

Radiology Administrator's Compliance & Reimbursement Insider

AUGUST 2001

IN THIS ISSUE

How to Handle State Medical Licensing Board Inquiries 1

Learn why it's important to take any contact from state investigators seriously and get some tips to help you if you ever attract their attention.

- ▶ What if the Investigator Has a Search Warrant? (p. 4)

Plugging Loopholes: Limit Your Risks When Agreeing to Exclusive Contract with 'Clean Sweep' Clause 4

If you're not careful, your hospital could sweep you out the door for no reason. Here's how to protect yourself.

- ▶ Model Contract Clauses: Require Automatic Renewal and Termination for Cause (p. 5)

Respond to Patients' Billing Questions Before They Try to Collect Bounty . . . 6

CMS now lets Medicare beneficiaries collect rewards for reporting suspected fraud. We'll tell you how to protect yourself.

When to Get Patient Consent or Authorization for Disclosures 7

Understanding these two HIPAA privacy requirements can be confusing. We'll point out the differences between consent and authorization and tell you when each is required.

Traps to Avoid: Avoid Three Traps When Buying Compliance Plan. 9

Many parties buy compliance plans from outside vendors. Here are some things to look for if you decide to go that route.

Show Your Lawyer 10

IN FUTURE ISSUES

- Certify Financial Need Before You Waive Copayments or Deductibles
- Protect Yourself from Inaccurate Data Bank Reports
- Include Seven Protections in Your Medical Director Agreement

How to Handle State Medical Licensing Board Inquiries

If you're like many physicians, you may assume that because you practice good medicine and don't bill fraudulently, you'll never have to deal with an inquiry from your state medical licensing board. That assumption is a mistake, says Illinois health care attorney Philip Pomerance. Regardless of how good a doctor you are, you may be the subject of a complaint to your state medical board. Disgruntled employees, hospital staff, competitors, and third-party payors often make complaints to state medical boards, according to Pomerance. And their complaints often have more to do with a physician's demeanor and perceived integrity than his clinical competence.

It's also a mistake to assume that if there's an inquiry, it will be cleared up quickly because you're a good doctor. "The first thing to understand about state medical boards is that there are no 'innocent' inquiries," Pomerance says. Any contact—whether an appearance at your office, a letter, or just a "routine" phone call—means trouble, he cautions. State medical boards usually don't have the budget to conduct random inquiries or routine checks. Their investigators contact physicians only when there's some indication of a real problem, Pomerance contends.

We'll point out some of the consequences of an investigation, and show you how the effects can follow you for the rest of your career. We'll fill you in on the way most state medical boards operate, and explain why it's so important to take any contact by your state board seriously. And we'll give you some tips on how to proceed if you ever have the misfortune to attract the attention of your state board.

Investigations May Have Devastating Consequences

In the current regulatory climate, a board investigation of even a relatively minor problem can have far-reaching, devastating consequences. Pomerance offers the following example from an actual case:

A physician who worked in a public health clinic inadequately documented her care of children, failing to note certain immunizations. After an anonymous complaint, perhaps from another worker in the clinic, the state medical board investigated. Applying the maxim that if it isn't documented it didn't happen, the state found a "deviation from the standard of care." It required the physician to take remedial education courses in pediatric care and suspended her from the state's Medicaid program for nine months or until her remedial courses were complete. When the physician completed the remedial work and was reinstated in the program, she thought her problems were over. But they had just begun.

■ Patients and colleagues learned of the Medicaid suspension, with obvious implications for her practice (all states make sanctions against physicians

(continued on p. 2)

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Subscriptions: *Radiology Administrator's Compliance & Reimbursement Insider* (ISSN 1527-2338) is published monthly. Subscription rate: \$355 for 12 monthly issues. Address all correspondence to: Brownstone Publishers, Inc., 149 Fifth Ave., New York, NY 10010-6801. Tel.: 1-800-643-8095 or (212) 473-8200; fax: (212) 473-8786; e-mail: jgormley@brownstone.com

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LICENSING BOARD INQUIRIES (continued from p. 1)

public, either by publishing a list of sanctioned physicians in a newsletter, posting the list on the Web, or responding to public queries by phone).

■ The Medicaid office reported the suspension to Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA), and she was excluded from Medicare and all other federal programs. Despite her reinstatement in the state's Medicaid program, reinstatement into Medicare and other federal programs requires a separate application—with no guarantee it will be accepted. She remains excluded from federal programs while her reinstatement application is pending.

■ Hospitals where the physician had privileges learned of her exclusion from the federal programs and revoked her hospital privileges.

■ Health plans summarily suspended her from their panels based on her exclusion from the federal programs.

■ CMS reported her exclusion from the federal programs to the National Practitioner Data Bank (NPDB), where the record will remain forever available to hospitals and health plans that are required to query the data bank.

■ The two other states where she's licensed have opened investigations to which she'll have to respond, and which likely will lead to sanctions.

Take Investigation Seriously

Obviously, a contact from your state medical board means trouble, and you must respond accordingly. Even if an investigation is closed with no further action recommended—the best result you can hope for—there still may be consequences, Pomerance points out. The state board will have an open file on you, and any future complaints it receives will get quicker attention and closer scrutiny than they otherwise might have. Plus boards sometimes follow up with a “warning” or “letter of concern.” Even though these warnings or letters aren't made public, they'll be held against you if there's ever another problem. Finally, some applications from health plans, hospitals, and the like ask whether you've *ever been investigated* by state licensing authorities. No matter how an investigation turns out, you must answer “yes” if asked that question, and provide a complete explanation, Pomerance emphasizes.

Also, keep in mind that state medical boards have broad authority over you, and they're not afraid to use it. The law considers your license to practice medicine a privilege, not a right, Pomerance explains. That means familiar concepts like innocent until proven guilty, or trial before a jury of peers may not control the investigator's conduct. Plus state medical boards are subject to pressure from the media and politicians, and they may respond to outside pressure in a way that could be seen as overly harsh or unfair, he remarks.

It's important to understand that most states' laws require medical boards to investigate every complaint they receive—and most states also accept anonymous complaints, says Pomerance. So unless a complaint is clearly not credible, the board is obligated to follow up in some way. But an initial complaint often only leads to the investigator starting a file, and then waiting until other complaints come in before contacting the physician. In practical terms this means that if an investigator contacts you, he probably thinks he's got something worth investigating, Pomerance explains.

Tips on How to Respond if Medical Board Contacts You
If you should ever get a call, letter, or visit from a state medical board investigator, Pomerance offers the following tips:

Respond promptly. Denial is a common reaction to a contact from an investigator, Pomerance reports. But failing to return phone calls or answer letters from an investigator can land you in even more hot water. The code of professional conduct in every state requires physicians licensed in that state to cooperate with the board's representatives, including investigators, he explains. Refusing to respond promptly to an investigator is considered unprofessional conduct, and could eventually lead to charges against you for failure to cooperate.

Instead, respond immediately and politely but don't answer questions or honor requests for copies of patient records. Tell the investigator that you're willing to cooperate but want to consult an attorney for advice. Promise to call back within a few days, and keep that promise—after you've gotten advice.

Get expert help. As soon as you have some indication that the state medical board is interested in investigating your practice, contact an attorney who's experienced in representing physicians before the board. Your local bar association, medical society, or malpractice insurer can refer you to an attorney who can help. And many malpractice insurers offer coverage for state medical board investigations as a rider to their professional liability coverage, so there's no financial argument for not seeking experienced help immediately.

Don't panic. Although the state medical board has enormous power, it isn't unlimited. Sometimes investigators may attempt to manipulate a physician by insinuation or intimidat-

tion, or by misrepresenting their authority, Pomerance cautions. If you're caught unawares and scared, as most physicians are when they first hear from an investigator, you might let an investigator get away with more than you should—especially if you feel you have nothing to hide. For example, medical board investigators in most states don't have authority to come in and seize your patient records or financial records without a search warrant specifically authorizing it, Pomerance says.

If investigators show up at your office and want to take records away, ask to see the written warrant and a list of the records they seek. If they don't have a warrant, promise to respond to the written request within a reasonable time—say 10 business days. Once you have the written request or list, immediately consult your attorney for advice on how to respond.

Insider Says: Get familiar with the professional conduct rules in your state, just in case the board ever contacts you. You'll handle any inquiry better if you're familiar with those rules and the extent of the medical board's authority, Pomerance says. Many state health departments or medical boards, and many professional societies, such as your state radiology society, will provide you with a copy of that information at no charge if you ask for it. And some states include the information automatically with your license renewal applications.

Don't get defensive. Medical board investigators are often nurses, or retired law enforcement officers with little or no medical background. Physicians are sometimes so incensed at having a nonphysician questioning them that they become defensive. You
(continued on p. 4)

► *What if the Investigator Has a Search Warrant?*

If a state medical board's investigators suspect criminal activity, they may refer an investigation to law enforcement authorities. In that case, state or federal officers may arrive with a search warrant. If that happens, take the following steps immediately:

- Call your attorney and explain that officers are at your office with a search warrant;
- Inspect the officers' credentials carefully and note their names and badge numbers;
- Read the search warrant carefully and make a note of what it authorizes;
- Take careful notes of what the officers are inspecting and make a list of what they take with them. It's worth asking if you can keep photocopies of whatever documents they seize, although the officers aren't required to allow this;
- Ask the officers to give you a list of what they took (even though you'll have your own list);
- Get a criminal defense attorney experienced in representing health care providers immediately. Ask your business attorney, your local bar association, or medical society to help you. This is a matter that requires specialized help. Although a good criminal defense attorney who lacks health care experience may be able to prepare you well for a grand jury or represent you well in court, but may not understand the "domino effect." For example, a settlement with a district attorney or state's attorney won't protect you from exclusion from Medicare, Medicaid, licensing sanctions, etc. You may get a very good outcome to the criminal proceedings but be left without a way to earn a living as a physician. But an attorney experienced in representing health care providers charged with crimes will know how to deal simultaneously with all the interested parties, to get you the best possible result.

LICENSING BOARD INQUIRIES

(continued from p. 3)

may feel insulted that someone is questioning your integrity or competence and respond angrily or arrogantly. If ever there was a time to swallow your pride, this is it, says Pomerance. Responding to a medical board inquiry is a complex and delicate process, and defensiveness only makes it more difficult and dangerous.

Tell the truth. You mustn't lie, hide the truth, or "parse the question" when responding to an investigator or other representative of a state medical board. State codes of professional conduct consider lies, omissions, and misrepresentations to be fraud—just like submitting a claim for services you didn't provide, or changing a patient's medical record, Pomerance explains. Most state boards seek license revocation whenever they suspect fraud.

Many physicians mistakenly believe that state medical boards reserve their serious punishment for physicians who are incompetent. In fact, most boards go easier on physi-

cians who demonstrate poor technical skills or faulty medical judgment, because practice monitors and additional training can remedy these flaws. Boards typically reserve their most severe punishments for physicians whose integrity is questionable, Pomerance emphasizes. And any lie, omission, or misrepresentation indicates lack of integrity, he says.

Try to reduce long-term consequences. State medical board inquiries can do tremendous damage, but there are ways to navigate the process to minimize the long-term effects, Pomerance says. Boards have limited budgets and prefer to spend the bulk of their money on the most flagrant cases. If you can address the board's concerns appropriately, it may be possible to reach an agreement that doesn't result in a "reportable sanction." So you may be able to avoid all the consequences that follow a report to the NPDB.

Even if the board imposes a reportable sanction, there are ways to

deal with that, Pomerance says. Often the contents of the NPDB report are at least somewhat negotiable. Your attorney and the board's representative may be able to agree on language that allows some room for interpretation. Plus you can compose a response and send it to the NPDB, and your explanation will be sent to anyone who queries the NPDB about you.

Although you must *always* disclose what happened in response to questions about investigations or reportable sanctions, health plans and hospitals may not automatically reject your application if you present a reasonable, accurate explanation of the situation and can demonstrate that it won't happen again, Pomerance reports. Get your attorney's help to make sure that you're explaining the situation accurately but in the best possible light, he advises. ■

Insider Source

Philip Pomerance, Esq.: Hinshaw and Culbertson, 222 N. LaSalle St., Ste. 300, Chicago, IL 60601; <ppomerance@HinshawLaw.com>

PLUGGING LOOPHOLES

Limit Your Risks When Agreeing to Exclusive Contract with 'Clean Sweep' Clause

More and more hospitals are offering radiology groups exclusive contracts. While these contracts provide radiologists with a captive pool of patients and access to equipment and technical support that might not be available in a private practice setting, they can be full of traps for the unwary, says Virginia health care attorney Thomas W. Greeson. One particular trouble spot in many exclusive contracts is a clause that's often referred to as a "clean sweep" clause. This clause says that when

the contract ends, for whatever reason, the radiologist's hospital privileges end, too. That can spell disaster for a radiology group, which may suddenly find itself with no place to practice.

We'll explain the implications of a clean sweep clause, and offer you some suggestions about how to limit its impact if a hospital won't offer you a contract without one. We also give you two Model Contract Clauses on p. 5 to help you carry out these suggestions.

What's the Problem?

Hospital accreditation rules and laws in many states require a hospital to provide you with a fair hearing in accordance with the procedures in its bylaws if it seeks to revoke your medical staff privileges. If you accept an exclusive contract with a clean sweep clause, you're signing away that hearing right under the bylaws, says Greeson.

You're getting something in exchange—exclusive access to the hospital's patients during the con-

tract. But you're vulnerable on two fronts, since exclusive contracts not only are for a set term but also usually have provisions that allow for early termination in certain circumstances. If the hospital chooses to terminate the contract early, or not to renew, and you've agreed to a clean sweep clause, you could be left without hospital privileges, and with no place to practice your profession.

How to Limit Clause's Impact
If you're confronted with a clean sweep clause, try to get rid of it. But, if the hospital won't budge, Greeson recommends you propose two changes to the contract to alleviate the harshness of the clean sweep clause. It's best if you can get both of these changes. Greeson has had some success getting hospitals to agree to similar proposals.

Get guaranteed renewals and adequate nonrenewal notice. Propose that the contract renew automatically for one-year terms [Clause 1, par. a]. And require that if either party chooses not to renew, it must give adequate notice of its intentions. Adequate notice in this situation would be at least six months, says Greeson [Clause 1, par. b].

(continued on p. 6)

MODEL CONTRACT CLAUSES

Require Automatic Renewal and Termination for Cause

Here are two contract clauses that can help you reduce the risks of a clean sweep clause, which ends your hospital privileges when the contract ends. Clause 1 makes the contract automatically renewable (par. a) and requires six months' notice of nonrenewal by either party (par. b). Clause 2 allows termination before the end of the contract only for good cause or mutual consent

(par. a), provides an alternative to termination if an individual is responsible for the conduct that's the basis of the good cause (par. b), and defines good cause (par. c).

Show these clauses to your attorney before adding them to a contract.

CLAUSE #1

RENEWAL

- a. **Automatic Renewal.** Upon expiration of the initial term of this contract, the contract shall automatically renew for term(s) of one year, and shall continue to renew every year, unless one party properly and timely notifies the other party of its intention not to renew.
- b. **Notification of Intent Not to Renew.** One party may choose not to renew the contract prior to the expiration of the initial term or any subsequent term of this contract. In the event one party chooses not to renew the contract, it must so notify the other party in writing, delivered by certified mail, return receipt requested, at least 180 days prior to the next renewal date. Notification of nonrenewal by any other means or with less than 180 days notice shall not be effective except by mutual written consent of the parties.

CLAUSE #2

TERMINATION

- a. **Good Cause/Mutual Consent Only.** This contract shall not terminate prior to the expiration of the initial or any subsequent terms except for good cause shown, or by mutual written consent of the parties.
- b. **Conduct Attributable to Individuals.** If the conduct that constitutes good cause for termination is attributable to one or more individuals employed by or under contract to a party, that party shall have the option to terminate the relationship with the individual. In the event the party timely terminates the relationship with the individual, this contract between the parties shall remain in full force and effect.
- c. **Definition of 'Good Cause.'** For the purposes of this paragraph, "good cause" shall mean:
 - (i) Loss of any required state license;
 - (ii) Exclusion from the Medicare, Medicaid, or other government-sponsored health insurance program;
 - (iii) Imposition of a corporate integrity agreement in settlement of a state or federal fraud or abuse investigation;
 - (iv) Suspension or loss of JCAHO accreditation;
 - (v) Suspension or loss of DEA license or state authority to prescribe medications, including controlled substances;
 - (vi) Misuse of drugs or alcohol; or
 - (vii) Conduct that poses an imminent danger to oneself or to others.

PLUGGING LOOPHOLES

(continued from p. 5)

Automatic renewal benefits both your group and the hospital because you're not constantly in a negotiating mode. Even more important from the radiologists' point of view, an automatic renewal clause with adequate notice means you won't be left out in the cold if the hospital suddenly decides to contract with a competing group and terminate your contract. Since termination means the end of your hospital privileges, the notice gives you time to make other arrangements and find another place to practice, Greeson points out. To help convince the hospital to agree to this change, you can remind it that it would also have time to find adequate coverage for radiology services if you should choose to terminate the contract.

Allow termination only for cause. Don't permit termination of the contract without cause, although many contracts allow it. If the hospital can terminate your group at its whim, for any reason or no reason, and the contract has a clean sweep clause, you could be left without a place to practice at any time, says Greeson. And don't agree to termination based on "conduct not in keeping with the goals and values of the institution" or other such catch-all phrases, Greeson advises. These are too vague, and give the hospital too much discretion, he says.

Instead, insist that the contract provide for termination only "for cause" [Clause 2, par. a]. And list the causes, such as:

- Loss of medical license;
- Exclusion from Medicare;
- Misuse of drugs or alcohol; and

- Conduct that poses an imminent danger to others [Clause 2, par. c].

You also want to block the hospital from terminating the whole group if just one member has done something that's cause for termination. Instead, to protect the group, the contract could say, for example, that the hospital can force you to terminate the physician with the problem, rather than terminating the contract with the entire group [Clause 2, par. b]. Hospitals will often agree to make this change if you insist on it, Greeson notes, because it protects the hospital from being stuck with a physician with legal or other problems that might affect the hospital, its patients, or staff. ■

Insider Source

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

Respond to Patients' Billing Questions Before They Try to Collect Bounty

A Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) program could expose you to a flood of requests for billing explanations from Medicare patients looking to make a killing on your mistakes. The program allows Medicare patients and others reporting suspected fraud to get rewards of up to \$1,000 for "reports" that lead to the recovery of Medicare overpayments.

This incentive may result in many patients questioning their bills looking for mistakes. "Some advocacy groups are educating their members to actively look for this type of fraud," says health care attorney Jeffrey F. Boothe. And, if you don't respond effectively to patients' complaints, you could find them reporting you to the OIG or to your carrier

or intermediary, which could then refer the matter to the OIG.

Memo Shows CMS Is Serious

Despite the small amount of the reward involved, CMS is serious about the program—and you should be too. CMS has sent a program memorandum to carriers and intermediaries advising them to treat as eligible for reward any complaints they get that could ultimately lead to legal sanctions. It also instructed them to track all eligible complaints in their tracking systems and, if they get a complaint about a provider outside their jurisdiction, to refer it to the appropriate carrier or intermediary.

What types of fraud and abuse does CMS have in mind? Among the

abuses CMS mentioned in its statement announcing the program were:

- Billing for services that weren't provided;
- Double billing for the same procedure;
- Billing for a more expensive procedure than the one actually provided; and
- Billing for medically unnecessary procedures.

Be Ready to Respond to Increased Inquiries

Physicians, hospitals, and other providers that deal directly with the public are most likely to feel the program's impact, says Boothe.

As the public becomes more aware of the program and more comfortable in challenging physicians, practices will have to develop inter-

nal systems to deal effectively with patients' billing questions. While your responses to individual questions will vary depending on the situation, you should keep the following points in mind if you want to avoid OIG scrutiny:

1) Respond promptly. Set a policy requiring a response to all patients' billing questions within 30 days of receipt. Resist the temptation to treat a question more casually because it's not coming from a carrier or intermediary, the OIG, or other governmental authorities, says Boothe. Since the government is now actively encouraging private citizens to report suspected fraud, it's best to think of the patient as the government's agent and to treat him or her with the same respect and professionalism as you would the OIG. By responding quickly, you're not only telling patients that you care about their concerns, you're also showing them you have nothing to hide.

2) Use plain English. When responding to a patient's question

about a bill, use plain English to explain why a particular procedure was billed a certain way. "A lot of complaints to the OIG come from the fact that people are confused and don't understand the explanations they get from their providers," says Boothe. And that can lead to trouble. Remember: Patients aren't well versed in either medicine or the fine points of Medicare law, so it's important that you spell out the reasons in your response. Keep your answer simple and try to put yourself in the shoes of someone who isn't a professional. If you think the ordinary customer won't understand your explanation, rewrite it. If you don't, patients may have more reason to suspect the worst—and call the OIG.

3) Use normal procedure for simple billing mistake. If you discover a simple billing error, such as an isolated overpayment that doesn't involve Medicare fraud, simply follow your normal procedure for reporting the overpayment and correcting the situation. You can then

inform the patient that you have caught the isolated error and properly corrected it.

4) Consult attorney first for potential legal violations. Your initial investigation of a suspected billing error may lead you to believe that you have a systemic or long-term billing or coding problem that violates Medicare law. If so, consult your attorney before conducting a full-scale investigation into the matter or responding to the patient. Doing either of these things could jeopardize your legal rights. Your attorney can advise you on how to handle the matter and whether you should take advantage of the OIG's self-disclosure protocol, which might reduce any penalties or fines. Whatever you do, make sure your attorney coordinates your disclosure to the government and your response to the patient. ■

Insider Source

Jeffrey F. Boothe, Esq.: Holland & Knight, 2100 Pennsylvania Ave. NW, Ste. 400, Washington, DC 20037.

When to Get Patient Consent or Authorization for Disclosures

The *final HIPAA privacy regulations* tell you when you can disclose protected health information (PHI) and when you can't. In most situations, if you're a health care provider, you'll have to get patient consent before using or disclosing the patient's PHI (health plans or health care clearinghouses may want to get it, although it isn't required). But in certain situations, getting patient consent isn't enough. If you're a health care provider, you'll have to get patient authorization.

Determining whether patient consent or patient authorization is

required before you disclose PHI can be confusing. And, if you get it wrong, you could be accused of violating the HIPAA privacy regulations. To help you avoid this compliance risk, we'll answer, with the help of health information attorney M. Peter Adler, common questions about when and how to get a patient's consent or authorization.

When Consent Is Required

Here are some answers to common questions about when and how to comply with the consent requirement:

What's consent? Consent is written permission from a patient

that allows a health care provider or other health care organization to use the patient's PHI for a broad range of purposes.

When is consent required? The final privacy regulations require that health care providers get a patient's consent before using and disclosing a patient's health information for purposes of treatment, payment, or health care operations. The term "health care operations" includes a wide variety of activities, including utilization review, quality assurance, medical training, and business

(continued on p. 8)

GET PATIENT CONSENT

(continued from p. 7)

planning and development, explains Adler. Even certain types of marketing and fundraising activities qualify as health care operations, he says.

Together, treatment, payment, and health care operations cover the majority of routine disclosures. So before a health care provider makes any of these disclosures, it first needs to get patient consent.

What are the exceptions to the consent requirement? The regulations describe five situations in which patient consent *isn't* required for health care providers:

- In emergencies, as long as the health care provider attempts to get consent as soon as reasonably possible after the patient receives the emergency treatment;
- When a health care provider is required by law to treat the individual, such as a publicly funded free clinic, as long as the provider at least tries to obtain consent;
- When the provider attempts to get consent but fails because of communication barriers and consent is understood, given the circumstances (for example, the patient is mentally incapacitated and in need of medical care);
- If a health care provider has an "indirect treatment relationship" with the patient because, for example, he provides services through another provider, such as a radiologist or pathologist; and
- When a provider is treating a prison inmate.

What must consent form include? According to Adler, the regulations say that the patient's consent must:

- Be written in plain language—that is, easy to read and understand;
- Refer the individual to your notice of privacy practices, which

must be provided in a separate document;

- Say that the patient has been given an opportunity to review your notice of privacy practices before signing the consent;
- State that your organization's notice of privacy practices may change and explain how a patient can get a copy of the notice if it's updated; and
- Explain some of the patient's rights, such as the right to request a restriction on how PHI is used, your right to deny such requests, and the individual's right to revoke the consent in writing, to the extent it hasn't already been relied upon; and
- Be signed and dated by the patient.

If the consent lacks any of the elements required by the regulations, it may be invalid, says Adler. For example, the consent is invalid if it fails to mention your notice of privacy practices.

Can the consent be part of another document? The regulations allow the consent to be in the same document as other types of legal permission, such as a consent for treatment or an assignment of benefits. But the consent must be set off from the rest of the document. One way to do this is to place a heading at the beginning of the consent language and highlight it by using boldface letters, all capitals, or a similar method, he says. So for example, at the beginning of the consent language you could place the following phrase, printed in boldface:

**Patient Gives XYZ Radiology
Permission to Use and Disclose
Patient's Confidential Health
Information for the Purposes Below.**

But the consent may not be combined with your notice of privacy practices, warns Adler.

May treatment or enrollment be refused if a patient refuses to give consent? The regulations permit

providers to make an individual's willingness to grant consent a condition of treatment and permit health plans to make it a condition of enrollment, says Adler. In other words, if a patient refuses to sign a consent form, you can refuse to treat him and a plan can refuse to enroll him. Without this protection, providers and plans would be in a tough position regarding patients who need treatment but refuse to grant consent, he explains.

When Authorization Is Required

Patient authorization is more specific than patient consent and is required in different circumstances, says Adler. Here are some answers to common questions:

What's authorization? Authorization is written permission from a patient that allows a health care provider or plan to use the patient's PHI for the specific purpose described in the authorization.

When does it apply? While patient consent is required for uses and disclosures for treatment, payment, and health care operations, authorization is generally required for disclosures made for purposes other than treatment, payment, or health care operations. All health care organizations covered by HIPAA—not just providers—must get patient authorization. So, if you need to disclose PHI for a reason not covered by the consent requirements, and the disclosure isn't otherwise permitted or required by the privacy regulations, you must get the patient's written authorization to do so, Adler explains.

What must authorization include? According to Adler, an authorization must:

- Be written in plain language—in a clear, concise, and readable manner;

- Be much more specific than consent. For instance, it must describe in detail the PHI that will be used or disclosed (such as “photographs of knee surgery performed on July 11, 2000”), who may disclose it (for example, “John Smith, MD”) and to whom (“to XYZ Medical Journal”);

- State when (on what date or event) the authorization will expire (for example, Dec. 31, 2001);

- State that the patient may revoke his/her authorization in writing, and explain how he/she may do this;

- State that the information, once disclosed to others, may be redisclosed by them to individuals or organizations that aren't subject to the HIPAA regulations, which means the information may no longer be protected;

- State that the individual has the right to refuse to sign the authorization (except for research involving the treatment of a patient); and

- Be signed and dated by the individual and a copy provided to the individual. You may also want the authorization to say that upon signing, the patient will be given a copy of it.

An authorization isn't valid if it doesn't meet all the requirements, warns Adler. For example, an authorization is invalid if the expiration date has passed, it hasn't been filled

out completely, it has been combined with another document, it has been revoked, or you know that key information in it is false, he explains.

Can the authorization be part of another document? Unlike a consent, an authorization generally must be a stand-alone document and cannot be combined with any other document. There are a few narrow exceptions to this rule (for example, an authorization to disclose an individual's PHI for research purposes may be combined with a consent for the individual's treatment associated with the research).

May treatment, enrollment, eligibility, or payment be refused to a patient who refuses to give authorization? With few exceptions, the authorization must contain a statement that the health care organization won't make the individual's willingness to provide the authorization a condition of treatment, enrollment, eligibility, or payment.

When Neither Consent Nor Authorization Is Required
The final privacy regulations also list two categories of disclosures that require neither consent nor authorization, Adler points out. The first category applies to disclosures made

in a patient directory or to a person involved in the patient's care, such as a friend or family member. Although you don't have to get the patient to sign a written consent or authorization for disclosures in this category, you must give the patient an opportunity to orally agree or object to the particular disclosure.

The second category includes many of the disclosures that are permitted or required by state law—often because disclosure serves a public, health care, or law enforcement purpose. For example, patient consent or authorization isn't required when disclosing PHI: for public health activities (for example, reporting birth and death health statistics to state agencies); about victims of abuse, neglect, or domestic violence; when required by law; for health oversight activities (for example, to government investigators looking into referral practices); and for judicial and administrative proceedings. In this category, you don't have to give the patient any opportunity to agree or object to the particular disclosure. ■

Insider Source

M. Peter Adler, Esq.: Foley & Lardner, Washington Harbour, 3000 K St. NW, Washington, DC 20007-5109.

TRAPS TO AVOID

Avoid Three Traps When Buying Compliance Plan

The OIG compliance program guidance for physician practices specifically mentions that practices may outsource some or all of the responsibility for developing and administering their compliance programs—including the written compliance plan. Many physician practices are taking note of this and buying compliance plans for their practices from outside vendors. Some practices say that it's worth the money

to have the outside expertise—and to spare themselves the hassle of putting together their own plans.

But there are risks as well as benefits to outsourcing the development of your compliance plan, warns Jackie Miller of Per-Se Technologies Consulting Division. If you decide that you would rather buy a compliance plan than write your own,

Miller points out the following three common traps to avoid.

Trap #1: Cookie-Cutter Compliance Plans

Many consultants, professional societies, law firms, and others offer pre-fabricated compliance plans to physician practices—often at a high

(continued on p. 10)

TRAPS TO AVOID (continued from p. 9)

price. Some people even sell the OIG's compliance program guidance, which is available free on the Web. Purchasing a prefabricated compliance plan and simply adopting it—as is—as your practice's compliance plan isn't a good idea, Miller warns. An effective compliance plan is one that helps your practice promote compliance and discover and prevent noncompliance. A compliance plan that works for some practices won't necessarily work for all practices, as each practice has its own specific risk areas. A cookie-cutter plan may be one your practice can't live up to, and that can be worse than no compliance plan at all, Miller says.

Trap #2: Plan Not Tailored to Your Needs

If you choose to buy a plan rather than write your own, buy it from someone with extensive experience working with radiology practices the size and complexity of yours. Also, make sure the vendor first talks with you about the particular issues you feel are problems in your practice. That way, she can tailor the plan to meet your needs. It's crucial that the compliance plan

your practice adopts be one that corrects any problems you've experienced in the past, provides a way to monitor these trouble spots, and prevents those problems from recurring in the future. And your plan should be flexible enough to grow and expand as your practice—and its resources—grows and expands.

Trap #3: Fly-by-Night Vendor

Unfortunately, some unscrupulous people discovered that there's money to be made in health care compliance. You want to be sure to buy a compliance plan from someone who will be available to help you implement it. Check your vendor's reputation with your local medical and specialty societies, attorney general's office, and the Better Business Bureau before you buy. And ask whether the vendor will remain available to discuss any questions about how to implement the plan in your practice, Miller advises. Some vendors will periodically review the plan and fine-tune it in response to changes in the law or new government initiatives. That can be a big help, so it's wise to ask if your vendor will do that, Miller remarks.

Insider Says: Continue to monitor and evaluate compliance on an ongoing basis. Even if you outsource the development and implementation of your compliance plan, you can't outsource compliance accountability, Miller cautions. The physicians who own the practice are ultimately responsible for the success or failure of the practice's compliance efforts. So, even if you outsource, you must demonstrate that compliance is a priority. Do this by rewarding compliance initiatives, promptly acting on reports of noncompliance, immediately correcting noncompliant behavior, and setting a zero-tolerance policy for intentional noncompliance, Miller suggests. ■

Insider Source

Jackie Miller: Per-Se Technologies, 2840 Mount Wilkinson Pkwy., Atlanta, GA 30339.

SHOW YOUR LAWYER

Here are the court cases and/or laws referred to in this issue.

- Final HIPAA privacy regulations: Fed. Reg., Vol. 65, No. 250, 12/28/00, pp. 82798-82829.