

Radiology Administrator's

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HHS Proposes Changes to HIPAA Privacy Regulations

In the March 27, 2002, *Federal Register*, HHS published proposed changes to the final HIPAA privacy regulations in a notice of proposed rulemaking (NPRM). According to an HHS press release issued March 21, 2002, the NPRM is intended to address problems in the HIPAA privacy regulations that could have impeded patient access to quality health care. The NPRM affects many parts of the HIPAA privacy regulations. Although the changes in the NPRM aren't yet final, it's critical that you understand them. Below is a summary of the most significant changes. Plus we'll answer some questions you might have.

What Are the Key Changes?

Consent and notice. The NPRM eliminates altogether HIPAA's consent requirement for providers. That is, a health care provider like a physician practice would no longer be required to get written patient consent before using protected health information (PHI) for treatment, payment, or health care operations. A provider *may* still obtain consent for treatment, payment, and health care operations, but wouldn't be required to do so.

The NPRM doesn't change the requirement that a health care organization (including practices) provide patients with its notice of privacy practices. And the NPRM doesn't change the content requirements for this notice. But the NPRM adds that a practice would still have to make a good-faith effort to get a patient's written acknowledgment that the patient got the privacy notice. If the practice doesn't get this acknowledgment, it would have to document its efforts and the reason the acknowledgment wasn't obtained. So a practice would be able to treat a patient and wouldn't be in violation of the regulations, even if the practice didn't get the patient's acknowledgment.

According to the HHS press release, these changes to the consent and notice requirements were proposed to ensure that patients would get and could consider an organization's privacy policies before making health care decisions. But at the same time, the changes would eliminate access barriers raised by the consent requirement.

Minimum necessary standard and oral communications. The NPRM doesn't change the requirement that a health care organization must make reasonable efforts to limit its uses and disclosures of and requests for PHI to the "minimum necessary" to accomplish the intended purpose. But the NPRM makes clear that if an organization complies with the minimum necessary standard, incidental uses and disclosures of PHI—that is, those that result from or are a by-product of a permitted use or disclosure—are allowed. In the NPRM's preamble, HHS gives some examples of permitted incidental disclosures:

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HIPAA PRIVACY REGULATIONS (continued from p. 1)

- Disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care;
- The use of joint treatment areas, sign-in sheets, calling out names in waiting areas; and
- Discussion of a patient's condition during training rounds.

According to the press release, these changes were proposed to make clear that a provider could discuss a patient's treatment with another provider involved in the patient's care without fear that such communications would lead to a HIPAA privacy violation.

Business associates. The NPRM makes no major changes to the business associate requirements in the HIPAA privacy regulations. But the date for compliance with those requirements would be affected. The NPRM would allow a health care organization to continue to operate under its existing contracts with its business associates for up to one year beyond the April 14, 2003, compliance date. This extra time would be available to an organization for an existing contract (or other written arrangement) with a business associate if the contract isn't renewed or modified between the effective date of the NPRM—that is, when it becomes final—and April 14, 2003. The bottom line—you wouldn't need to amend your contracts with your business associates to comply with the HIPAA privacy regulations' business associate requirements until whichever of the following dates comes earlier: 1) the date the contract is renewed or modified after April 14, 2003; or 2) April 14, 2004.

The NPRM also includes an appendix with model provisions that you can incorporate in your business associate contracts. According to the HHS press release, these model provisions were added to make compliance with the business associate requirements easier and less costly for health care organizations.

Marketing. The NPRM simplifies the HIPAA privacy regulations' requirements for the use and disclosure of PHI for marketing purposes by clarifying the definition of marketing and explicitly requiring health care organizations to get a patient's authorization before sending him any marketing materials. For example, health care organizations are barred from selling lists of patients or enrollees to third parties, or from disclosing their PHI for the independent marketing activities of a third party, unless each patient or enrollee involved has given his authorization.

The NPRM eliminates the entire section in the current privacy regulations that permits an organization to engage in marketing activities simply by meeting certain conditions. For example, under the current privacy regulations, a physical therapist could send marketing materials about a local fitness center to her patients if she makes certain required disclosures to the patient (such as identifying who's making the communication and whether there's any compensation for making the communication) and she provides the patient with an opportunity to opt out of future marketing communications. In contrast, the NPRM would prohibit this and all similar marketing communications unless an authorization is first obtained.

According to the HHS press release, these changes were made in response to concerns that the existing marketing provisions don't adequately protect individuals' privacy.

Insider Says: According to the preamble to the NPRM, organizations can freely communicate with patients about treatment options and other health-related topics. These include disease-management programs, wellness programs, and the sending of prescription refill reminders.

Disclosures for treatment, payment, or health care operations of another entity. The NPRM clarifies that an organization can disclose PHI for the treatment, payment, and certain health care operations of another health care organization. For example, a hospital can—without patient authorization—disclose a patient's PHI to the ambulance service provider that delivered the patient to the hospital so that the ambulance service provider can get paid for its services. According to the preamble, this clarification was added to ensure that the HIPAA privacy regulations wouldn't interfere with access to quality, timely, and effective health care.

The NPRM also clarifies that an organization that participates in an "organized health care arrangement" (OHCA) may share PHI for the health care operations of the OHCA.

Parents and minors. The NPRM addresses the issue of a parent's access to her minor child's medical records by clarifying that state law governs this access to parents. For instance, the NPRM would permit disclosure to a parent who isn't the child's personal representative, if state law permits or requires such disclosure.

Uses and disclosures for research purposes. The NPRM simplifies the HIPAA privacy regulations' research requirements by eliminating the need for researchers to use multiple authorization forms. Instead, researchers could use a single combined form to address both informed consent and information

privacy. The NPRM also simplifies other research provisions so that the privacy regulations conform to the format of the Federal Policy for the Protection of Human Subjects (which is known as the "Common Rule" and governs federally supported, conducted or regulated human research).

De-identification. Currently, the HIPAA privacy regulations permit an organization to freely use and disclose PHI if the PHI is de-identified—that is, all identifiable information is first removed. In the NPRM, HHS requests comments on establishing an alternative approach to this de-identification standard—one that removes directly identifiable information but leaves in certain identifiers. This alternative approach would apply only to uses and disclosures of PHI for research, public health, and health care operations. In its press release, HHS said that it's requesting comments on this alternative approach because it received so many comments on the topic from researchers.

Patient authorization. The NPRM includes proposed changes to HIPAA's patient authorization requirements. The NPRM doesn't change the requirement that an organization must get written patient authorization before making a use or disclosure of PHI that's not otherwise permitted under the HIPAA privacy regulations. But the NPRM would standardize the provisions that must be included in all authorization forms—and eliminate the existing requirement to develop and maintain several different forms, each for a different situation.

Accounting of disclosures of PHI. The HIPAA privacy regulations give an individual the right—with certain exceptions—to get an accounting of disclosures of his PHI made by a health care organization. To be consistent with the NPRM's changes to the authorization requirements, the

NPRM says that an organization wouldn't be required to account for any disclosure of PHI made under a patient's written authorization.

Sale of business. The NPRM changes the definition of "health care operations" to ensure that medical records may be transferred to another health care organization upon a sale, transfer, merger, or consolidation. This change is meant to ensure that the privacy regulations won't interfere with necessary treatment or payment activities upon the sale of an organization's business.

Will the Compliance Dates Change?

With the exception of the business associate extension outlined on p. 2, the deadlines for compliance with the HIPAA privacy regulations will remain the same—April 14, 2003, for most health care organizations, including physician practices—and April 14, 2004, for small health plans.

When Do the NPRM Changes Become Final?

The NPRM was published on March 27, 2002, and is subject to a 30-day comment period that runs through April 26, 2002. HHS says it will then consider the public comments and publish the final version of the HIPAA privacy regulations, which may include additional changes. If HHS wants to keep the April 14, 2003, deadline for compliance with the privacy regulations, it must publish the final version of the regulations in the *Federal Register*, with a specified effective date of no later than Oct. 13, 2002.

How Can I Submit Comments to HHS?

You can submit comments on any area of the NPRM. In addition, HHS

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HIPAA PRIVACY REGULATIONS

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has specifically requested public comments on the following topics:

- Identifying specific types of communication that should or shouldn't be considered marketing;
- The model business associate contract language given in the NPRM's appendix;
- Whether any barriers exist for health plans not covered by the HIPAA privacy regulations to obtain the PHI they need for payment purposes;
- Limiting the uses and disclosures of PHI for research purposes after a patient's revocation of her authorization; and
- The feasibility and acceptability of the alternative approach outlined in the NPRM to the PHI de-identification process.

You can submit comments on the proposed changes through April 26, 2002, in one of three ways:

► *By mail.* Send one original and, if possible, three copies and a floppy disk to the following address: U.S. Department of Health and Human Services, Office for Civil Rights, Attn.: Privacy 2, Hubert H. Humphrey Bldg., Rm. 425A, 200 Independence Ave. SW, Washington, DC 20201.

► *By delivery.* Deliver one original and, if possible, three copies and a floppy disk to the address given for mailed comments, above. They must be received by 5 P.M.

► *Electronically.* Send your comments electronically by going to the following Web site: www.hhs.gov/ocr/hipaa/. They must be received by 5 P.M.

Where Can I Get a Copy of the NPRM?

The NPRM, which includes a preamble (background, overview, and descriptions of changes to the privacy regulations), an appendix, and the

proposed changes to the HIPAA privacy regulations, was published in the *Federal Register*, Vol. 67, No. 59, 03/27/02, pp. 14776-14815. The NPRM is also available at the HHS Office of Civil Rights Web site: www.hhs.gov/ocr/hipaa/.

Where Can I Get a Copy of the HHS Press Release?

To read HHS' March 21, 2002, press release, go to www.hhs.gov/news/press/2002pres/20020321a.html. To read HHS's fact sheet summarizing some of the proposed changes, go to www.hhs.gov/news/press/2002pres/20020321.html.

Insider Says: The NPRM also contains several changes to definitions and technical changes. In future issues of the *Insider*, we'll update you on the status of the proposed changes and tell you how, if they become final, they could affect your HIPAA compliance efforts. ■

CMS Introduces Streamlined Medicare Enrollment Process

CMS recently changed the way providers, including physicians, enroll in the Medicare program. CMS hopes that the changes will eliminate confusion and make the Medicare enrollment process quicker and easier, according to a press release.

Different Forms for Different Kinds of Providers

Under the former enrollment system, physicians, group practices and clinics, hospitals, nursing homes, suppliers, and other health care service providers all used the same form—Form HCFA-855—to enroll in the Medicare program. This caused difficulty because different kinds of health care providers and businesses had to complete different sections of the

form, and often that was confusing. So as a result, many health care providers made mistakes when completing the form.

Now physicians and other practitioners have an enrollment form specifically for them, Form CMS 855I. Group practices and clinics have their own form, Form CMS 855B. And hospitals and other entities that bill fiscal intermediaries have their own form, too—Form CMS 855A. Physicians who wish to reassign their Medicare benefits must complete Form CMS 855R. These specific forms should be easier for the applicants to complete than the old Form HCFA-855 was. And CMS hopes that the simplified forms that are geared to certain types of health care

providers will reduce the number of mistakes—and the processing delays those mistakes caused.

New Process Attempts to Ease Paperwork Burden

CMS is also trying to cut down on the paperwork associated with participating in the Medicare program. For example, in the past, physicians had to request, complete, and submit separate forms to reassign Medicare payments, have Medicare payments issued by direct deposit to a bank account, or electronically submit claims. Under the new system, these three forms are sent to each provider when it requests the initial Medicare enrollment application. By sending these forms with the application,

CMS eliminates one step in the process. Plus all the forms are available on CMS's Web site and can be completed and filed electronically. You can download the new enrollment forms plus enrollment instructions in either electronic or pdf versions at www.hcfa.gov/medicare/enrollment/forms.

CMS also made the following changes that should be particularly helpful to physicians and physician practices:

- Continuing education information will be attached to the Medicare enrollment application form but needn't be described within the form;

- Practitioners who provide all of their services in a group practice setting will be able to indicate that on the Medicare enrollment application form. That means they'll have to fill in less information on the form, since much of the information can be taken from the group's application form; and

- The Medicare enrollment application form will include specific information about billing agreement requirements so providers can assess whether their billing agreements are up to snuff. Practices can still get into trouble if their billing agreements don't meet Medicare requirements, but the practice's billing agreements no longer need be attached to the application form. ■

OIG Revamps Web Site

The OIG, the enforcement arm of the Medicare program, has redesigned its Web site to make it more user-friendly. Before, you had to get to the OIG site through the site of the Department of Health and Human Services (HHS). But you can no longer do so. Instead, you can visit the OIG site directly, at <http://oig.hhs.gov>.

The intent of the revamped site is to provide "one-stop shopping" convenience to people who need access to information about Medicare fraud and abuse issues, according to an OIG spokesperson. The changes to the site will make it easier to find OIG publications of interest to physician practices—like special fraud alerts. And it will be easier to search the OIG's database for excluded providers and other health care entities.

We'll tell you where on the revamped Web site the information most valuable to physician practices is now located. And we'll tell you how to find the more general information on the site.

Left Column Organizes Information Most Providers Need

When you visit the OIG's revamped Web site, you'll see a column on the

left-hand side of the page with the following headings in red:

What's New. Clicking on this heading brings you to a comprehensive and up-to-date list, in reverse chronological order, of all the OIG's public statements and reports. This includes press releases, audit reports, Congressional testimony, as well as periodic releases, like the Semiannual Report and the monthly List of Excluded Providers and Entities.

E-Mail List. You can subscribe to the OIG's listserv by clicking on this heading. If you subscribe, you'll get an e-mail update whenever the OIG releases new information or posts a new document on its Web site.

HIPDB. This heading links you to the Healthcare Integrity Protection Databank (HIPDB) and the National Practitioner Databank (NPDB). Only physicians who may make "self-queries" to see their own NPDB report, or state licensing boards, hospitals, and insurance companies, which may check on the licensure status and malpractice history of physicians requesting coverage or credentials, may have access to the NPDB. And insurance plans may check the HIPDB from this site to see

whether a physician has been convicted of health care fraud.

Exclusions Database. Click on this heading to check on whether a particular physician, clinician, or health care business is excluded from the Medicare program. Once you're there you have two choices:

- If you want to check many names, you can download the entire database (which is updated monthly). The database will be a zipped, self-extracting dbf file. That means you'll have to unzip the file once you've downloaded it, and you'll need a spreadsheet program like Excel or a database program like Access to use it.

Insider Says: There are instructions on how to open and use this downloaded database at <http://oig.hhs.gov/fraud/exclusions/instructions.html>.

- If you have to check only a few names, you can check up to five at a time in the "online searchable database." Clicking on this heading brings up a page that lets you type in the person's first and last name or the business name, to find out if the person or business is on the OIG's excluded list—and if so, why.

Hotline. Clicking on this link brings up a page with the phone num-

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OIG REVAMPS WEB SITE*(continued from p. 5)*

ber of the OIG's fraud reporting hotline, where callers can report suspected instances of provider fraud. It also offers users the option of reporting suspected fraud, through an e-mail link.

Right Column Contains General Information

The revamped OIG site also has a column on the right-hand side of the page, with headings in blue. These headings are useful for more general investigative or educational purposes:

Authorities & Federal Register Notices. Clicking on this heading gives you access to laws and regulations published in the *Federal Register*.

Publications. This heading brings you directly to OIG publications like the Semiannual Report, Workplan, and other legally required periodic reports.

Reports. This heading brings you to a list of OIG audit reports and inspection and evaluation reports.

Hearing Testimony. Clicking on this heading will allow you to pull up pdf files of the testimony OIG officials have given before Congressional committees. Testimony is organized in reverse chronological order.

Fraud Prevention & Detection. Here's where you'll find OIG Special Fraud Alerts, the antikickback law safe harbors, advisory opinions, and other fraud-related materials.

Reading Room. This heading gives you access to all the OIG's written reports, alerts, opinions, and testimony—all this information is organized by category and date.

Organization. Clicking on this heading brings you to a description of the OIG's mission, structure, and authority.

Employment Opportunities. This heading links you to a current list of employment opportunities within the OIG, as well as instructions on how to apply for a job with the OIG. ■

Help Your Radiologists Dictate Thorough Reports

The radiologist's report of his findings and diagnosis is the basis for everything your practice does: The patient's treatment, your reputation among your referral sources, and your billing all depend on the thoroughness of the interpretive report the radiologist dictates. Unfortunately, busy radiologists sometimes cut corners or make assumptions when they dictate their interpretive reports. This can cause serious problems for your patients and for your practice.

We'll spell out the benefits of providing thorough interpretive reports—and the consequences of inappropriately terse reports. And we'll explain the guidelines that the American College of Radiology (ACR) suggests that diagnostic radiologists follow when dictating reports. Plus we'll give you a Model Checklist, on p. 8, that you can give your radiologists to help them dictate thorough interpretive reports.

Thorough Reports Are Good for Your Practice

When your radiologists promptly dictate thorough interpretive reports, your practice benefits in many ways, says Atlanta-based health care consultant Jackie Miller. Here are some of the benefits of providing treating physicians with high-quality interpretive reports:

Improved patient care. A detailed report is good practice from a patient care perspective. The more information you provide a referring physician, the better the physician's treatment plan for the patient is likely to be, Miller points out. By the same token, a report that skips over details can lead to problems later—sometimes important clues that affect a patient's treatment course are found in the details or secondary findings, she says.

More referrals. Generating thorough reports will help your practice develop and retain referral sources.

Physicians will be more likely to refer patients to your practice if they know that they'll receive a thorough interpretive report from you. So good reporting makes good business sense, Miller remarks.

Less professional liability. Producing thorough interpretive reports reduces the risk that a patient will win a malpractice suit against you. Good documentation in the form of a thorough interpretive report shows that the radiologist carefully noted all findings and evaluated them in light of the patient's clinical history. If the radiologist's diagnosis turns out to be wrong—even if she missed an anomaly that's found in a retrospective analysis of the exam—she's far less likely to be held liable for malpractice if the interpretive report shows that she was careful and considered all the relevant factors before making her diagnosis. On the other hand, even if the radiologist did everything right and considered all relevant data,

Miller notes, "if it's not documented, it wasn't done." If the patient has a bad outcome, your goose could be cooked. Bad documentation loses as many malpractice suits as bad medicine does, Miller asserts.

More compliant coding. The more precise information the radiologist provides, the more accurately your practice's coding and billing staff can code the claim. This has three distinct benefits, Miller says—less likelihood of being audited, better chances of surviving an audit without incident, and more appropriate reimbursement. Many coders have to make assumptions from the medical record about a patient's diagnosis and/or the test performed because the interpretive report isn't explicit enough. By letting your coders do this, you are, in effect, letting nonphysicians make medical judgments and submit claims for payment based on those medical judgments. That's a very bad practice that can lead to denied claims, requests for repayment, audits, and even fraud charges, Miller warns.

More accurate reimbursement. Including all relevant information in the interpretive report means that you're more likely to get all the reimbursement you're entitled to. For example, Miller reports that many diagnostic radiologists will simply dictate "knee exam," rather than "knee exam, three views." Adding the additional information may add a few seconds to the dictation time, but it can result in many dollars of additional reimbursement, she notes.

ACR Guidelines Suggest What Report Should Include

The ACR first published guidelines on communication for diagnostic radiology—including interpretive reports—in 1991, and they've been amended several times since then.

The guidelines are meant to give diagnostic radiologists a starting point—deviation from the guidelines doesn't mean a report is inadequate. Similarly, sometimes adherence to the guidelines won't be enough—some cases may require even more detail and information, to be truly comprehensive. But if you can get your diagnostic radiologists to consistently dictate reports that conform to the guidelines, they'll be well on their way to producing high-quality interpretive reports, Miller says.

Use Checklist to Follow ACR Guidelines

Miller suggests giving diagnostic radiologists a checklist that they can use when they're dictating interpretive reports. Our Model Checklist, based on the ACR guidelines, was put together with her assistance. If the radiologist follows it when dictating, his interpretive report will cover all the following major points that the ACR guidelines suggest:

Patient-identifying information.

Radiologists should dictate sufficient information to identify the patient, the study, and other relevant information. For example, our Model Checklist lists the patient's name (you can adapt this if you wish to add or substitute an identifying number, such as a medical record or Social Security number), the patient's gender and age, the name of the referring physician, the name of the interpreting physician, the date of the examination, the time of the examination, and the date of the dictation [Checklist, sec. 1].

Sometimes radiologists skip some of these items, believing that the transcriptionist will fill in these details from the medical record. Miller recommends that radiologists include all this information in the dictation because it serves to double-check the

information in the patient's medical record. In other words, the transcriptionist or medical records clerk is more likely to find a discrepancy if the information appears in the transcribed interpretive report, she believes.

Recording the time of the exam can be particularly important in the case of exams that are frequently repeated, such as chest X-rays on ICU patients, Miller notes. Including the exam time can help billing staff identify and correctly code repeat exams, which in turn will help prevent denials for claims that may appear to be duplicates. And if the patient should suffer an adverse outcome, the exam time can also help in reconstructing the sequence of events, she explains. And that's a real advantage when defending malpractice lawsuits.

Clinical information. Remind the radiologist to include the patient's relevant medical history and signs and symptoms in his report [Checklist, sec. 2]. Again, this is a portion of the dictation that some radiologists give short shrift to, on the theory that the patient's clinical history is clear from her medical record and needn't be reiterated in the dictation. Miller cautions that insufficient attention to the patient's history and symptoms can often have serious repercussions in the event of a malpractice suit.

If there's no proof in the interpretive report that the radiologist considered the patient's history when he evaluated the clinical findings of the radiological exam, a savvy plaintiff's attorney can make it seem as if the radiologist didn't consider the patient's history at all—and that makes a bad impression on a jury. The clinical history can also, of course, be vital in ensuring assignment of the correct ICD-9 diagnosis code, which, in turn, helps produce appropriate reimbursement.

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MODEL CHECKLIST

Use Checklist to Help Diagnostic Radiologists Dictate Complete Reports

Incomplete documentation is a problem in all medical practices, including radiology practices. Some diagnostic radiologists are a little too terse when describing their findings and don't always include information like study limitations, negative findings, and secondary or differential diagnoses. But including all this information is important to patient care, risk management, and compliance.

Providing diagnostic radiologists with a checklist they can use when they dictate interpretive reports can help them to dictate thorough reports. Here's a checklist we developed with the help of Jackie Miller of Per-Se Consulting. You can adapt it, as needed, or just copy it and give it to your radiologists.

DIAGNOSTIC RADIOLOGIST DICTATION CHECKLIST

SECTION 1: IDENTIFYING INFORMATION

- Patient Name _____
- Age _____
- Sex _____
- Referring Physician _____
- Examination Ordered _____
- Interpreting Physician _____
- Date of Exam _____
- Time of Exam _____
- Date of Dictation _____

SECTION 2: CLINICAL INFORMATION

- Relevant History (describe all relevant events and conditions) _____
- Signs and Symptoms (thoroughly describe clinical indicators for the exam as provided by referring physician and/or patient, and as evident from physical exam, if applicable) _____

SECTION 3: EXAMINATION & FINDINGS

- Physical Exam Findings (if applicable) _____
- Radiological Exam Performed (if different from exam ordered, clearly describe reason for order change and date of referring physician's approval of change) _____

- Number of Views (describe each view, e.g., lateral, anteroposterior, oblique) _____

- Drugs Administered (if applicable; identify drug, dosage, form of administration, time of administration, any notable reaction) _____

- Radiological Findings (describe findings concisely and specifically) _____

- Limitations (describe any limiting factors that may affect the accuracy of your findings) _____

- Comparison to Prior Radiological Exams (if applicable) _____

- Note to Referring Physician (if applicable; respond as completely as possible to any questions the referring physician raised in the test order) _____

SECTION 4: CLINICAL IMPRESSION

- Diagnosis _____
- Secondary Diagnosis _____
- Recommendations for Follow-up Care (if applicable) _____

DICTATE THOROUGH REPORTS

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Description of exam and findings. Prompt the radiologist to thoroughly discuss the type of exam done [Checklist, sec. 3]. If the radiologist follows along with the checklist when dictating his interpretative report, he'll be prompted to discuss many issues that the ACR recommends be included in interpretive reports but that are sometimes skipped over, such as:

- The results of any physical exam, if one was performed;
- The type of radiological exam performed. If the radiologist performed an exam that was different from the exam the referring physician ordered, the report should state this and reflect why the change was made, and confirm that the referring physician was informed of the change;
- The number of views, and a description of each;
- A description of the type and dose of any drugs administered during the exam, as well as any reaction or complication the patient may have had to the exam or drugs;

- A concise description, as specific as possible, of the radiologist's findings;

- Any limitations to the sensitivity or specificity of the exam—like being unable to get a clear view because of old scar tissue, for example;

- Any issues that the referring physician raised in the request for the exam; and

- An explicit description of any comparison with prior radiological exams.

This is more than many radiologists typically include in an interpretive report, but all this information will assist in the practice's compliance effort, help the coders code properly, and foster goodwill among referral sources. By responding to any issues the referring physician raised, and carefully describing any comparison with previous tests, the radiologist makes the referring physician's treatment decision easier, says Miller. Plus the radiologist also conveys the impression that he's part of the treatment team—and that helps keep the

referrals coming, she adds. What's more, the coding and billing staff need this information to code the claim properly, and in a well-run practice, the information will come straight from the radiologist's mouth.

Clinical impression. Prompt the radiologist to report any clinically relevant findings, including a diagnosis and a secondary diagnosis, when appropriate [Checklist, sec. 4].

Interpretive reports should include recommendations for any repeat, follow-up, or additional studies. Our Model Checklist reminds the radiologist to give these recommendations. Including recommendations in the report shows that the radiologist was considering the patient's long-term diagnostic and treatment needs. And it helps the treating physician establish a treatment plan, Miller notes.

Insider Says: You can get a copy of the ACR standard on the ACR's Web site at www.acr.org/. ■

Insider Source

Jackie Miller: Per-Se Consulting Group, 2840 Mt. Wilkinson Pkwy., Atlanta, GA 30339.

PLUGGING LOOPHOLES**Make Sure Contract Terminates Automatically if Plan Stops Operating**

Most plan contracts will let you terminate the contract if the plan stops operating. For instance, a plan may shut its doors because it lost its license or decided to pull out of your area. But beware of a big loophole found in many of these contracts: The contract doesn't say that it will *automatically* end when the plan stops operating.

With this loophole, you run the risk that the contract will be sold or otherwise assigned, and that you'll have to continue providing services in

accordance with the contract. You may end up working with a plan you're not familiar with and don't want to be contracted with. And it may be harder at that point to terminate the contract because you're not sure where or to whom you should send your termination notice.

Surgeons Stuck Giving Discount in 'Dead' Contract

For example, several Colorado surgeons joined a PPO owned by a local

hospital and agreed to a 10 percent discount off their fees. The PPO contract didn't have a clause that said the contract would automatically terminate if the PPO stopped operating. The PPO eventually went out of business, and the surgeons assumed that their contracts had ended, so they never bothered to send termination notices to the PPO.

But the PPO's former executive director assigned the contracts to

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PLUGGING LOOPHOLES

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a Texas workers' compensation managed care organization. That organization applied the contract's 10 percent discount to claims submitted by the Colorado surgeons for services provided to injured employees. The surgeons hadn't even known that the employees were covered by a contract, let alone a contract they believed no longer existed. They were shocked to be paid 10 percent less than they'd expected.

Worse, they could no longer send a termination notice to the PPO, as it no longer existed. And since they had no direct contract with the Texas organization, they didn't know which person at the organization to complain to, or how and where to send a notice to terminate the contract. "Until the surgeons find out where to send a termination notice, they're stuck," pointed out managed care consultant Maria K. Todd, who's familiar with the situation.

How to Protect Yourself

To keep from being stuck in a contract with a plan that's no longer operating, make sure the contracts you're negotiating have a clause that specifies that the contract automatically ends if the plan stops operating. This clause is most likely to be found in the "termination" or "termination for cause" sections of the contract.

If the contract doesn't say that it automatically ends if the plan stops operating, ask the plan to add that to the contract. "Plans shouldn't have any problem agreeing to add this," says Todd. If a plan seems hesitant, offer to make the clause mutual.

To make the change, add the following sentence to the termination section of the contract:

Model Contract Language

Unless otherwise prohibited by law, this Contract shall automatically terminate in the event Plan loses its license to provide or administer services to Members,

stops conducting its business, or otherwise ceases to operate.

Insider Says: If you believe that a plan you're contracted with is about to file for bankruptcy or insolvency, don't rely on an automatic termination clause to get out of the contract. Send the plan a termination notice—and do it before it files for bankruptcy or insolvency protection. Even if the plan stops operating (which isn't always the case in a bankruptcy), you'll be stuck in the contract unless the bankruptcy court lets you or the plan terminate it, cautions Todd. Your state's insolvency laws may also prevent you from terminating the contract this way. ■

Insider Source

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