

Radiology Administrator's

Compliance & Reimbursement Insider

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Protect Your Practice When Hiring New Physicians

Are you thinking of adding another radiologist to your practice? Maybe you need someone else to share the workload, or your practice needs to expand the services it offers to remain competitive. Adding another radiologist can solve a lot of problems, but it can also lead to problems. It's hard to tell beforehand how a new physician will work out. So before you hire is the time to consider all the circumstances under which the new physician might *leave*, says Philadelphia health care attorney Joan M. Roediger. A prudent physician will get certain contract protections when adding a new physician to her practice, she remarks. Think of it as a prenuptial agreement for your practice.

We'll point out the three big problems that can arise when a physician leaves a practice, and show you how to deal with them ahead of time—when you sign the contract with the physician. We'll even give you some Model Contract Clauses (see p. 3) that you can adapt and use in your employment contracts to make an eventual parting as painless as possible.

Minimize Three Major Risks

There are three main ways that the departing physician can damage your practice, Roediger says. The departing physician can:

- 1) Directly compete with you for patients;
- 2) Steal your patients and employees or interfere with your business relationships; and
- 3) Spill your secrets and confidential information.

A well-drafted contract between a practice and a physician can limit these risks by including three specific clauses: a restrictive covenant, a nonsolicitation clause, and a confidentiality clause. A contract should also provide remedies for violations of any of these clauses.

All three clauses, says Roediger, must be negotiated "at arm's length." That essentially means that you must give the new physician at least the opportunity to have his own attorney review the contract and explain the contract's clauses to him. But if the new physician chooses not to have his attorney review the contract, it would still be enforceable as long as the physician had the opportunity to do so, Roediger explains.

Restrictive Covenants

Many people believe that restrictive covenants—that is, agreements not to work in competition with a former employer—are unenforceable. But that's wrong, Roediger says. In fact, except in certain states, such as Massachusetts, which bar restrictive covenants, every state recognizes and will enforce some type of agreement not to compete, she explains.

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PROTECT YOUR PRACTICE (continued from p. 1)

Although states vary in what they will enforce, all enforceable restrictive covenants have certain common elements, explains Roediger. Our first Model Clause assumes that the state where the practice is located fully enforces restrictive covenants. But depending on your state, some portions of our Model Clause might not be enforceable. So it's important to consult an attorney who's familiar with your state's laws. Although the details of your restrictive covenant may vary according to your particular circumstances and the state your practice is in, in general it should meet these basic requirements:

Time frame must be reasonable. Usually Roediger bars the departing physician from setting up shop in direct competition with the practice for at least two years after the departure date [Clause 1, par. a]. The longer the time frame, the less likely a court is to enforce the restrictive covenant. But in some cases, a longer time frame may be appropriate—for instance, where the departing physician is quite well established and his presence in the area, even years later, may drain patients from the original practice, she says.

Geographical scope must be reasonable. You want to bar the departing physician from competing with you directly for patients. So in general, your restrictive covenant should protect your "cachment area"—the area where 75 percent or more of your patients reside. The size of that area will depend on where your practice is located. In certain rural areas it may be reasonable to bar a departing physician from setting up practice within the same county as any of your practice's offices. But in certain urban areas, a radius of a certain number of blocks around a particular office may be reasonable, and a court may deem any radius larger than that unreasonable, Roediger notes. You can describe the radius by using counties, zip codes, or even a map—just as long as the restricted area is related to the area where most of your patients and referral sources are located, she says [Clause #1, par. a].

Scope of the barred activity must be reasonable. If your restrictive covenant bars a physician from practicing any type of medicine, it's less likely to be upheld than one that is limited to the services the physician performed for your practice, Roediger says. Your contract should bar the physician from doing only radiology (or whatever other specialty he or she did for you)—plus any related medical services, Roediger says [Clause #1, par. b].

Insider Says: You may also want to require that a physician who leaves the practice must resign her privileges at all hospitals where the practice's physicians provide professional services [Clause 1, par. c]. Some states bar this type of clause, but if your state allows it, the clause can prevent a departing physician from poaching your patients and help you to maintain your referral relationships at the hospital without the departing physician's interference. Also, if your practice has an exclusive agreement with a hospital, the hospital agreement may mandate such a clause.

Nonsolicitation Clause

When a physician leaves your practice, he may hope to take your patients or employees with him. He may also want to practice at some of the same health care facilities, or accept some of the same payor contracts. Your contract with

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MODEL CONTRACT CLAUSES

Include Protections in Your Employment Contracts

You can make the split with a physician who has been working in your practice a lot easier if you decide how to handle certain termination issues before the physician even starts working for you. Include the following three clauses—a restrictive covenant, a nonsolicitation clause, and a confidentiality clause—in the employment contract that you and the physician sign. Courts usually will enforce the contract if state law per-

mits these clauses and they are reasonable, and if the physician had the opportunity to get legal counsel before signing it, says health care attorney Joan M. Roediger. Adapt the following Model Clauses to your practice situation. Courts handle these clauses a little differently in every state, so it's important to have your attorney review the language before you add it to your employment contracts, Roediger cautions.

EMPLOYMENT CONTRACT CLAUSES

CLAUSE #1: RESTRICTIVE COVENANT

You acknowledge that in the event your employment with the Practice terminates for any reason or in any manner, your continuing practice of [*insert specialty, e.g., radiology*] in the area would be detrimental to the Practice's ongoing business. Accordingly, you agree that:

- While you are an employee of the Practice and for a period of [*insert time, e.g., two years*] after your employment ends for any reason, you will not render any [*insert services, e.g., radiology services*] or practice any related medical disciplines on behalf of yourself or any business entity within [*insert radius, zip codes, names of counties, or areas specified on attached map*] of any office of the Practice or location where the Practice's physicians render professional services (Restricted Area).
- You will not engage in the practice of [*insert specialty, e.g., radiology*] or related medical disciplines in at any hospital, clinic, or health care facility or entity within the Restricted Area for a period of [*insert #, e.g., two*] years after your employment with the Practice ends.
- Upon termination of your employment with the Practice for any reason or in any manner you shall resign your privileges at all hospitals, clinics, or health care facilities or entities at which the Practice's physicians provide radiology services.

CLAUSE #2: NONSOLICITATION

You agree that if your employment with the Practice ends for any reason or in any manner, for a period of [*insert time period, e.g., two years*] following the termination of your employment with the Practice, you will in no event:

- Solicit for treatment any former or existing patient (or any member of a patient's household) of the Practice;
- Induce or attempt to influence any employee or patient of the Practice to terminate his or her relationship with the Practice;
- Induce or attempt to influence any nursing home, assisted living facility, skilled nursing facility, long-term care facility, hospital, other health care facility or entity, or any physician or other professional with a

referral relationship with the Practice to terminate or alter that relationship; or

- Solicit any contractual arrangement of the Practice that relates to the delivery of radiology services or related medical disciplines.

CLAUSE #3: CONFIDENTIALITY

You acknowledge that as an employee of the Practice you will have access to information of or related to the Practice, its patients, employees and operations, and business and financial affairs ("Confidential Information"). You acknowledge and agree that all Confidential Information is the property of the Practice and constitutes trade secrets of the Practice. You further agree that:

- During your employment at the Practice and at all times thereafter, you will not disclose to or discuss with any third party any of the Confidential Information of the Practice, nor shall you use the Confidential Information for any purpose whatsoever in a manner adverse to the interests of the Practice.
- The Practice has sole discretion to determine your access to Confidential Information, if any. Your access to such Confidential Information shall be limited to that necessary to carry out your employment duties and obligations.
- No Confidential Information shall be removed from the offices of the Practice or from the Practice's custody and control, or disclosed to any third party, unless reasonably required for patient care or unless the Practice authorizes you in writing to remove or disclose the Confidential Information.
- Upon termination of your employment with the Practice for any reason or in any manner whatsoever, or sooner upon request of the Practice, you will return to the Practice all Confidential Information, including but not limited to documents and tangible items, together with any and all copies, recordings, abstracts, notes, or reproductions or any kind made of or from the documents and tangible items or the information they contain, provided to you or created by you, which relate to the Confidential Information of the Practice.

PROTECT YOUR PRACTICE

(continued from p. 2)

the physician should deal clearly with these issues before the physician even begins working for your practice, Roediger cautions. Although you can't prevent one of your patients from following a departing physician to a new practice if the patient wishes, you can bar the physician from enticing the patient away, she explains. And you can prevent the physician from poaching your employees, interfering with your contractual or referral relationships, or (in some states) practicing at the same hospitals as you.

Your state's laws may affect the specifics, but as a general rule, your nonsolicitation clause should cover the following elements:

Departing physician may not solicit the practice's patients' households. The contract should bar a departing physician from contacting patients or their family members when he leaves [Clause 2, par. a]. But Roediger notes that you can't bar a patient from departing of her own free will, and you must make medical records available upon the patient's request. Consider whether the departing physician should bear the cost of copying the charts, Roediger suggests.

Departing physician may not solicit employees. When a physician leaves your staff he may try to take one or more of your employees with him. That can really disrupt your practice, so you should bar the departing physician from doing this [Clause #2, par. b].

Departing physician may not interfere with the practice's business relationships. You must protect your relationships with referral sources and with hospitals and other health care facilities where your prac-

tice provides services. Your contract should bar the departing physician from attempting to alter those relationships [Clause 2, par. c]. Your contract should also bar the departing physician from soliciting the payors with which your practice does business [Clause #2, par. d].

Confidentiality Clause

A physician who works in your practice gains an intimate knowledge of your business affairs and other sensitive information, Roediger points out. If the departing physician discloses this information to patients, payors, hospitals, or other providers, it could harm your reputation. Or if the departing physician has knowledge of your business plans—say, that you plan to retire in a few years—he could leak that information to potential patients or employees, to your detriment. So it's important that you bar the departing physician from disclosing any confidential information about you or your practice, Roediger says. And your contract should also bar him from using this information during his tenure in your practice for any purpose except in the service of your practice.

Every state recognizes the practice's right to keep its secrets and confidential information private. So you can easily adapt our third Model Clause to fit your contracts. Like ours, your confidentiality clause should:

Acknowledge that the physician may have access to private information. It's important that the physician acknowledge at the beginning of the relationship that he may learn sensitive information about your practice during the course of his employment, and that this information is the practice's property [Clause 3]. That will

make it easier to enforce the confidentiality clause if you need to, because the departing physician will have already acknowledged that he knew the information was sensitive and private, Roediger says.

Forbid the departing physician from disclosing the information.

Bar the physician from disclosing this information to anyone outside the practice. You should also bar the physician from using this information in a way that's detrimental to the practice [Clause 3, par. a]. You don't want the departing physician mentioning your private information to your hospital, payors, patients, or colleagues.

Acknowledge the practice's control of information. The contract should say that the practice will determine the physician's access to information [Clause 3, par. b]. The physician shouldn't think that free access to information is a part of his employment, Roediger points out. Also, bar the physician from removing the information from the practice's office without the practice's written permission [Clause #3, par. c].

Require the physician to get written permission for any disclosure. The clause should allow the physician to disclose confidential information only as required by law or with the practice's written consent, Roediger says [Clause 3, par. c]. That's because there may be situations in which the physician must disclose the information outside the practice for a legitimate purpose that isn't adverse to the practice's interests, she notes. For example, the physician might apply for a research grant or for participation in a clinical trial. The application for the grant or the trial may require the physician to disclose some of the practice's confidential information.

Require the physician to return any information. Give yourself the right to demand the return of any confidential information that's in the physician's possession at any time, including any copies or notes made from the confidential information [Clause #3, par. d].

Remedies if the Departing Physician Violates the Contract

Of course, putting the above clauses in your contract is only half the battle. You should also put remedies in the contract that will "make you whole" if the departing physician violates the contract, and that will give you the flexibility you need to make the appropriate business decisions for your practice.

These remedies are penalties or damages that the departing physician will incur if she violates your contract. Below are some of the remedies that typically appear in physician employment contracts. One or more of them may be appropriate for your circumstances, but check with your attorney before putting them in your contracts. Not all of these remedies are enforceable in every state and in every situation.

Injunction. An injunction is a court order barring certain behavior, says Roediger. Usually a court won't issue an injunction unless the party that asks for the injunction can show "irreparable harm" if the injunction isn't issued. In other words, the prac-

tice must show that there's no other way to prevent irreversible damage.

Money damages. Your contract could say that if the physician leaves your practice in violation of the contract, you'll be entitled to money damages. That's a way to make the departing physician responsible for any actual costs you incur associated with her departure, such as legal fees, changing computer passwords or updating security, and advertising for a replacement. Also, the damages could include any money the departing physician earns in violation of the contract, Roediger says. The contract may discourage the radiologist from leaving before expiration of the contract by imposing financial penalties for doing so—for instance, by taking any money she earns elsewhere before her contract with you is up. Again, the enforceability of this provision is dependent on state law, she explains.

Liquidated damages. You may want to include a "liquidated damages" clause. This clause says that because the damage to the practice will be unique and difficult to calculate, the damages will be a certain predetermined amount. This figure should be large enough to make it expensive for the departing physician to violate the contract, Roediger advises. But the clause won't be enforceable if the amount is too large. Your attorney can advise you about what amount will be considered reasonable in your locality, Roediger says.

Time limitation extended. Your contract could also contain a statement saying that if the departing physician violates any of the provisions in the restrictive covenant, nonsolicitation clause, or confidentiality clause, the time limitation on the barred activity begins as of the date of the physician's last violation. Say, for example, a physician who signed a contract with a restrictive covenant that bars him from practicing radiology within your area for two years sets up shop across the street 18 months after leaving your practice. When your practice enforces the covenant by obtaining an injunction that stops the physician from practicing across the street, the restriction will last for two years from the date he closes the office—not from the date he left your practice.

Insider Says: Include a provision in your contract that says that your violation of any part of the contract doesn't constitute a defense to him for violating the restrictive covenant, nonsolicitation clause, or confidentiality clause. In other words, if you violate the contract, these clauses will remain in force. The physician can't ignore the clauses without incurring the established penalties. ■

Insider Source

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Reducing Record Retention Requirements

The Situation

All physicians must keep records of their services and operations, either on paper or electronically. State and federal laws set limits on how long you must keep various records. Plan contracts also impose requirements for record retention. Record retention is of concern to plans because typically they want to be able to access and review your records. For example, a plan may need to see a member's medical records to help it defend itself in a malpractice lawsuit. Or a plan may want to review past claims of its contracted providers as part of a coding audit.

The Form Contract

We reviewed one national health plan's form physician contract, which says:

Participating Physician agrees to maintain or cause to be maintained all medical and administrative records pertaining to Plan or Covered Persons...and such records shall be retained in a legible format by Participating Physician for at least seven (7) years for an adult Covered Person, and for pediatric Covered Persons, until seven (7) years after the patient reaches the age of eighteen (18) years old or as required by law or such longer periods as may be requested by Plan.

The Problem

A clause like this creates several problems. First, it places an unnecessary burden on you. The plan is requiring you to retain records longer than the law may require. Many state and federal record retention laws require providers to hold onto their medical records for less than seven years after treating a patient (or in the case of a pediatric patient, less than seven years after the patient reaches 18). For instance, Medicare requires most providers to hold onto medical records for only five years after the date of service.

Also, the plan is requiring you to hold onto your administrative—that is, your nonmedical—records for as long as you keep your medical ones. So if you discard your claims records, or even your tax returns, before the seven-year limit, you're violating the contract. But many laws don't set a particular length of time for you to keep your administrative records and most of those that do have time limits of less than seven years.

The longer record retention requirement can also create administrative hassles for you. The longer you must store records, the more time and effort your staff must spend. And if your records are on paper, they may take up a lot of space, so their storage may cost a great deal. Even if you retain your records in an electronic format, your staff will still need to maintain them, and keep them secure and confidential, as required by the federal Health Insurance Portability and Accountability Act and applicable state laws. It's also a hassle to treat a plan's records differently from records relating to other plans and nonplan patients, instead of handling all of your records uniformly.

Finally, the clause as written is confusing. It requires you to retain the records for "seven years" or "as required by law" or for "such longer periods as requested by Plan." But the clause doesn't say which requirement applies. You're left guessing which requirement you should follow. And if you guess incorrectly, the plan could later accuse you of violating the contract.

The Concession

The *Insider* has learned from internal instructions to plan negotiating representatives that plans will often agree

to soften this clause if you ask during negotiations. For instance, the national health plan that uses the clause quoted above gives its negotiating representatives some leeway on several points. They have authority to change the clause to require the provider to retain records for only as long as the law requires. Or they may reduce the seven-year requirement for both medical and administrative records to five years.

The national health plan is also willing to change the clause's last sentence to delete the phrase "or such longer periods as may be requested by Plan." This makes the requirement much less confusing. It also reduces the risk that you would be violating the contract if, say, you never got the plan's request to hold your records for a longer time and had gotten rid of them before the new deadline.

How Concession Helps

The concession makes the contract less burdensome and eliminates the confusing language. It either makes the record retention requirement conform to what the law requires or at least shortens the plan's original retention period. That should reduce the time, effort, and money you spend on record retention. The concession also eliminates the plan's ability to arbitrarily extend the record retention period in the middle of the contract. You diminish the risk that you'll violate the contract by inadvertently discarding records too early.

You may want to keep your medical and administrative records longer than the law requires if, for instance, your attorney has suggested holding onto records longer in case you're sued. But that should be your decision, not the plan's. ■

Are You Ready for Mammography Equipment Phase-In Deadline?

There's an important deadline looming for mammography facilities that you must be aware of. When the *Mammography Quality Standards Act* regulations were finalized in 1997, they included a five-year period for facilities to phase in certain mammography equipment upgrades. That phase-in period expires on Oct. 28, 2002.

The FDA permitted the long phase-in period because it recognized that many mammography facilities couldn't afford to upgrade or replace all of their equipment at once, says New York health care attorney Matthew I. Kupferberg. Requiring

them to do so would have imposed a financial hardship that might even have forced some facilities to close, he remarks. The five-year phase-in period let mammography facilities accomplish needed upgrades as they followed their normal equipment replacement schedule.

But there may be a downside to the FDA's generosity, warns Kupferberg: After giving facilities such a long lead time, the FDA is likely to come down hard on any facility that misses the deadline, he explains. Kupferberg says he won't be surprised if the FDA immediately

revokes the registration of any facility that hasn't upgraded its equipment by the Oct. 28 deadline.

Insider Says: The FDA has posted an information sheet on its Web site that lists the standards a facility's equipment must meet or exceed by Oct. 28, 2002. You can find it at www.fda.gov/cdrh/mammography/oct282002.html. ■

Insider Source

Matthew I. Kupferberg, Esq.: Harris Beach LLP, 500 Fifth Ave., New York, NY 10110.

Is Your Practice Adjusting to 'Definitive Diagnosis' Coding?

On Jan. 1, 2002, CMS's program memorandum on diagnosis coding for diagnostic tests performed in outpatient facilities and physician offices went into effect. That program memo clarified that the diagnosis code for claims for diagnostic tests that yield a "definitive diagnosis" should be the patient's actual diagnosis (as indicated by the test result) rather than the signs and symptoms that led to the order for the test.

Before Jan. 1, about half the Medicare carriers nationwide required that claims for diagnostic tests be coded with the patients' signs and symptoms, while the other half already required definitive diagnosis coding.

If your practice is in an area served by a carrier that required "signs and symptoms" diagnosis coding, your coders should have adjusted the way they code claims for diagnostic tests. Now is a good time to check

that they've made the adjustment smoothly, says Georgia-based coding consultant Melody Mulaik. And it's a good idea to check that your carrier has made the necessary adjustment, too. We'll tell you how to review your claims to make sure that both you and your carrier are following the program memo.

CMS Program Memorandum Clarifies Diagnosis Coding

The CMS program memo doesn't eliminate signs and symptoms coding, explains Mulaik. Instead, it clarifies when a definitive diagnosis code must be used, and when signs and symptoms coding is appropriate. Here's what the program memo says, in a nutshell:

- If a diagnostic test result yields a definitive diagnosis, that diagnosis must be coded with the claim for the test.
- If a test result is normal and doesn't yield a diagnosis, then the

diagnosis code for the test should be the signs and symptoms that led to the test order.

■ If the test result yields a diagnosis but that diagnosis doesn't fully explain the symptoms that prompted the test order, the test should be coded with the diagnosis—but the unexplained symptoms may be coded as an additional diagnosis.

Insider Says: The CMS program memo is available on the Web at www.hcfa.gov/pubforms/transmit/AB01144.pdf.

Check if Coders Are Using Definitive Diagnosis

If you practice in an area that had to make the change from signs and symptoms coding to definitive diagnosis coding, you should be able to see a shift in diagnosis code usage already—that is, if your coders have

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'DEFINITIVE DIAGNOSIS' CODING

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responded to the change effectively. To make sure your coders are coding correctly, Mulaik suggests that you run a report of your claims for diagnostic tests for the first two months of the year, and compare it to the first two months of 2001. If your coders have made the adjustment correctly, you should see evidence of more claims submitted with definitive diagnosis codes.

"The difference won't be extreme because you'll still have normal tests coded with signs and symptoms," says Mulaik. But she believes that you should see some difference when you compare: There should be more definitive diagnosis codes in the 2002 claims.

What if there's no difference? Talk to your coders, Mulaik suggests. They may not understand that this is a national policy. Because signs and symptoms coding is generally faster and easier, your coders may be afraid that their productivity will decrease, affecting their job security or their

pay. Or they may need a refresher on definitive diagnosis codes. In either case, set aside some time to go over the CMS program memo with your coders. Reassure them that you recognize the change to definitive diagnosis coding may slow things down for a bit. And to make sure that they understand what's involved in definitive diagnosis coding, give them some real world examples from your practice to illustrate the coding change, Mulaik advises.

Make Sure Your Carrier Is Adjusting to the New Methodology

Mulaik reports that some carriers aren't making the necessary adjustments to handle the change to definitive diagnosis coding. Some carriers' local medical review policies (LMRPs) don't include all the diagnoses that should be paid for a given diagnostic test. And that leaves practices in a pickle, Mulaik asserts. If the test result yields a diagnosis that isn't reimbursable according to the LMRP, the claim may not be paid, she explains.

This leaves coders with the feeling that they should be assigning codes for signs and symptoms in these cases or the practice will lose reimbursement.

To deal with this problem, Mulaik suggests opening a dialogue immediately with your carrier if it looks like legitimate claims are being rejected because the carrier isn't prepared for definitive diagnosis coding. "Often it's just a matter of the carrier's adding a few diagnoses to its LMRP," she says. Once you've explained the problem, the carrier should be willing to do this in short order. But if your carrier is unresponsive, Mulaik says, don't hesitate to contact the regional CMS office. "The definitive diagnosis program memo is national policy, and carriers don't have discretion on this one," she emphasizes. If your carrier won't take the appropriate steps to facilitate definitive diagnosis coding, the CMS office may have to get involved. ■

Insider Source

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Don't Reveal Your Compliance Snafus Online—the Government May Be Listening

Internet message boards, list serves, and chat rooms are excellent ways for practice administrators to network and share information with colleagues. But beware. When you participate in one of these forums, you may not be communicating just with colleagues. Government employees may also be listening. Experts involved in these forums tell the *Insider* they suspect this is the case; some even say that they've recognized the names of government investigators and auditors they know personally who've answered questions or participated in online dis-

cussions. So if you confess any sins online, you may not only be inviting the government to investigate but also handing the government evidence it can use against you.

What You Say Online May Be Used Against You

It's natural for practice administrators to seek advice from colleagues and ask how they handle different billing, coding, and compliance problems. So don't stop using these valuable Internet resources. But take precautions

when participating in online message boards, chat rooms, and list serves.

Rule #1: Don't Confess to Wrongdoing

When administrators ask (or answer) questions online, they may reveal things they're doing wrong. For example, South Carolina health care attorney Neil B. Caesar says it's common for administrators to say something like, "One of the physicians in my practice is miscoding procedure X.

What should I do?" This is the kind of thing the government can seize upon.

So don't admit online that you're doing anything wrong. "Be careful about how you word your questions and answers," warns West Virginia consultant Fred Wolfe. Patrick B. Marion, a health care consultant who used to be an OIG investigator, recommends thinking of your online communication as a postcard that anybody—including government agents—can read.

Rule #2: Don't Reveal How You Code Specific Services

Keep in mind that you can get into trouble just by revealing how you handle a problem—especially if it involves billing and coding. Billing and coding is one of the topics administrators most often discuss online. But even coding experts often disagree about which code to use.

So think twice before revealing how you code something. Even if you think it's okay, the government may consider your method improper and want to investigate.

For example, participants often assure list serve participants who raise coding questions that "We always use this code and we always get paid," notes Maureen Angel, of the Medical Group Management Association. She warns never to word your response in that manner. If you happen to be wrong about your coding practice, you've just drawn the government's attention to the fact that you always bill improperly.

Rule #3: Don't Reveal Documentation Methods

Documentation is another area where you need to watch what you say. If you describe exactly what you do, it could backfire—even if you don't think what you're describing is wrong, cautions Wolfe. For example, one participant in a list serve posted

a message admitting that the physician she worked for didn't follow documentation guidelines, since there was no legal requirement to do so. The post was accurate, says Wolfe, but unwise. Saying that a physician doesn't properly document raises a red flag for a Medicare auditor, he explains. And practitioners without good documentation will have a hard time defending themselves if they're audited.

Rule #4: Don't Assume You Can Hide Your Identity

You may think you can remain anonymous by not signing your name or identifying yourself in the message. That's a mistake, warns Wolfe. Even if participants don't sign their posts or otherwise identify themselves, it's often very easy to identify them, he says. People who e-mail from organizations usually leave a direct trail back to themselves, he explains.

Rule #5: Don't Assume Private Communications Are Safe

Instead of revealing something on a list serve, many administrators communicate directly with colleagues via e-mail. These one-on-one communications may be safer than postings on list serves. But they're not necessarily safe. Consultant Don Self advises you to carefully word any private e-mail you send because Internet security is not perfect. People with the right software and the right programming skills can intercept Internet transmissions, warns Self. So you always need to be careful what you say and how you say it.

What You Can Safely Say

Following these rules doesn't mean you have to stop participating in Internet discussions. You just need to phrase your questions and answers in

more general or hypothetical terms. This can help you avoid inadvertent confessions. Safer questions about coding practices may include, "I attended a seminar where I heard you should code this procedure using XYZ code," or "I had lunch with a friend who suggested this code for this specific procedure," suggests Caesar. When answering coding questions, instead of saying "We always use this code," you may want to tell the questioner, "Try using this code" or "This code may be applicable." This helps the questioner without revealing what your practice or facility does.

Even hypothetical questions have their pitfalls. When hypothetical questions are too specific, Caesar warns, they may still raise government suspicions. And if you think someone you work with is deliberately miscoding or committing other violations, Caesar advises against asking for any advice online—even hypothetically. Instead, consult your attorney. Your attorney can also help you by posting a question on a list serve or message board for you, using his name and e-mail to protect your anonymity. ■

Insider Sources

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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 them to (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail them to jgormley@brownstone.com

Radiologist Billing in ED Isn't Always Fraudulent

Q A company that supplies physicians to emergency departments (EDs) in our area has been circulating a "legal opinion letter" to our local hospitals. According to the company, the letter proves that it's fraudulent for radiologists to bill Medicare for an interpretation (professional component) if the ED physician also billed for it. Our hospitals now want us to stop billing for interpretations we provide in the ED. We think that we're entitled to bill if we do an interpretation, and it's not our problem if the ED physician bills, too. Is it?

A You may bill for professional interpretations for ED patients, under certain circumstances, but it's up to you to bill for interpretations appropriately, says Georgia health care consultant Jackie Miller. The rules for billing for radiological interpretations for patients who present to the ED were published in 1996, but they still cause a lot of confusion, she says. You must be careful because Medicare doesn't pay for interpretations that aren't medically necessary. The bottom line is that radiologists can bill for their interpretations of x-rays or other radiological tests taken on ED patients, only in certain circumstances. Here are the current rules for billing for the professional component of tests performed in the ED:

1) Medicare reimburses only one physician for the interpretation. Medicare will pay for one medically necessary interpretation performed by either the ED physician or the radiologist. But whoever provides the interpretation must provide a complete interpretive report in order to fulfill Medicare requirements and be reimbursed for the professional component of the test.

2) Reimbursable interpretation affects treatment plan. When both the ED physician and the radiologist bill for an interpretation, Medicare will reimburse only the interpretation that was used to make a diagnosis or estab-

lish a plan of treatment. In practical terms, that means that if the radiologist performs the interpretation and communicates the result to the ED physician while the patient is still in the ED, the radiologist's interpretation will be the only one that's covered. But if the radiologist performs or communicates an interpretation after the patient has been diagnosed and the treatment plan established, then Medicare won't pay the radiologist for it, Miller says. In this case, Medicare will reimburse the ED physician for the interpretation and will consider any subsequent interpretation by a radiologist not medically necessary, Miller explains.

3) Interpretation meets 'unusual circumstances' exception. Medicare recognizes certain "unusual circumstances" when it might be appropriate for both the ED physician and the radiologist to bill for an interpretation of the same test. Those circumstances include:

- When the physician who does the initial interpretation believes that another physician's expertise is needed to resolve a questionable finding; and
- When the second physician who interprets the test makes a significant finding in addition to the finding of the original interpreting physician—for example, when a radiologist confirming an ED physician's diagnosis of a fracture finds a tumor on the x-ray, which the ED physician missed. ■

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.

- Mammography Quality Standards Act regulations: 21 CFR Part 900.