

# Radiology Administrator's

## Compliance & Reimbursement Insider

JULY 2002

### Get Your Hospital to Adopt Protocol on Radiology Test Orders . . . . . 1

Some hospitals don't allow radiologists to order diagnostic tests for inpatients, even though Medicare rules permit it. Here's a way to get your hospital to allow radiologists to order diagnostic tests.

► Model Protocol: Establish Test Order Protocol at Your Hospital (p. 3)

### In the News: New FDA Rule Says States Can Apply to Certify Mammography Facilities . . . . . 4

The FDA hopes to delegate some of its MQSA certification responsibilities to the states, which may mean fewer hassles for your practice.

### CMS Starts Publishing Quarterly Update for Providers . . . . . 5

Now you can find in one place all recent CMS publications that affect your radiology practice.

### Fight ERISA Plan Payment Denials by Savvy Use of Administrative Appeals . . . . . 6

Here's an effective yet little-known strategy to get your payment—without spending too much time or money.

► Model Letter: Use Letter to Start ERISA Appeals Process (p. 8)

### Semiannual Index . . . . . 10

### Show Your Lawyer . . . . . 10

#### IN FUTURE ISSUES

- Make Sure Your Staff Bills "Converted" Mammograms Correctly
- Accreditation Can Improve Quality and Help Market Your Practice
- Consider Executive Committee for Your Practice

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## Get Your Hospital to Adopt Protocol on Radiology Test Orders

Although radiologists in freestanding imaging centers and private practice must get an order from a treating physician before they can perform a test for Medicare patients, the rules are different for hospital-based radiologists. The law permits them to order a test or modify a treating physician's order on their own initiative—that is, without a treating physician's order—in the appropriate circumstances.

But many hospitals' internal policies or bylaws require their radiologists to get orders from a treating physician anyway. If your hospital has such a policy, we'll explain why it might be worthwhile to try to convince your hospital to change its policy and allow its radiologists to order tests and modify orders. We'll explain how this change in policy benefits patients. And we'll show you how to limit the risk associated with this change in policy. Finally, we'll give you a Model Protocol (see p. 3) that you can present to your hospital as an example of a simple, workable test-ordering policy.

### What Medicare Rules Allow

The general rule under Medicare—that a radiologist must have a treating physician's order to perform a diagnostic test—doesn't apply to diagnostic tests performed in a hospital, says Virginia health care attorney Thomas W. Greeson. So in the absence of specific regulations, hospitals should be guided by Medicare's conditions of participation (COP) for hospitals. The COP says that "Radiologic services must be provided only on the order of practitioners with clinical privileges...authorized by the medical staff and the governing body to order the services."

Because hospital-based radiologists are "practitioners with clinical privileges," says Greeson, there's no legal prohibition against their ordering tests.

There's no reimbursement issue, either, because any radiologic procedure ordered, performed, and supervised by an appropriately credentialed radiologist would be a covered service when performed in a hospital setting, Greeson explains.

**Insider Says:** CMS's instructions to carriers and intermediaries regarding diagnostic tests is available on the CMS Web site at [www.hcfa.gov/pubforms/transmit/R1725B3.pdf](http://www.hcfa.gov/pubforms/transmit/R1725B3.pdf).

### Arguments in Favor of Allowing Radiologists to Order Tests

Because radiologists are highly trained and fully licensed physicians, Greeson believes they should have the authority within the hospital to "do the right thing" for their patients—including ordering medically necessary tests and mod-

(continued on p. 2)

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## ADOPT PROTOCOL (continued from p. 1)

ifying existing orders. Plus there are medical reasons why it may benefit patient care to let radiologists order tests. So when trying to persuade hospital policymakers to allow radiologists to order tests, mention these two benefits to patient care:

**1) Radiologist may order more appropriate test than treating physician.** Technology in radiology is developing so rapidly that it's hard for anyone who isn't a radiologist or radiology tech to keep up. That's one good reason for radiologists to order tests when they think it's appropriate, says Dr. Leonard Berlin, chair of the Radiology Department at Rush North Shore Medical Center in Illinois. Sometimes a treating physician will order a test that he's familiar with. But another—perhaps newer—test that the treating physician doesn't have much experience with might be more appropriate for the particular patient. In that case, it benefits everyone if the radiologist can modify the order to perform the more appropriate test, Berlin notes.

**2) Radiologist may order needed follow-up test more quickly than treating physician.** The result of a particular test may indicate the need for another one, which the radiologist could order and perform right away. Or the patient's signs and symptoms may indicate that the patient should have a test in addition to the one the treating physician ordered. Berlin offers this example: A patient's treating physician orders a CT scan of the abdomen, but on reviewing the patient's complaints, the radiologist thinks it would be a good idea to get a CT scan of the pelvis, too. The radiologist ought to be able to order and perform the test without waiting for a treating physician's okay. That's better for the patient and more cost-effective for the hospital, Berlin remarks.

Greeson has heard of a hospital that wants the radiologists at its breast center to write orders for follow-up diagnostic mammograms and ultrasound studies. This way, the breast center can track those women who need close follow-up more easily, without depending on the treating physician to send the patient for follow-up mammograms and ultrasound.

## How to Respond to Arguments Against Allowing Radiologists to Order Tests

Although radiologists can legally order tests in a hospital setting, and the interests of patient care often favor it, many hospitals (and radiology departments) require radiologists to get orders from treating physicians before performing diagnostic tests. They give the following two reasons (for which we've provided appropriate responses):

**1) Fear of increased medical liability.** Some radiologists are concerned that their acceptance of greater responsibility for ordering diagnostic tests will lead to greater malpractice liability if there's a bad outcome. Also, treating physicians and hospitals are concerned that if the radiologist alters an order, and the patient has a bad outcome, the patient may sue the treating physician and hospital, too.

*Response:* Greeson believes that these issues may be overblown. In fact, a patient who wants to sue is most likely to sue everyone who treated her—regardless of who made the error. He suggests that radiologists can mini-

mize their individual liability by consulting the treating physician whenever possible and only adding tests or modifying orders on their own when the treating physician is unavailable. And like all medical liability issues, thorough documentation is the key to a successful defense. If radiologists take these steps, Greeson sees no reason why having the authority to order tests should increase their liability. "The point of granting a radiologist authority to order tests is to make the radiologist a part of the treatment team for the benefit of patients—not to convert the radiologist into a treating physician," he remarks.

## 2) Political or cultural obstacles.

Among older physicians, in particular, there's still a tendency to see radiologists as scientists, as opposed to physicians, says Berlin. Sometimes treating physicians don't like the idea of the radiologist's having direct communication with their patients, much less suggesting a particular test or describing a treatment plan, Berlin notes. These cultural or political issues are behind many hospitals' policies barring radiologists from ordering tests or modifying test orders, he believes.

*Response:* These old-fashioned, chauvinistic ideas are changing, Berlin says. Many younger physicians recognize that with radiologic technology developing so rapidly, it's hard for nonradiologists to keep up. So these physicians may be more willing to accept the radiologist's input.

Plus as radiologists are forced to take a more active role in communicating with patients—by the legal requirements of the Mammography Quality Standards Act, for example—treating physicians are getting used to radiologists' having more direct patient contact. Treating physicians have been reassured that the radiologist isn't going to undermine their

relationship with their patients, Berlin remarks.

Finally, managed care has changed the physician-patient relationship, Berlin believes—that is, patients don't go to the same physician for decades anymore. This change has lessened the degree of "paternalism" treating physicians exert over their patients, and has made treating physicians more open to the concept of having a radiologist on the treatment team.

## How to Change Hospital Policy

If your hospital's policy doesn't let radiologists order a diagnostic test or modify an order without prior approval from the treating physician, you may want to try to change that policy, Greeson says. The way you go about it will depend on the origin of the policy:

**Bylaws.** Some hospitals' bylaws bar the radiologist from ordering tests. In that case, you'll need to get the medical staff to amend the bylaws.

**Hospital credentials.** Your hospital may not credential radiologists to order tests. In that case, you'll have to approach the credentialing committee to make the change.

**Radiology department rules.** Some radiology departments have rules that bar radiologists from ordering tests. In that case, you'll have to canvas the department chair and other radiologists in the department and, if necessary, convince them that it's in everyone's interests to make the change.

## Adopt Test-Ordering Protocol

You can use protocol language, like our Model Protocol, to amend hospital

(continued on p. 4)

## MODEL PROTOCOL

### Establish Test Order Protocol at Your Hospital

If your hospital bars radiologists from ordering tests, you may want to approach the appropriate people at your hospital with this Model Protocol. It can be adapted as an amend-

ment to your hospital medical staff bylaws, presented to your hospital's credentialing committee, or adopted as a new rule for your hospital's radiology department.

#### RADIOLOGISTS' PROTOCOL FOR ORDERING DIAGNOSTIC RADIOLOGIC TESTS

1. ABC Medical Center recognizes that radiologists are fully licensed medical professionals and, accordingly, credentials radiologists to order a diagnostic test and/or modify a treating physician's order when such order or modification is medically appropriate in the radiologist's judgment.
2. If a radiologist orders a diagnostic test without a treating physician's order, or modifies a treating physician's order, the radiologist shall make every effort to communicate with the treating physician to discuss the new and/or modified test at or prior to the time the test is performed. In any event, the radiologist will provide the treating physician with an interpretive report of all tests performed, regardless of the source of the order. If the results of any such test are positive or equivocal, the radiologist shall directly communicate such results to the treating physician as soon as possible.
3. The radiologist must fully and completely document the reason for ordering any test or modifying any order. Such documentation should be written directly in the patient's chart or included in the radiologist's interpretive report, as appropriate.

**ADOPT PROTOCOL** (continued from p. 3)

medical staff bylaws, establish a new credentialing protocol, or change a radiology department rule. Like our Model Protocol, yours should:

**Permit radiologist to order test and modify order if medically appropriate.** Your proposal should permit a radiologist to order a test or modify an existing order only if there's a documented medical reason to do so [Protocol, par. 1]. The treating physician is still the best source for the order of any test, Greeson states—and the protocol should reflect that. That's medically appropriate, and it will help you convince your colleagues to adopt the protocol if it's clear the radiologists

aren't trying to step on the treating physician's toes, Berlin remarks.

**Require radiologist to inform the treating physician as soon as possible.** Your protocol should make clear that the radiologist must inform and/or consult the treating physician as soon as possible whenever the radiologist orders a test or modifies an order. The radiologist must provide an interpretive report of all tests to the treating physician—regardless of whether the treating physician or the radiologist ordered them. And the protocol should emphasize that if the radiologist gets a test result that is positive or equivocal, the radiologist must communicate the result directly

to the treating physician at the first opportunity [Protocol, par. 2].

**Require radiologist to document reason for order or modification.** For everyone's protection, documentation requirements should be set forth in your protocol [Protocol, par. 3]. Thorough documentation of the reason for ordering any test or modifying an existing order is key to easing any fears about added liability associated with radiologists taking more responsibility for test orders, Greeson says. ■

**Insider Sources**

**Leonard Berlin, MD:** Rush North Shore Medical Center, 9600 Gross Rd., Skokie, IL 60076.

**Thomas W. Greeson, Esq.:** Reed Smith LLP, 3110 Fairview Park Dr., Ste. 1400, Falls Church, VA 22042.

**I N T H E N E W S**

## New FDA Rule Says States Can Apply to Certify Mammography Facilities

In May, the FDA published final *MSQA regulations* that describe how a state can apply to be the certifying agency under the *Mammography Quality Standards Act* (MQSA). The state could then handle all aspects of the MQSA certification process for mammography facilities within its borders.

Currently, several private or government agencies may be involved in different aspects of certifying a mammography facility under MQSA in any given state. The new rule aims to streamline the MQSA certification process in those states that opt to handle MQSA certification for their local facilities. We'll tell you what the final rule says and what it might mean to you.

### Current Process Is Cumbersome

Mammography facilities are subject to myriad federal, state, and local

regulations. Plus many state and local governments have separate inspection requirements or specific regulations dealing with facilities that emit radiation or produce radioactive waste. Complying with all these regulations is a cumbersome process because different agencies oversee different aspects of a facility's operation—so you may feel as though a different agency is contacting you every week.

The FDA is hoping to ease the administrative burden on facilities by delegating its certification duties under the MQSA to the states, says FDA Consumer Safety Officer Roger Burkhart, who's in charge of the state certification program. The MQSA established national minimum quality standards for mammography and mammography facilities. Every mammography facility must be certified under the MQSA. And to meet this

MQSA certification, a mammography facility must do the following:

- Comply with certain standards regarding personnel, equipment, quality assurance (QA) procedures, and reporting and record keeping;
- Submit to a clinical quality evaluation every year; and
- Undergo an annual inspection conducted by an FDA-certified government inspector.

The MQSA permits the FDA to delegate MQSA certification duties to others—and the FDA has done so to some extent, Burkhart notes. To date, the FDA has accredited certain states and organizations to handle different aspects of this certification process. For example, it accredited:

- The American College of Radiology and the states of Arkansas, California, Iowa, and Texas to conduct the MQSA-mandated annual clinical

quality evaluations of mammography facilities; and

- 47 states, the District of Columbia, New York City, and Puerto Rico to conduct the MQSA-mandated annual inspections of mammography facilities.

### **New Rule Lets Each State Apply to Handle All Parts of MQSA Certification**

Because the FDA recognizes that mammography facilities are subject to oversight by many private, state, and local entities, it's trying to make MQSA compliance and certification as simple as possible, Burkhardt remarks. The FDA is committed to simplifying the process for facilities by allowing states to take over more MQSA certification responsibilities and encouraging them to do so, he says.

The FDA wants the states to have the option to handle *all* the steps connected with MQSA certification—including issuing, renewing, revoking, and suspending MQSA certificates; conducting annual facility inspections and follow-up inspections; and implementing and enforcing the MQSA quality standards.

### **States Must Meet Certain Requirements**

Each state won't automatically be accredited to act as an MQSA-certifying agency, Burkhardt explains. Instead, the state must demonstrate that it can take over the MQSA certification process and maintain MQSA quality standards at mammography facilities. The FDA wants this process to be easier for mammography facilities, but not at the expense of the quality of services the health care consumer can expect."

In order to be considered for accreditation as an MQSA certification agency, a state must demonstrate that it:

- Has enacted laws and issued regulations at least as stringent as MQSA standards;
- Has the legal authority—and the qualified personnel—to enforce those laws and regulations;
- Has the financial resources necessary to administer and enforce those laws and regulations; and
- Has a process in place to provide the FDA with information and reports about its MQSA certification program, as required.

Burkhardt notes that several states are already in the process of applying to be accredited MQSA-certifying

bodies, and the agency hopes more will follow suit soon. The agency hopes that if more states take over all the MQSA certification responsibilities, the regulatory burden on mammography facilities will be diminished, and the expense associated with MQSA certification may be reduced in some cases.

### **FDA Retains Certain Rights**

Under the final rule the FDA will retain certain rights and responsibilities, such as:

- The right to revoke a mammography facility's MQSA certificate or impose other appropriate sanctions against a MQSA-certified mammography facility; and
- Exclusive responsibility for establishing MQSA quality standards, approving or withdrawing approval of accrediting bodies, approving or withdrawing approval for state MQSA certification agencies, and maintaining oversight of state MQSA certification programs. ■

#### **Insider Source**

**Roger Burkhardt, PhD:** Consumer Safety Officer, Division of Mammography Quality and Radiation Programs, FDA, 1350 Piccard Dr., Rockville, MD 20850.

## **CMS Starts Publishing Quarterly Update for Providers**

On April 22, 2002, CMS published the first issue of a new publication called "Quarterly Provider Update—The One Source for National Medicare Provider Information" (Provider Update). CMS posted this first issue of the Provider Update on its Web site, and it plans to post a new issue on the first business day of each quarter—in January, April, July, and October.

According to a press release, the purpose of the Provider Update is to make it easier for providers to

understand and comply with Medicare regulations and instructions. In the press release, the administrator of CMS is quoted as saying that CMS believes communicating new or changing requirements to providers on a predictable schedule will help them improve care for Medicare beneficiaries.

We'll tell you what information will be included on the Web site, and how you can access the information you need.

### **What's on the Web Site?**

The press release says that each Provider Update will contain the following:

**New regulations.** It will give a list of all regulations CMS published in the *Federal Register* during the preceding quarter. This list will include the *Federal Register* citation of each regulation, as well as a summary of each regulation.

(continued on p. 6)

**QUARTERLY UPDATE** (continued from p. 5)

**Pending regulations.** The Provider Update will also include a list of the regulations CMS plans to publish in the *Federal Register* over the next 90 days. But according to the CMS press release, the list of upcoming regulations won't include any detailed information on them—you'll have to wait for publication in the *Federal Register* for that.

**Recent nonregulatory changes.** The Provider Update also will include certain nonregulatory changes that may affect providers, which were issued during the past quarter. For example, it will include *Medicare Carrier Manual* updates and instructions, and Program Memoranda and Transmittals.

### How to Find Information You Need

To access the Provider Update on the CMS Web site, go to <http://www.cms.hhs.gov/providerupdate>.

**Search by profession.** If you want to know about all recent CMS activity that affects you, the top of each Provider Update is organized into information for:

- Consumers;
- Professionals; and
- Public affairs.

Clicking "professionals" brings you to information organized according to provider type (such as ambulatory surgical centers, physicians, and hospitals). If you then click on the appropriate provider type, you'll see a list of the regulations affecting that provider type.

**Search by document or subject.** If you're looking for a specific document, and you know what type of change or the subject of the regulation you're looking for, the table of contents organizes changes according to subject matter:

- Listings for Medicare+Choice Organizations;

- Listings for Medicaid, which include regulations published in the preceding quarter, regulations published in the current quarter, and regulation under development in the current quarter;

- Listings for other CMS business, which include other business regulations published last quarter, other business regulations published in the current quarter, and other business regulations under development in the current quarter;

- Regulations and instructions for this quarter, which, despite the title of the category, include regulations published in the preceding quarter, regulations developed in the current quarter, as well as meeting notices, instructions released in the current and preceding quarters, program memoranda released in the current quarter, and manual transmittals released in the current quarter. ■

## Fight ERISA Plan Payment Denials by Savvy Use of Administrative Appeals

If your physician practice is typical, you probably find it frustrating to deal with payment denials for patients who are members of a plan governed by the Employee Retirement Income Security Act (ERISA). Most ERISA plans, which typically are self-funded by employers or other payors, are exempt from state laws that might help a practice get paid. And it's hard for a practice to win a payment lawsuit against an ERISA plan in federal courts, which often defer to plan decisions to deny payment on a claim.

Fortunately, there's an easier, better way to try to get a payment denial overturned, experts say: Use the plan's internal administrative appeals

process to appeal the denial on the patient's behalf. You must appeal the denial the right way to increase your chances of winning the appeal—or of winning in court quickly if the plan refuses to overturn the denial. We'll tell you what steps you should take. And we'll give you a Model Letter you can adapt and use to start the appeals process (see p. 8).

### Why Use Plan's Administrative Appeals Process?

Many practices don't bother to appeal payment denials by ERISA plans. And those that do, go straight to court and sue instead of using the plans' administrative appeals process.

But that's a mistake, according to Washington, D.C., attorney Sherwin Kaplan. "A provider's best shot at overturning a denial is to use the plan's administrative appeals process," he says. During the appeals process you get to ask for all the documents the plan used to decide your claim, challenge the plan's decision, and submit information to show that the plan should pay the claim.

Often a well-crafted administrative appeal will be enough for a plan to overturn its initial denial and pay you. "After all, your real goal is to get paid, not to have to sue the plan," points out Illinois chiropractor Jin Zhou, who frequently uses the admin-

istrative appeals processes to appeal ERISA plans' payment denials. "Since 80 percent of all claims involve ERISA, it's worth it to learn how to appeal these denials," he says.

There's an added benefit to using a plan's administrative appeals process. If you're savvy about what documents to ask the plan for, and the plan gives you those documents, you'll have more information to help you challenge the denial. If the plan doesn't give you those documents and refuses to overturn the denial, that gives you better legal ammunition if you decide to sue. You can ask the court to rule in your favor immediately (called "summary judgment") based only on the record of documents created during the administrative appeal proceeding.

"During the appeals process, the plan is obligated to produce the documents you've asked for within 30 days of getting your request for them," says Baltimore attorney Christine Williams. "If it doesn't, then many judges will conclude that it didn't act fairly, and won't give it a chance to present new evidence once the case goes to court," she explains.

If the plan didn't give you documents you asked for as part of your appeal, the court is much more likely to agree to rule immediately, and to rule in your favor, says Zhou, who has gotten several denied ERISA claims paid this way.

It's also much cheaper to appeal ERISA denials than you may have thought. Unless the claim is extremely complicated or involves many documents, you don't necessarily need an attorney to appeal a payment denial through a plan's administrative appeals process, says Kaplan. And if the plan didn't give you the documents you requested during your administrative appeal, and later you

need to get an attorney and sue, you'll spend much less money, time, and effort if neither you nor the plan is allowed to submit any new evidence, says Williams.

**Insider Says:** A new ERISA regulation, recently adopted by the U.S. Department of Labor, expands the types of documents that plans are required to provide during the administrative appeal process, says Williams. The regulation will apply to claims filed as of the first day of the first plan year beginning on or after July 1, 2002 (but it will apply no later than Jan. 1, 2003). It was originally scheduled to go into effect on Jan 1, 2002, but was delayed. You can find the regulation on the Internet at [www.access.gpo.gov/su\\_docs](http://www.access.gpo.gov/su_docs). Click on a search of the *Federal Register*. The regulation is in the Nov. 20, 2000, *Federal Register*, Vol. 65, p. 70246.

### Take Three Steps

To maximize your chances of using a plan's administrative appeals process successfully, take these three steps, experts say:

**Step #1: Get right to appeal from member.** To use a plan's administrative appeals process to appeal a claim denial, you need to represent the member and appeal the denial on her behalf, not on your own behalf. "ERISA grants the right to use a plan's appeals process to the patient, not the provider who treated the patient," says Kaplan.

It's relatively easy to file an appeal on a member's behalf. The best way is to get the member to appoint you as his authorized representative to appeal the denial. "Then there's no doubt about your right to appeal," says Williams. Some plans may have additional procedures for you to follow to be appointed a member's authorized representative.

If you don't have a formal authorization, you may still be able to appeal the payment denial on behalf of a member if the member signed a broadly worded "assignment of benefits" form granting you the right to the member's plan benefits, including the right to appeal on behalf of the member. Typically, an assignment of benefits form says that the member transfers to you the right to get paid directly from the plan. Some plans and courts will accept an assignment of benefits form as adequate proof that you also have the right to appeal the denial on the member's behalf, but only if the assignment is written broadly enough, notes Zhou. If you're not sure whether your assignment of benefits form gives you the authority you need, ask your attorney to review it for you.

**Step #2: Send letter.** Send a letter to the plan to get the appeals process started. You should send your letter to the person who handles the plan's administrative appeals process. If you don't know who that is, call the plan and find out. Like the *Insider's Model Letter*, your letter to the plan should:

► *Explain that you're the member's authorized representative.* You need to tell the plan that you have the authority to file the appeal and to get the documents you're requesting. If you don't have the authority, then the plan has no obligation to deal with you, says Kaplan. "The plan needs to be put on notice that you're the member's representative," he says. You should also tell the plan that you've attached a form proving that you're the member's representative [Ltr., par. 1].

► *Say that you're appealing the denial, and ask about appeal procedures.* Let the plan know that you'll be appealing its denial of the claim.

(continued on p. 8)

**FIGHT ERISA** (continued from p. 7)

This starts the administrative appeal process, says Kaplan. Also, ERISA allows plans flexibility in how they establish and implement their admin-

istrative appeals process. Since each plan's process will differ, you'll need to ask the plan to tell you its procedures and timelines so that you can follow them yourself and make sure

the plan complies, says Kaplan [Ltr., par. 2].

► *Request documents.* Ask the plan for the documents you'll need to conduct an appeal. "Your request

**MODEL LETTER****Use Letter to Start ERISA Appeals Process**

Here's an example of a letter that you can adopt and send to an ERISA plan to appeal a payment denial. The letter was prepared with the help of Jin Zhou, a chiropractor who has used a similar letter, and attorney Sherwin Kaplan. Send the letter to the person who handles the plan's administrative appeals process.

Paragraph 1 of the letter informs the plan that you have the authority to appeal the payment denial on the member's behalf. Paragraph 2 says that you'll be filing an appeal, and asks the plan to provide you with its specific procedures and timelines

so that you can follow them. Paragraph 3 asks for all of the documents you need to appeal the denial. Paragraph 4 warns the plan that if it doesn't give you those documents within ERISA's 30-day deadline, it has caused the member harm, and "an adverse inference will be drawn" against the plan. Paragraph 5 gives your telephone number to the plan.

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

**BY CERTIFIED MAIL**

[insert date]

**Re: Jane Smith, patient; Claim # [insert claim #]**

Dear Ms. Doe:

1. We are in receipt of your denial of the above claim. Please be advised that we have been authorized to file an appeal of that claim denial on behalf of Jane Smith. A copy of our valid form authorizing us as Ms. Smith's representative hereunder is attached for your information.
2. We are hereby notifying ABC Plan that we intend to appeal the denial of the above claim. Please provide us with your procedures and timelines on your administrative appeals process so that we may proceed accordingly.
3. As the authorized representative of patient Jane Smith, we hereby request the following specific documents so that we can prepare and file our appeal:
  - The plan's summary plan description explaining its benefits, and all other documents regarding benefits;
  - All documentation the plan considered in denying the claim;
  - All documentation relating to the claim that the plan had or received but didn't consider in denying the claim;
  - All documentation indicating the grounds the plan or its agents used to decide the claim, including its utilization review criteria, the criteria used by third-party reviewers, any contracts between the plan and any third-party administrators, and any reports from third-party reviewers;
  - The plan's guidelines in reviewing and deciding claims, including lists of factors used to decide claims, and restrictions, such as age;
  - The plan's rulings in other, similar claims;
  - Documentation showing whether the plan was consistent in reviewing and deciding claims;
  - The plan's usual and customary fee schedule and formulae for determining it.
4. Please be advised that if ABC Plan fails to provide the above-requested information within the 30-day limit imposed by the Employee Retirement Income Security Act, ABC Plan will have caused harm to Ms. Smith, an "adverse inference" will be drawn by us, and we will ask any court to do the same.
5. If you have any questions or would like to discuss this matter, please call us at (123) 456-7890.

Yours truly,  
John Jones, Administrator  
XYZ Radiology

should be broad but spell out the specific types of documents you want," says Williams. Make sure your request is reasonable, warns Kaplan. "If you ask for information you clearly don't need, the plan has a good reason to deny your request, and the plan or a judge will take you less seriously," he says.

The documents you ask for should include:

- The plan's summary plan description explaining its benefits, as well as any other documents explaining them;
- All documentation the plan considered in denying the claim;
- All documentation related to the claim that the plan had or received but didn't consider in denying the claim;
- All documentation indicating the grounds the plan or its agents used to decide the claim, including its utilization review criteria, the criteria used by third-party reviewers, any contracts between the plan and any third-party administrators, and any reports from third-party reviewers;
- The plan's guidelines in reviewing and deciding claims, including lists of factors used to decide claims, and restrictions, such as age;
- The plan's rulings in other, similar claims;
- Documentation showing whether the plan was consistent in reviewing and deciding claims;
- The plan's usual and customary fee schedule, and formulae used to determine it, if applicable to your denial.

It's important to ask a plan about both its and any third-party reviewer's utilization review criteria because they sometimes differ, says Kaplan. "If an outside utilization review company applied criteria that you didn't know about or that are different from what the plan required, then you have a

good argument that the denial was unfair and the criteria aren't valid," says Kaplan [Ltr., par. 3].

► *Warn plan of consequences.* Tell the plan that if it doesn't give you the requested documents within ERISA's 30-day deadline for providing them, it will cause you harm, and you will ask the court to "draw an adverse inference" against the plan. That means you ask the court to assume that the plan is treating you unfairly, says Williams. "If the plan wasn't fair in the administrative process, the court is more likely to bar the plan from submitting additional evidence and rule in your favor," she says [Ltr., par. 4].

► *Provide telephone number.* It's a good idea to give the plan a telephone number so it can ask any questions it has or contact you about the appeals process or the claim itself [Ltr., par. 5].

### Step #3: Submit your evidence.

After the plan has responded to your request for documents, submit your evidence to the plan to support your position that the denial should be overturned. What you submit will vary based on the claim and what you find. You'll want to describe the reasons the denial should be overturned, and attach all clinical and other documentation to support your reasons. For instance, you would probably want to submit the patient's medical record, any supporting information, such as articles from medical journals, or clinical treatises, says Williams.

There may also be significant information in the documents the plan gave you. For instance, you may find that the plan mistakenly denied the claim because it misidentified which person in the member's family you treated, says Kaplan. In that case, you should include documentation in your appeal that points out the plan's mistake. "An ERISA

appeal can be short, but you should include everything that may help," says Williams.

And if the plan refused to give you some or all of the documentation you asked for, point out in your appeal that this refusal causes harm to the member, and that an "adverse inference" should be drawn, says Williams.

There's also the possibility that the plan's response to your document request will show that the plan denied the claim properly, and you have no right to get paid, warns Kaplan. In that case, there's no point in filing an appeal. "But at least you know that now, and you won't waste any more energy trying to get the plan to pay your claim," he says.

### If Plan Sticks to Its Denial

Sometimes the plan will overturn its original denial based on your administrative appeal, says Williams. But if it doesn't, and you still believe the claim is valid, or you need documents the plan has refused to send you to evaluate the claim's validity, you should check with your attorney and decide whether you want to sue the plan. If you do decide to proceed, and the plan has refused your document request, you'll at least have gotten yourself into the best position possible by the time you get to court, says Zhou. "This way, ERISA becomes one of the best protections for providers and patients, not one of the worst, as many of them believe," he says. ■

#### Insider Sources

**Sherwin Kaplan, Esq.:** Piper, Marbury, Rudnick & Wolfe, 1200 19th St. NW, Washington, DC 20036.

**Christine Williams, Esq.:** Gordon, Feinblatt, Rothman, Hoffberger & Hollander, LLC, 233 E. Redwood St., Baltimore, MD 21202.

**Jin Zhou, DC:** 1260 Bamberg Ct., Hanover Park, IL 60133.

## SEMIANNUAL INDEX

*This index lists all articles published in the Insider from January through June 2002.*

### ► ABNS

"Use Informational Brochure to Persuade Patients to Sign ABNs," March, p. 1.

### ► BILLING & CODING

"Ask the *Insider*: Billing for MRI Sedation," Jan., p. 4.

"Ask the *Insider*: Hospital-Based Practice May Bill Globally in Certain Circumstances," Feb., p.6.

"In the News: CMS Delays 2002 OPDS Changes Indefinitely," March, p. 5.

"Is Your Practice Adjusting to 'Definitive Diagnosis' Coding?" April, p. 7.

"2002 CCI Contains Some Changes for Radiology," March, p. 6.

"What's New in CPT 2002," Jan., p. 5.

### ► CMS (CENTERS FOR MEDICARE & MEDICAID SERVICES)

"CMS Introduces Streamlined Medicare Enrollment Process," May, p. 4.

"In the News: CMS Announces Medicare to Cover More PET Services," June, p. 4.

### ► COMPLIANCE PLANS

"Dos & Don'ts: Consider Outsourcing at Least One Audit," June, p. 8.

### ► FALSE CLAIMS

"How to Avoid Trouble as Insurers Target 'Over-Reads,'" Feb., p. 4.

### ► HIPAA

"Dos & Don'ts: Bar Employees From Keeping Passwords Near Computers," June, p. 7.

"Dos & Don'ts: Don't Give Employees Access to Health Information Until Training Is Completed," June, p. 8.

"HHS Proposes Changes to HIPAA Privacy Regulations," May, p.1.

"In the News: Providers Can Get More Time to Comply with HIPAA Electronic Transaction Standards," March, p.5.

"Six Rules to Help You Identify Protected Health Information," Jan, p.1.

### ► IDTFS

"Get Familiar With IDTF Supervision Requirements," Feb, p. 9.

### ► MAMMOGRAPHY

"Are You Ready for Mammography Equipment Phase-in Deadline?" April, p. 7.

"Ask the *Insider*: Billing for Mammogram of Patient With Breast Implants in Absence of Signs and Symptoms," Feb., p.6.

### ► MANAGED CARE

"Overturn Payment Denials When Plan Verified Coverage by Mistake," June, p. 1.

"Plugging Loopholes: Make Sure Contract Terminates Automatically if Plan Stops Operating," May, p. 9.

"Reducing Record Retention Requirements," April, p. 6.

### ► MEDICAL RECORDS

"Ask the *Insider*: Radiologists Must Provide Reports to Patients Upon Request," March, p. 10.

"Help Your Radiologists Dictate Thorough Reports," May, p. 6.

### ► OIG

"In the News: OIG Releases 2002 Workplan," Jan., p. 6.

"OIG Revamps Web Site," May, p.5.

### ► PHYSICIAN-HOSPITAL DISPUTES

"Ask the *Insider*: Radiologist Billing in ED Isn't Always Fraudulent," April, p. 10.

### ► PRACTICE MANAGEMENT

"Consider Compensation Options for Interventional On-Call Duty," March, p. 8.

"Don't Reveal Your Compliance Snafus Online—the Government May Be Listening," April, p. 8.

"How to Avoid IRS Interim Sanctions," Jan., p. 7.

"How to Improve the Performance of Employed Physicians," June, p. 5.

"Protect Your Practice When Hiring New Physicians," April, p. 1.

"Protect Yourself From Inaccurate Databank Reports," Feb., p. 7.

"Take Nine Security Measures When Employee Quits or Is Fired," Feb., p. 1.

### ► RISK MANAGEMENT

"FDA Warns of Pediatric Radiation Risk from CT Scans," March, p. 7.

"Reduce Risks When Interpreting Films Off-Site," June, p. 8.

### ► STARK

"In the News: Part of Stark II Delayed," March, p. 5. ■

## SHOW YOUR LAWYER

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

■ Final MQSA regulations: Fed. Reg., Vol. 67, No. 25, 2/6/02, pp. 5446–69.

■ Mammography Quality Standards Act: 42 USC §263b.