

Radiology Administrator's

Compliance & Reimbursement Insider

DECEMBER 2003

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Make sure you have a proper code to bill for a new device or drug. Using the wrong code can get you in trouble with Medicare and private payors.

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Ask the Right Questions Before Buying or Billing for New Devices and Drugs

Sales representatives for device and drug manufacturers are always trying to market their new products to you. As part of their sales pitch, they may tell you that you'll have no trouble getting reimbursed for a new device or drug if you use a particular CPT code to bill for it. But radiology practices and facilities that rely on a sales rep's billing advice can get into hot water because the rep, who isn't a coder, may be giving the wrong code or other incorrect billing information, says health care attorney William Sarraille. "Billing Medicare for reimbursement under an improper code may qualify as filing a false claim and can be punishable, in some circumstances, by harsh civil and criminal penalties," he explains. Among other things, you can be excluded from participation in Medicare and Medicaid.

Using improper codes can hurt you in other ways, too, says reimbursement consultant Kevin Corcoran. "If you're audited and found to be billing for a device or drug under the wrong code, Medicare or a private payor can ask you to pay back all the money it has paid you for services related to that device or drug," he says. You can also be responsible for interest and other penalties. And if you buy a device or drug that you can't get reimbursed for, you've wasted a lot of money.

To keep this from happening to you, it's important to do your own research to determine which codes you can use to bill for a particular device or drug, and how much you'll be reimbursed. Experts suggest using a checklist to make sure you've asked all the right questions before buying or billing for a new device or drug. To help you, we'll give you a Model Checklist that you can adapt for use at your practice (see p. 3).

Why Sales Reps Give You Wrong Codes

Sometimes an aggressive sales rep will give you improper reimbursement information intentionally, to sell his product. More often, sales reps who give you the wrong information do so because they aren't experienced in coding. "Some manufacturers don't have coders or reimbursement experts on their staffs who are familiar with the CPT or ICD-9," says Corcoran. Manufacturers, also, may push improper information on you because they don't realize the consequences of using an improper code. "If a sales rep tells you something that sounds too good to be true, it probably is," says Corcoran.

What's at Stake

The *Insider* has heard about many providers getting burned because they took a manufacturer's word on how to bill for a particular device or drug. For example,

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NEW DEVICES & DRUGS (continued from p. 1)

one provider in the state of Washington is being investigated for submitting false claims after using the wrong codes when billing for imaging services. He also risks losing his license to practice. The provider had followed a manufacturer's advice, instead of doing his own research.

In another case, a manufacturer promoting a diagnostic test told providers to bill for the device using a completely unrelated immunology code. The product's packaging also included instructions telling providers to use that code. Many providers billed according to the manufacturer's instructions. Ten years later, a Medicare carrier learned of the mistake and demanded repayment. We've also heard of practices that have spent large sums on equipment, expecting to bill for its use under a CPT code the manufacturer gave them. They later found out that the code was wrong and no code existed for them to bill for using the equipment. Result: The practices were out a lot of money.

Practices and facilities that use incorrect codes to bill Medicare also open themselves up to potential false claims charges. "A practice is unlikely to be able to hide behind a manufacturer and say 'They told me to code this way,'" says Sarraile. "The government can and will hold a practice and its physicians liable for submitting a false claim if that practice or physician chose to ignore whether it was using the accurate codes or decided to remain ignorant of the coding rules," he explains.

Use Checklist to Ensure Reimbursement

To avoid these problems, create a checklist for each new device or drug you're considering buying. A checklist can help you make sure you've asked all the right questions in determining how to code for a new product and how much you'll be reimbursed for it. Be sure to keep the completed checklists (with any accompanying documentation) in your files. Then, if the government or a payor ever investigates you, you'll have written documentation to support your use of a particular code.

Your checklist, like our Model Checklist, should include the following questions:

1) Is there a valid CPT code for the device or drug? The most important thing to figure out is whether there's a valid CPT code you can use to bill for the new device or drug. Start your research with the manufacturer and the CPT manual. "While the manufacturer may not always be right, it's a good idea to ask what code it recommends and what research it has done to support the recommendation. Sometimes you'll find it has done some valid research," says Sarraile. "If the research the manufacturer shows you is supported by valid third-party references, such as the CPT manual, citations from relevant statutes or regulations, or payor policies relevant to your practice or facility, it provides a reasonable starting point, but you'll still want to secure third-party confirmation," he says.

You should always verify the accuracy of the recommended code independently. "This is best done by speaking with any payors—like Medicare—and confirming their guidance back to them in writing in a letter sent by

certified mail," Sarraille suggests. Coding consultants' opinion letters are useful to include with the manufacturer's materials in these letters to payors. Be sure to get the manufacturer's information and research in writing, Sarraille adds.

You may also try to find out how your colleagues are coding, or start combing the CPT handbook yourself. But you shouldn't ever rely solely on incomplete research or unsupported advice from a manufacturer, another practice's advice, or your own best guess. In these cases, don't bill under a code unless you've confirmed its validity with a recognized authority. To do this, Corcoran recommends working with a certified biller or qualified consultant and checking the medical and government literature that discusses using the device or drug. This can include a review of the CPT manual, the ICD-9 handbook, CMS program memoranda, CMS regulations, the Social Security Act, your carrier's or intermediary's local medical review policies (LMRPs) and special bulletins, your other payors' policies, and information from medical and industry associations.

It's always a good idea to contact your local Medicare carrier or intermediary, other private payors, and your local CMS office to confirm the use of a particular CPT code. You can also contact the CPT Advisory Panel. Make sure that when you contact any of these entities, you provide a detailed description of the device or drug and how it will be used. And always ask for an answer or clarification in writing, says Nancy Jo Vinson, clinical director of an ambulatory surgery center (ASC). But not all organizations will be willing to verify their advice in writing. So instead, as Sarraille suggests, send a letter of your own to the organization, con-

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MODEL CHECKLIST

Make Sure You'll Get Reimbursed for Using New Device or Drug

Here's a Model Checklist you can use to help you figure out how to bill for a new device or drug and to make sure payors will reimburse you for it. The answers to the questions on this checklist will help you determine whether there's a valid CPT code you can use to bill for the device or drug, how much you'll be reimbursed for it, and how likely you are to get payment for it. The checklist

also reminds the staff member doing the research to attach written verification to support the answers she gets.

We developed the Model Checklist with the help of reimbursement expert Kevin Corcoran. Review it with your billing staff, attorney, and compliance officer and/or risk manager to decide how to adapt it for use at your practice or facility, says Corcoran.

REIMBURSEMENT CHECKLIST FOR NEW DEVICE OR DRUG

Name of product: _____

Name of manufacturer: _____

Manufacturer representative:

▶ Name: _____

▶ Address: _____

▶ Tel. #: _____

1. Do you have a valid CPT code for the device or drug? yes no
If yes, list code: _____

2. Do you have one or more valid ICD-9 codes to support the medical necessity of using the drug or device? yes no
If yes, list code(s): _____

3. Will all our payors accept the code? yes no
If no, list payors that won't accept it: _____

4. Do all our payors appear to have a straightforward process for reimbursing this item? yes no
If no, explain why. (For example, will we need to use a "miscellaneous" code that the payor will review on a case-by-case basis?): _____

5. Will our payors reimburse the product at an acceptable level? yes no
If no, list payors that will not reimburse in full, and specify how much they will discount the reimbursement: _____

6. Will payors reimburse for additional equipment or drugs that the product must be used with? yes no n/a
If no, what are those additional products, and how much will they cost? _____

7. Have you attached written verification from the manufacturer, our Medicare carrier or intermediary, our private payors, our local CMS office, and/or the CPT Advisory Panel, to support your answers to questions 1-6? yes no

NEW DEVICES & DRUGS (continued from p. 3)

firming the information. "Having written verification can help you defend yourself if you're ever accused of billing improperly for the product," Vinson explains. Written documentation is important for another reason as well, according to Corcoran. "A recent study—verified by a CMS coding expert—found that Medicare representatives answered questions over the phone incompletely or incorrectly almost 85 percent of the time," he explains.

Your checklist, like our Model Checklist, should have a place to write down the CPT code(s) you plan to use to bill for the product [Ckfst., ques. 1].

2) Is there a valid ICD-9 code to support using the device or drug?

Be sure you also have a valid ICD-9 code based on the patient's condition to support the use of the CPT code, says Corcoran. Once you have a valid CPT code, your reimbursement will still depend on having an acceptable ICD-9, or diagnosis, code for using the device or drug. Here again, "don't depend on the manufacturer to tell you the right ICD-9 code—do your own research," says Corcoran. Start by checking your carrier's or intermediary's LMRPs, which should list acceptable ICD-9 codes for some products and procedures. Also check with your private payors. And don't forget that you'll have big problems if you plan to use a particular drug or device for an indication that isn't on the LMRP list or okayed by your private payors. "It's close to impossible to get a payor to change its mind on what indications merit using a particular device or drug," Corcoran explains.

Like our Model Checklist, yours should have a place to write down the ICD-9 code(s) you plan to use to sup-

port billing for the product [Ckfst., ques. 2].

3) Will all your payors accept the CPT code? Find out whether all your payors will accept the CPT code you plan to use. "Even if you've got a valid CPT code, you may not get paid for the device or drug. So you've got to check out your payor's policies," says Corcoran. To research this area, you should review your carrier's and intermediary's LMRPs, your state regulations related to insurance coverage and reimbursement, Medicare's national coverage policies, and your other payors' reimbursement policies. When in doubt, you should also contact your carrier or intermediary, your local CMS office, and your other payors. And get written confirmation where you can, adds Vinson.

Like our Model Checklist, your checklist should have a place to write down any payors that won't accept the CPT code [Ckfst., ques. 3].

Insider Says: Billing the patient for a noncovered service is an alternative way to get paid for the service or product, says Corcoran. "But payment isn't a sure thing in these cases," he says. Normally, you can bill Medicare patients for noncovered services if you explain in advance that Medicare doesn't cover the service and that the patient will be responsible for payment. If Medicare sometimes covers the service, but may not in the patient's case, then you can still bill the patient as long as you get him to sign an advance beneficiary notice before you provide the service.

4) Do your payors have a straightforward process for reimbursing this product? Although payors may accept a particular CPT code for the use of a device or drug, they may not promptly reimburse you for the service. That's because

for services or products that are rarely provided, unusual, or new, a payor may assign a "miscellaneous" CPT code that requires you to provide additional documentation that the payor will review before deciding whether to reimburse you for the service or product, says Corcoran. "In these cases, a payor will decide on a case-by-case basis whether the service is appropriate and should be reimbursed," he explains. "If your device or drug falls under a miscellaneous CPT code, there are significant administrative hassles to getting reimbursed," he adds.

You'll also run into reimbursement obstacles if the device or drug you want to use requires so-called add-on codes or is designated as a "separate procedure." That's because add-on codes and separate procedures are sometimes bundled with the primary procedure and not paid separately, says Corcoran.

Your checklist, like our Model Checklist, should have a place to describe the payors' processes for reimbursement [Ckfst., ques. 4].

5) Will reimbursement be acceptable? Once you've determined that you can bill for a particular CPT code, find out the rate of reimbursement. You'll need this information to figure out whether it's cost-effective to buy the manufacturer's product. The best way to get the information is to go to your payors directly, says Corcoran. "You can often research payors' current reimbursement policies by visiting their Web sites and viewing their policies and rates for the particular device or drug, or for the procedure performed using the product," he explains. Be sure to print out any information you find. You can also contact your payors directly and ask them to tell you *in writing* what their reimbursement

rate is for the product or procedure in question.

Like our Model Checklist, yours should have a place to write down whether your payors will reimburse the product, and the amount of their reimbursement [Ckfst., ques. 5].

6) Will payors reimburse you for additional equipment or drugs used with product? Sometimes the device or drug you're considering buying must be used with additional equipment or another drug. In these cases, it's important to factor into your purchasing decision whether those additional products will be reimbursed by all of your payors, and at what level, says Corcoran. You should work with your clinical staff to figure out what additional products are needed, he advises. Then work with your administrative staff to find out what the

products will cost and how much reimbursement you can get for them. Use the same methods described above to research government and medical literature and to contact the appropriate authorities. And be sure to get written documentation of the costs and reimbursement rates of all the additional products you'll need, Corcoran adds.

Like our Model Checklist, your checklist should have a place to write down any additional products needed, their costs, and their reimbursement rates [Ckfst., ques. 6].

7) Have you gotten written verification to support your answers? As we've stressed, it's important to get written verification from all the sources you use to support your decision to bill under a particular CPT code. This would include, at the very

least, any helpful information from the manufacturer, your Medicare carrier or intermediary, your private payors, your local CMS office, the CPT Advisory Panel, and any other applicable authority. If a payor doesn't have a formal written policy, a written record of your correspondence with someone in authority will provide evidence of the steps you took in deciding you could bill for a device or drug under a particular code, says Vinson [Ckfst., ques. 7]. ■

Insider Sources

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OIG 2004 Work Plan Reveals Continued Focus on Issues Relevant to Radiology

Every year, the Office of Inspector General (OIG), the enforcement arm of the Department of Health and Human Services, issues a "work plan"—a document that outlines its enforcement priorities for the coming fiscal year. Savvy compliance professionals know that the OIG work plan offers helpful guidance about where they should be focusing their own compliance efforts.

The OIG released its work plan for fiscal 2004 in early October. It identifies several issues relevant to hospital-based radiology practices, radiology offices, and independent imaging centers, as areas of concern for the coming fiscal year. We'll point out those areas of concern and tell you what the work plan reveals about

why the OIG plans to concentrate on them during the coming year.

Services Provided Through Hospitals

The OIG work plan discusses several issues of concern regarding services provided in hospitals, two of which are significant to radiology practices, says Virginia health care attorney Thomas W. Greeson.

Diagnostic testing in the emergency department. Like the 2003 work plan, the 2004 work plan indicates that the OIG will focus on the provision of diagnostic testing services in the emergency department. Specifically, the OIG seeks to determine whether "services were medically necessary and whether the

tests were interpreted contemporaneously with the beneficiary's treatment." Greeson notes that the OIG seems to take the position that only tests interpreted in time to affect the care and treatment provided to the patient are to be considered "medically necessary." But that point of view is in conflict with CMS rules, he says, which set no strict limit on the time frame for completion of the interpretation. "With its inference that the interpretation must be made contemporaneously with the patient's treatment to be medically necessary, OIG seems to be trying to assert a time frame for the interpretation that doesn't necessarily reflect the realities of emergency medicine procedures," Greeson says.

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OIG 2004 WORK PLAN (continued from p. 5)

Insider Says: CMS takes the position that it won't reimburse both the emergency room physician and the on-call radiologist for interpreting the same X-ray. In essence, this means that the first claim in "wins." But the proliferation of telemedicine capability and nighthawk services means that two professionals rarely attempt to bill for interpreting a single test, Greeson explains. And the OIG doesn't mention duplicate claims for interpretations of tests performed in the emergency department as an area of concern for 2004.

Outpatient prospective payment system (OPPS). The OIG work plan indicates that it will continue to investigate whether payments made under OPPS are appropriate. It indicates transitional pass-through payments are a special area of interest. This focus should concern hospital radiology and nuclear medicine departments, Greeson says, because it may indicate a continuing suspicion about the justification for keeping certain drugs on the transitional pass-through list. But folding the cost of the drugs into the APC classification may limit patient access to the drugs as hospitals find that they lose money by providing them. Greeson reports that professional organizations, including the American College of Radiology (ACR), are encouraging CMS to continue to provide transitional pass-through payments for many drugs. But he notes that the OIG's interest in these payments may indicate a suspicion that the transitional pass-through payment system is being abused.

Physician Services Provided Outside the Hospital

The OIG's 2004 work plan reveals many areas of concern regarding

physician billing. Some of the specific concerns the OIG identified aren't of particular import for the average radiologist, but several areas of concern that the OIG identified directly affect radiology practices, Greeson cautions.

Use of modifiers to defeat CCI edits. The OIG continues to be concerned that modifiers are being used inappropriately to bypass CCI edits that bundle certain services. The 2004 work plan points out that modifiers are to be used only when the particular unusual circumstances of the case justify unbundling of services.

Radiation therapy management. The 2004 work plan expresses concern that physicians may be overpaid for radiation therapy management services. Current Medicare regulations allow physician reimbursement for one billable unit of radiation therapy management for every five radiation sessions a patient receives. The work plan notes that an audit of one particular carrier found a high percentage of overpayments to physicians for these services, so the OIG has decided to broaden the scope of its inquiry to all carriers. Greeson advises that radiation oncology practices and others providing radiation therapy take care to ensure that radiation therapy management isn't billed unless the patient receives five sessions of radiation therapy.

Ordering physician excluded from Medicare. For the first time, the 2004 work plan expresses concern about excluded providers ordering tests. Radiology practices should take note, says Greeson, because non-hospital-based radiology practices must have treating physician orders for the diagnostic tests they perform. The OIG work plan indicates that the OIG will consider a service provided on the basis of an order from an exclud-

ed physician to be improper and not reimbursable exposing a radiology practice to requests for repayment if the practice performed a test that was ordered by an excluded physician, Greeson cautions. So he advises radiology practices, as part of their ongoing compliance efforts, to make periodic checks that referring physicians aren't excluded from the Medicare program, just as they do for employees and other partners.

Insider Says: You can check a physician's Medicare status by going to the OIG's Web site, www.oig.hhs.gov. Click on "Exclusions Database" on the left side of the page. Then, under "List of Excluded Individuals/Entities," click "online searchable database." That will bring up a screen that allows you to input up to five individual names or business names to determine whether any have been excluded from the Medicare program.

IDTFs. Like the 2003 work plan, the 2004 work plan identifies the medical necessity of services provided at independent diagnostic testing facilities (IDTFs) and the qualifications of IDTF personnel (including supervising physicians) as areas of OIG concern. In addition, in the 2004 work plan the OIG expresses concern that IDTFs perform only those tests they're approved to perform. If your practice operates or has a relationship with an IDTF, Greeson suggests that you review the IDTF's form 855 to make sure that the IDTF is performing only approved tests, and that all personnel are appropriately qualified. Greeson cautions that supervising physicians at IDTFs must be proficient in the tests they're supervising. So make sure to evaluate the qualifications of your supervising physician with that in mind—for

IDTFs that perform imaging services, that generally means a radiologist or a nuclear medicine specialist, or at least a physician with some specific training or qualification in imaging procedures, he says.

Insider Says: If you would like to keep a copy of the 2004 work plan handy, you can find it at www.oig.hhs.gov. Click on "Publications," then "Work Plan," then "Current Fiscal Year." That will bring up the various sections of the OIG work plan, so you

can download only the sections that are relevant to your practice. ■

Insider Source

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ASK THE INSIDER

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Leasing Imaging Center Time to Another Practice

Q Our radiology practice has an MRI facility that isn't operating at full capacity. We've been approached by a local orthopedic practice that's interested in leasing the MRI facility one day a week for a flat fee. The orthopedic practice would bill its own services. We know that under Stark we have to charge fair market value rent and have a written lease. Is there anything else we should be concerned about?

A Arrangements like these raise a lot of issues, says New Jersey health care attorney Michael F. Schaff. The laws in your state will determine whether this sort of arrangement will work for you—and whether you can do it at all. Here are some potential obstacles:

CON. Some states require a certificate of need (CON) for freestanding MRI facilities and the like. The CON process is meant to ensure that health care resources are delivered in a fair manner and that all health care facilities are operating safely. If your facility is in one of those states, you have your CON already. But if you lease out the facility to another entity, like the orthopedic practice, some states may require the orthopedic practice to get a CON for the same facility. "It doesn't make a lot of sense, since the state has already determined there's a need for the facility, but that's how it works in some states," Schaff says.

Licensure. Even in states that don't require a separate CON, there may be a licensure issue. Most states license freestanding facilities, Schaff explains, so you'll need to determine whether the state will require the orthopedic practice to obtain a separate license to operate the facility on the days that the practice is renting it from you.

Liability. Even if the state doesn't require the orthopedic practice to get a separate license, are you willing to

allow the orthopedic practice to "piggyback" on your license? Allowing it to piggyback involves liability for your practice, Schaff points out. You'll be responsible for whatever goes on there when the orthopedic practice is operating the facility. So you'll want to get strong protections in your lease that indemnify your practice from the misdeeds of the orthopedic practice. But keep in mind that "the limit of the indemnification is the depth of their pockets," Schaff says. In other words, if the orthopedic practice causes the facility to lose its license, all you can get from the practice is money—cold comfort if your facility is out of business. And, he adds, the money isn't likely to be enough to make you whole.

The take-home message is that deals like these can't be done between physicians on the golf course. Both parties must get experienced health care attorneys to investigate the CON and licensure issues. Because many states haven't dealt with these questions before, navigating that process may take a while—and be expensive. Once the CON and licensure issues have been resolved, your attorneys will need to negotiate an agreement that sufficiently protects both parties. So before you decide that leasing out your facility will solve your under-utilization problem, you should carefully consider the costs involved in setting up such a deal. They're likely to be substantial—which doesn't mean it can't be the right solution for you, Schaff emphasizes, just that it shouldn't be entered into lightly and without expert advice. ■

Insider Source

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What to Include in an Accounting of PHI Disclosures

Even though the April 14, 2003, compliance date for the HIPAA privacy regulations has passed, many practices are still struggling with the regulations' *accounting requirement*. It gives individuals the right to request a written accounting of disclosures of protected health information (PHI) to persons and organizations outside the practice, unless the disclosure is for payment, treatment, health care operations, or certain other permitted reasons. To comply with the requirement, organizations covered by HIPAA must track these disclosures.

Many practices are still unsure about which disclosures of PHI to

include in an accounting. This is largely because the HIPAA privacy regulations describe the exceptions to the accounting requirement, but don't list the disclosures of PHI that must be included in an accounting.

To help you get a handle on this, we've put together an extensive list of the types of disclosures of PHI that practices should include in an accounting (see pp. 8-9). The list is based on one created by HIPAA privacy analyst Tanya Lang. You can use the list as a HIPAA awareness training tool, and as a compliance tool to help your organization track and account for its disclosures of PHI. At the end of the list,

we've also noted the exceptions to the accounting requirement.

Please note that every effort was made to make this list exhaustive. But because the HIPAA privacy regulations set only a floor and may be affected by more stringent state law requirements, the list may not include additional disclosures of PHI that your state law may require in an accounting. You should expect the list to develop over time, as you get some experience putting the accounting requirement into practice, says Lang. ■

Insider Source

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ACCOUNTING OF PHI DISCLOSURES

INCLUSIONS

Disclosures of PHI for any of the following activities, purposes, and reporting requirements, including any documentation relating to such disclosures, are subject to HIPAA's accounting of disclosures requirement. These disclosures must be tracked and available for inclusion in an accounting of disclosures.

► DISCLOSURES TO PUBLIC HEALTH AUTHORITIES

- For public health surveillance activities (tracking infectious diseases)
- For public health investigations
- For public health interventions (e.g., actions taken to limit the spread of an infectious disease)
- To foreign governments collaborating w/U.S. public health authorities (for example, with China, to track and limit the spread of SARS)
- Birth records reporting
- Death records reporting
- Child abuse/neglect reporting
- Elder abuse/neglect reporting
- Teen suicide reporting
- Patient safety reporting (such as to a state department of health)
- To prevent serious harm (needlestick reporting)
- Communicable disease reporting

► DISCLOSURES TO FOOD & DRUG ADMINISTRATION

- Reporting of adverse events, product defects, or biological product deviations
- To track products
- To enable product recalls, repairs, or replacements
- To conduct post-marketing surveillance
- To manufacturers of defective products

► DISCLOSURES TO EMPLOYERS

- To employer requesting that health care be provided to an employee when made w/o the employee's authorization for medical surveillance purposes, in relation to a work related injury or illness, and needed for the employer to comply with OSHA, the Mine Safety and Health Administration (MSHA), or similar state law

► DISCLOSURES TO HEALTH OVERSIGHT AGENCIES

- Required reporting to government benefit programs (such as Medicare, Medicaid)
- Compliance activities (such as compliance with government benefit programs)
- Required by civil rights laws
- Reporting to trauma registry
- Reporting to tumor registry
- Vital statistics reporting
- Alzheimer's and other dementia reporting
- Disclosures in judicial and administrative proceedings
- In response to a court order
- In response to a subpoena

ACCOUNTING OF PHI DISCLOSURES (continued)

► DISCLOSURES TO LAW ENFORCEMENT

- As required by law
- In response to court order, court-ordered warrant, subpoena, or summons
- In response to an administrative request
- For purposes of locating a suspect, fugitive, material witness, or missing person
- During emergency treatment, crime is elsewhere
- About crime victims
- About crimes on the health care organization's premises
- About suspicious deaths (suspected homicide or suicide)
- To avert a serious threat to health or safety (of an individual or the public)

► DISCLOSURES REGARDING DECEASED PERSONS

- To coroner or medical examiner
- To funeral directors
- For organ, eye, or tissue donation/procurement purposes

► DISCLOSURES FOR RESEARCH PURPOSES

- When an institutional review board waiver is used in place of a patient authorization to release PHI
- In reviews preparatory to research
- In research on decedent's information

► DISCLOSURES FOR SPECIALIZED GOVERNMENT FUNCTIONS

- For military and veterans' activities
- To protective services
- To department of state related to medical suitability (for example, an individual's PHI may be disclosed to determine if she is available to serve overseas)

- By government programs providing public benefits
- About foreign military personnel to appropriate foreign military authority

► DISCLOSURES FOR WORKERS' COMPENSATION PURPOSES

- To comply w/existing laws (see state law)
- To state health data commission (unless operations)
- To U.S. embassies
- To contractors and business associates (if not for treatment, payment, or health care operations)
- To vendors (if not for treatment, payment, or health care operations)

EXCEPTIONS

The following are the exceptions to the accounting requirement. You may include these types of disclosures of PHI in an accounting of disclosures, but you are not required to do so:

- To carry out treatment, payment, and health care operations
- To individuals, of PHI about them
- Incident to a permissible use or disclosure of PHI
- In response to a HIPAA-compliant patient authorization
- For the facility's directory or to persons involved in the individual's care or other notification purposes
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Occurring before the HIPAA compliance date for the covered organization (April 14, 2003, for most organizations or April 14, 2004, for small health plans)
- As part of a limited data set

Beware of Companies Claiming Endorsement by Medicare or HHS

Beware of compliance consultants and vendors that imply that Medicare or HHS either endorses their compliance materials or programs or requires you to buy them. In April 2003, the HHS Office of Inspector General (OIG) issued an alert warning that federal law bars individuals and organizations from misusing "HHS departmental words, symbols, or emblems to market their services." The OIG alert re-emphasized a warn-

ing that appeared in a June 2001 OIG Special Advisory Bulletin, "Practices of Business Consultants," which cautioned providers about improper practices a small minority of consultants were using to get clients.

We'll tell you what practices the OIG has said you should look out for. And we'll give you some tips to help you spot and avoid compliance consultants and vendors who are trying to mislead you.

Misleading Practices of Concern to OIG

The OIG said it issued the recent alert because of the "particularly egregious violations" by one California corporation that offers reimbursement and coding seminars to health care providers. The OIG accused the corporation of misusing the word "Medicare" in its marketing practices. It alleged that the corporation's marketing mate-

(continued on p. 10)

BEWARE OF COMPANIES CLAIMING ENDORSEMENT (continued from p. 9)

rials “used the words and letters of the Medicare program and HHS in a manner that reasonably could be construed as conveying the false impression that its seminars are approved, endorsed or authorized by Medicare.” Here are some examples of statements in the marketing materials that the corporation mailed to providers, which the OIG claimed were improper:

- In a brochure, the words “FORMAL NOTICE of [a] WORKSHOP DETAILING LOCAL [STATE] MEDICARE CHANGES,” a reference to a Medicare bulletin, and a statement that “Compliance [is] Required.”

- On a postcard mailed to providers, a statement that this was “Final Notice” of Medicare code changes and that compliance with the changes was “legally required.”

- On the same postcard, a statement that an instruction session had been scheduled for the provider and the provider must call to confirm the session or request removal from the update list.

“Neither Medicare nor HHS has ever endorsed private companies or

individuals,” and a communication implying such an endorsement violates federal law, the OIG alert said.

How to Avoid Falling for Misleading Marketing

What should you do to protect your lab from consultants and vendors like the California company described in the OIG alert? Here are some tips compiled with the help of health care attorney Carol E. Bowen:

- Don't fall for claims or assertions that Medicare, HHS, or the OIG recommends or *requires* you to attend a specific educational program or buy a specific compliance product or service;

- Investigate any claims of a consultant or vendor before buying the services or product being marketed. That means you should check with your colleagues at other labs to determine the consultant's or vendor's reputation and experience in providing the service, and the merit and effectiveness of its product or service;

- Investigate the asserted or implied credentials of any individual providing a seminar, authoring a product, or working on your consulting project. For example, don't just believe marketing materials or sales-

people that imply the company and/or its consultants, seminar presenters, or authors are “Medicare representatives” or otherwise have “government experience,” “government connections,” or an “inside track” to Medicare, HHS, or the OIG.

Insider Says: You can find the OIG alert on the OIG Web site at www.oig.hhs.gov/fraud/docs/alertsandbulletins/040803MisuseofHHSSymbols.pdf. You can also find the OIG's 2001 Special Advisory Bulletin at www.oig.hhs.gov/fraud/docs/alertsandbulletins/consultants.pdf. ■

Further reading: *Insider*, Oct. 2001, p. 1, “OIG Cautions Providers to Take Care When Choosing Consultants.”

Insider Source

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SHOW YOUR LAWYER

For more information about the cases and/or laws referred to in this issue, show your lawyer the legal citations listed below.

- Accounting requirement: Accounting of disclosures of protected health information: 45 CFR 164.528.