the deluge of paper claims, so there could still be a substantial delay in payment." And a return to paper claims would only be a temporary fix.

And unless you're a very small provider, you'll still have to file claims electronically, not on paper, if you want to be reimbursed by

Medicare, says Tennant. After Oct. 16, Medicare will require all but the smallest providers to file electronically. And experts agree that, eventually, other payors will require electronic-only claims, as well.

Four Steps to Take Now

How can you keep your organization financially sound after Oct. 16 if your claims are held up for a few months? Tennant suggests four steps to start on now to make sure that Oct. 16 doesn't leave you without money to operate.

1) Set aside cash reserves. Hold off on major capital investments, such as big equipment purchases, until after October, if you can. You'll need your available cash to continue operating while the payor works out its problems. So instead of buying new equipment or refurbishing your facility now, says Tennant, reserve that money for payroll, electric bills, supplies, and similar items until the payor can start reimbursing you again. Consider reserving cash to cover operating expenses for 30 to 90 days.

2) Establish line of credit. Start talking to your local banks about establishing a line of credit. Chances are, your payroll expenses eat up a sizable chunk of your income each month. You'll need to meet those expenses even if your payors aren't reimbursing your claims, says Tennant. But your cash reserves may not be enough. So you'll need something else to draw on—such as a line of credit. The good thing about a line of

credit is that you can draw on it only when needed. But it may take a while to set it up, so you'll want to get started now.

3) Identify payors offering direct claims submissions online.

Earmark which of the payors you work with allow you to submit your claims through the payor's Web site, also called "direct data entry", or DDE. To submit claims through DDE, the content of the claims must meet the standards but the claims' format doesn't have to. So theoretically, there will be fewer problems submitting claims this way and fewer cash flow problems with these payors, says Tennant. To identify which payors offer DDE, either ask your payor contact or check on the payor's Web site.

4) Develop relationship with HIPAA-compliant clearinghouse.

Even if you think you'll be able to submit electronic claims on your own as of Oct. 16, Tennant suggests that you develop a relationship now with a HIPAA-compliant clearinghouse in case you have problems later.

According to Tennant, providers that think they'll be ready to file electronic claims on Oct. 16 may run into some snags when they actually start submitting the claims. "Right now, many providers have direct connectivity to a payor, so they can file electronic claims," says Tennant. But if the payor can't support that connection or something happens to it for any reason after Oct. 16, you won't be able to get your claims through and you won't get paid. Clearinghouses can file your claims for you, making sure they get to the payor. Just make sure before signing on with the clearinghouse you choose that it's HIPAA-compliant and capable of handling the additional work, he recommends.

► CMS Issues Guidance on TCS Standards

On July 24, CMS released "Guidance on Compliance with HIPAA Transactions and Codes Sets," which helps explain CMS's enforcement approach to the TCS standards. You can access that guidance at: www.cms.hhs.gov/hipaa/hipaa2/guidance-final.pdf.

Also, compliant clearinghouses can convert whatever claims form you're currently using into a HIPAA-compliant electronic health care claim form, also known as an ASC X12N 837, or 837 form. You may not even know that you aren't using a HIPAA-compliant claims form now, because payors don't require them yet. But after Oct. 16, payors can't accept any electronic claims form other than the ASC X12N 837. That form probably

requires more information than your current form. A clearinghouse can turn your form into the ASC X12N 837, automatically filling in a lot of the missing information for you.

Insider Says: If payors aren't ready to accept electronic claims on Oct. 16, they're required by law to direct you to a clearinghouse that will process the electronic claim for it, advises Tennant. Clearinghouses can

be expensive, but payors who can't process electronic transactions are supposed to pay the clearinghouse's fees. "The clearinghouse should do it on the payor's dime," says Tennant. "A lot of providers don't know that." ■

Insider Source

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HOSPITAL RELATIONS

OIG Signs Off on Hospital/Radiology Practice Joint Venture

On May 29 the OIG released Advisory Opinion 03-12, giving its approval to a proposed joint venture between a hospital and a radiology practice to own and operate an MRI facility. Although this OIG approval is limited to the particular arrangement described in the advisory opinion, the advisory opinion offers some useful guidance about the characteristics that the OIG looks at to determine whether a joint venture is a compliance risk, says Washington, D.C., health care attorney Allison Weber Shuren. This guidance is especially important in light of the Special Advisory Bulletin on Contractual Joint Ventures that the OIG released only a month before its release of the advisory opinion. In the bulletin, the OIG expressed concern about certain joint ventures to provide health care services, Shuren says. (You can read more about the Special Advisory Bulletin in the July 2003 issue of the *Insider*.)

We'll tell you how getting an OIG advisory opinion can help you. We'll explain the characteristics the OIG looked at in deciding that this particular joint venture deserved its approval. And we'll show you how these char-

acteristics differ from those the OIG warned about in its special advisory bulletin. Understanding the distinctions should help you structure your joint ventures in a manner that won't get you into trouble.

Advisory Opinion Protection Limited to Requesters

When someone wants to enter into an arrangement that doesn't fit exactly into one of the *antikickback law* safe harbors, the parties to the arrangement may request an OIG advisory opinion. If the OIG provides an advisory opinion that approves the proposed deal or arrangement, the parties are protected from prosecution, as long as:

- The parties disclosed all material facts in the request for the advisory opinion; and
- The deal or arrangement doesn't differ from the terms that the OIG approved in its opinion.

An advisory opinion is binding only on the parties who requested it, but the OIG provides a legal analysis with its advisory opinions that illuminates its thinking and enforcement priorities, Shuren says. So although

you're not guaranteed protection if your arrangement is similar to an OIG-approved arrangement, if you carefully consider and address the OIG's areas of concern, you can minimize your risks, she notes.

Details of the Proposed Joint Venture

Here are the relevant facts of the proposed joint venture in the recent advisory opinion:

Parties' investment interest.

The parties that requested the advisory opinion—the investors—were a hospital and a group practice of six radiologists who are the exclusive providers of radiology services for the hospital. These investors proposed to establish an MRI facility to be jointly owned by the hospital (51 percent ownership) and the radiology practice (49 percent ownership). The percentage of ownership is based on the capital contributions of the investors—that is, the hospital put up 51 percent of the money to establish the facility, and the radiology practice put up 49 percent.

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HOSPITAL RELATIONS (continued from p. 5)

Referral patterns. The hospital employs several physicians who may refer patients for MRIs at the facility. In addition, because the proposed facility will be the only one in the area, hospital inpatients who require MRIs are likely to be referred there, too. When physicians who work for the hospital refer a patient to the facility, or when a hospital inpatient needs an MRI, the hospital plans to disclose in writing to the patient that it has a financial interest in the facility. In its request for the advisory opinion, the hospital certified that less than 10 percent of the facility's referrals will come from hospital inpatients or referrals from hospital-employed physicians.

Proposal Raises Concern Under the Antikickback Law

The antikickback law makes it a criminal offense to knowingly offer, pay, solicit, or receive any remuneration to induce or reward referrals for services payable by a federal health care program. According to the advisory opinion, the proposal raises concern under the antikickback law because there will be no "disinterested" investors in the facility. That is, everyone who owns a part of the facility will be in a position to make referrals and to benefit financially from those referrals. And although there are several safe harbors to the antikickback law, the proposed arrangement doesn't meet the requirements to fit into any of them.

Reasons the OIG Gave Its Approval

The OIG gave its approval to the proposed joint venture, even though it doesn't fit within a safe harbor, because it determined that "the potential risk of fraud and abuse is acceptably low," according to the advisory

opinion. The OIG cited the following factors in support of its conclusion:

Physician/investors not referral sources. The radiologists who are the investors in this joint venture aren't referral sources for either the hospital/investor or the facility. Radiologists typically are referral dependent, rather than generators of referrals. Shuren notes that the OIG's opinion about the joint venture might have been different if the physician investors were surgeons, for example.

Hospital/investor will provide limited referrals. Only a small percentage of the facility's referrals will come from the hospital or its employed physicians. The hospital stated in the request for an advisory opinion that less than 10 percent of the facility's business would be referred from the hospital.

Hospital/investor will take steps to limit its influence. The hospital recognized that it must limit its ability to control referrals to the facility, and so it asserted in the request for an advisory opinion that it would:

- Refrain from taking any action to require or encourage its physicians to refer to the facility;
- Not track referrals by its physicians to the facility; and
- Not tie compensation to its physicians based directly or indirectly on the number of referrals or amount of other business the physician generates for the facility.

Return on investment not influenced by referrals. Under the proposed arrangement, profits and losses will be distributed in direct proportion to the amount of the investor's capital contribution. According to the advisory opinion, the terms of the investment interests in the facility aren't "related to the previous or expected volume of referrals, services fur-

nished, or the amount of business that might otherwise be generated from the investor to the facility."

No payment between investors for services at facility. The radiologist investors will bill their patients and third-party payors directly for professional services rendered at the facility. The hospital/investor won't be compensating the radiologists for the services they provide there.

How This Differs from Joint Ventures OIG Is Concerned About

Several other characteristics distinguish this proposed joint venture from the contractual joint ventures that the OIG recently expressed concern about in its special advisory bulletin, notes Shuren. We'll explain them so you can be aware of what the OIG considers risk factors in joint ventures.

Not anticompetitive. One important factor is that the joint venture isn't serving to eliminate or reduce competition among MRI providers. In its special advisory bulletin, the OIG mentioned that it would look askance at joint ventures in which one party to the contract entered into a new line of business by buying an already existing provider. In other words, the OIG frowns on one party's starting a new business by buying a potential competitor. In this case, the proposed facility will be the only MRI provider in the area, and neither party could provide the service on its own. So the net result of the joint venture would be increased patient access to medical services, rather than reduced access, Shuren explains.

Both investors assume financial risk. In the joint ventures that the OIG cited in its special advisory bulletin, one party to the joint venture assumed the bulk of the risk and contributed the bulk of the capital, and

the other party primarily provided a referral stream. That's very different from this joint venture, in which each party puts up an almost equal portion of the capital investment in the project and assumes a nearly equal level of risk, Shuren points out.

Neither investor a significant source of referrals. In its special advisory bulletin, the OIG emphasized that joint ventures are problematic when one or both parties are rewarded for referrals to the joint venture. In this joint venture, neither party will be making significant referrals to the

joint venture, and the parties' return on investment isn't related to its referrals to the joint venture. Shuren believes that this weighed heavily in the OIG's determination that the radiology/hospital joint venture posed little risk of fraud and abuse.

Insider Says: You can find both the advisory opinion and the special advisory bulletin on the OIG's Web site, www.oig.hhs.gov. From the home page, click on "Fraud Prevention & Detection." Click on "Advisory Opinions," and when the next page comes up, click on "Advisory Opinions"

again. Scroll down to "May 29, 2003, Advisory Opinion 03-12." To get the special advisory bulletin, go back to the "Fraud Prevention & Detection" page, click on "Fraud Alerts, Bulletins, and Other Guidance." Then click on "Bulletins," and look for "Special Advisory Bulletin: Contractual Joint Ventures," dated 04/23/03. ■

Insider Source

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Follow Six Rules for Correct 'Incident to' Billing

Clinical specialists—such as nurse practitioners, physician assistants, and clinical nurse specialists—are fixtures in many modern radiology practices. These clinical specialists provide valuable, cost-effective patient care services and can free up radiologists' time for other duties, allowing practices to use all their resources most efficiently.

But practices employing clinical specialists must confront Medicare's "incident to" rules. These rules allow practices to bill for certain clinical specialists' services that are an integral, though incidental, part of a physician's professional services.

According to the Medicare Carriers Manual, incident to services can be billed as though the physician provided the services personally. And the practice will get paid at 100 percent of the physician fee schedule for the service.

Here are six rules that the Medicare Carriers Manual requires you to follow when billing for services provided incident to physician services. These rules are complex, and many

practices have trouble with them. With the help of Maryland radiology coding and billing expert Claudia Murray, we'll explain these six incident to rules.

Rule #1: Services Must Be Furnished in Physician Office or Non-Hospital Facility

Services that a clinical specialist furnishes in a hospital setting *cannot* be billed under the incident to rules. But clinical specialist services provided in a physician office, freestanding imaging center, or IDTF may be billed as incident to services, as long as these services meet all the other requirements for incident to billing, Murray says.

Rule #2: Services Must Be Within Clinical Specialist's Scope of Practice

You can't bill for a clinical specialist service under incident to rules if the service is outside the clinical specialist's scope of practice, Murray explains. So check with your state's licensing board to find out what your

clinical specialist is allowed to do in your state. There are several other good reasons that you mustn't permit your clinical specialist to work outside her scope of practice:

- Both your physicians and the clinical specialist can get into trouble with your state licensing boards;
- Malpractice insurers may deny coverage if the service furnished is outside the insured's scope of practice; and
- Medicare and private payors may assert that a claim for payment for a service provided outside a clinical specialist's scope of practice is a false or fraudulent claim.

Rule #3: Physician Must Directly Supervise Incident to Services

This rule is a source of a lot of confusion, Murray notes. You can't bill for an incident to service unless the clinical specialist's service is incidental to a physician's service.

That means that a physician must perform the initial service. And the

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FOLLOW SIX RULES (continued from p. 7)

physician must perform subsequent follow-up services at an interval that indicates that the physician is actively managing and participating in the patient's treatment. Plus the physician must be present in the office suite and available to provide assistance to the clinical specialist while the specialist is furnishing the service that will be billed as incident to, Murray explains.

Rule #4: Service Must Be Performed by the Physician's Employee

Services can be billed as incident to only if the person who provides the service is either an employee of the physician who's managing the patient's treatment or an employee of the same entity that employs the managing physician—like the physician's group practice. This rule defines "employee" broadly.

For example, Murray points out, part-time employees qualify as employees for the purpose of the incident to billing rules. And so do "leased employees," under the following circumstances:

- The person providing the service does so while acting in the capacity of an employee of the physician or physician group, although he's employed by a temporary agency, leasing company, or other entity;

- The physician or physician group exercises control over the actions of the person providing the service with regard to rendering medical services to the same extent as would exist if the person were a direct employee of the physician or physician group; or

- The person providing the service would be considered an employee of the physician or physician group under the common law test for employees; that is, he doesn't set his own schedule or direct his own activities but works at the direction of the physician or physician group.

Rule #5: Service Must Be Provided in Connection with a Covered Condition

Sometimes a practice will bill for an incident to service that's not covered by Medicare. If the patient has a disease or injury that Medicare doesn't cover, then you can't bill incident to for services to diagnose and

treat that noncovered condition, Murray notes. And you can't bill incident to if the service isn't covered, she adds—even if the patient has a covered condition.

Incident to billing doesn't expand the range of services that Medicare will cover; it merely allows a qualified professional working under a physician's direct supervision to perform a medically necessary service for a patient with a covered condition.

Rule #6: Service Must Be Commonly Furnished in Physician Office or Clinic and Included in Physician's Bill

In other words, an incident to service must represent a service or expense that a physician normally would incur in the course of treating a patient. But you can't bill a service that's normally provided by some other entity—like an off-site lab, for example—as an incident to service because the costs associated with performing lab tests are borne by the lab, not the physician. ■

Insider Source

Claudia Murray: Provider Practice Analysis LLC, 2612 Greene Rd., Ste. 201, Baldwin, MD 21013.

Use Bonuses to Recruit, Retain Radiologists

Radiologists have recently found themselves in demand when it comes to finding employment. A recent survey by Merritt, Hawkins & Associates, a national physician search and placement firm, found that radiologists are currently the most difficult of all specialists to recruit. That's great for radiologists who are seeking

employment but tough for a practice that's looking to add a radiologist.

In a competitive environment, offering a joining bonus and a chance to earn further bonuses can mean the difference between a radiologist's choosing your practice and choosing another, says Mark Smith, executive vice president at Merritt, Hawkins &

Associates. But offering bonuses can be risky if you don't do it carefully. Bonuses can complicate your taxes and cost you more than you bargained for.

We'll explain how to structure a bonus program for your radiologists that will increase your practice's attractiveness as an employer, encour-

age long-term commitment from your radiologists, and be tax efficient. And we'll give you Model Clauses that define the terms of the bonus (see below), which you can adapt and use in your employment contracts.

Signing Bonus Often Works

There are several creative ways that radiology practices have begun enticing new radiologists to join them, including offering flexible work schedules, increased vacation time, and accelerated partnership tracks, Smith says. But for practices that can't offer a lot of flexibility, good old-fashioned cash still works, he says—especially when you're trying to hire a young physician who may be carrying a lot of education debt. It lets a radiologist just starting out retire some of her debt and/or establish a decent standard of living as soon as she begins working, and that's hard to resist, notes Philadelphia health care attorney Joan Roediger. So she urges practices seeking radiologists to consider offering a substantial financial incentive if they can, especially if the practice can't be flexible on work hours or the number of years a radiologist must wait until partnership.

'Paper' the Bonus

In their zeal to rope in an attractive candidate, some practices will pay a cash bonus before the new physician even starts working. Occasionally, a recruit will take the money and run and never show up for work. For this reason, some practices prefer to structure the bonus payment as a loan and then forgive portions of the debt at regular intervals. But it's important to remember that a signing bonus is supposed to act as an incentive to induce the candidate to join your practice, rather than another. Making the bonus a loan may make it less

attractive to a candidate, says Roediger. Plus structuring the bonus as a loan raises tax complications, she says—the candidate must get a Form 1099, not just for the amount of the "loan" that is "forgiven" but for the forgiven interest, too.

She suggests other ways that practices can protect themselves. For

example, you can pay a bonus in installments by making monthly payments, starting at the time the candidate signs the employment agreement or by paying half the bonus when the candidate signs the agreement and half when she begins working.

(continued on p. 10)

MODEL CLAUSES

Define Terms of Bonus in Letter of Intent and Employment Agreement

Here are two Model Clauses that define the terms of a bonus a practice offers a radiologist in a letter of intent and/or an employment agreement. Your attorney can adapt and use whichever clause better suits your offer. Each clause offers a bonus of \$20,000.

Clause #1 structures the bonus as an installment payment that begins when the practice gets the candidate's signed employment agreement. It also explains when and how the radiologist must repay the bonus if he leaves before completing two years at the practice.

Although many practices prefer to

structure the bonus in installments, in this competitive market, if your heart is set on a particular candidate, you may have to agree to a lump-sum bonus payment. So Clause #2 is simply a lump-sum bonus payment, with language indicating that it's consideration for the candidate to join the practice and to abide by the restrictive covenant but with no repayment required if the candidate doesn't remain with the practice for a specified period of time.

Be sure to get the advice of your attorney and accountant before using these clauses.

CLAUSE #1

- a. In consideration of Radiologist's agreement to join Practice and abide by paragraph [*insert par. # of restrictive covenant*], Practice agrees to pay Radiologist the sum of \$20,000, payable in five equal monthly installments of \$4,000, the first installment to be paid upon Practice's receipt of the fully executed employment agreement from Radiologist and subsequent installments payable on the first day of each succeeding month until the full amount of \$20,000 has been paid.
- b. Should Radiologist leave employment with Practice prior to completing two full years of service, Radiologist shall repay Practice the greater of \$20,000 or such amount as has been paid pursuant to paragraph a hereof, reduced by 1/24th for each full month that Radiologist provided full-time service to Practice. Such repayment amount is due within 30 days of cessation of Radiologist's employment with Practice, provided, however, that should such termination of employment be due to Radiologist's death, disability, or termination by Practice without cause, no repayment shall be due.

CLAUSE #2

In consideration of Radiologist's joining Practice and agreement to abide by paragraph [*insert par. # of restrictive covenant*] of this agreement, Practice shall pay Radiologist the sum of \$20,000 following Practice's receipt of the fully executed employment agreement from Radiologist.

USE BONUSES (continued from p. 9)

Regardless of the method you choose to make payments, the best way to protect your practice is to "paper" the bonus agreement, says Roediger. That is, have your attorney put together a document for you and your recruit to sign that establishes the terms of what you're offering.

Ideally, the attorney will draft a letter of intent when you and a candidate seem like a good fit. The letter of intent will define the terms of the employment you're offering, including the terms of the bonus arrangement.

The candidate then may try to negotiate certain points in your offer. Once you and the candidate have come to an agreement, the attorney will use the letter of intent to draft an employment agreement. Your attorney can adapt one of our Model Clauses, depending on whether your offer is a bonus payable in full at the time of signing or in installments over the course of time.

Make sure you have a signed document before you hand over any money, Roediger emphasizes. If the candidate takes your money and runs, you'll have a much better chance of

eventually getting something back if you've got a document—even if it's just a signed letter of intent—that shows that the money was lent or paid in consideration of the candidate's coming to work for you.

Insider Says: If your state permits restrictive covenants—that is, agreements that bar an employee from competing with your practice after leaving your employ, document that the bonus was paid in consideration of the candidate's agreeing to the restrictive covenant, too, adds Roediger. That shows that the candidate received some benefit for agreeing not to compete with your practice and makes the restrictive covenant that much more enforceable, she says.

Consult Accountant Before Offering a Bonus

Depending on your practice's particular circumstances, for tax purposes, there are several different ways the bonus can be treated. So it's crucial to consult your accountant before deciding how to structure a bonus, Roediger says. You want to set the bonus up in a way that leads to the most advantageous tax treatment for your practice.

Your accountant will advise you whether to report the bonus either as miscellaneous income on Form 1099 or as W2 wages. And your accountant should advise you about issues like Social Security and payroll tax deductions on the bonus payment and whether the payment counts toward vesting in profit sharing and retirement plans. Failure to get good accounting advice before starting a bonus program can end up costing you a lot more than just the bonus, so factor in the cost of the advice as part of your program from the beginning. ■

Insider Sources

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Mark Smith: Executive Vice President, Merritt, Hawkins & Assocs., 5001 Statesman Dr., Irving, TX 75063-2414.

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).
- Medicare Program Integrity Manual: Ch. 10, Sections 5.1-5.8.