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Six FAQs About Using Clinical Specialists in a Radiology Practice

Radiology practices are using nurse practitioners (NPs), clinical nurse specialists (CNSs), and physicians assistants (PAs) more than ever before. These physician extenders—more commonly called clinical specialists—can greatly enhance a radiology practice's productivity. Clinical specialists can take patient histories, administer drugs for fluoroscopies, set up PICC lines, monitor post-surgical patients in interventional practices, and do many other time-consuming tasks that your radiologists would otherwise have to do themselves.

But the rules regarding using clinical specialists and billing for their services can be tricky. We've asked our experts for the answers to six frequently asked questions about using clinical specialists in radiology practices. Knowing the answers will help you minimize the risks and enjoy the benefits of using these professionals in your practice.

What Can Clinical Specialists Do?

That depends on the state in which you're practicing, says Virginia health care attorney Thomas W. Greeson. Each state sets its own rules regarding the "scope of practice" of NPs, CNSs, and PAs—that is, the duties their licenses qualify them to perform. In some states, clinical specialists may write prescriptions for drugs, perform evaluation and management services, and do certain invasive procedures. But in other states the scope of practice of these professionals is more limited. In all states, though, clinical specialists can perform physical examinations, take detailed clinical histories, monitor postsurgical patients, and administer intravenous drugs. Check with your state's medical licensing board or medical society to learn about the scope of practice your state permits for each type of clinical specialist, Greeson advises.

How Closely Must Radiologists Supervise Clinical Specialists?

Greeson says that required supervision levels vary according to state, too. Plus the degree of supervision required depends on the license of the clinical specialists—for example, PAs have more autonomy in most states than NPs do.

Most states require a physician to always be available for consultation with the clinical specialist and to ensure that he works within his scope of practice. States that allow these specialists to work independently usually require that the physician review the specialists' clinical notes. For example, in New York a PA can work independently as long as he has a "collaboration agreement" with a physician, which must be written and submitted to the state health department. The collaborating physician must be available by phone if the PA needs to discuss anything, and the physician must review and sign off on the PA's notes at least monthly. In general, Greeson thinks that the burden of supervising clinical

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specialists is outweighed by the skills and efficiencies they can bring to a radiology practice.

Can We Bill for the Radiologist's Time Spent Supervising Clinical Specialists?

No, says radiology compliance and reimbursement specialist Claudia Murray. Even though supervising the clinical specialist takes up the radiologist's time, the cost of supervising your clinical specialists—like the cost of supervising your techs—is built into the technical component fee that you get and isn't separately billable. Even if you work in a hospital-based practice—and aren't getting the technical component fees—you still can't bill for supervising the clinical specialist, Murray emphasizes. But you might be able to negotiate with the hospital to get it to contribute toward the costs associated with supervising the hospital's techs, NPs, CNSs, and PAs, she suggests.

Can Clinical Specialists Order and/or Supervise Diagnostic Tests?

Sometimes, but it's complicated, says Greeson. Clinical specialists can order diagnostic tests as long as they're performing services that would be physician services if a physician were performing them, and if ordering the test is a function that's within the scope of the clinical specialist's license in the state.

Clinical specialists may not act as stand-ins for radiologists when it comes to supervising diagnostic tests, Greeson emphasizes. However, when the clinical specialist is performing the diagnostic test on his own order, he may be able to supervise it. For example, Medicare rules allow PAs to perform and interpret MRIs with contrast. So a PA—if his license permits—may perform the MRI, supervise the contrast administration, interpret the test, and bill Medicare directly for the services. But a PA may not merely supervise the MRI with contrast if it's to be interpreted by a radiologist, he explains.

Can We Bill Medicare Directly for the Services the Clinical Specialist Provides?

Many practices bill clinical specialists' services "incident to" physician services, but the incident to billing rules are complicated. Plus clinical specialists' services provided in a hospital setting may not be billed incident to physician services. But Medicare permits NPs, CNSs, and PAs to get their own provider numbers and bill directly for their services, says Murray. If the clinical specialist is your employee, he can reassign his right to payment to your practice just as a radiologist would, she explains. So you can bill Medicare directly for any service that's within the clinical specialist's scope of practice in your state. And the clinical specialist's services usually will be reimbursed at a rate that's 85 percent of the Medicare fee schedule for physicians.

Can We Bill Other Third-Party Payors for the Services the Clinical Specialist Provides?

It depends on the payor and what your contract with the payor says, Greeson notes. Many contracts specify that the contract is for physician services. So

a payor may refuse to pay for a service provided to an enrolled member if a nonphysician provided the service, even though the payor would pay if the radiologist had rendered the service. This is unfair because the services are being provided by a licensed medical professional acting within the scope of his licensure—and the patient is getting exactly the same service that the radiologist would provide. Plus using clinical specialists means you're probably providing services in a more cost-effective manner than if you were using only radiologists to provide these services—and that should make the payors happy.

Keep these arguments in mind when it's time for you to renew your contracts or negotiate new ones, Greeson says. If you insist on it, most payors will allow you to bill and be reimbursed for services provided by nonphysician practitioners as long as you identify who is providing the service and the service is within his scope of practice. But never bill any payor for a service that a clinical specialist provided, as if the radiologist provided it—that's fraud, Greeson warns. ■

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Final Changes to HIPAA Privacy Regulations Published

In the Aug. 14, 2002, *Federal Register*, HHS published the final changes to the HIPAA privacy regulations. According to an HHS press release issued Aug. 9, 2002, these changes are intended to address problems in the HIPAA privacy regulations that could have hampered patient access to quality care. The changes affect many parts of the HIPAA privacy regulations. Most of the major changes differ in only minor ways from those proposed in March 2002 in a Notice of Proposed Rulemaking (NPRM).

The changes go into effect on Oct. 14, 2002, and compliance with the HIPAA privacy regulations is required by April 14, 2003 (2004 for small health plans). Below is a summary of the most significant changes. In future issues of the *Insider*, we'll focus on individual changes and give you tips and strategies to help you comply with the HIPAA privacy regulations as they now stand.

What Are the Key Changes?

Here are the key changes to the HIPAA privacy regulations:

Consent and notice. These changes are very important for physicians:

▶ *Consent removed*. The changes eliminate HIPAA's consent requirement for providers, including physician practices. That is, a health care provider is no longer required to get written patient consent before using protected health information (PHI) for treatment, payment, or health care operations. Now, the HIPAA privacy regulations say that a provider *may* obtain consent for treatment, payment, and health care operations, but isn't required to do so.

▶ *Notice of privacy practices still required*. The changes don't affect the requirement that a health care organization (including physicians) must provide patients with its notice of privacy practices. And the content requirements for this notice are also unchanged. But the changes now require a provider to get a patient's written acknowledgment that the patient got the privacy notice. Previously, written consent rather than an acknowledgment was required. If the provider doesn't get this acknowledgment, it must document its efforts and the reason the acknowledgment wasn't obtained. So a provider can treat a patient and won't be in violation of the privacy regulations even if the provider doesn't get the patient's acknowledgment.

Minimum necessary standard and incidental disclosures. The changes to the final regulations don't alter the requirement that a health care organization must make reasonable efforts to limit its uses and disclosures of and requests for PHI to the "minimum necessary" to accomplish the intended purpose. But the changes make clear that if an organization complies with the minimum necessary standard, incidental uses and disclosures of PHI—that is, those that result from or are a by-product of a permitted use or disclosure—are also allowed. According to the preamble of the changes, HHS included this provision in the changes to ensure that communications essential to providing quality health care would continue to be allowed. Here are some examples of permitted incidental disclosures:

■ Disclosures about a patient made at a nursing station that might be overheard by personnel not involved in the patient's care;

■ The use of joint treatment areas, sign-in sheets, calling out names in waiting areas; and

■ Discussion of a patient's condition during training rounds.

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HIPAA PRIVACY REGULATIONS
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Business associates. The changes affect the business associate requirements in the following way:

▶ *Compliance date changed for some.* The date for compliance with the business associate requirements is affected. The changes allow a health care organization to operate under its existing contracts with its business associates for up to one year beyond the April 14, 2003, compliance date. This extra time is available to an organization for an existing contract (or other written arrangement) with a business associate if the contract isn't renewed or modified between the effective date of the final regulations (Oct. 14, 2002) and April 14, 2003.

The bottom line—you won't need to amend your contracts with your business associates to comply with the HIPAA privacy regulations' business associate requirements until the earlier of: 1) the date the contract is renewed or modified after April 14, 2003; or 2) April 14, 2004.

▶ *Sample contract language offered.* The changes to the privacy regulations include an appendix with sample contract provisions that can be incorporated into your business associate contracts. The sample language in the appendix differs slightly from the "model language" originally published in the March 2002 NPRM. In the preamble to the changes, HHS explains that these sample provisions are to be used as a guide to help organizations meet some of the business associate requirements. But HHS cautions that you don't have to use the sample provisions to comply with the business associate requirements, nor do the provisions alone create a binding contract. That is, you'll also need to add other provisions to each of your contracts to accurately reflect the relationship you have with the particular business associate and any applicable state law requirements.

Marketing. The changes to the privacy regulations toughen the requirements for the use and disclosure of PHI for marketing purposes by clarifying the definition of marketing and explicitly requiring health care organizations to get a patient's authorization before sending him any marketing materials. The only exceptions for which marketing is allowed are: face-to-face encounters; and products and services of nominal value (such as a free toothbrush).

All other forms of marketing require patient authorization. For example, a pharmacy is barred from selling lists of its customers to a business that wants to market its own products or services to those customers. But the changes clarify that privacy regulations' marketing provisions don't interfere with an organization's ability to communicate freely with its patients about treatment options and other health-related topics, such as disease-management and wellness programs, since these activities don't fall within the definition of marketing.

Disclosures for treatment, payment, or health care operations of another entity. The changes to the regulations clarify that an organization can disclose PHI for the treatment, payment, and certain health care operations of another health care organization without getting patient authorization. For example, a hospital can—without patient authorization—disclose a patient's PHI to the ambulance service provider that delivered the patient to the hospital so that the ambulance service provider can get paid for its services. The changes also clarify that an organization that participates in an "organized health care arrangement" (OHCA) may share PHI with entities within the OHCA for the health care operations purposes of the OHCA.

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

Uses and disclosures for research purposes. The changes simplify the HIPAA privacy regulations' research requirements by eliminating the need for researchers to use multiple authorization forms. Instead, researchers will be able to use a single combined form to address both informed consent and information privacy. The changes also simplify other research provisions so that the HIPAA privacy regulations conform to the format of the Federal Policy for the Protection of Human Subjects (which is known as the "Common Rule" and governs federally supported, conducted, or regulated human research).

Patient authorization. The changes alter HIPAA's patient authorization requirements. An organization must still get written patient authorization before using or disclosing PHI that's not otherwise permitted under the HIPAA privacy regulations. But the changes specify the elements that must be included in a valid authorization form (although they note that additional elements may be added to the form as long as they're consistent with the required elements). The changes also require that a valid authorization include several separate statements (such as a statement describing the patient's right to revoke the authorization in writing). Plus the changes eliminate the requirement for

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organizations to develop and maintain several different forms, each for a different situation.

Protected health information. The changes specify that certain information that would otherwise qualify as PHI, doesn't. For example:

■ Education records that are subject to the Family Educational Rights and Privacy Act, and certain education records of post-secondary education students aren't considered PHI.

■ Employment records that a health care organization holds as an employer aren't PHI. For example, if a hospital employee submits a doctor's note to her supervisor to document her absence from work, the hospital/employer needn't treat that note as PHI.

Sale of business. The changes alter the definition of "health care operations" to allow medical records to be transferred to another health care organization upon a sale, transfer, merger, or consolidation. This change is meant to prevent the HIPAA privacy regulations from interfering with necessary treatment or payment activities when an organization's business is sold.

Limited data set. The changes add a new term, "limited data set," to the HIPAA privacy regulations. This is a data set that includes PHI but doesn't include certain directly identifiable information (such as names, addresses, telephone numbers, Social Security numbers). The changes allow disclosure of a limited data set for research, public health, and health care operations. But before this disclosure, the organization and the recipient (of the data) must sign a data-use agreement. This agreement must limit how the recipient may use the data set, ensure the security of the data set, and state that the recipient won't identify the information or use it to contact any individual.

Accounting for disclosures of PHI. The HIPAA privacy regulations give an individual the right—with certain exceptions—to get an accounting of disclosures of his PHI made by a health care organization. To be consistent with the final regulations' changes to various requirements, the changes clarify that an organization isn't required to account for any of the following disclosures of PHI:

■ Made incident to a use or disclosure otherwise permitted under the regulations;

■ Made under a patient's written authorization; or

■ Made as part of a limited data set.

Where Can I Get a Copy of the Changes?

The changes published in the Aug. 14, 2002, *Federal Register* include a preamble (background, overview, and description of the changes to the privacy regulations), an appendix, and the actual changes to the HIPAA privacy regulations. To get a copy of the changes, go to the *Federal Register,* Vol. 67, No. 157, 08/14/02, pp. 53812–53273. They're also available at the HHS Office for Civil Rights Web site: www.hhs.gov/ocr/hipaa/.

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

To read HHS's Aug. 9, 2002, press release, go to www.hhs.gov/news/press/2002pres/20020809a.html. To read HHS's fact sheet summarizing some of the changes, go to www.hhs.gov/news/press/2002pres/20020809.html. ■

Use Correct Modifier When Billing for Noncovered Service

Radiologists often encounter situations where a patient needs a service that Medicare doesn't cover. If you perform the noncovered service, there are legitimate reasons why you may still want to submit a claim to Medicare.

But there's a right way and a wrong way to submit a claim to Medicare for a noncovered service. And if you submit an improper claim, you could wind up in hot water. For example, if Medicare notices that a practice is submitting an excessive number of improper claims for noncovered services—what CMS calls an "abusive billing pattern"—that practice will probably be audited and could get into a lot of trouble.

One key to avoiding trouble is using the right modifier. CMS has identified three modifiers for noncovered services: -GA, -GY, and -GZ. You'll need to append one of these three modifiers to the claim, says New Jersey billing and reimbursement expert Barbara J. Cobuzzi. We'll tell you why you might want to bill Medicare for a noncovered service. We'll also explain what each of the three modifiers means. And we'll tell you when you should—and shouldn't—use them.

Why Bill Medicare for a Noncovered Service?

At first glance, it may seem silly to submit a claim to Medicare if you know they're not going to pay you. But there are several reasons why

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USE CORRECT MODIFIER
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you might do this, Cobuzzi explains. For example:

- You may need to get a denial from Medicare before a patient's secondary insurer will pay; or
- You may have a signed advance beneficiary notice (ABN) and want to bill the patient. You're billing Medicare to get a denial with an EOB that says you can bill the patient.

Medicare recognizes that there are legitimate reasons to submit a claim for a noncovered service. But it's wary of practices that simply submit claims for services they're not entitled to be paid for without acknowledging this. That's why it's important to code these claims with a modifier that indicates that you don't expect Medicare to pay them, Cobuzzi explains.

Get Familiar with Modifiers for Noncovered Services

The right modifier to use when submitting a claim for a noncovered service depends on the reason you're submitting it, Cobuzzi notes. Here's a thumbnail sketch of how and when to use each of the three modifiers CMS introduced for use with noncovered services:

-GA modifier: Waiver of liability on file. Cobuzzi explains that this is the modifier to use when you have an ABN on file for the service. You should always get a patient to sign an ABN before you provide a service that you suspect Medicare won't cover for medical necessity reasons. For example, say that the referring physician ordered an MRI to confirm his diagnosis, but according to your carrier's or FI's LMRP, the diagnosis the physician suspects won't be covered with the signs and symptoms the patient reports. In that case, you must get an ABN and you must append the -GA modifier to the claim. When Medicare denies the claim, you'll be able to seek payment from the patient directly or from her secondary insurer.

If you don't use the -GA modifier, Medicare will deny the claim and you won't be entitled to bill the patient—or anyone else. So you'll have to eat the costs, Cobuzzi warns. Plus your carrier may suspect that you aren't getting ABNs when you should—and that's a patient abuse issue that the carrier may want to investigate, she says.

-GY modifier: Item or service statutorily excluded. Sometimes you'll provide a service that isn't a Medicare benefit. For example, you may provide a screening test that Medicare doesn't cover. In that case, you don't need an ABN because Medicare won't cover the service under any circumstances. But the patient's secondary insurer may cover it, and the patient may need a Medicare denial to show the secondary insurer. Or the patient may insist you submit the claim to Medicare because he mistakenly believes that the service is covered. Append the -GY modifier to claims for these "statutorily excluded" services so that Medicare will know you're not trying to cheat.

-GZ modifier: Item or service expected to be denied as not reasonable and necessary—no ABN on file. Use this modifier if you've messed up by failing to get an ABN when you should have, Cobuzzi says. You can also use this modifier if you tried to get the patient to sign an ABN and the patient refused—but you provided the service anyway.

The purpose of this modifier is to let the carrier know that you're not trying to get away with anything, says Cobuzzi. That is, CMS says this modifier lets the carrier know that you don't expect to get paid by Medicare, the patient, or a secondary insurer. But Cobuzzi suggests that frequent use of this modifier is unwise because it announces to your carrier that that you didn't get an ABN when you should have. If you notice that your practice is using the -GZ modifier more than once or twice a year, it's time to give your staff a refresher course on ABN usage, Cobuzzi advises. ■

Insider Source

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MARKETING

Follow Three Tips on Testimonial Advertising to Steer Clear of FTC and State Violations

Radiology facilities often try to boost business by marketing their services to the public. One way to do this is through "testimonial" advertising—that is, advertising in which a patient describes his positive experience with your facility. Testimonial advertising is especially popular with facilities that provide "open" MRI, whole body screening, and other upscale services. But because testimonial advertising may mislead patients, federal and state governments vigorously investigate and prosecute providers that use suspect testimonial advertising, says health care attorney William A. Sarraille. So you need to be careful when using it, he explains.

If you set up your testimonial advertising the right way, you can avoid violating federal and state laws. To help you reap the benefits of testimonial advertising without violating the law, we'll give you three tips to follow.

What's at Stake

The Federal Trade Commission Act (FTCA) bars businesses from unfair or deceptive acts or practices. This includes unfair, deceptive, or fraudulent testimonial advertising by any health care provider, including any facilities, says Sarraille. If the Federal Trade Commission (FTC) finds that you've violated the FTCA, it can prosecute you. If you're found guilty, the penalties for violating the FTCA can include civil monetary penalties as well as various enforcement actions. For example, the FTC can issue an injunction that orders you to stop any illegal testimonial advertising. The cost of defending yourself, and the potential penalties, can really add up—and the lawsuit can harm your reputation, as well, warns Sarraille.

Many states also have laws that make it illegal for you to use false or misleading testimonial advertising. "States really run the gamut on these laws, so it's important to check with your attorney," advises Sarraille. Some states, such as Texas and Illinois, flatly ban testimonial advertising by physicians or anyone acting on their behalf. But it's debatable whether these bans are constitutional. In fact, the Texas attorney general said in a recently issued opinion that barring health care providers from using testimonial advertising is "highly likely" to be unconstitutional. He explained that testimonial advertising isn't inherently misleading; so any absolute ban against it can violate the First Amendment.

But even if the courts decide that states can't ban testimonial advertising, states can still restrict health care providers from advertising deceptively. For example, many state medical practice acts and state facility licensing regulations ban false advertising or unlawful or deceptive conduct. "Facilities can lose their licenses if they use testimonial advertising that confuses or deceives patients. And physicians who advertise deceptively can lose their licenses to practice," says Sarraille. States can also charge physicians or facilities that advertise deceptively with other offenses such as failing to give patients proper information about a procedure before getting their consent, adds Sarraille.

Three Tips to Set Up Ads the Right Way

To avoid costly litigation, potential penalties, loss of license, and harm to your reputation, practices that use testimonial advertising should take care. Here are three tips to follow. It's also always a good idea to get your attorney's okay before going ahead with any testimonial advertising, Sarraille warns.

Tip #1: Disclose that endorser has been paid. Often, people are paid to give endorsements in testimonial advertising. But that's not always obvious to the public. If you pay an endorser, always let the public know that you've paid for his testimonial. Unless it's obvious that a testimonial was paid for—because you're using a celebrity endorser, for example—include a prominent disclaimer that states "this is a paid endorsement," says Sarraille. Otherwise, the federal or state government may accuse you of deceptive advertising.

***Insider* Says:** Make sure your disclaimer is prominent in relation to the endorser's claim, advises Sarraille. "In print advertising, the FTC and most states measure prominence by comparing the sizes of the claim and the disclaimer," says Sarraille. For example, if your advertising is on a billboard and your endorser claims in five-foot-high letters that his surgery was a success, the disclaimer must be reasonably prominent, he explains.

Tip #2: Make clear that results vary. Always let the public know that results vary for different patients.

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MARKETING (continued from p. 7)

The FTC and most states expect you to include a prominent disclaimer with your testimonial advertising, saying that "results may vary," or something similar.

A patient in an open MRI advertisement may exclaim: "It was quiet and quick, and I didn't get claustrophobic." Because patients are unique, each patient may not have the same experience from the procedure. "While this may be obvious to some patients, others may go to your facility expecting exactly the same results," explains Sarraille. Also, don't make guarantees in your testimonial advertising. For example, don't guarantee that a specific procedure is "painless," even if most patients only need an over-the-counter painkiller. If any painkiller is given, the procedure isn't "painless."

Tip #3: Don't make claims you can't prove. Don't make claims in your testimonial advertising that you can't objectively verify. The FTC and states will look suspiciously on any claims that mislead patients into thinking that something is true if it can't be shown to be true, says Sarraille. For example, a typical testimonial advertising claim is that the facility has the "Best Physicians in the Area." The claim is vague, subjective, and hard to prove because the claim doesn't define the "area" being referred to, the types of procedures the physicians are best at, or the criteria used to evaluate them. "The FTC and states know that such advertising is likely to mislead patients and are likely to investigate such unsubstantiated claims," says Sarraille. Other claims to avoid for similar reasons are "Best Facility in the Area," "Best Place for Mammography," and "Highest Patient Satisfaction."

***Insider* Says:** In addition to checking with an attorney when you set up a testimonial advertisement, it's a good idea to check the FTC Web site, advises Sarraille. On its Web site, the FTC publishes consent orders, settlements, and advertising guidelines. These can guide you on what types of testimonial advertising violate the law, and what types of health care advertising violations the FTC is pursuing. You can also check with state medical boards for guidance, as well as with various professional societies that put out guidelines on advertising specific types of procedures. ■

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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 (718) 243-2298; 3) call (718) 243-2337, and speak with the editor; or 4) e-mail jgormley@brownstone.com*

Billing for Services Performed at IDTF and Interpreted Elsewhere

Q We're a hospital-based group of radiologists that have entered into an agreement with an IDTF to interpret films taken at the IDTF. The films will be transported from the IDTF to the hospital, where our radiologists will read them. The IDTF will bill Medicare for the technical component of this service, and we'll bill Medicare for the professional component. But when we bill, should we designate the IDTF or the hospital as the "place of service"? Some of my colleagues who have similar arrangements have told me that we should designate the IDTF as the place of service, but this doesn't seem right to me.

A You should designate the hospital as the place of service, says Virginia health care attorney Thomas W. Greeson. Your claim for professional services must accurately reflect the location where the professional services were rendered—that is, the hospital. Otherwise, you're violating Medicare rules.

Greeson has heard anecdotes reflecting that some carriers are advising radiologists to submit claims designating the IDTF as the place of service—even when the radiologists read the films off-site. But this advice is clearly incorrect in Greeson's opinion. If a carrier gives you this advice, get it in writing before billing this way, he says. Also, Greeson suggests writing to the Medicare regional office to inform it of the carrier's policy. This will help to protect you, should Medicare ever investigate you for submitting false claims. ■

Insider Source

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GETTING PAID

Protect Revenues by Adding Automatic Fee Escalator to Your Contracts

In many plan contracts, the plan pays you based on a set rate or fee schedule—for example, a set case rate or 110 percent of Medicare's fee schedule for your region. That rate or fee schedule may have looked fair and reasonable when you negotiated the contract. But the next year or the year after that, it may not look so great. If your costs to provide the services increase, but the plan is still paying the same amount, your revenues will decline, warns Texas attorney Hal Katz. This is especially a problem for contracts that renew automatically.

You can protect your revenues without having to resort to terminating or renegotiating the contract, experts say. Add an "automatic fee escalator" clause when you negotiate the contract. An automatic fee escalator clause says that if you and the plan can't agree on new rates each year by a set deadline, the fees will automatically rise—either by a set percentage or according to an outside published percentage index, such as the consumer price index (CPI). We'll tell you about this clause and give you a Model Contract Clause you can use (see box at right).

How Providers Get Hurt

"The problem is prevalent because so many contracts automatically renew every year," explains managed care consultant Maria K. Todd. Automatically renewing contracts, also called "evergreen" contracts, are attractive to many plans and physicians because they can maintain their relationship and avoid having to renegotiate a new contract every year.

But you can have a problem with evergreen contracts—or even those that you must agree to renew—if your reimbursement is based on any system other than a percentage discount off your billed charges. Your reimbursement in later years won't take into account any increases in the cost of living or the cost of providing your services. "Over time, the plan ends up paying proportionately lower rates by 'aging the contract' this way," explains Missouri consultant Eric Vanderhoef. "That's why plans sometimes agree to higher rates to begin with," he says. They know that inflation can quickly turn high rates into low ones. And they get away with not having to increase the rates in subsequent years because there's nothing in the contract that requires them to even discuss an increase, much less increase the rates automatically.

A physician's only other option, then, is to terminate the contract and negotiate a whole new contract. But this is frustrating and time consuming—and you run the risk that the plan may not want to contract with you again, warns Todd.

Put Protection in Contract

You can get plans to increase your reimbursement in contracts with set rates or fee schedules, experts say, by getting plans to agree to a fee escalator clause. Plans are often willing to

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MODEL CONTRACT CLAUSE

Require Plan to Renegotiate or Else Let Fees Increase Automatically

The following clause can be used if a plan agrees to renegotiate set rates or fee schedules, and to have them increase by a certain amount or percentage automatically if you and the plan can't otherwise agree to an increase. The clause is based on one used by Texas attorney Hal Katz, and should be placed in the compensation section of the contract. The dates and time frames in the clause are negotiable and can be adapted to your contract needs.

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

FEE INCREASES

a. **Annual Renegotiation.** Plan and Physician realize that the terms of compensation are subject to periodic review and revision. These negotiations of fees will begin no later than October 1 of each year and will conclude by December 15 of each calendar year for the following contract year.

b. **Automatic Increase.** Should Plan and Physician not execute an agreement by December 15, as noted above, the fees for the subsequent calendar year shall be calculated by increasing the Fee Schedule in Attachment A for the then current calendar year by a percentage equal to the average of the "MCPI" for the most recent twelve (12) -month period for which rates are available. MCPI means the All U.S. Cities Consumer Price Index for Medical Care for the contract year expressed as a percentage as published by the United States Department of Labor.

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GETTING PAID (continued from p. 9)

agree to a clause with this type of automatic escalator because it's reasonable and limits the increase to an agreed-upon amount or percentage, says Katz, who regularly negotiates this clause into contracts on behalf of his physician clients. "You can always ask for a bigger increase, but at the least you'll be able to keep pace with rising costs," he says. If the plan drags its feet during renegotiation of your fee schedule, or for political or other reasons can't agree to a higher rate, at least you'll get the automatic increase.

If a plan insists that you sign an evergreen contract but is hesitant about agreeing to the clause, tell the plan you won't do it, recommends Debbie Welle-Powell, head of managed care for a Colorado health system. "We rarely sign a contract that automatically renews, unless there's an automatic fee escalator in it," she explains. "It's better to let a contract expire, which forces the plan to renegotiate," Welle-Powell notes. She even terminated a contract with a national plan because it wouldn't add an automatic escalator. That made the plan reconsider and agree to add one.

What Clause Should Say

Your escalator clause, like our Model Clause, should acknowledge that the fees in the contract are subject to periodic revision, recommends Katz. It should set out when the plan and physician must start and end renegotiation of the fees. And if they aren't able to renegotiate fees within that time frame, it should require the fees to increase automatically.

One way to set the automatic increase is to use a known index. There's no one best index to use as a benchmark for an automatic escalator. "Any objective benchmark you use will work," notes Todd. Katz often uses the national urban CPI for medical care, since it most closely tracks the percentage rise in costs in the industry. That's the index used in our Model Contract Clause. Welle-Powell prefers using the regional medical services component of the CPI for urban areas for the Rocky Mountain region, which is where her health system is located, because it's higher than the national CPI and better reflects the changing costs in her market. An alternative is to use a set percentage, or tie the increase to the increase in the plan's premium that it files with the state insurance department. (For more information about the various CPIs, go to www.bls.gov/cpi/).

If Plan Balks

If the plan refuses to add an automatic escalator clause, at least try to negotiate language that requires renegotiation of the rates. This is a reasonable compromise, especially for physicians who don't have the leverage to get the automatic escalator, says Vanderhoef. While your rates won't automatically increase, it forces the plan to come to the bargaining table. If the plan must meet with you, there's at least a chance of an agreement for some increase, Todd points out.

***Insider* Says:** If you get the plan to agree to renegotiate the rates each year, with or without the automatic escalator clause, be sure to keep track of the time frame for renegotiation. Many physicians miss these windows of opportunity, and plans will rarely renegotiate after the deadline, cautions Vanderhoef. ■

Insider Sources

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SHOW YOUR LAWYER

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