

Radiology Administrator's

Compliance & Reimbursement Insider

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Overturn Payment Denials When Plan Verified Coverage by Mistake

Sometimes a plan will verify that a plan member has coverage for a service, or even “preauthorize” the service, but later refuse to pay you for the service because it made a mistake. For instance, a plan may verify that a member is covered for physical therapy services but later find that the member had already received the maximum annual amount of physical therapy and deny payment. That’s unfair to you. You’ve contacted the plan to make sure the service is covered, and followed any utilization management rules the plan has, and you still don’t get paid.

You don’t have to accept the plan’s payment denial, experts say. You may be legally entitled to get paid for claims that were mistakenly verified or preauthorized—even if your contract doesn’t specifically say you can. If you fight back by sending a letter that says the denial is unacceptable, many plans will reverse the denial, says Texas health care attorney Randal Payne. He frequently drafts such challenge letters for his provider clients to send to plans.

We’ll tell you what steps to take. And we’ll give you a Model Letter (see p. 3) you can adapt for your own use.

Why Plans Deny Payment for Verified or Preauthorized Claims

Plans often mistakenly verify coverage or preauthorize a service because the employee who takes your call only checks if the member generally has that service as a covered benefit. Then, after you’ve provided the service and the plan reviews the claim, it discovers other information—for instance, the member’s employer never told the plan that the member had left her job and was no longer covered by the employer’s health insurance. At that point, the plan often will refuse to pay the claim, according to Texas attorney Lisa Manziel. “There has been a big increase in this type of denial,” she warns.

Sometimes physicians don’t even realize that the plan denied a claim for this reason. “The denials sometimes aren’t that specific, and the physician’s billing department writes off the claim when it really isn’t necessary to just eat the claim,” explains Atlanta attorney John Clark.

Most plans point to the contract to justify their denials in this situation. In particular, they may note that the contract contains a disclaimer that “any preauthorization or verification of coverage is not a guarantee of payment.” Even if the contract doesn’t have this disclaimer, the plan may have used disclaimer language when initially verifying coverage or giving preauthorization. Or it may just include it as a justification in its denial letter. Some plans also try to justify their right to deny these claims by telling the provider that the plan is governed by the Employee Retirement Income Security Act (ERISA), which may bar lawsuits dealing with denials of benefits.

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OVERTURN PAYMENT DENIALS (continued from p. 1)

Send Letter to Overturn Denials

To get these denials overturned, send the plan a tough letter challenging the denial. This often will work because you have the law on your side, explains Manziel. "If a plan is going to give a physician verification or preauthorization, it has a duty to do it in good faith and with due care," she says. "The practice relies on that verification or preauthorization when it provides services to the member." And any disclaimer in the contract isn't automatically enforceable against you, says Payne. "Pro-plan contract language won't affect your legal claim that the plan deceived you," he explains. "Having the disclaimer doesn't give plans a license to lie," notes Clark. These disclaimers probably won't hold up in court, he says.

In addition, in many states, laws or court decisions specifically protect physicians from this type of payment denial (see box on p. 3). These protections vary widely. For instance, some states flat out say that a plan can't retroactively deny payment for preauthorized services. Other states don't automatically bar plans from retroactively denying payment, but their courts have ruled that ERISA doesn't bar the provider from suing the plan for payment.

Experts say there's no downside to sending a letter challenging the payment denial. "Providers have absolutely nothing to lose," says Texas reimbursement specialist Tammy Tipton. "Often the letter itself is enough for the plan to reverse the denial." And if you send a letter, you don't have to immediately get an attorney involved, notes Sandy Locascio, director of patient accounting for a regional health care system. Send the letter to the person who sent the denial. If there's no name on the denial, send the letter to the head of the plan's claims department.

A letter worked well for one Texas hospital, according to Manziel. The hospital submitted a \$500,000 bill to a plan that had verified a member's coverage before the hospital provided the services. The plan then discovered that the member hadn't been a plan member for two years before the hospital called to verify coverage. It refused to pay the \$500,000 claim and demanded that the hospital return a \$50,000 payment for the member's prior admission made six months earlier that had also been verified. The hospital sent a letter challenging the denial, including proof that it had properly verified the coverage for both admissions. The plan quickly paid \$500,000 and dropped its demand for a refund.

What Letter Should Say

Like the *Insider's* Model Letter, your letter to the plan should:

Say that denial is unacceptable. Acknowledge that you got the plan's denial, and say that it isn't acceptable. Point out that you properly verified coverage or obtained preauthorization according to the plan's own procedures. Specify the steps you took that show that you believe you're entitled to payment. For instance, our letter says that you followed the plan's verification procedures and had no reason to believe that the member or the service wasn't covered.

Also say that you relied on the plan's verification or preauthorization when you provided the services. This bolsters your argument that you relied

on the plan's assurances to your detriment, says California attorney Michael Thornhill. And say that you acted in good faith when you got verification or preauthorization, so the plan can't claim that you knew in

advance that the member wasn't covered [Ltr., par. 1].

Insider Says: When you verify coverage or get preauthorization, make sure to keep a detailed record. Write

down the name of the plan representative you talked to, the date and time of the call, benefit information, any assurances you received that the coverage wasn't subject to some preexisting

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MODEL LETTER

Tell Plan Its Denial Is Unacceptable

Here's an example of a letter you can adapt and send to a plan that has denied payment on a claim after it verified coverage or granted preauthorization. The letter is based on one drafted by reimbursement specialist Tammy Tipton. Send the letter to the person who sent you the denial, if known. Otherwise, send it to the head of the plan's claims department.

Paragraph 1 of the letter acknowledges the denial and tells the plan that the denial isn't acceptable. It says that you acted in good faith and relied on the preauthorization (or verification) when you went ahead and provided services. It also outlines the steps you took to properly verify or get preauthorization,

according to the plan's own procedures. Paragraph 2 cites the general legal rule that says that the plan also must act in good faith and with due care, and can include references to any state law that's helpful. Paragraph 3 points out that any plan disclaimers concerning the verification or preauthorization may not be enforceable. Paragraph 4 tells the plan that it may also be violating your contract. Paragraph 5 says that you expect to be paid, and warns the plan that you may take "further action" if it doesn't pay you by the stated deadline.

Show this letter to your attorney and get his or her approval before using a similar letter.

BY CERTIFIED MAIL

June 10, 2002

Re: Claim # [insert claim number]

Dear Ms. Doe:

1. We are in receipt of your denial of the above claim. This denial is unacceptable. We properly obtained preauthorization for the procedure and relied on that preauthorization when we performed the procedure. We called and spoke to Mr. Smith in your office at 2:30 P.M., on June 22. Mr. Smith confirmed that the member was covered, that the procedure was a covered benefit, and that the coverage wasn't exclusively contracted to any specialty provider. We acted in good faith and had no knowledge that ABC HMO would find that it had made a mistake.
2. According to general law, plans must act in good faith and with due care. Once you preauthorize the procedure and we perform it, you can't deny coverage.
[optional] In addition, under [insert state] law, a plan can't retrospectively deny coverage for health care services provided to a covered person when the provider has obtained prior approval unless the approval was based on fraudulent information. You preauthorize the procedure, and there was no fraud involved. You therefore are required by state law to pay the claim.
3. As you know, any disclaimer that says preauthorization or verification "does not guarantee payment" is not automatically or necessarily legally enforceable.
4. In addition, section [insert #] of our contract states that ABC HMO agrees to perform "in good faith." We believe that denial of this claim is not in good faith, and that it is a violation of our contract.
5. We hereby request that you reverse the denial and pay the claim in full within 30 days of the date of this letter. If you do not, then we may have no choice but to take further action to protect our interests.

Yours truly,
Mary Jones, Office Manager
XYZ Radiology Group

OVERTURN PAYMENT DENIALS

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condition or maximum limit, and any other relevant information, says Locascio. Plans are more likely to reverse an initial denial if they see that you can back up your claim that you did what you're supposed to do. And courts are more likely to rule in your favor if you have this proof, notes Payne.

Refer to law. Refer to the general legal rule that the plan is supposed to act in good faith and take due care when it verifies coverage or preauthorizes services.

Also, mention any court decision or state law that bolsters your argument. For instance, a state law may say that a plan that denies coverage after verifying it can be found guilty of negligent misrepresentation. Your state medical society or specialty society can provide you with information about the laws in your state.

Point out disclaimer may not be enforceable. Don't let the plan rely on any disclaimer that verification or preauthorization is no guarantee of payment, whether in the contract or used elsewhere (such as in the denial letter or by phone when you called to verify). Point out that the disclaimer isn't automatically or necessarily enforceable, especially if it wasn't

part of the contract, recommends Clark [Ltr., par. 3].

Refer to contract. If your contract helps you in any way, be sure to include that information. For instance, the contract may say that the plan will perform it in good faith. And some physicians have negotiated for their contracts to say that the plan guarantees payment of claims for services that the provider preauthorized, or agrees to use consistent procedures in denying or approving coverage.

Request payment and warn plan of consequences. Point out that you expect to be paid, and ask the plan to review the denial in light of your letter. Give the plan a deadline. (If your state has a "prompt pay" law, you may want to point that out and make your deadline correspond with the state law, suggests Locascio.) Tell the plan that if it doesn't pay the claim by the deadline, you may need to take "further action" to protect your interests, if necessary. By using deliberately vague language, you don't limit your future options [Ltr., par. 5].

Insider Says: Make sure you send your letter by certified mail, return receipt requested. You want to make sure that the plan gets your letter, notes Tipton. And copy your employer on your letter, Clark suggests. The

plan won't want to lose your employer's business.

If Plan Refuses

In many situations, the plan will pay you what it owes after getting this letter. If a plan ignores you, send a second letter, this time with a copy to the plan's chief executive officer and medical director. "It pays to be persistent," says Thornhill.

If the plan still doesn't respond or refuses to pay you, you may want to consider suing the plan. "Sometimes suing may be the physician's best course of action, and physicians are more willing to assert their rights than before," notes Clark. ■

Insider Sources

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IN THE NEWS**CMS Announces Medicare to Cover More PET Services**

CMS made two announcements recently that it intends to expand Medicare coverage of positron emission tomography (PET). These two announcements are good news for hospitals, radiology practices, and imaging centers that have PET scanners or are considering offering PET services, says Washington, D.C., health care attorney William A. Sarraille.

We'll tell you about these two announcements and explain how they may help your practice or facility.

Two Announcements

The two announcements concern expanding Medicare coverage of PET services when they're related to the following:

Ischemic heart disease. In February, CMS announced that it intends to cover PET when it's used to diagnose myocardial viability in patients with ischemic heart disease, to determine whether the patient is a good candidate for revascularization.

Breast cancer. In March, CMS announced it was increasing coverage of PET for managing the care of

breast cancer patients. For these patients, Medicare will reimburse providers who use PET scans as an adjunct to standard imaging modalities for:

- 1) Staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; and
- 2) Monitoring women with locally advanced and metastatic breast cancer to determine how tumors are responding to treatment.

CMS hasn't announced an imple-

mentation date for these coverage changes yet, but implementation is expected by the end of the year, according to a CMS spokesperson.

How Can the Changes Help You?

These changes in CMS policy are good news for hospital imaging departments and entrepreneurial radiologists, says Sarraille. "Many hospitals and imaging centers have been on the fence when it comes to performing PET scans. The combination of

very high acquisition costs for PET scanners and limited Medicare coverage have made PET scanning a difficult, if not impossible, option," he explains. Because of these two changes, many more hospitals and radiology groups may now find it financially worthwhile to acquire the technology, he adds, particularly if physicians and hospital partners are willing to share the costs. ■

Insider Source

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How to Improve the Performance of Employed Physicians

If your practice has, or plans to have, employed physicians on staff, it's important to have a procedure to ensure that they're productive contributors to the overall success of your practice.

To do this, consider conducting orientations for newly employed physicians and giving them periodic performance reviews. You may already be giving orientations to your clerical and nonphysician employees and conducting performance reviews of them. But for some reason, many practices don't do this for employed physicians. That's a shame because investing some time in an orientation and periodic performance evaluations is a great way to show an employed physician what you expect from her and what you perceive as her strengths and weaknesses.

We'll give you some pointers on what to cover during an orientation to help the physician's employment begin smoothly. And we'll tell you a few things you need to know about the legal issues surrounding performance reviews. Finally, we'll give you tips on how to let an employed physician know what you expect and how

well she's doing, without causing you unnecessary aggravation or exposing your practice to lawsuits.

Give New Physicians a Brief Orientation

It's important that your employee physicians—especially physicians at the beginning of their careers—know from the beginning what you expect of them. Many practices just show the new physician around the office and put her to work—expecting the office staff to teach her as various nonclinical issues arise. This is inefficient and could lead to compliance problems, says New Jersey health care consultant Bruce Topolosky.

Instead, he advises, when the employed physician comes on board, make sure she sits down for an orientation with a senior physician who explains the following:

Office hierarchy. Make sure the employed physician knows who does what job and who's responsible for which aspects of the practice. It's important that a new physician know where to take a particular problem.

Productivity expectations. The senior physician should give the employed physician a goal as to the average number of patients she's expected to see in an hour, Topolosky advises. Young physicians are often slow. And that can lead to problems with the other physicians in the practice because time is money. On the other hand, more experienced physicians who join your practice are used to working at a certain pace, and it may not be the pace that works best in your office.

Demeanor. Make sure your senior physician tells the employed physician how she's expected to behave with office staff, patients, and colleagues. Sometimes physicians let their egos run away with them, and they treat others in their workplace disrespectfully. In some practices that's acceptable, but in others it's not.

Reimbursement. As part of the orientation, the senior physician should educate your employed physicians about the reimbursement functions that they're responsible for in your practice, Topolosky says. You may also want

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HOW TO IMPROVE PERFORMANCE

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these physicians to meet with the office/billing manager to review third-party payor contracts and any coding issues unique to the practice. If the practice uses an outside billing service, arrange for the service's billing manager to meet with the new physician, Topolosky advises. Young physicians may never have completed a superbill, may not know how to document evaluation and management services, or may never have had any experience with coding. On the other hand, experienced physicians who are new to your practice may not do these things the way you want them done.

Avoid Giving Formal Performance Reviews

After the orientation, you should give the employed physician periodic reviews of how she's doing. It may be tempting to give the physician formal performance reviews—with written reports of her performance, strengths, and weaknesses. In fact, several templates for evaluating employed physicians are available from consultants and specialty societies, and some practices use them to make decisions about promotions and compensation. But although implementing formal performance reviews of employed physicians may seem like a great idea, health care attorney Michael Schaff says it's not necessarily so. There's a downside to having documented evidence of your opinion of an employed physician's work, good or bad.

Grounds for lawsuit after firing.

An employed physician who's fired may sue the practice for improper dismissal. If your practice gave the physician a good review but dismissed her anyway, Schaff says, the fired physician could use the review to show that the dismissal wasn't based on her performance but on some other, discrimi-

natory factor—say, race or age.

Although the physician may not win that lawsuit, she can still cause you a lot of aggravation and expense.

No promotion/partnership. In another common scenario, an employed physician may use the contents of a good review to bring a discrimination lawsuit if she isn't promoted or offered a partnership. Schaff says this may happen when a physician is disappointed about not being offered a partnership or if the terms of the partnership are different from those the physician expected.

Obligation to report to payor/hospital. If you give the employed physician a bad review, you may then have an obligation to report this information to a hospital or a third-party payor, Schaff notes. This is a decision no practice wants to make. Many contracts with payors and hospitals may require you to report to them if you learn that a physician in your practice has either clinical deficiencies or a demeanor problem. If you fail to report this problem, you may be sued for breach of contract, he cautions.

Four Tips for Conducting Thorough, Informal Performance Reviews

Even though formal reviews can be

risky, it's still crucial that you periodically communicate your clinical and productivity expectations to your employed physicians and let them know how they're measuring up, says Topolosky. Some practices avoid doing this—it may be a fear of lawsuits or just a general discomfort with treating physicians the same as any other employee. Either way, it's a mistake, says Topolosky. Putting your cards on the table can lead to a more successful and productive relationship for everyone, he believes.

There's a way to ensure your employed physicians have appropriate direction and feedback without exposing your practice to unnecessary risk: Conduct your periodic performance reviews on an informal basis—without documenting anything in the employee's personnel file. That way, you can reap most of the benefits of formal performance reviews, without the associated risks. Here are Topolosky's tips for conducting an informal, but effective, performance review:

1) Make senior physician conduct review. The single fastest way to alienate an employed physician is to have a nonphysician conduct any aspect of the performance review, Topolosky says. Instead, have a senior physician in the practice do it. Even

► How to Terminate Relationship with Employed Physician

You don't need formal performance reviews to get rid of a problem physician (but, as the article notes, you should record in the physician's personnel file any problem and steps you took to correct it). Most employed physicians work on a contract basis with a practice, at least in the beginning. So if the relationship isn't working out, you can opt not to renew the physician's contract. And these contracts usually have an escape clause, which lets you immediately terminate the contract if the physician commits certain egregious acts—like committing fraud or endangering your patients or staff.

Sometimes problems arise that need to be dealt with immediately—like a physician who's abusive to patients or the people he works with, or who has inadequate clinical skills. Nip problems like this in the bud by immediately confronting the physician with the problem. If the physician doesn't correct the problem immediately, terminate the contract with him.

though most of the topics of the review will be nonclinical—such as punctuality, demeanor with patients and staff, documentation, and coding—it's best that a physician do the review, Topolosky suggests. The employed physician will probably be more receptive, and the substance of the discussion has a better chance of sinking in, he remarks.

2) Tailor tone and emphasis to the audience. Use common sense in the manner in which you deal with employed physicians, depending on their personal circumstances. For example, many older physicians sell their practices and then work for the buyer as an employed physician for a period of time. You shouldn't talk to a physician in this situation in the same way as you would a physician who's fresh out of training and working for a practice for the first time, Topolosky contends. Older physicians may have a hard time not being the boss anymore, he notes. And they may need to be counseled gently about following office procedures that may differ from the way they're used to doing things. On the other hand, new physicians may need very basic things explained to them—many new physicians have no idea how dependent reimbursement is on documentation, for example.

3) Provide specific feedback. After three or four months, once the new physician has settled in—and

every six months or so thereafter—the senior physician should sit down with the new physician and provide specific feedback about the new physician's performance. Topolosky suggests that the discussion cover at least the following points:

▶ *Productivity.* Discuss whether the physician is seeing an appropriate number of patients or reading an appropriate number of films. If he isn't, discuss the possible reasons why the physician may be lagging behind.

▶ *Documentation.* Discuss whether the physician is completing his charts in a timely fashion and whether the documentation is thorough and complete. It's a good idea to have examples of the physician's charts to go over together, Topolosky says, so that you can point out places where the documentation is particularly good or bad. Your practice's reimbursement—and even its compliance—depends on the adequacy of your charts, so it's worthwhile spending extra time on this area.

▶ *Staff supervision.* Your employed physician is probably giving orders and instructions to other people in your practice, such as nurses, medical assistants, techs, and nonclinical staff. Discuss with the new physician how his relationships with those people are developing. Find out from others he works with whether his instructions to them are clear and timely—if not, discuss the need for working cooperative-

ly and providing clear instructions to the other staff members.

4) Keep notes, not documentation. The senior physician conducting the informal review should have some notes to remind him of points to cover with the employed physician. But, Schaff says, it may be best not to have an official performance review form or write-up of the discussion. If there's ever a problem with the physician in the future, the physician could use the form or write-up as evidence against your practice.

Insider Says: There's an exception to the no documentation rule: When there's a specific problem with the physician, record the problem behavior and steps you took to correct it (for example, notifying the physician), Schaff says. The record should state the nature of the physician's infraction and contain the substance of any discussion of the problem with her. You can use this documentation if you ever have to show that there were problems with her performance. Plus the record proves that you notified the physician of these problems before taking further action—say, firing her. ■

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DOS & DON'TS

✓ Bar Employees from Keeping Passwords near Computers

As part of your patient privacy protection policy, bar your employees from writing down their passwords and keeping them near their computers, says health care attorney Todd C. Brower. Instead, tell employees to keep any written record of their passwords in a more secure place, such as their wallet or purse. Another option is to have your supervi-

sors keep a list of employee passwords in a secure location, suggests Brower. To give the policy some teeth, he says, consider including sanctions for employees who violate it.

Setting this policy is important because employees often write down their password on a nearby memo pad or sticky note. Remembering passwords can be tough, especially when they're changed every month or so or when

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DOS & DON'TS (continued from p. 7)

you have multiple passwords for different computer applications. But leaving a password in plain view creates a security risk. It increases the likelihood of a security breach by an unauthorized user, which could lead to unauthorized disclosure of your patients private information.

X Don't Give Employee Access to Health Information Until Training Is Completed

Don't give a new employee access to confidential health information until he completes his security and privacy training and education, advises Karen G. Grant of Partners HealthCare Systems, Inc. Also, withhold access until you document that the training is completed, as required by the proposed HIPAA security regulations. Be sure that your documentation method makes sense for your practice, she says. For example, once training is completed, you could fill out a form that includes the employee's name, dates of training, completion date, and access rights. Then have the employee sign off on the record as accurate.

If you give an employee immediate access to confidential health information without first training that employee and explaining his duty to maintain security and confidentiality of health information, you may be subjecting yourself to unnecessary risks, explains Grant. It's no different from giving a teenager the keys to your car without first giving him driving lessons, she says. ■

✓ Consider Outsourcing at Least One Audit

When planning an auditing schedule for your practice, consider hiring a professional auditor to get you started. Although in general it's a good idea to handle your compliance matters—including audits—internally, an outside auditor can look at your books with a fresh pair of eyes.

And that can really be helpful, says Atlanta health care consultant Jackie Miller.

For example, an outside auditor may recognize institutionalized errors in the way you code and bill that wouldn't be caught if your staff had conducted the audit. Miller once worked with a practice that billed all fine needle aspirations as needle core biopsies. The error wasn't picked up during internal audits, and it wasn't corrected until Miller pointed out the problem.

There are other advantages to having an outside auditor. A professional who audits medical practices may be more informed than you are about what CMS (formerly HCFA) and the OIG are looking for. Also, if there are systemic problems in your practice, they may receive more attention if the auditor makes your practice's owners aware of them. That's because a professional auditor probably has more credibility and clout than your billing manager or office manager. "So some practice owners are more likely to trust compliance information an outsider gives them than the same information their staff provides," Miller explains.

There's one other big benefit to hiring an outside auditor: Many outside auditors will train your staff in auditing techniques and will assist you in developing the internal expertise to implement the audit portion of your compliance plan. So even if you don't want to outsource all audit responsibilities, getting at least one outside audit—especially early on in your audit program—can really help you get your coding and billing house in order, Miller notes. ■

Insider Sources

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Reduce Risks When Interpreting Films Off-Site

Many radiology practices have agreements to review and interpret images taken by family practices, IDTFs, or other practices or facilities. Sometimes the agreement is that the radiology practice will provide an "overread" of the image, and sometimes the agreement is that the radiology practice will provide the

original interpretation of the image. Both of these types of arrangements are becoming very common. But there are significant malpractice risks associated with them, warns New York health care attorney Matthew Kupferberg.

We'll explain why it's riskier for your radiologists to interpret images

created off-site—that is, generated by another practice or facility—than it is to interpret images that were generated in your own practice. And we'll describe some steps you can take to minimize the risk that your radiologists will be slapped with a malpractice suit if they engage in off-site interpretations.

Off-Site Review Carries Malpractice Risk

Professional liability insurers are reporting an increase in malpractice lawsuits filed against radiologists as a result of off-site interpretations, says Kupferberg. Typically the suits arise in one of two ways:

1) A patient with a bad outcome will sue the treating physician and the practice or facility that took an image. And the insurer for the practice or facility will bring the interpreting radiologist into the suit.

2) A patient with a bad outcome will sue the interpreting radiologist directly, even though the patient was never referred to the radiologist or in the radiologist's office.

Although radiologists get sued by patients who come into their offices too, there are some special problems that occur more often when a radiologist interprets films generated off-site, Kupferberg remarks.

Reliance on referring practice.

Interpreting images off-site is riskier than interpreting images on-site because the radiologist has less control, Kupferberg asserts. The radiologist must depend on the competence of the referring practice or facility to provide good quality images, appropriate views, thorough history, and prior films. And it must rely on the referring practice or facility to act prudently and promptly in response to the radiologist's report.

Sloppiness. There may be a tendency among some radiologists to get a little sloppy when reading a film off-site because of logistical complications, Kupferberg says.

Example: A radiologist gets an X-ray to interpret and sees something that might be an anomaly but probably is just an artifact. If the patient had come to the radiologist's office and a history and prior X-ray were

available, the radiologist would likely review the history and make a comparison of the X-rays. But if all that information is across town and it would be an inconvenience to have it delivered, the radiologist might just assume he saw an artifact and leave it at that. Although this is an extreme example, radiologists do get in trouble this way, Kupferberg reports.

Get Six Protections When Performing Off-Site Interpretations

If you have an off-site interpretation agreement, there's not much you can do to completely avoid being sued for malpractice. But there are steps your radiologists can take to limit the risk, and to make it easier to defend a malpractice lawsuit. Here are Kupferberg's suggestions, along with Model Language that you can adapt and include in the off-site interpretation agreement you sign with the family practice, IDTF, or other practice or facility:

1) Check out equipment. Your radiologists are used to interpreting images taken on equipment of a certain quality. Don't enter into an agreement to provide interpretations if the equipment the referring practice or facility is using is of inferior quality, Kupferberg says. It's their obligation to make sure that the referring practice or facility has what it needs to produce good quality images. Also, your practice needs the right in the agreement to inspect the equipment. And your practice should have the right to terminate the agreement if the equipment the referring practice or facility is using is taking poor images.

Model Language

a. Warrant. Practice warrants and agrees that its radiographic equipment is adequate to produce high-quality radiographic images.

b. Inspection right. Radiologist may, at its sole discretion and upon reasonable notice, inspect such equipment for the purpose of ensuring

that it (i) will produce images of adequate quality for Radiologist to make an accurate diagnosis with a reasonable degree of medical certainty, and (ii) is being properly maintained.

c. Termination right. In the event that Radiologist determines, in its sole and absolute judgment, that images from such equipment are of inferior quality such that Radiologist may not make a diagnosis with a reasonable degree of medical certainty, Radiologist may terminate this Agreement upon ten (10) days' prior written notice.

2) Check out personnel. Your practice must also verify the techs' credentials at the practice or facility, Kupferberg says. "A good tech can assess the patient's complaint and history and will make sure that the radiologist gets an appropriate number of views, and the correct views, in order to make an accurate diagnosis," Kupferberg points out. A less competent tech is more likely to take fewer views—increasing the likelihood that the radiologist will miss a significant finding. So before your practice enters into an off-site interpretation arrangement, make sure you know exactly who'll be producing the image, Kupferberg says. And make sure the radiologists are comfortable with each tech's credentials and competence, he emphasizes. Your agreement should give your practice the right to inspect the credentials and licensure of everyone at the practice or facility who'll be generating images, as well as the right to refuse to interpret images if someone you have doubts about produced them.

Model Language

a. Warrant. Practice warrants and agrees that its technologists are appropriately trained, certified, and competent to produce high-quality radiographic images appropriate to the patient's condition or disease.

b. Inspection right. Radiologist may, at its sole and absolute discretion, inspect the credentials of Practice's technologists to ensure appropriate training, certification, and licensure; and may, with reasonable notice and

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at Radiologist's sole discretion, personally observe the technologists at work for the purpose of ascertaining the technologists' competence.

- c. Right of refusal.** Upon prior notice to Practice, Radiologist may refuse to interpret images produced by a given technologist at Radiologist's sole discretion.

3) Don't do interpretation if you don't like the images. Don't let your radiologists be pushed into interpreting images that they wouldn't interpret if they were produced in your office. If a radiologist needs a better quality image or an additional view, she must ask for it, he says. If a radiologist interprets a poor image or "makes do" when another view is necessary, the radiologist is committing malpractice, Kupferberg points out. Make sure your agreement with the referring practice or facility gives your radiologists the right to refuse to interpret an image under these circumstances, he says.

Model Language

Radiologist reserves the right to refuse to interpret any given image or set of images at the Radiologist's sole discretion if the image or set of images is, in the Radiologist's sole opinion, insufficient or inadequate to allow the Radiologist to render an accurate diagnosis with a reasonable degree of medical certainty.

4) Don't do interpretation in absence of patient history. Make sure that the referring practice or facility provides your practice with the patient's clinical history along with the image. It's crucial that your radiologist has access to the patient's clinical history as she interprets the image—she shouldn't have to request it specially. If the practice or facility doesn't provide the patient history, the radiologist shouldn't do the interpretation.

Model Language

Practice agrees to include a comprehensive patient history with every image or set of images it forwards to Radiologist. Radiologist reserves the right to refuse to interpret any image or set of images that is not accompanied by such comprehensive patient history.

5) Ensure access to prior films or images. Failure to compare prior images is a major reason radiologists lose malpractice suits, Kupferberg reports. The facilities and practices that your practice interprets for must realize that your radiologist needs to see all the patient's prior images if she's to provide a good interpretation. In your agreement with the referring practice or facility, make it responsible for tracking prior images and forwarding them along with the image they want interpreted.

Model Language

Practice warrants and agrees that it has established a system of tracking patient's prior images generated by Prac-

tice or in Practice's possession; and Practice agrees to forward all such prior images to Radiologist along with the current image or set of images, for purposes of clinical comparison. Radiologist reserves the right to refuse to interpret any image or set of images that is not accompanied by such prior images.

6) Take reporting seriously.

Comprehensive reporting is always important, but since off-site interpretation carries risks you can't totally control, you should concentrate on those aspects of the arrangement within your sole control, Kupferberg advises. One excellent way to defend a malpractice suit is by showing that the referring practice got a thorough, formal, written interpretive report that fully discusses the radiologist's findings, limitations to the findings, and recommendations, he notes.

Insider Says: Your malpractice insurer may have certain protocols it wishes your radiologist to follow if your practice is engaging in off-site interpretations. To be sure that your radiologists will be covered, check with your practice's insurer before you enter into an agreement for off-site interpretations—and follow the insurer's recommendations. ■

Insider Source

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