

# Radiology Administrator's

## Compliance & Reimbursement Insider

NOVEMBER 2003

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## Selective Reassignment Can Solve Some Reimbursement Problems

Many hospital-based radiology practices prefer to bill the professional component of the radiology services they provide at the hospital and let the hospital bill the technical component. A radiology practice may prefer this billing method because it lets the practice keep control of its own billing and retain the revenue its professional services generate. Plus the practice won't be responsible for any billing mistakes the hospital makes.

But in some circumstances, it may be beneficial or even necessary to let the hospital bill globally for certain procedures, says Virginia health care attorney Thomas Greeson. In those cases, it's possible to structure a selective reassignment arrangement. That means the hospital bills globally for certain select services only—and it pays your practice a fair market value fee for your professional services—and you continue to bill directly for your professional fee for all the other services you provide.

We'll tell you about two circumstances in which a selective reassignment arrangement can be a practical solution to certain thorny reimbursement problems. And we'll give you a Model Clause that you can adapt and use in your reassignment agreement with the hospital (see p. 3).

### Selective Reassignment May Counter Inadequate Reimbursement

The most common reason for a selective reassignment arrangement is that the reimbursement for a professional service is inadequate to cover the costs or risks of providing the service, Greeson remarks. Screening mammography is a good example. The reimbursement for the professional component is low, and the radiologists' malpractice risk is high, yet hospitals and radiologists want to offer this important service to their patients.

Some of Greeson's clients have entered into selective reassignment arrangements with their hospitals. The radiology practice reassigns its right to bill for the professional component of screening mammograms to the hospital. So the hospital bills globally for screening mammograms and pays the radiology practice a fair market value fee for each of its interpretations. This way, the radiologists get a fair price for their professional interpretations, and the hospital eats a bit of the cost of providing screening mammograms to its patients. "The hospital may end up losing some money by entering into this agreement, but it's fulfilling its charitable purpose and offering a valuable service to the community," Greeson says. In his experience, hospitals are often amenable to these types of arrangements.

### Selective Reassignment Can Solve Difficult Stark Problems

Another problem that may be solved by a selective reassignment arrangement occurs when there's more than one physician in a family and they both practice

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## SELECTIVE REASSIGNMENT (continued from p. 1)

in the same locality. This situation can lead to Stark violations. For example, say a radiologist father (Dr. Father) has a cardiologist daughter (Dr. Daughter). Dr. Father is a partner in the radiology practice at the only local hospital, and the practice bills its professional fees directly. Dr. Daughter practices in the same town, and from time to time she sends a patient to the hospital for radiology tests.

This creates a compliance and reimbursement issue because the Stark law bars a physician from making a referral for certain designated health services (including diagnostic radiology services and therapeutic radiology services) to any entity in which the referring physician or *her immediate family member* has a financial interest, Greeson explains. Under the Stark law, the entity receiving the referral may not bill any federally supported health care program for a service provided pursuant to a referral that violates Stark, he adds.

So under this scenario, Dr. Daughter may not send her patients to the hospital for radiology tests because her father has a financial interest in the professional radiology services provided there. And if she ignores Stark and sends her patients there, anyway—or if the patients choose to have their radiology tests at the hospital for reasons of convenience—the radiology practice may not bill any of the federally supported health care programs for its professional services.

Selective reassignment can solve this dilemma, says Greeson. Here's how it works: The radiology practice can reassign to the hospital its right to bill any radiology services it performs on patients that Dr. Daughter refers there. In this way, Dr. Daughter isn't barred from making the referral because Dr. Father's financial interest is in the radiology practice, not the hospital. And Stark doesn't bar the hospital from billing for the service, so the hospital can bill both the technical and professional components of the services Dr. Daughter refers her patients for. Then the hospital would pay Dr. Father's practice a fair market value fee for any interpretations it does on those patients.

## Follow Simple Steps

Taking several simple steps ensures that the selective reassignment arrangement comes within a Stark exception and passes regulatory scrutiny, Greeson asserts. "I've used this method in the past to help clients who have found themselves in similar 'Stark-infested waters,'" he quips.

**Step #1: Ensure compensation is Stark compliant.** In our example, above, Dr. Father or his partners would get referrals from Dr. Daughter but be paid by the hospital for those services Dr. Daughter refers. Stark requires that the compensation be based on the fair market value of the services the practice provides, Greeson explains, and not be influenced by the volume or value of referrals the radiologists can provide to the hospital (either directly or through Dr. Daughter).

In addition, Stark requires a written compensation agreement between the hospital and the practice. In order to comply with Stark, the compensation agreement must:

- Be signed by the hospital and the practice;

- Specify the services covered by the agreement (in this case, only services for patients referred by Dr. Daughter);

- Not violate the antikickback law or any regulations governing billing or claims submissions; and

- Not vary during the term of the agreement in any manner that takes into account the volume or value of referrals.

**Step #2: Execute reassignment agreement.** In general, Medicare will remit payment for a covered item or service only to the provider of the covered item or service. But the *Medicare rules* permit a physician to reassign his right to bill for Part B services to the hospital at which he performs services by executing a reassignment agreement. The reassignment agreement can apply to all services provided or to just one category of services. All members of the radiology practice must enter into the reassignment agreement with the hospital, permitting the hospital to submit claims on their behalf, explains Greeson. And the hospital must then submit a form 855R to the Part B carrier for each member, he adds.

### Get Written Reassignment Agreement Appropriate to Your Situation

In general, reassignment agreements are very simple. But in a selective reassignment situation like this—when you're not reassigning the right to bill all services you provide, but only some of them—you must be careful when putting your reassignment agreement together, Greeson says. Your selective reassignment agreement, like our Model Clause, should affirm that your practice will continue to bill for its professional services [Clause, par. 1], except in one (or both) of the following circumstances, Greeson says:

**Certain procedures.** If you're entering into a selective reassignment agreement because professional component reimbursement for a given service is inadequate, reassign the practice's right to bill certain CPT codes to the hospital [Clause, par. 1a].

**Certain physician.** If a radiologist's family member refers patients to the hospital for radiology services, reassign the practice's right to bill all services for patients referred by a given physician [Clause, par. 1b].

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## MODEL CLAUSE

### Execute Selective Reassignment Agreement

Selective reassignment can be a creative way to deal with certain reimbursement problems without giving up control of all your practice's billing, suggests Virginia health care attorney Thomas Greeson. But it's crucial that you dot the i's and cross the t's when entering into a selective reassignment agreement. The Medicare reassignment rules require a written agreement stating that the practice reassigns to the hospital the practice's right to bill Medicare. And if you're reassigning the right to bill only certain types of claims, your agreement must make that clear.

Here's a Model Clause you can use in your reassignment agreement. It affirms that your practice will bill for its professional services, except in two cases—you can choose either or both cases, according to your needs. Show this clause to your attorney if you're considering selective reassignment to combat a reimbursement or Stark problem. And remember that in addition to the agreement, the hospital must complete and submit a form 855R on behalf of each radiologist, reassigning to the hospital his right to bill Medicare.

- 1. Radiologists will bill professional fee.** Radiologists will have the full and exclusive responsibility for billing and collecting all professional fees for Radiologists' services rendered pursuant to this Agreement, except as set forth in paragraph [*select subparagraph A or B, or both, as appropriate*], below. Hospital shall cooperate with and assist Radiologists in the preparation of any and all financial, billing, and insurance records and reports and any other documentation required for proper billing and payment of claims.
  - a. Radiologists reassign right to bill certain procedures.** From time to time, Radiologists and Hospital may mutually agree that Hospital will bill both the technical and the professional components of certain radiological procedures listed in Schedule 1, attached hereto and made a part hereof [*attach Schedule 1 that lists reassigned procedures by CPT code*]. Hospital agrees that it will pay Radiologists a fair market value fee per interpretation of each procedure for which Radiologists have assigned the right to bill the professional fee, as listed in Schedule 2, attached hereto and made a part hereof [*attach Schedule 2 listing agreed-upon fees*]. [*and/or*]
  - b. Radiologists reassign right to bill for certain patients.** Radiologists and Hospital agree that Hospital will bill the technical and professional components of all radiological procedures for patients referred by Dr. [*insert name of physician(s) who are immediate family members of a member of radiology practice*]. Hospital agrees that it will pay Radiologists a fair market value fee per interpretation of each procedure for which Radiologists have assigned the right to bill the professional fee, as listed in Schedule 3, attached hereto and made a part hereof [*attach Schedule 3 listing agreed-upon fees*].

**SELECTIVE REASSIGNMENT**

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Both subparagraphs provide that the hospital will pay the radiologists fair market value for the professional services that are being reassigned. When you reassign based on procedure code, you and the hospital should mutually agree to a fee schedule for each procedure and should

update that schedule periodically. When you reassign based on referral source, it's hard to know ahead of time what procedures you'll be doing, so the agreed-upon fee for each procedure sent by the referral source is likely to be a percentage of the Medicare fee schedule or some similar arrangement, Greeson says.

Regardless of which subparagraph(s) you use, all members of the radiology practice must sign the agreement, Greeson notes. ■

**Insider Source**

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**H I P A A C O M P L I A N C E****Create Script to Answer Common Patient Questions About NPP**

Now that patients have gotten your notice of privacy practices (NPP), some of them will undoubtedly have questions about it. Don't let your staff get caught by surprise by these questions. Prepare any staff who deal with patients to respond appropriately and consistently, urges HIPAA Compliance Officer Chris Apgar.

For example, suppose you mailed an NPP to a patient, along with an acknowledgment of receipt form, and asked the patient to sign and return the acknowledgment form. If the patient calls with a question or two, she should be connected to someone who's able to respond appropriately. If she calls again later with a related question, the person who handles that call should also be able to respond appropriately. And the responses given in both calls should be consistent, even if given by different people.

With the help of our experts, we'll give you some tips on how to prepare your staff to respond clearly and consistently to questions about the NPP and acknowledgment. And on p. 5, we give you a Model Script that you can adapt and use to train your staff and that they can use in their dealings with patients. It consists of a list of common questions about the NPP and acknowledgment, with scripted responses for

staff to follow. (For more information on NPPs, see "Be Prepared to Notify Patients of Privacy Practices Even if You're an Indirect Provider," *Insider*, April 2003, p. 1.)

**Prepare Frontline Staff**

You don't necessarily have to prepare every person who works for your practice to field questions about your NPP and acknowledgment of receipt. Instead, prepare your frontline staff, suggests Apgar. Frontline staff would include anyone who has direct patient contact—whether in person or over the phone, he explains. In a physician practice, it may include everyone from reception and billing to nursing and professional staff.

**Use Scripted Responses for Accuracy and Consistency**

To make it easier for staff to respond to questions about the NPP and acknowledgment, prepare scripted responses to the most common questions, suggests health information consultant Margret Amatayakul. Preparing scripted responses means that you'll anticipate patient questions and create brief responses that your staff can give to patients, she explains. Using scripted responses should help you accomplish two

key goals: that the questions are answered correctly; and that the responses given are consistent throughout your organization.

**Insider Says:** Consider creating scripted responses to common patient questions on other aspects of HIPAA. They can be just as effective for such topics as a patient's right to request amendments to PHI as for the NPP and acknowledgment requirements.

**Send Tough Questions to Privacy Contact**

From time to time, a patient will ask a tough question—one that the staff can't or shouldn't answer. Avoid the risk of inappropriate responses by your staff by instructing them to direct any questions not covered by your script to the appropriate person (such as your practice's privacy officer or other privacy contact, as listed in your NPP), suggests Amatayakul. It's easy to include these instructions in your script, as our Model Script does. ■

**Insider Sources**

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## MODEL SCRIPT

### Give Frontline Staff NPP Script They Can Follow

Here's a Model Script that gives your staff a script they can follow to answer common questions about your organization's notice of privacy practices and acknowledgment. The script was developed with the help of HIPAA Compliance Officer Chris Apgar of Providence Health Plan. It can easily be adapted for either providers that have a direct treatment relationship with

patients or for plans. Use this script as part of your HIPAA privacy training efforts, and give it to all frontline staff—that is, those who deal directly with patients in person or over the phone.

Show this script to your attorney before using it. It's also a good idea to get input from your staff on any other questions they would like to see addressed in the script.

## MODEL RESPONSES TO QUESTIONS ABOUT NPP & ACKNOWLEDGMENT

Here are some questions that a patient might ask over the phone or in person about our Notice of Privacy Practices and the acknowledgment of receipt of that notice. To answer these questions, you can follow the responses below.

### Q1 What does this notice say?

**RESPONSE:** It lets you know that we take privacy very seriously and describes how and when we may use and disclose your confidential protected health information.

### Q2 Why do I have to sign this acknowledgment?

**RESPONSE:** We need to keep track of who received a copy of our notice, and this acknowledgment helps us do that.

### Q3 What will happen if I don't sign the acknowledgment?

**RESPONSE:** Nothing. If you really don't want to sign it, we'll simply note in our files that you refused to sign. But please keep a copy of the notice, anyway.

### Q4 I already got one of these notices and signed an acknowledgment. Why do I need to do it again?

**RESPONSE:** You may have gotten a notice from another health care provider or plan. Since we don't have a record of your getting one from us, we're required to give you our own notice and get your acknowledgment.

### Q5 Why do you have to share my health information?

**RESPONSE:** We need to share health information for your treatment, payment for that treatment, and for other health care activities. We take care to share only the information that is needed to carry out treatment, payment, and health care activities.

### Q6 Don't you need to get my permission before you can share my health information?

**RESPONSE:** We're not required to get your permission when we share health information specifically for your treatment, payment for that treatment, and for

other health care activities (such as reviewing our staff's credentials), and when complying with certain laws.

### Q7 Do you ever need my permission to share my health information?

**RESPONSE:** Yes. If we're sharing information at your request for purposes unrelated to our regular health care activities, we're required to get your written authorization in advance. For example, we would need that authorization if someone requests your health information for life insurance eligibility purposes or if a lawsuit requires release of your health information. The authorization will explain specifically what information is being shared with whom, why, and how long the authorization is valid.

### Q8 What if I don't want you to share any of my health care information?

**RESPONSE:** You have the right to request restrictions on whom we share your health information with. You'll need to complete a written request form, though. Where we're able to, we'll make every effort to honor your wishes.

### Q9 How can I get a copy of my medical record?

**RESPONSE:** Simply complete a written request form describing what information you want, and we'll process it in a timely manner. There's a fee for the costs of copying and postage.

### Q10 ANY QUESTION THAT'S NOT ON THIS LIST

**RESPONSE:** Let me give you the name and phone number of our organization's privacy [contact/officer], who's familiar with all of our privacy policies and procedures. He can better address that question: It's [insert name & tel.#].

## ASK THE INSIDER

The INSIDER welcomes questions from subscribers. You can 1) send your questions to Brownstone Publishers, Inc., "Ask the Insider," 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 2) fax (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail [jgormley@brownstone.com](mailto:jgormley@brownstone.com)

### Payment for Radiology Consultations

**Q** One of the radiologists in our practice is sometimes asked to review films or studies that have already been performed, interpreted, and billed to the patient's insurer by someone else. Typically, a patient's primary care physician will request a consultation and give us several studies to review. We then charge the requesting physician an hourly fee for our radiologist's service. Recently, a primary care physician, who sometimes refers patients to us for diagnostic testing, requested a consultation for one of her patients and balked at paying our fee. She argued that there's a CPT\* code for this type of consultation and that it was improper for our radiologist to expect payment from the physician for the consultation. Should we instead be billing the patient or her insurer directly for the consultation?

**A** Your current method of handling payment for physician-generated radiological consultations is common and appropriate in the situation you describe, says radiology compliance expert Claudia Murray.

Although there's a CPT code that describes radiological consultations—76140—few, if any, payors reimburse for it, Murray explains. And because it can be quite time-consuming to review studies on a consulting basis, the radiologist shouldn't be expected to provide this service for free. So, many consulting radiologists charge the requesting physician a consultation fee. Charging an hourly fee makes sense because it means that the physician is charged more—and the radiologist gets paid more—for the more time-consuming consultations. And some practices set their consultation fees on a case-by-case basis, charging more for the more complex cases, Murray points out.

In your case, the primary care physician's assertion that it's improper to charge her for a consultation is wrong. Here's why:

**Fee for service isn't payment for referral.** Although it's improper to demand a "referral fee" under many state laws, that's not what's happening here. Expecting payment for a consultation isn't the same as demanding a fee for the referral of business, Murray points out. Here, if

the primary care physician doesn't pay you for the consultation, you don't get paid at all, she notes. This differs fundamentally from a situation in which a physician refers a patient to a colleague for a service for which the colleague will be paid. Laws barring the payment of referral fees are meant to prevent referring physicians from demanding a portion of the payment for the service the other physician provides in return for the referral, Murray explains.

#### Free consultation could violate antikickback law.

The antikickback law bars a physician from offering or paying anything of value in return for a referral or services reimbursed under one of the federally supported health insurance programs or to induce continued referrals. Since the physician requesting the consult is a referral source for your practice, providing the consultation for free could be a violation of the antikickback law. Offering the free service might be construed as an inducement for the physician to give your practice more referrals for paid services, like diagnostic tests.

Many consulting radiologists charge the physician rather than the patient because, typically, the consulting radiologist never sees the patient. So the consulting radiologist doesn't have the opportunity to explain to the patient the reason the consultation is needed, ask the patient for her insurance information, or inform the patient that she'll be responsible for payment, Murray explains. Plus the request for the service originated with the first interpreting physician, and the insurer expects to pay for a service only once, though there may be exceptions in certain cases. But if the patient initiates the consultation—for example, if the patient contacts the radiologist directly to ask for a second opinion—then it's appropriate to bill the patient for the consultation, Murray adds. ■

#### Insider Source

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

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## Complain About Plans Anonymously to AMA via the Internet

As a physician, you now have a new tool for reporting your problems with plans to the American Medical Association (AMA). The AMA recently introduced a Health Plan Complaint Form on its Web site. The AMA intends to compile the information gathered through the complaint form and use it to identify trends, pinpoint problems, and raise issues with national insurers and lawmakers, according to AMA Secretary-Treasurer Donald J. Palmisano, M.D.

Only a physician (or someone authorized by a physician) can access the complaint form. But the physician

doesn't have to be an AMA member. "This is the only national electronic means for physicians to register complaints about health plans. We hope that all physicians will share with us what problems they're experiencing," Palmisano explains. The AMA has more clout in getting problems resolved on behalf of all physicians (and, by extension, all providers) than a physician who approaches a plan on her own, he notes.

The form is comprehensive and easy to use. It includes drop-down menus that allow the user to select from names of plans around the coun-

try, types of complaints, and other relevant lists. It doesn't require physicians to personally identify themselves, only to provide limited information about the physician's specialty and geographic region. So you can complain anonymously as often as you would like.

To find the complaint form, go to [www.ama-assn.org/go/psa](http://www.ama-assn.org/go/psa). Then click on "Health Plan Complaint Form," on the side of the page. ■

### Insider Source

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## Participation in Supergroups May Be Attractive Option for Radiologists

Over the past decade or so, a trend has emerged among medical practices: Small practices have been merging into larger ones, often to become multispecialty group practices, or "supergroups." That's because the high cost of medical practice overhead and the increasing competition for health care dollars have made survival difficult for the smaller medical practice. Plus medical practices that offer a wider range of services and longer office hours are more attractive to managed care plans.

Until recently, radiologists were the odd men out in this trend, notes Washington, D.C., health care attorney William A. Sarraille. Many supergroups continued to refer out their radiology testing, rather than bring a radiologist on board. And many radiologists were reluctant to join supergroups because they couldn't expect the higher salaries and regular office hours that they enjoy in single-specialty radiology practices. But a

wrinkle in the *final Stark II regulations* permits more flexibility in the way group practices compensate their partners—so membership in a supergroup may be a more attractive option for radiologists than it was before.

We'll tell you how supergroup membership can benefit radiologists. And we'll tell you how the final Stark II regulations have helped all group practices—including supergroups—develop compensation structures that meet the requirements of radiologists.

### Many Benefits to Supergroup Membership

There are a number of good reasons why physicians—even radiologists—find supergroup membership beneficial, says Sarraille. The reasons have to do with greater purchasing power, increased clout with managed care plans, professional management, and efficiency.

**Purchasing power.** All medical practices, regardless of specialty, need certain things, such as:

- Office supplies;
- Medical supplies;
- Computer and communication equipment;
- Office space; and
- Bank loans and other financing.

In medicine, as in every other business, the biggest customers get the best deals. And besides getting better bargains on the essentials every medical practice must have, in a supergroup, the cost of the practice's basic overhead is spread among many physicians, rather than just a few.

**More clout.** Managed care plans like to add supergroups to their provider panels. That's because these groups can provide patients with a wide range of services, and plans use

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## PARTICIPATION IN SUPERGROUPS

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that convenience to patients as a marketing tool. Supergroups can use this increased clout to their advantage when negotiating with managed care plans, Sarraille remarks.

### Professional management.

Supergroups can afford to hire and retain professional managers. This relieves the physicians of many of the day-to-day, nonmedical burdens associated with running a practice—burdens they would have to shoulder in a smaller practice.

**Efficiency.** There's increased efficiency associated with having other specialists in the practice, Sarraille says. For example, if the radiologist in a supergroup has an order from his orthopedist colleague that he thinks should be modified, the process of getting a revised order is much simpler when both physicians are members of the same supergroup. Communicating results to patients can be quicker, which improves patient relations. And equipment is often used more efficiently in a supergroup, Sarraille says, because much radiology equipment like, MRI and CT, is used by other specialties, too. The supergroup can buy one piece of equipment and keep it busy with patients from radiologists, cardiologists, internists, neurologists, and orthopedic surgeons, Sarraille points out.

### Stark II Proposed Regulations Burdened Group Practices

Salary has been an issue that has prevented more radiologists from joining

supergroups, notes Eileen L. Kahaner, a Washington, D.C., health care attorney. The supergroups couldn't offer radiologists the salaries that they were accustomed to because of the requirements that the 1998 proposed Stark II regulations imposed on group practices.

Stark II bars any physician from referring a Medicare or Medicaid patient for certain designated health services (DHS) to an entity with which the physician or a family member of the physician has a financial interest. But there's an exception in the law that permits such referrals among members of the same group practice.

But when the proposed Stark II regulations came out, it was clear that CMS (then HCFA) was concerned about the possibility of "sham" group practices forming solely to take advantage of the group practice exception, Kahaner reports. So the proposed Stark II regulations imposed rigid restrictions on group practices, including something called the "unified business test." This test had many components, but among other things, it would have prevented group practices from using different profit distribution systems for different practice cost centers, satellite offices, or specialties within the practice. So the unified business test would have required "sharing" of the profits from radiology within the group—which meant that supergroups couldn't compete effectively with single specialty radiology groups for radiologists' services, Sarraille explains.

### Stark II Final Regulations Solve Salary Problems

When the final Stark II regulations were published in 2001, the unified business test was substantially altered and became much more flexible, Sarraille says. The new unified business test permits group practices to maintain separate cost centers for different locations or specialties as long as the compensation method isn't directly related to the volume or value of referrals for DHS. This means that a supergroup can now structure a compensation package for a radiologist that's competitive with what single specialty groups may offer, Kahaner remarks, by setting up separate revenue and cost centers for pre-merger radiology services. If the practice develops new imaging services after merger, the profits from those services can be shared among the group in a manner that is consistent with the in-office ancillary services exception, Sarraille adds.

Although there isn't yet a mass migration of radiologists to supergroups, Sarraille believes it's an emerging trend. "Now that they can participate in supergroups without making financial compromises, the benefits of supergroup participation should lure more and more savvy radiology specialists. And in a most interesting development, some radiologists are attempting to form their own supergroups, using this model," Sarraille says. ■

#### Insider Sources

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## Maximize Reimbursement by Billing Member's Auto Insurer Before Billing Plan

When treating a plan member injured in an auto accident, you may assume that you must submit your claims just to the plan and accept the plan's contracted discount for treating the member's injuries. But that's not necessarily true, say several experts we talked to. Many members also have insurance through their auto insurer that covers these injuries. If state law and your contract allow, you can bill the auto insurer before the plan. Not only will the auto insurer usually pay your full billed charges, it's also likely to pay you faster than the plan would.

We'll tell you how to check whether you can take advantage of this highly effective payment method and show you what to do.

### Benefits of Billing Auto Insurer

Many states either allow or require drivers to have medical coverage as part of their auto insurance coverage, according to Ohio attorney Michael Williams. It's called "medical payments" (Medpay) or "personal insurance protection" (PIP) coverage. (We'll refer to it as Medpay.) The name varies from state to state, and some states even use both, says Massachusetts attorney Carlin Phillips.

If you can bill an auto insurer for Medpay, it's much better than billing a plan, says Williams. "The auto insurer will pay your billed charges and will typically pay you faster than the 60 to 90 days it would take a plan to pay you," he explains. If the member's Medpay coverage is less than your bill, you can still bill the plan as a secondary payor. And because you've been able to collect from more than one payor, it's less likely that you'll have to

write off any outstanding amounts that haven't been paid, says Williams. Williams recently helped one hospital client get paid \$1 million—and avoid having to write off that amount as bad debt—by billing Medpay.

### Providers Don't Bill Auto Insurers

You can't take advantage of these benefits, though, if you don't bill members' auto insurers for Medpay insurance. "Providers, especially hospitals, lose millions every year by failing to bill a patient's Medpay insurance," notes Ohio attorney Daniel W. Dreyfuss. "Many providers don't know about Medpay, and many patients aren't even aware that they have Medpay coverage, let alone bring it up to the provider," says Phillips.

Also, some providers unwittingly agree not to bill Medpay insurance. Although plans generally prefer that you bill and collect from the member's auto insurer first, some plans prefer to control billing and tell providers to bill only the plan or bill the plan first. That can hurt you, warns Williams. For instance, one hospital provided \$15,000 of services to a member injured in a car accident. The hospital, following instructions from the member's plan, billed the plan, not the member's Medpay insurance. But then the plan delayed paying the hospital while it investigated a \$10,000 payment that was made to the member directly by her auto insurer under her Medpay insurance, says Williams, who's familiar with the situation. "Had the hospital billed Medpay, the carrier—not the member—would have paid the hospital the \$10,000, and there wouldn't have been a reason for the plan to delay paying the remainder," he says.

### Take Three Steps

Here are three steps you should take so you'll be ready and able to bill and collect Medpay insurance:

#### Step #1: Review state law.

Check if and how your state law regulates Medpay insurance. Because the laws vary considerably, get your attorney's help to do this. Some states allow drivers to buy Medpay insurance as a rider; others require that drivers have Medpay insurance, and include it in the basic auto insurance package. Some states require Medpay to be the primary payor. Other states allow it to be primary but also let the auto insurance policy or the plan contract dictate which insurance would be primary. A handful of states won't allow providers to bill an auto insurer, says Phillips. In that case, you're stuck billing the plan and/or filing a lien against any recovery a patient may get from the person who caused the injury.

If you treat patients from different states or you have locations in more than one state, check the laws in each state, says Williams.

**Step #2: Check contract and negotiate needed changes.** Review your contracts to see whether there's anything that would bar or restrict you from billing Medpay and/or billing it before billing the plan. If nothing does, don't let the plan push you into not billing Medpay.

You probably won't find any specific reference to auto insurance in the contracts. Any general language that could be interpreted as barring or restricting you will probably be under the "hold harmless," "coordination of benefits," "third-party payment," or "billing" clauses. For example, the

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**MAXIMIZE REIMBURSEMENT**

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hold harmless clause may be so broad that it bars you from billing anyone other than the plan for covered services, Williams says. But check the entire contract, just in case.

If you're negotiating a contract and come across language that would restrict you from billing Medpay in any way, ask the plan to delete the language. Many plans will agree to do this because you'll reduce their costs by collecting from Medpay insurance, says Williams.

Some plans will go further and agree to add language to the contract, clarifying that you can go after Medpay first, says Williams, who has been able to negotiate this on behalf of several of his clients. To do this, add a sentence to the contract clause that addresses billing entities other than the plan.

Here are two versions, both recommended by Williams. The first version is broader—it says you'll bill other payors or insurers first, before seeking payment from the plan. If a plan wants to limit the clarification to only auto insurance, use the second version:

**Model Contract Language**

**Version #1:** Provider shall have the right to pursue other primary payors or third-party insurance coverage available before billing Plan, to the extent allowed by law.

**Version #2:** Provider shall have the right to bill automobile insurers insuring any Member for insurance coverage of medical expenses, to the extent allowed by law, before billing Plan pursuant to this Contract.

**Step #3: Set up Medpay billing program.** If you don't already pursue Medpay insurance, develop a program to do that. "It doesn't take a lot of time and effort to set up a program, and it's worth it in terms of the revenue it produces," says Williams. Williams regularly helps providers establish programs to identify and pursue Medpay amounts.

Your program should:

- Identify which members are seeking treatment for injuries suffered in auto accidents;
- Determine if those members have Medpay coverage (by asking members or their attorneys);
- Get the information (from members or attorneys) needed to bill the auto insurers; and
- Bill the auto insurers.

Most members are willing to cooperate because Medpay insurance often pays amounts that they would otherwise have to pay, such as copayments or deductibles, says Williams. If a member isn't sure if he has Medpay, ask him to check his auto insurance policy's "coverage selections page" or to contact his insurance agent—or let you do so, says Phillips. "Once you know how to get the information, it's not hard to find," he says. ■

**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.*

- Final Stark II Regulations: Fed. Reg., 1/4/01, Vol. 66, No. 3, pp. 856-965.
- Medicare rules: Medicare Carriers Manual §3060.2.