

# Radiology Administrator's

## Compliance & Reimbursement Insider

AUGUST 2002

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## Make Provisions for Patient Records When Closing or Selling Your Practice

Handling patient records is one of the most tedious, but important, administrative tasks that you face. According to your state's laws, you must retain patient records for a certain length of time, give patients certain rights of access to their records, and fulfill an ethical and legal obligation to maintain your patients' privacy. These record maintenance, access, and confidentiality obligations don't end just because a physician retires, closes, or sells his practice. In almost all states, the laws governing medical practice require physicians to ensure both the continued maintenance of records for the statutory period as well as patients' continued access to their records.

We'll explain the basic obligations physicians have regarding their patients' records in most states. We'll show you how you can comply with these obligations without having to keep all these records in your office. And we'll give you a Model Contract Clause (see p. 3) that your radiologist can adapt and use when he retires, sells, or closes your practice. The clause makes the buyer the radiologist's agent for record maintenance and patient access, and requires the agent to maintain the confidentiality of the records. It also frees the radiologist to give up possession of the records and responsibility for responding to patients' requests for them.

### Physicians' Obligations Regarding Patient Records

In most states, the physician is considered the owner of the medical records he generates, says New York health care attorney Matthew Kupferberg. But the concept of "ownership" in this case is limited because the physician can't just do whatever he wants with a patient's medical records. The laws governing medical practice vary from state to state, but there are some basic principles that apply wherever your practice is located, Kupferberg says. In general, a physician is obligated to:

**Generate a complete record.** A physician must clearly and thoroughly record the treatment he provides to each patient. This is not only required by law, but it's a physician's ethical obligation, as well, Kupferberg notes.

**Maintain the record.** A physician must store the patient's medical record for a minimum period set by state law. Usually the period is a certain number of years after the patient's last date of treatment, Kupferberg explains. For minors, the period is often a certain number of years after the patient reaches the age of majority, he adds.

**Protect the patient's confidences.** A physician must keep the patient's medical history, including the patient's medical record, confidential. Confidentiality issues are growing more complicated now that the *HIPAA privacy regula-*

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## CLOSING OR SELLING YOUR PRACTICE (continued from p. 1)

tions apply, Kupferberg points out. These regulations require providers to take various steps to keep their patients' protected health information (PHI) confidential—including giving patients a "notice of privacy practices" that tells how the provider may use the PHI.

The HIPAA requirements are in addition to the traditional confidentiality requirements imposed by medical ethics as well as by most states' laws. Although confidentiality requirements vary, some general rules of thumb regarding patient record confidentiality are:

- No one should have access to the patient's written record without the patient's consent;
- The physician may not discuss the patient's condition without the patient's consent; and
- The physician may not dispose of an old record in a manner that could violate the patient's privacy.

Plus if there's anything in the record pertaining to substance abuse treatment, certain federal confidentiality laws may be triggered. And many states have special rules for handling medical records that contain references to HIV, sexually transmitted diseases, and rape and incest. Your state medical society can tell you if there are special rules in your state.

**Insider Says:** When you develop your notice of privacy practices to give to patients, include a sale or closure of your practice as one circumstance under which your radiologist may disclose a patient's PHI, Kupferberg says. That way your patients will be aware that if the radiologist leaves practice, another health care provider will be assuming control of the records and may be able to access the PHI in them, he remarks.

**Provide patient reasonable access.** In most states, patients are entitled to get copies of their medical records upon request, Kupferberg remarks. The specifics vary. For example, in some states the request must be made in writing, the physician may have a period of time in which to compile and copy the records, or the physician may be able to charge the patient. There are also some special cases to consider. For example, a radiologist must give a patient an original of her mammogram—not a copy.

## Appoint Agent to Fulfill Departing Radiologist's Obligations

A physician's obligations to maintain records, allow patients access to their records, and protect the patients' confidentiality don't end when he quits practicing, Kupferberg emphasizes. But fulfilling those obligations once the physician no longer has an office and a staff can present a big problem.

Some physicians move the records to their basement or garage when they retire. But that's a huge burden—patients may be requesting records for years after the physician ceases active practice. And there's a risk the records will be damaged or destroyed, Kupferberg explains. Maintaining confidentiality in those circumstance can be difficult. For instance, if the physician suddenly dies or is hospitalized, the physician's family members or executor

may be left to deal with the records. That's bad for the physician, for the patients, and for those left to deal with the records.

To avoid these problems, Kupferberg recommends that his retiring or relocating physicians appoint an agent to maintain patient records and respond to patient requests. Usually the agent will be another physician of the same specialty practicing in the same geographic area. Here's how to appoint an agent when:

**Closing practice.** If the practice is just being closed, not sold, it's usually not difficult to find a physician in the same specialty who will agree to act as the generating physician's agent for medical records. After all, the patients may wind up coming to the agent for their medical care now that their physician is no longer practicing. If there are no other physicians practicing your specialty in your area, you may consider a physician of another specialty, or even a hospital. But whomever

you appoint should be a health care provider who's bound by state medical record confidentiality laws and HIPAA, Kupferberg suggests. And your radiologist should sign a contract with the agent that binds the agent to protect your patients' confidentiality, he adds.

**Selling practice.** If your radiologist decides to sell your practice, he should include a clause in the contract of sale designating the buyer as his

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## MODEL CONTRACT CLAUSE

### Make Written Agreement with Records Custodian

When your radiologist leaves practice he needs someone to continue to be responsible for handling your practice's medical records. He can handle the records himself, but it's a hassle and may be risky if something happens to him. New York health care attorney Matthew Kupferberg advises his clients to appoint an agent to act as custodian of the practice's records. The agent

could be the buyer of the practice, or another physician—or even a hospital—providing health care services in the same geographic area where your practice was located.

Here's a Model Contract Clause like one that Kupferberg uses in his practice sale contracts. Your attorney can easily adapt it to fit your special circumstances.

#### CUSTODIAN OF PATIENT RECORDS

- a. Buyer Is Custodian.** Seller designates Buyer as custodian of Practice's patient records, and Buyer agrees to assume all of Seller's responsibilities and obligations to maintain and handle Practice's patient records in accordance with all applicable laws and regulations, and ethical obligations as set forth by the American Medical Association. Buyer specifically agrees, warrants, and affirms that:
- i. Buyer, as custodian, will retain and maintain in good condition all patient records for the statutory period as required by applicable state and federal law and regulations.
  - ii. Buyer will protect and maintain the confidentiality of all Practice's patient records in accordance with all laws, rules, and regulations (including, without limitation, HIPAA privacy regulations). Buyer acknowledges that his duties and obligations as custodian do not entitle him to access the patient information contained in Practice's patient records without the specific written consent of the patient.
  - iii. Buyer will promptly respond to a patient's legal and valid requests for copies of his records in accordance with all applicable state and federal laws and regulations.
  - iv. Buyer will permit Seller reasonable access to specific patient records if such access is necessary to:
    - (A) Defend a medical malpractice lawsuit;
    - (B) Respond to a third-party payor audit; or
    - (C) Respond to any inquiry or investigation by any government administrative or law enforcement agency.

Such request for access must be made in writing and must set forth the specific records Seller requests access to and the reason access is desired.
  - v. Buyer will dispose of patient records in a manner consistent with all applicable laws and regulations and ethical obligations imposed by the American Medical Association.

## CLOSING OR SELLING YOUR PRACTICE

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agent. The agent would assume the responsibility to maintain the patient records and respond to patient requests. We'll discuss this clause in detail below.

### What Agent Agreement Should Say

Whether your radiologist is selling your practice or just closing it, she should have a written contract with the agent she appoints to maintain patient records. Our Model Contract Clause is one Kupferberg uses in the practice sale contracts he negotiates, but your attorney can easily adapt it to fit your special circumstances. Like our Model Contract Clause, your clause should:

**Designate the buyer as an agent—or “custodian”—of medical records.** The agent agrees to assume all of the seller's obligations with regard to the medical records [Clause, par. a].

**Require the agent to maintain the records for the period of time the law in your state requires.** [Clause, par. a (i)].

**Bar the agent from accessing the information in the records without the patient's consent.** The clause should make clear that although the agent has physical custody of the records, he has no right to the information contained in the records unless the patient agrees [Clause, par. a(ii)].

**Require the agent to respond to patients' requests for records in accordance with all applicable laws.** Your attorney will adapt the clause based on what your state law requires [Clause, par. a(iii)].

**Give your radiologist reasonable access to the records in certain circumstances.** For instance, if he's sued for malpractice, or if there's a third-party payor audit or a state licensing board investigation, he may need access to the patient's records to defend himself. This is very important, Kupferberg explains, because a physician can be audited or sued years after he last treated a patient.[Clause, par. a(iv)].

**Obligate the agent to dispose of old records appropriately.** The agent should be able to get rid of records after the statutory period to maintain them has expired, but must dispose of them in a manner that doesn't breach the patients' confidentiality [Clause, par. a(v)].

### Notify Patients

Some states require a physician who's leaving practice to notify patients that he'll no longer be practicing. And it's important to do this even if your state doesn't explicitly require it, Kupferberg says. That's because patient abandonment is an ethical violation and professional misconduct—in some states it's even a crime. Also, abandonment is a basis for malpractice suits.

So give your patients at least 30 days' written notice if your radiologist is going to retire, sell your practice, or close up shop, Kupferberg suggests. Your letter should inform patients where their records will be and how to get copies of them. Be sure to tell your patients who your designated records agent will be.

Most medical and specialty societies—such as your state radiological society—provide sample practice closure letters to their members, as do medical malpractice insurers, Kupferberg says. Typically these sample letters include a records request form as a tear-off section or an attachment. It's best to use one of these sample letters because they're likely to cover all the necessary legal bases. You can always adapt it to add any personal expressions of gratitude or goodwill that you would like to share with your patients, Kupferberg notes. Many practices also place ads in local newspapers announcing a practice's closure or transfer of ownership, he adds. ■

#### Insider Source

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

### ► Most States Bar Physicians from Selling Medical Records

In most states it's illegal to sell medical records, says health care attorney Matthew Kupferberg. Although the number of active patients is one of the primary determinants of the value of a practice, physicians generally can't sell their patient records.

That's because most states protect a patient's right to choose who will provide his medical treatment and who will have access to his records. When selling their practices, physicians are selling the hard assets, like property and equipment, and “goodwill”—which is roughly related to the number of active patients they have and the quantity and quality of their referral sources, Kupferberg explains.

## I N T H E N E W S

### CMS Expands PET Scan Coverage

In a May 2, 2002, program memorandum, CMS implemented new National Coverage Determinations (NCDs) that expand Medicare coverage of PET scans for staging and restaging breast tumors in certain patients and assessing myocardial viability in certain patients. And CMS has issued several new and revised HCPCS codes that you should use when billing Medicare for PET scans for breast cancer and myocardial viability assessment.

The new NCDs go into effect Oct. 1, 2002. So if your practice offers PET scans, you must start familiarizing your staff with the NCDs as well as the appropriate HCPCS codes. We'll tell you what you need to know to get your staff up to speed.

#### **PET Scans for Breast Cancer Patients Covered in Some Cases**

Medicare will begin covering PET scans for some breast cancer patients on Oct. 1, 2002, says Georgia radiology coding consultant Melody Mulaik. The NCD says Medicare will cover PET scans "as an adjunct to standard imaging modalities" for breast cancer patients for the following purposes:

- Staging tumors in patients with distant metastasis;
- Restaging tumors in patients with locoregional recurrence or metastasis; and
- Monitoring tumor response to treatment for women with locally ad-

vanced and metastatic breast cancer when a change in therapy is anticipated.

But Mulaik points out that Medicare still doesn't cover PET scans for the initial diagnosis of breast cancer and staging of axillary lymph nodes. And PET scans will be covered in the above cases only when they're used as adjuncts to other imaging techniques like mammography or ultrasound, she emphasizes.

**New HCPCS codes.** CMS has issued three new HCPCS codes for PET scans for breast cancer patients. You can use these codes starting Oct. 1, 2002.

- G0252—PET imaging for breast cancer, *full and partial-ring PET scanners only*, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (such as for initial staging of axillary lymph nodes). Note that this code isn't payable because diagnosis and initial staging of breast tumors aren't covered by Medicare.

- G0253—PET imaging for breast cancer, *full and partial-ring PET scanners only*, for staging/restaging of local regional recurrence or distant metastasis; in other words, staging/restaging before or after a course of treatment.

- G0254—PET imaging for breast cancer, *full and partial-ring PET scanners only*, for evaluation of response to treatment, performed during course of treatment.

#### **PET Scan Assessment of Myocardial Viability Sometimes Covered**

Medicare currently covers PET scans to determine myocardial viability following an inconclusive single photon computed tomography test (SPECT). Starting in October, Medicare coverage will expand to include PET scans used as a primary or initial diagnostic study for determining myocardial viability before revascularization.

**HCPCS codes.** Mulaik says that PET scans for myocardial viability determinations should be billed using one of the following revised codes:

- G0230—PET imaging, metabolic assessment for myocardial viability following inconclusive SPECT study; *full and partial-ring PET scanners only*.

- 78459—PET myocardial imaging, metabolic evaluation; full and partial-ring PET scanners. Use this code for determination of myocardial viability as a primary or initial diagnostic study before revascularization.

**Insider Says:** You can get a copy of the CMS transmittal on the Web at <http://cms.hhs.gov/coverage/download/8b3-vv1.pdf>. ■

#### **Insider Source**

**Melody W. Mulaik:** Coding Strategies Inc, 168 N. Johnston St., Ste. 103, Dallas, GA 30132.

## ASK THE OIG

*From time to time, the Insider will report to you on OIG advisory opinions, letters, and other documents that answer specific questions from radiology practices and other providers about the legality of their arrangements.*

### Restructuring of Radiation Oncology Practice Won't Trigger Sanctions

Two physicians who own equal shares of a radiation oncology group asked the OIG whether their plans to reorganize the group into two legal entities would run afoul of the antikickback law. The group has a Certificate of Need (CON) to provide radiation therapy services at three locations. The group owns or leases the radiation therapy equipment at all three locations and provides professional services at each of them. The group proposes to reorganize so that the corporation that holds the CON would provide only radiation therapy services at each of the three locations. The physician owners would establish a new professional corporation to provide professional services at the three locations. The two physi-

cians would each own one-half of both corporations.

In a May 7, 2002, advisory opinion, the OIG declined to impose sanctions against the physicians' proposed reorganization. It noted that courts have interpreted the antikickback law to be violated if even one purpose of an arrangement is to obtain payment for referrals of services reimbursed by Medicare or Medicaid or to increase such referrals. But although splitting the radiation oncology practice into two separate corporations would lead to referrals between them, the OIG said the reorganization as described wouldn't create a substantial risk of fraud or abuse.

The OIG explained that the ownership of the radiation oncology

group wouldn't change, and that the three locations would continue to provide radiation oncology services in the same manner as they had before the proposed reorganization. So the OIG said the "mere reorganization of a unified radiation oncology group practice into two separate legal entities" wouldn't lead to an increased risk of fraud or abuse of the Medicare and Medicaid programs. But the OIG cautioned that any change in ownership or operation of the two corporations resulting from the reorganization might lead to a different result.

**Insider Says:** You can get a copy of the advisory opinion on the OIG's Web site at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0205.pdf>. ■

### Be Prepared for MQSA Inspection

If mammography is part of your practice, you know that you've got to be certified under the *Mammography Quality Standards Act* (MQSA) to operate a mammography facility. A facility that isn't properly certified may not receive payments under Medicare or any other government-supported health insurance program. Part of the MQSA certification process is an annual inspection by an MQSA inspector. There are standard things that an MQSA inspector looks for, says Roger Burkhart of the FDA's Division of Mammography Quality and Radiation Programs. We'll explain what the inspectors look for and the steps you can take to make sure you sail through your MQSA inspection.

#### What MQSA Inspectors Look for

There are several areas an MQSA inspector will look at, and it's important for you to be prepared in all of them, says Burkhart. You could have perfectly working state-of-the-art equipment and the most highly qualified personnel, and yet fail an inspection because your record keeping is sloppy. An MQSA inspector will evaluate the following during the inspection:

**Equipment.** The inspector will test all the mammography equipment at your facility—it doesn't matter whether you own or lease the equipment or even if you're just evaluating

a piece of equipment for possible purchase. If it's there, the inspector will make sure that it's operating properly and producing images of adequate quality.

**Equipment records.** The inspector will review the records for each mammography unit. These records include:

- Those pertaining to each unit's accreditation status;
- Evaluations of new or repaired equipment;
- The two most recent annual MQSA inspection reports;
- Quality control testing records; and

■ Written evidence of any corrective action the facility has taken regarding equipment operation.

**Quality assurance/quality control (QA/QC) personnel.** Mammography facilities must have extensive, formal QA/QC procedures in place, overseen by appropriately credentialed professionals such as an interpreting physician, a medical physicist, and a quality control technician. The MQSA inspector will check to make sure that the appropriate professionals have been designated to oversee the various aspects of the facility's QA/QC program and that their credentials are in order.

**QA/QC records.** According to the MQSA, mammography facilities must regularly perform certain tasks to ensure quality. These tasks include weekly phantom image tests, quarterly analyses of fixer retention in film, and semiannual reports of darkroom fog, to name a few. The MQSA inspector will look at the records of those tasks to make sure that all MQSA-required tasks were conducted properly, and that any deficiencies that were discovered were corrected promptly.

**Insider Says:** You can get a copy of the quality control test items, information about how often to conduct them, and examples of acceptable documentation on the FDA's mammography Web site, [www.fda.gov/cdrh/mammography](http://www.fda.gov/cdrh/mammography).

**Physicist's reports and documentation.** Each mammography facility must have a medical physicist conduct an annual survey to detect radiation leakage and other equipment problems. The facility must present the two most recent annual survey reports to the MQSA inspector. In addition to making these annual reports, a physicist must do a survey every time new equipment is installed in the facility. Burkhart points out that

“new” in this context means new to the facility and can include used equipment. Also, whenever a piece of radiographic equipment is disassembled for any reason, it must be re-inspected by the physicist after it has been reassembled but before it's used. You must keep all the physicist's inspection reports plus any documentation the physicist provides. And make all these reports and documentation available to the MQSA inspector upon request.

**Personnel qualifications.** The MQSA sets out the qualifications that the interpreting physicians, radiological technologists, and medical physicists who work in a mammography facility must possess. The MQSA inspector will examine the facility's personnel records to check that everyone who works there is appropriately qualified, has maintained appropriate licensure, and has kept up-to-date on his continuing medical education (CME) requirements. Failure to complete CME requirements in a timely manner—or to document that CME has been completed—can lead to deficiency findings in MQSA inspections.

**Medical records.** The MQSA is very specific about the types of information that a patient's medical record must contain. The MQSA inspector will select records at random to check that they're being generated and maintained correctly. And the inspector will check whether the mammogram results are sent to the referring physician and the patient within 30 days of the test. Also, in cases where the radiologist's findings are suspicious or suggest malignancy, the inspector will check to make sure that the results were communicated to the referring physician and the patient right away. According to Burkhart, inspectors sometimes find problems with medical records that can lead to written deficiency findings at facili-

ties that would otherwise pass an MQSA inspection easily.

**Medical audit and outcomes analysis data.** Mammography facilities are required to track positive findings on mammograms and correlate them with biopsy results. So facilities are required to request biopsy reports whenever they recommend a patient undergo a biopsy. Plus if a facility determines that a patient's mammogram is negative—meaning the film shows nothing suspicious—and then the facility subsequently learns that the patient has cancer, the facility must track that patient, too. Tracking patients with positive findings and false negative findings is called “outcomes analysis”—or doing an “outcomes audit.” It's meant to help the facility evaluate the quality of its services and improve them.

The facility must initiate this outcomes audit within 12 months of the facility's first becoming certified, and it must continually audit thereafter. The audit results must be reviewed at least every 12 months by a “reviewing interpreting physician” hired for this specific purpose. The MQSA inspector will check the audit records to see whether the audit is being conducted properly, whether the reviewer is appropriately qualified and making appropriate findings, and whether the facility is implementing the reviewer's findings and recommendations. The inspector also will check whether the facility is requesting and analyzing biopsy results promptly.

## Results of Inspection

The FDA inspector will analyze all the items above and make a note of any deficiencies. Ideally, your facility will sail through the process and get a report that says your facility is certified with “no findings.” But because

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**MQSA INSPECTION** (continued from p. 7)

there are many parts to the inspection, it's not unusual for the inspector to find a deficiency. Also, the FDA seems to be stepping up enforcement of the MQSA and coming down harder on facilities that show deficiencies, say several *Insider* sources who have had MQSA inspections recently.

There are three levels of deficiencies. The inspector assigns a level to the facility based on his opinion of the overall quality of the service the facility provides, evaluating everything he reviewed during the inspection as a whole.

- Level 1 deficiency is a finding that deviations from MQSA standards seriously compromise the quality of the service the facility offers. If the inspector finds a Level 1 deficiency, he sends a warning letter to the facility. And the facility must respond in writing and initiate corrective action within 15 days.

- Level 2 deficiency means that there are deviations that compromise the quality of service at the facility. A facility that gets a Level 2 finding must respond in writing to the finding within 30 days.

- Level 3 deficiency is the least serious finding and means that the facility is satisfactory, but there are some minor deviations that it should correct before the next inspection.

Burkhart notes that over the six years that the FDA has been conducting inspections, the number of facilities that pass without any findings has risen to over 58 percent of facilities inspected. But the number of facilities receiving Level 1 or Level 2 findings has also increased, to over 31 percent of facilities inspected. Burkhart suggests that the increase may be due to MQSA regulations that went into effect in 1991, and simply represents a learning curve while facilities adjusted to the new regulations. He also points out that if a Level 3 deficiency is identified but not corrected by the next inspection, the facility may receive a higher level of deficiency next time.

**Take Corrective Action**

If your facility gets a finding of deficiency when it's inspected, you should take immediate corrective action to protect your facility's right to continue to operate. The warning letter or notice of deficiency is generally quite specific about what the inspector didn't like. And it almost always will offer possible solutions to the problem(s). But, Burkhart reports, if you believe a different solution will work better in your facility, the FDA will generally accept it, as long as it solves the problem(s) the inspector found.

If the inspector made a finding of a Level 1 or Level 2 deficiency, you must immediately rectify the prob-

lem(s) and send a letter to the FDA explaining what action you took to solve the problem(s) the inspector found. If you don't respond promptly to a Level 1 or Level 2 finding, the FDA could shut down the facility or Medicare could refuse to reimburse you for services you provided before the problem was solved. When implementing the solution to the deficiency, be sure to document everything that you did to try to solve it.

Even if the inspector made a Level 3 deficiency finding—the least serious kind—you shouldn't ignore it, Burkhart advises. Instead, take immediate steps to correct the problem and make sure it won't recur—and document everything you did. Keep all those documents and records, and show them to the inspector at the next year's inspection. This is important because if a Level 3 finding isn't corrected by the next inspection, the inspector can assess a Level 2 or even a Level 1 deficiency at the next inspection for the same problem that merited only a Level 3 finding the first time. Fixing problems quickly and keeping good records of the action will help prevent minor problems from becoming major headaches. ■

**Insider Source**

**Roger Burkhart, PhD:** Consumer Safety Officer, Division of Mammography Quality and Radiation Programs, Food and Drug Administration, 1350 Picard Dr., Rockville MD 20850.

## Save Big Bucks by Using Check Sheets to Detect HMO Underpayments

You may be getting shortchanged on your managed care claims without realizing it. It's not unusual for managed care plans to pay physician practices less than the contract rate for services. This is usually the result of honest mistakes, not a deliberate attempt to cheat you. Even so, these

underpayments, if they go undetected, can cost you thousands of dollars each month.

To avoid these losses, you must detect whether a plan is underpaying you. There's a quick, easy, and inexpensive way to do this, says Houston CPA and billing consultant Reed

Tinsley. Create a reimbursement check sheet that lists the 20 or 30 services you most often bill and what the different plans you contract with are supposed to pay for each one. Tell your staff members to refer to the check sheet when they post payments so that they can tell if the

payment amount they're posting matches the contract rate listed on the check sheet. Here's how to use this strategy.

### **Why You Need to Check Plan Payments**

Plans sometimes inadvertently underpay (or overpay) the providers they contract with. One reason is that employees who process claims for plans generally work on a quota basis. That means they must process a specific number of claims per hour. This often leads to mistakes like punching in the wrong provider or clinic identification number on the computer. And this often causes the plan to pay the wrong amount.

Serious mistakes also occur when plan employees enter the provider contract into the plan's information system. For instance, Tinsley says, one client he represented negotiated a contract with a national HMO paying an across-the-board rate of 175 percent of Medicare. But the HMO inadvertently entered the payment schedule of another group that required it to pay only 80 percent of Medicare. For four months, nobody noticed the error. All the while, the HMO underpaid the practice on every claim processed.

### **Use Cross-Checking to Detect Underpayments**

The lesson: When a plan sends a payment, don't automatically assume it's the right amount. Check for yourself. The staff member who posts the payment should compare the amount listed in the explanation of benefits (EOB) form against the plan contract—specifically, the rate listed in the contract fee schedule, which is usually attached to the back of the contract.

This may sound like a cumbersome task, and it would be if it meant that staff members had to hack their way through a contract each time they posted a payment. But they won't have to do that if you give them a check sheet to refer to instead.

### **How to Create Check Sheet**

The check sheet is simple to create.

**List 20 to 30 common procedures.** In the left column, list the CPT codes of the procedures you most often bill plans for. Although your plan contracts may cover dozens of different procedures, listing every procedure defeats the purpose of having the sheet. It makes it hard for staff members to find at a glance the procedure they're looking for on the sheet. Instead, Tinsley says that you should list the 20 to 30 procedures that account for the largest part of your billings. "As a rule of thumb, these procedures should make up at least 70 percent of your volume," he adds.

**Write in plans' contract rates for each procedure.** Next, create a separate column for each of the plans you contract with. Then, list in each of those columns the dollar amount that the particular plan has agreed to pay for each of the procedures whose CPT code you listed on the left.

### **How to Use Check Sheet Effectively**

Here are some pointers to help you make the most effective use of the check sheet:

**Keep it handy.** Tell staff members to keep the check sheet on a bulletin board, near their computers, or in some other location where they can easily see it. Tinsley also recommends laminating the sheet.

**Check it when posting payments.** Whenever staff members post payments, they should refer to the check sheet to be sure that the payment amount they're posting matches the contract rate listed on the check sheet.

**Record and tally payment errors.** Open a payment check file for each plan you contract with. If a staff member discovers a payment error, she should circle the payment listing on the EOB, jot down the correct rate for that procedure under the contract, and put the EOB in that plan's file. At the end of the month, have your billing manager or another administrator go through the files and tally all the payment errors for each plan for that month. Then the billing manager can send each plan a letter itemizing each underpayment and requesting payment of the total underpayment amount for the month. (If you discover that you were overpaid, you should send the plan a refund.)

**Create a file for the EOBs of plans not listed on the check sheet.** These may be silent PPOs or out-of-network payors trying to claim discounts they're not entitled to.

**Revise your check sheet regularly.** Do this once a month, if possible. Payment arrangements can change quickly. Rate increases may take effect, you may contract with a new plan, or you may terminate a contract with an old one. As a result, check sheets quickly get stale. ■

#### **Insider Source**

**Reed Tinsley, CPA:** Reed Tinsley & Assocs., 19748 SH 249, #323, Houston, TX 77070; (281) 379-5988; reedt@theglobal.net.

## ASK THE INSIDER

RACRI welcomes questions from subscribers. You can 1) send your questions to Brownstone Publishers, Inc., "Ask the Insider," 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 2) fax them to (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail them to [jgormley@brownstone.com](mailto:jgormley@brownstone.com)

### Using the -QV Modifier

**Q** We're an academic practice, and from time to time we get patients who are getting services as part of a research study. There's some confusion in our office about how and when to use the -QV modifier. Is it appropriate for billing all services the participant gets in connection with the research study, or only for billing the services that are related to some adverse effect of participating in the study?

**A** You should use the -QV modifier whenever the patient is a Medicare beneficiary and is getting the item or service as part of, or as the result of, a Medicare-qualified clinical trial, says Georgia reimbursement consultant Melody Mulaik. That includes services rendered in the treatment of complications from the patient's participation in a Medicare-covered clinical trial, she notes. According to a National Coverage Decision (NCD) developed by CMS, Medicare will cover the routine cost of both a qualifying clinical trial *and* reasonable and necessary items and services that are used to diagnose and treat complications arising from a patient's participation in a qualifying clinical trial.

### What's a 'Designated Record Set'?

**Q** The final HIPAA privacy regulations include the new term "designated record set." Is it any different from what we traditionally call a medical record?

**A** Yes, a designated record set is different from a traditional medical record, says professional practice manager Gwen Hughes of AHIMA. According to the final HIPAA privacy regulations, a designated record set generally includes the medical and billing records used to make decisions about a patient, she explains. It doesn't include records that aren't kept in the medical and billing records.

Often, protected health information (PHI) that's created or maintained by a health care provider for administrative or other purposes isn't kept in a patient's medical or billing record, and therefore isn't part of a designated record set. Examples of locations where PHI may be found but not be part of a designated record set may include:

- Patient satisfaction surveys;

- Lists of patients who are due for certain diagnostic tests or medical treatments;
- Fund-raising records; and
- Working notes that are later summarized and dictated into the medical record.

Why the term is important. The term designated record set is important, Hughes points out, because of two rights that the regulations give to patients:

- The right to access PHI; and
- The right to request amendments to PHI.

These patient rights apply only if the PHI is contained in a designated record set, she says. For instance, if a patient requests copies of his PHI from his physician, the physician is required by the regulations to give the patient only PHI contained in the patient's designated record set. If a patient requests PHI that's not in the designated record set, the physician can deny the request. In the same way, if a patient requests an amendment to PHI that's not contained in a designated record set, that request can also be denied. ■

### Insider Sources

**Gwen Hughes, RHIA:** Professional Practice Manager, American Health Information Management Assn., 233 N. Michigan Ave., Ste. 2150, Chicago, IL 60601-5519.

**Melody W. Mulaik:** Coding Strategies, Inc., 168 N. Johnston St., Ste. 103, Dallas, GA 30132.

## 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.*

- HIPAA privacy regulations: Fed. Reg., Vol. 65, No. 250, 12/28/00, pp.82798-82829.
- Mammography Quality Standards Act: 42 USC §263b *et seq.* (1992).