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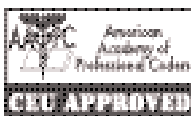

Organize Your Radiology Practice for Ease of Management

As recently as a decade or two ago, most radiology practices consisted of three or fewer physicians. But with managed care, government regulation, and the need for radiology practices to maintain expensive equipment to compete effectively, this has changed. Now, larger group practices make more economic and competitive sense. But a large group practice can be difficult to run efficiently and fairly—especially for physicians who have no formal training or expertise in management.

Many "old style" practices have no formal management structure at all, with the result that all shareholders may have a say in decision making. Juggling many different opinions while conducting business can lead to ill will among your physicians, inefficiency, and loss of business opportunities, says New Jersey health care attorney Michael F. Schaff. Worse, if everyone has a say in managing a large group practice, it's only a matter of time before the older physicians who founded the practice find themselves outvoted—or frozen out of decision making—by the younger physicians they brought into the practice, Schaff asserts.

One way to solve these problems is to establish a formal management structure for your practice as soon as it starts to grow—by setting up a board of directors and a management committee (or committees), says Schaff. We'll explain how a board of directors and a management committee can help a large group practice operate efficiently while preserving the authority—and the financial stake—of the physicians who started the practice. We'll give you a Model Amendment (see p. 3) that establishes a board of directors and gives the board the right to set up a management committee as well as other standing committees. Show this Model Amendment to your attorney, who can tell you which legal documents, depending on the legal form of your practice and which state you're in, you'll need to amend. Your attorney can adapt the amendment to suit your wishes for your practice's management structure.

Establish Board of Directors with Management Authority

Schaff recommends that the physicians in a small practice start considering establishing a board of directors as soon as they begin to think about adding physicians. Otherwise, Schaff notes, it may be difficult to make this change should the practice make new physicians partners in the practice. Before the founding physicians realize it, the newer physicians may outnumber them—and the practice may start heading in a direction that the founding physicians disapprove of.

Delegating management responsibility to a board of directors is one way to take full advantage of the benefits of being in a large group practice, while mak-

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ORGANIZE YOUR RADIOLOGY PRACTICE (continued from p. 1)

ing sure that the founding physicians maintain a majority on the board, will ensure that they retain their authority within the practice.

FAQs About How a Board of Directors Works

Here are the answers to some frequently asked questions about how a board of directors might work, with references to our Model Amendment. You can adapt the amendment language to suit your situation. Schaff suggests that the founding shareholders consider all of these questions and discuss them among themselves and with their attorney so that the amendment they adopt in your practice reflects their wishes.

The amendment should spell out the manner of selecting and removing directors, as well as their duties and responsibilities. Because some states have laws governing some or all of these issues, your attorney will discuss these issues with you to make sure that the amendment to your organizational documents reflects both the shareholders' wishes and state law requirements.

What are the responsibilities of the board of directors? You can make the board responsible for as much of the management of your practice as you choose. But Schaff recommends including as many management duties as possible. Some duties you may delegate to the board of directors include decisions about capital expenditures, personnel issues, purchase and lease of equipment and office space, and developing new business [Amend., par. 1].

Who should be on the board? You have several options for determining the makeup of the board of directors. The board may consist of:

- The founders of the practice or the more senior shareholders;
- The shareholders who have held their shares for some minimum period of time; or
- The shareholders with the greatest amount of equity in the practice.

Any one of the above options ensures that the founding shareholders retain control. But your amendment may instead mandate that directors be elected by a vote of all the shareholders.

Or you may decide to select directors by some combination of the above methods. For instance, in our Model Amendment, of five directors, the three physicians with the largest share of the practice's equity get to be permanent directors [Amend., par. 1a]. The other two "at-large" directors are elected by majority vote of all the shareholders [Amend., par. 1b]. This way, the founding shareholders (assuming they have greater equity) retain their influence, while the newer shareholders in the practice have some opportunity for input, too, Schaff says. You can use whatever method works best for your practice and allows you the most flexibility as your practice grows.

What if you need to remove a director? It's important to think about how you'll remove a director before you ever need to do it. So you should write a sort of prenuptial agreement for your practice, Schaff says. Because the purpose of the board is to establish management authority and stability, you may want to make it difficult to remove a director. One way to do that is to say that directors may be removed only for cause, by

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MODEL AMENDMENT

Amend Organizational Documents to Establish Effective Management

As a radiology practice grows, it may need to amend its organizational documents to reflect its founders' desire for a more formal, effective, and efficient management structure. Organizational documents can be the practice's corporate bylaws (for a professional corporation), its partnership agreement (for a partnership or an LLP), its operating agreement (for an LLC), and/or its certificate of incorporation (depending on the state). Your attorney can advise you about which documents to amend. Our Model Amendment assumes the practice is a professional corporation, but your attorney can adapt the amendment to fit any corporate form.

Our Model Amendment, written with the help of New Jersey health care attorney Michael F. Schaff, establishes a board of directors, states who may serve on the board, and defines the board's responsibilities. It also gives the board the right to establish and disband committees for various management or advisory purposes.

AMENDMENT TO ORGANIZATIONAL DOCUMENTS

WHEREAS, the owners of ABC Radiology intend to expand their practice and improve the range and quality of services it may offer its patients, and

WHEREAS, in order to fulfill this intention, ABC Radiology must establish a formal system to manage the practice's business affairs,

Now, therefore, the owners of ABC Radiology vote to amend their corporate bylaws as follows:

1. **BOARD OF DIRECTORS.** The Corporation shall be governed by a Board of Directors that shall be responsible for managing all aspects of the Corporation including, but not limited to:
   i. Capital expenditures and improvements;
   ii. Hiring and retention of personnel;
   iii. Compensation and benefits of employees;
   iv. Acquisition and maintenance of facilities and office locations;
   v. Business development; and
   vi. All other aspects of the management of the Practice.

   a. **Permanent Directors.** The Board of Directors shall have three (3) Permanent Directors. The Permanent Directors shall be the three (3) Shareholders who hold the greatest number of shares of the Corporation (and to the extent that there is equal ownership, the most senior). A Permanent Director shall serve until such time as he/she relinquishes some or all of his/her shares in the Corporation such that he/she no longer holds sufficient shares to qualify as a Permanent Director as set forth, above.

   b. **At-Large Directors.** The Board of Directors shall have two At-Large Directors. The At-Large Directors shall be elected by majority vote of all the Shareholders of the Corporation. The At-Large Directors shall serve for a term of three years unless removed for cause prior to the expiration of the term.

2. **COMMITTEES.** The Board of Directors shall have the power to create a committee or committees for any purposes that the Board of Directors may deem to be in the best interests of the Corporation, and to elect or appoint any of the Directors or Shareholders as members thereof, provided, however, that a vote of the majority of the total number of Directors shall be required to delegate any powers or authority of the Board of Directors to any such committee. All committees appointed without such majority approval of the Directors shall function in only an advisory capacity to the Board of Directors.

   a. **Ad Hoc Committees.** The Board of Directors may, at its discretion, establish a temporary, or ad hoc, committee to handle a discrete issue. The ad hoc committee shall be disbanded upon completion of its mandate.

   b. **Standing Committees.** The Board of Directors may, from time to time, authorize and appoint standing committees to handle certain matters that the Board shall, in its discretion, define. Each such committee is deemed discharged when a new committee is appointed for the same task. The following standing committees of the Board of Directors shall consist of three members, each of whom [*must/need not*] be a [*Shareholder/Director*] and who shall be appointed by the President of the Corporation:
      i. Auditing, Billing, and Compliance Committee, which shall be empowered to make recommendations to the Board of Directors pertaining to the billing practices of the Corporation and the Corporation's compliance with health care and hospital laws, rules, and regulations;
      ii. Compensation Committee, which shall be empowered to make recommendations to the Board of Directors pertaining to the amount of Physician/Shareholder compensation. The President shall be member and Chair of the Compensation Committee;
      iii. Management Committee, which shall be empowered to make recommendations to the Board of Directors pertaining to the day-to-day management of the Corporation's business.

   c. **Committees serve at Board's pleasure.** All committees established by the Board of Directors, whether standing committees or ad hoc committees, shall exist, and members thereof shall serve, at the pleasure of the Board of Directors, and the Board of Directors may disband or abolish any such committee and remove any member appointed or elected to it with or without cause at any time.

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ORGANIZE YOUR RADIOLOGY PRACTICE
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a unanimous vote of the board (except for the affected director). If you expect a number of changes over the next few years—say, if several of your senior shareholders may retire soon—you may want to make removal a little easier, Schaff says.

In our Model Amendment, permanent directors may not be removed unless they give up their shares in the practice, but at-large directors serve for a three-year period unless they're removed for cause. This gives the permanent directors—the senior shareholders of the practice—special protection against an uprising by the junior shareholders of the practice, Schaff points out [Amend., pars. 1a and 1b].

Consider Management Committees for Efficient Management

Even with a board of directors, it can be time consuming and stressful to make the decisions necessary to manage a large or growing group practice effectively, Schaff points out. And not every director will have the time, the skills, or the personality to handle every aspect of a practice's management. Some groups allow their board of directors to set up a management committee—or several committees—that are responsible for handling the day-to-day issues that arise, and Schaff thinks it's a good idea to do this. The committee(s) can meet regularly—Schaff recommends that management committees meet once a week—and can distribute minutes of their meetings to directors and/or other shareholders. Forming committees helps to ensure that no director is overburdened with management issues, and allows various shareholders of the practice to pursue areas they're interested in—like quality control or new technology, Schaff says.

Should committees be temporary or permanent? Temporary, or ad hoc, committees are useful for dealing with decisions that require research but aren't likely to be ongoing issues—for example, selecting a manager for the practice's retirement plan or choosing an interior designer for new offices. Schaff recommends permanent committees—called "standing committees"—to assume day-to-day responsibility for ongoing business and management issues [Amend., pars. 2a and 2b].

How much authority should committees have? You can set up committees any way you like. They can be purely advisory or the board of directors can delegate authority to certain committees. Our Model Amendment allows the directors to establish either of the two sorts of committees. A majority of the board must vote to delegate its authority to a committee, otherwise the committee's role is purely advisory [Amend., par. 2]. Doing it this way offers maximum flexibility, Schaff notes.

What committees should our board establish? What works in a given group depends on the size and culture of the group, the expectations of the shareholders, and the complexity of its business model, Schaff notes. He says committees are particularly effective at handling issues like personnel, compensation and benefits, compliance, and real estate—which may involve scouting new offices or locations, physically maintaining existing locations, and dealing with office leases. Our Model Amendment establishes standing committees to handle auditing, billing and compliance, compensation, and management [Amend., par. 2b].

Who should be a committee member? Like most other management issues, there are various ways to determine who can be on a committee. Some groups require the committee members to be directors. In other groups, any shareholder may serve. Sometimes a practice will require that the CEO of the practice serve as the chair of a certain committee—this is often the case with the compensation and benefits committee, for example [Amend., pars. 2a and 2b].

How do we disband a committee or remove a committee member? The board also should retain the power to disband a committee and/or remove an individual committee member at will. Keeping that power with the board leads to greater stability within the practice, Schaff says, because it helps prevent a small group of shareholders with "issues" from disrupting the management of the practice. Our Model Amendment makes clear that committees exist at the pleasure of the board and that members can be removed at the board's will [Amend., par. 2c]. ■

Insider Source

Michael F. Schaff, Esq.: Wilentz Goldman & Spitzer, 90 Woodbridge Center Dr., Ste. 900, Box 10, Woodbridge, NJ 07095.

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MQSA Policy Addition Clarifies Deadline to Correct Noncompliant Mammography Equipment

The *Mammography Quality Standards Act regulations* (MQSA), which set out national quality standards for mammography services, give mammography facilities until Oct. 28, 2002, to bring their mammography equipment into compliance with the law. If you're scrambling to replace outdated equipment by the deadline, there's good news—you may be able to relax a little, according to a recent addition to the MQSA policy guidance. We'll tell you what the addition says and what it means for your facility.

FDA Posts MQSA Addition on Web Site

From time to time the FDA posts new MQSA policy guidance—or a modification or addition to existing guidance—on its Web site. And that's what it did in March, says FDA mammography program spokesperson Roger Burkhart. "We wanted to make sure that mammography facilities are clear about what the Oct. 28 deadline really means to them," he says. Some facilities are preparing to take noncompliant equipment out of service on Oct. 28, and that may not be necessary, Burkhart explains.

The addition to the policy guidance is in the form of a question and answer. The question asks whether a facility that learns before Oct. 28 that its mammography equipment may not meet the new equipment requirements that go into effect on Oct. 28, must remove the noncompliant equipment from service on Oct. 28. The answer is no, according to the addition. A mammography facility needn't take any equipment out of service until the equipment fails a clinical quality control test, annual physics survey, or MQSA inspection test that's performed *after* Oct. 28, 2002.

But the addition goes on to say that the FDA "strongly recommends" that mammography facilities use the time between discovering noncompliance and the next test or inspection scheduled for after Oct. 28, 2002, to bring the equipment into compliance. If you wait until the equipment is documented as noncompliant before you start looking into repairing or replacing it, you could be in trouble. Once equipment is documented as noncompliant, there is a 30-day time limit for completing repairs.

***Insider* Says:** The FDA has compiled all its final guidance documents about the MQSA into a computerized Policy Guidance Help System. You can find it at www.fda.gov/cdrh/mammography/guidance-rev.html. To see the addition, click on "What's New," and then click on "Guidance Document: 'The Mammography Quality Standards Act Final Regulations Modifications and Additions to Policy Guidance Help System #4; Guidance for Industry and FDA.' " ■

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.

IN THE NEWS

CMS Issues Proposed 2003 Physician Fee Schedule

CMS published its proposed physician fee schedule for 2003 in the June 28, 2002, *Federal Register*. If the proposed fee schedule goes into effect as currently written, payments to physicians will decrease by an average of 4.4 percent next year, according to a CMS press release. According to the American College of Radiology (ACR), certain cuts in the practice expense allowance may disproportionately affect the professional component for radiology services—so you may see even more of a reduction if the fee schedule is adopted as currently written.

We'll explain the cause of the decrease. Plus we'll tell you why radiology practices may be hit especially hard.

Cause of Decrease

According to the CMS press release that announced the publication of the fee schedule, the fee schedule for each year is established based on a formula in the Medicare law. CMS has no discretion in applying this formula, even though it has led to substantial reductions in payments to physicians in each of the past several years. But CMS is working with Congress to devise ways to provide adequate payment to physicians to ensure continued access to health care services for Medicare beneficiaries—a process that may involve a new law establishing a new formula, says CMS spokesperson Ellen Griffith.

Change to MEI May Cushion the Blow

CMS is proposing to change the way it calculates the Medicare Economic

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IN THE NEWS (continued from p. 5)

Index (MEI)—that's a measure of inflation in providing physician services. The proposed change to the MEI will help lessen the amount of the overall average reduction in the 2003 Medicare physician fee schedule. But if CMS doesn't go forward with this change, payments to physicians will decrease in 2003 by an estimated 5.1 percent, rather than the 4.4 percent decrease CMS calculates if the proposed change in calculating the MEI does happen this year, Griffith notes. And she emphasizes that the estimated reductions are just that—estimates—so the amount of the reduction in the final rule may differ from current CMS estimates.

CMS will consider comments until Aug. 27 and will publish the final fee schedule sometime in November. It will go into effect on Jan. 1, 2003.

Proposed Fee Schedule Will Hit Physicians Hard

The ACR is studying the proposed 2003 fee schedule and anticipates there may be some bad news for radiology practices. "The way the proposed fee schedule reads now, it appears that the cuts in the practice expense ratio and the conversion factor may have an adverse impact on our membership. We're studying the proposed fee schedule and will submit comments to CMS with our concerns by the Aug. 27 deadline," says a spokesperson in the ACR's Department of Economics.

***Insider* Says:** You can get a copy of the press release about the proposed 2003 fee schedule at www.cms.hhs.gov/. Click on "public affairs," then "press releases," and you'll find the release dated 6/27/02. You can find the proposed fee schedule in the *Federal Register* at www.access.gpo.gov/su_docs/fedreg. Click on the date—June 28, 2002—and you'll be able to bring up the entire proposed fee schedule. ■

Insider Source

Ellen Griffith: Press Officer, Dept. of Health and Human Services, Centers for Medicare & Medicaid Services, Rm. 303-D, 200 Independence Ave. SW, Washington, DC 20201.

Protect Your Payment Rights if Plan Seeks Its Treatment Costs from Member's Third-Party Payment

When a plan member is injured by a third party—for example, in a car accident—the law in most states lets the plan recover its costs of treating the member from any money the member collects from the third party or his insurer. You may think that this recovery right, called "subrogation," isn't your concern because it's an issue between the plan and the member.

But more and more practices are getting burned when plans pursue their subrogation rights against plan members. Many plans are now delaying their payment to physicians until they collect from the member. That may mean you have an unpaid claim for months or years while the plan and the member resolve the claim. Sometimes a plan never collects on its subrogation claim and doesn't pay you at all. Also, practices are increasingly being pulled into legal battles between plans and members over whether a member must turn over to a plan money from a third party. This is a hassle for you and damages your relationships with both the plan and the member.

You can protect yourself from these unfair problems, experts say. Add a clause to your plan contracts that clarifies both your rights and obligations when the plan decides to pursue its subrogation rights against a member. We'll tell you what to do and give you a Model Contract Clause you can use (see p. 8).

More Plans Pursue Cost Recovery

Plans generally have subrogation rights when payments are made to a member either by a third party who caused the member's injury or by the third party's insurer (such as fire, car, or workers' compensation insurance, but not other health insurance). In the past, many plans didn't bother to exercise their subrogation rights or did so only for large, catastrophic claims. "Subrogation is adversarial and often requires lawsuits that involve members, plans, and third parties, so plans didn't want to antagonize their members," explains Washington, D.C., attorney Barbara Ryland.

But in recent years, more and more plans have been aggressively pursuing their subrogation rights against members to recover their expenditures for treatment costs. "It was a natural evolution as plans work to become more cost-efficient and explore ways to increase revenue," says California attorney Carol Lucas.

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Why You Need Contract Clause

The increase in subrogation activity is hurting practices, as well as catching them by surprise. In virtually all states, the law generally doesn't give subrogation rights to plans until they have paid the provider and suffered a loss. But many plans are ignoring the law and delaying or denying payment to providers until after they've collected from the third party, warns Delaware attorney Laura Sunstein Murphy. "Some plans have even gone so far as to put language in their provider contracts that lets them delay payment until they get paid from the third party," warns Ryland.

A contract clause that addresses subrogation rights could help you avoid this problem. "A contract clause can make your right to get paid first a contract requirement, so the plan can't later try to delay your payment due to subrogation activity or create an exception to its obligation to pay you by a deadline set out in the contract," says Illinois attorney Paul Armstrong. "The practice shouldn't be hurt by a payment delay or denial because a member isn't cooperating with the plan or because there's a lawsuit," he says.

A contract clause is also important because it can clarify each party's rights and responsibilities under subrogation. "You'll be able to avoid getting caught in any battles over subpoenas and medical records," says Ryland. For instance, suppose the member doesn't want you to release his medical records to the plan concerning the injury, despite having signed a blanket release when first treated. If the contract clause requires you to cooperate with the plan, you can make a stronger argument to the member (and his attorney) that if you don't comply with a plan's request for records, you'll be violating your contract. "If your contract clarifies your obligation to cooperate, you're less likely to be dragged into the lawsuit yourself," Ryland points out.

There's another powerful reason to add a contract clause on subrogation. If the contract doesn't have clear language permitting a plan subrogation rights, you can lose your right to enforce liens you may file against any money a member gets from the third party. Many plan contracts require the provider to accept the contract amount as "payment in full," notes Arizona attorney Joseph Mislove. Many states even require it. In a growing number of lawsuits, judges are ruling that if the contract only addresses payment from the plan and the member's copayment and coinsurance, and doesn't have clear language on subrogation, the practice doesn't have the right to enforce liens against money the member gets from a third party, warns Mislove. "With subrogation on the rise, this has caught the attention of attorneys representing plan members fighting plans' and practices' attempts to subrogate or file liens, often to the detriment of the plan and the practice," he says.

Take Two Steps

Take two steps to specify in your contract what happens when the plan pursues its subrogation rights against plan members:

Step #1: Review contract language. Whenever you review a plan contract, check for language that addresses subrogation. Many contracts won't have any language about subrogation. Some contracts have general language or a short paragraph that discusses subrogation, or lump subrogation into the coordination of benefits provision. "Having some language is better than nothing, since it shows that there's an understanding and intent to subrogate. But the contract really needs the details about subrogation, such as that the practice will cooperate, and that subrogation won't affect the practice's payment," says Ryland.

Step #2: Add/modify clause. If the contract doesn't address subrogation, ask the plan to add a clause that specifies what happens if the plan pursues its subrogation rights against a plan member. Or if the contract refers to subrogation only generally, ask the plan to modify the general clause. Almost all plans will agree to add language to the contract to clarify the parties' subrogation rights and obligations, Mislove says. "It benefits the plan as well as the practice," he notes, if the language requires you to help the plan and clearly shows the intent to allow subrogation.

***Insider* Says:** Check your state law regularly for changes in the laws on subrogation. Several states have laws that affect or limit a plan's right to pursue its subrogation rights against plan members. Other states are considering new laws that could affect you, says Mislove.

What Clause Should Say

Like the *Insider*'s Model Contract Clause, your clause should:

Specify that you get paid. Say that the plan may enforce its subrogation rights, but that you still get paid according to the contract. "The plan shouldn't be able to pay you only if it gets paid. You want to make sure that you get paid on time, regardless of what the plan decides to do about subrogation," says Lucas [Clause, par. a].

Require you to cooperate and to refund duplicate payments. You should be willing to reasonably help the plan pursue its subrogation

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PROTECT YOUR PAYMENT RIGHTS
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rights—and the clause should say this. Most often this cooperation would include sharing your information about the member's injuries with the plan, notes Ryland. You should also agree—and the clause should say—that you'll abide by the resulting determination of who's financially responsible for paying for the treatment. For instance, if a court rules that a member's back injury occurred while on the job, then you would look for payment for treating the injury from the worker's compensation insurer covering that member, not from the plan.

In this kind of situation, you may get paid twice—first by the plan and then by workers' compensation insurance. So the clause should say that in such an event, you agree to refund the amount of payment to the plan—up to the full amount the plan paid. "This type of fair, comprehensive language really helps to get plans to agree to a detailed subrogation clause," notes Mislove [Clause, par. b].

MODEL CONTRACT CLAUSE

Specify Your Rights and Responsibilities if Plan Uses Subrogation

Here's a clause you can use to protect yourself from payment and other problems when a plan decides to pursue its subrogation rights against a plan member. The clause is based on one drafted by Arizona attorney Joseph Mislove. The clause should be placed in a separate section of the contract so it will stand out.

Paragraph a says that the plan can pursue its subrogation rights, but that you still get paid according to the contract. Paragraph b requires that you cooperate with the plan, abide by any determination of who's responsible for paying you, and refund to the plan any duplicate payments you get from a payment by a third party (or the third party's insurer) to the member. Paragraph c preserves your rights to get paid more than your contracted amount to the extent you're entitled to do so.

Show this clause to your attorney, and get his or her okay before using it.

SUBROGATION

a. Plan's Subrogation Rights. In the event a Member is injured by the act or omission of a third party, Plan may elect to pursue its subrogation rights against the third party or the third party's insurer. Plan shall, however, make payment to Provider in accordance with this Contract while pursuing those subrogation rights.

b. Provider's Cooperation. Provider shall reasonably cooperate with Plan when it pursues its subrogation rights. Provider shall abide by any final determination of responsibility for the Member's injuries and, upon receiving payment from the responsible party, will remit the amount of the payment to Plan, up to the total amount paid by Plan to Provider for the services involved.

c. Excess Payments to Provider. Provider shall be entitled to keep any payments received in excess of the amounts paid to it by Plan. Nothing in this Contract, including Provider's agreement to accept amounts received under this Contract as payment in full from Plan for all Covered Services or Provider's promise to hold Members harmless for cost of Covered Services except for Copayments, Coinsurance, and Deductibles, shall preclude any collection efforts by Provider as set forth in this Contract.

Permit you to keep excess payments or bill member for them. Sometimes you may be able to get paid more than the amount you're entitled to under your plan contract. For example, you may have filed a lien against any recovery or settlement an injured member may get in a lawsuit against a third party, seeking the difference between what the plan must pay you and your billed charges. "Some states allow providers to get the full amount of their bill in these situations and not be limited by just the discount in the contract," says Murphy. Check with your attorney to find out what the law allows in your state.

You want the clause to say that you're entitled to keep amounts over and above the amount the plan pays you (assuming your state law allows this). This preserves your ability to keep the difference between the contracted discount and your billed charges or to bill the member for it, and helps to stop any arguments by the plan—or the member's attorney—that you can't. "Since the member usually bases his damages claims against the third party on the provider's billed charges, not the contracted discount, the provider should be able to get paid its billed charges," says Mislove [Clause, par. c].

***Insider* Says:** Review your contracts and make sure they don't have language that conflicts with the Model Contract Clause. For example, delete any language that lets the plan delay payment while it pursues its subrogation rights. Also, check the "hold harmless" clause, which bars you from collecting from the member for covered services that the plan is responsible for. "The hold harmless clause should apply only to HMOs and only in states that require the language," says Mislove. "If your contract says that you can collect

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copayments only from a member, a court can rule that you agreed that the plan's payment to you is payment in full and refuse to let you collect more, even if your state law would let you," he points out. ■

Insider Sources

Paul Armstrong, Esq.: Principal, Medical Lien Recovery, Ltd., 210 Catalpa Pl., Wilmette, IL 60091.

Carol Lucas, Esq.: Fulbright & Jaworski, LLP, 865 S. Figueroa, 29th Fl., Los Angeles, CA 90017.

Joseph Mislove, Esq.: Coppersmith Gordon Shermer Owens & Nelson, 2633 E. Indian School Rd., Ste. 300, Phoenix, AZ 85016.

Laura Sunstein Murphy, Esq.: Morris, James, Hitchens & Williams, 222 Delaware Ave., 10th Fl., Wilmington, DE 19801.

Barbara Ryland, Esq.: Crowell & Moring, 1001 Pennsylvania Ave. NW, Washington, DC 20004.

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 jgormley@brownstone.com*

Ask Patient in Private About Disclosure of PHI to Family

Q Must we get the patient's permission in private before discussing protected health information (PHI) in the presence of the patient's family?

A Ideally, yes, says health information consultant Mary Brandt. The section of the final HIPAA privacy regulations that describes appropriate uses and disclosures of PHI requires you to get the patient's permission before disclosing the patient's PHI to her family members. Although you needn't get the patient's written authorization, you must discuss this disclosure with the patient, give the patient an opportunity to agree or object to the disclosure, and allow the patient to limit the information disclosed to family members, she explains.

The regulations don't require this disclosure permission to be discussed privately between the patient and his health care provider—that is, without any family members present. But that's the best way. This ensures that the patient's true wishes are expressed. Otherwise, some patients may be too uncomfortable or intimidated by the presence of family members to speak openly, and may not feel able to ask one or all of them to leave, Brandt points out.

For instance, in a hospital or nursing home setting, family members are often present at the patient's bedside. But don't assume that their presence means that the patient wants her PHI disclosed to those family members, warns Brandt. Instead, ask the patient in private whether it's okay to discuss PHI in the presence of family. To do this, in some cases, you may have to politely ask the family to leave the room for a few minutes to have a private conversation with the patient. Getting this private time with the patient will also allow discussion of other issues that the patient may be reluctant to bring up in front of family members. This way, you can be more sensitive to the patient's overall needs, she adds.

Suppose that a patient asks that her spouse remain in the room. In this situation, you may infer the patient's permission to discuss PHI in the presence of the spouse. But be sure it's the patient's choice. If a patient simply says "I want my husband to hear this too," you can assume it is. But if the husband says "I want to stay," that's not good enough.

Billing for Out-of-Plan Services Not Preauthorized by Medicare HMO

Q We recently provided services to a patient who's a member of a Medicare HMO. We're not on the HMO's panel, and the HMO didn't preauthorize the services. There's a debate around the office about who—and how much—to bill for the services. Can we bill the patient our usual and customary charge? Or are we required to bill the HMO and accept the Medicare fee schedule payment from the HMO as payment in full?

A Bill the patient your usual and customary charge, says Atlanta health care reimbursement consultant Jackie Miller. But be aware that you may eventually have to make a partial refund to the patient if the HMO decides to cover the service.

HCFA—now CMS—dealt with this issue in guidance about Medicare private contracts that it published in the *Federal Register* in 1998. According to that guidance, if a patient who's enrolled in a Medicare HMO gets an out-of-

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ASK THE *INSIDER* (continued from p. 9)

network service that isn't preauthorized, the physician providing the service may directly bill the patient for the physician's usual and customary charge.

But if the patient's HMO later determines that the service provided to the patient was a Medicare-covered service, then you must return any overpayment you received —that is, any amount over and above the Medicare allowable (if you participate in traditional Medicare) or the limiting charge (if you do not participate). So if the patient paid you your usual and customary charge, you must refund the difference between that charge and the Medicare allowable or limiting charge to the patient, Miller cautions.

Physician Supervision at 'Provider-Based' Mobile Unit

Q Our radiology practice contracts with a hospital to staff its mobile MRI unit. Our techs work in the mobile unit, and one of our radiologists interprets the images. Our radiologists aren't always on the premises to supervise when the techs put the patient through the MRI. Since the mobile unit has "provider-based" status, we believe the supervision rules that apply in a hospital setting apply there, too—that is, only general supervision is required. But the hospital says we must always have a radiologist in the mobile unit to supervise the MRIs, and our radiologists are up in arms. Who's right?

A You both are, says Virginia health care attorney Thomas W. Greeson. According to a CMS transmittal published last year, MRIs with contrast performed in physician offices or provider-based freestanding facilities (which would include a mobile unit that has provider-based status) require the *direct* supervision of a physician. That means that one of your radiologists (or another duly licensed and credentialed physician) must be on the premises when your techs perform contrast studies. But MRIs without contrast still can be performed under general supervision (meaning that the physician needn't be on the premises).

Diagnostic radiological procedures in hospitals require only general supervision, regardless of the procedure. That's because it's assumed that there are plenty of physicians available at all times in a hospital to deal with any emergency. But that's not the case in an off-campus or mobile facility—even if it has provider-based status for Medicare billing purposes. So the supervision rules that apply in a physician office or an independent diagnostic testing facility apply in a provider-based facility, as well, Greeson explains. ■

Insider Sources

Mary Brandt, MBA, RHIA, CHE: President, Brandt & Assocs., 4610 Braeburn Dr., Bellaire, TX 77401.

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

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

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.

- Guidance re: Medicare private contracts: 63 Fed. Reg. No. 211, 11/2/98, p. 58851.
- Mammography Quality Standards Act regulations: 21 CFR Part 900.

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