Radiology Administrator's
Compliance & Reimbursement Insider

SEPTEMBER 2001

IN THIS ISSUE

Include Seven Protections in Your Director Agreement 1
Try to negotiate these protections in your department director contract.
▶ Consider Listing Director's Duties in Your Contract (p. 3)

Ask the *Insider* 4
▶ Referrals from Family Member

Use New CMS Transmittal to Get Paid for Certain Pre-Op Exams and Tests 5
CMS has clarified that some pre-op services are reimbursable.

Getting Paid: Take Two Steps to Complain About Unpaid Claims 6
We spoke to the experts to find out how to get paid without suing the plan.
▶ Model Letter: Get Plan to Pay Claims (p. 7)

Offer Incentives to Attract New Radiologists to Your Practice 8
Many practices are having a tough time trying to expand. We'll give you some ideas for making your practice more appealing to young radiologists.

Dos & Don'ts 9
▶ Create Separate Documentation for Each Internal Audit Issue
▶ Don't Set Specific Audit Schedule in Your Compliance Program

Show Your Lawyer 10

IN FUTURE ISSUES

- Include contract protections when adding a new physician to your practice
- Get proof of financial need when waiving copayments or deductibles
- Take security precautions when an employee quits or is fired

Include Seven Protections in Your Director Agreement

If your practice signs an exclusive agreement to provide radiology services to a hospital, chances are that a member of your practice will be appointed as the director of the hospital's radiology department. The director typically assumes the administrative and managerial duties running the department.

Although being the director may be an honor, it's also a big responsibility. The director will be the front man—and maybe the fall guy—if the hospital implements policy changes or fiscal cutbacks. The director will have to represent the best interests of the practice to the hospital and the best interests of the hospital to the practice—that may lead to conflicts with the hospital or within the practice. The duties associated with the position can be quite time consuming, as well. Finally, serving as the director may raise compliance issues, especially for referral-dependent physicians such as radiologists, says New Jersey health care attorney Michael F. Schaff.

To be protected, you should add certain provisions in the director's agreement your practice signs with the hospital. Usually the director's agreement is part of the contract that spells out the practice's arrangement with the hospital. But sometimes the hospital and the practice sign a separate agreement that deals solely with the director's position. We'll give you a checklist of seven provisions to try to include in the director's agreement, whether it's a separate document or part of another contract. And we'll explain how each provision protects your practice. Plus we'll give you Model Language, based on language that Schaff often uses, that you can adapt and use in your agreement.

❑ Get Right to Select Director

To ensure that you retain some control over how the radiology department is run, your practice should have the right to select the practice member who will serve as the director. You want your director or chair to be someone whose loyalty is to your practice and the patients, rather than someone appointed by hospital administration. Your agreement should say that:

- Your practice (typically referred to as "Group" in the agreement) has the right to select one of its members to be the director;
- The hospital has the right to approve your selection (make sure you add that it can't unreasonably withhold this approval); and
- The director must be a member—either an employee or an owner—of your practice.

Model Language

Group shall designate a physician who is employed by the Group (Group Physician) to serve as the Director of the Department of Radiology, which

(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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INCLUDE SEVEN PROTECTIONS (continued from p. 1)

appointment shall be subject to approval by the Hospital in accordance with the requirements for appointing department directors as set forth in the Hospital Medical Staff Bylaws, such approval not to be unreasonably withheld. In no event shall the Director be a physician other than a Group Physician.

❑ Get Right to Replace Director

You also need to anticipate the possibility that the director may have to step down at some point. Your practice may be vulnerable to a power play by the hospital in this circumstance, Schaff cautions. Although your agreement says that the director must be a physician from your practice, you want to be sure you get to select the replacement—rather than allow the hospital to pick. If the agreement doesn't say how a replacement should be picked, then the hospital may attempt to foist someone on you. Schaff advises including language in the agreement that permits the practice to choose one of its physicians to replace the director if he or she ever has to step down.

Model Language

In the event the Director cannot or is unable to serve as department director for any reason whatsoever, Group shall designate a replacement to serve as Director subject to the approval of the Hospital in accordance with the requirements for appointing department directors as set forth in the Hospital Medical Staff Bylaws, such approval not to be unreasonably withheld.

❑ Spell Out Director's Duties

Spell out the director's duties to avoid any ambiguity and to get a sense of how much time the director will have to devote to clinical matters. Some hospital bylaws set forth the department director's duties, and in that case your agreement may just refer to the bylaws. Although these duties may be added obligations for the director, they keep a representative of your practice involved in hospital processes. This involvement is especially important for radiologists, who typically don't generate a lot of revenue for hospitals and so have minimal bargaining power.

The agreement also should say that it's the director's responsibility to make sure the practice adheres to the contract with the hospital. This ensures that the practice has a measure of control over its activities at the hospital.

Model Language

The Director shall be responsible for administering the Department in accordance with the Hospital Medical Staff Bylaws; Hospital administrative policies; any rules, regulations, or statutes governing the activities of the Department and the Hospital; and this Agreement.

If the hospital medical staff bylaws aren't explicit about department directors' duties, the contract should list the specific duties. These duties are subject to negotiation between your practice and the hospital. Even if the bylaws list department directors' duties, you may want to include additional duties in your agreement because you can gain a measure of control in the guise of performing a duty, Schaff says. For example, if you make participation in the budget development process a duty of the director, your practice has some protection, or at least warning, about possible budget problems that may affect the department, he explains. We've given you some typical director's duties and Model Language that you may want to adapt and put in your contract (see p. 3).

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❑ Negotiate Director's Time Commitment

In some cases, being the department director can be a full-time job. To make sure that the hospital, your practice, and the director are all on the same page, you should discuss time commitments before the contract is signed, says Schaff. Once everyone agrees about how much time the director will allocate to administrative versus clinical responsibilities, spell it out in the agreement, Schaff suggests.

Model Language

Group shall assure that the Director provides to the Hospital:

a. No more than an average of [*insert number*] hours per week of professional services at the Hospital; and

b. No more than an average of [*insert number*] hours per week of administrative, supervisory, and teaching services in the Department, during which time the Director cannot be counted as one of, and must be in addition to, the scheduled physicians providing professional services needed to comply with the minimum staffing requirements set forth hereunder.

❑ Get Director Fair Market Value Payment if Duties Take Significant Time

Hospitals frequently don't pay department directors anything for their services as director, Schaff reports. This practice raises a compliance issue if the director is spending a lot of time on departmental duties—particularly for captive, referral-dependent physicians such as radiologists. The OIG might think that the practice and the director are giving the director's administrative services to the hospital free of charge in return for the ability to provide services to the hospital's patients. Under the federal fraud and abuse laws, as well as many states' laws, this might be considered an illegal kickback. Although Schaff isn't aware of any cases in which the OIG went after a hospital or a radiology practice for this kind of violation alone, he says it's better to be safe than sorry. If the director's duties and time commitment are more than incidental—that is, if they require more than two or

(continued on p. 4)

▶ Consider Listing Director's Duties in Your Contract

When negotiating your director's agreement, you may want to include a list of the duties the director will perform.

Here are some typical director's duties that you might want to include in your agreement, along with some Model Language that you can easily adapt for your circumstances. Your agreement may include some or all of these. This list isn't exhaustive—there may be other duties that are appropriate to include in your contract.

SCOPE OF AUTHORITY

You may want to spell out the scope of your director's authority by giving her the explicit duty to oversee the department, ensure that hospital policies are adhered to, and make sure that the members of the department are appropriately qualified.

Model Language

The Director shall:

a. Monitor the completeness of the professional services portion of the Hospital record for all services rendered to patients in the Department by the Group's physicians;

b. Monitor the Department's activities and standards of professional performance of all Group's providers within the Department through performance evaluations;

c. Develop, implement, and enforce the Department's goals and policies consistent with the Hospital and medical staff bylaws;

d. Develop Department criteria and make recommendations to the credentials committee for the granting of clinical privileges within the Department; and

e. Participate in the improvement of case management, patient satisfaction, and turnaround times, and in the establishment of criteria to the satisfaction of [*insert name of person to whom Director reports on clinical matters*].

PARTICIPATION IN HOSPITAL COMMITTEES

You probably want your director to serve on various important hospital committees, so that your department will be represented in making hospital policy.

Model Language

The Director shall:

a. Participate in the Hospital's executive committee;

b. Participate in the preparation of annual budgets; and

c. Participate in the Hospital medical staff's executive committee meetings.

OBLIGATIONS TO DEPARTMENT

You may want to spell out your director's responsibilities within the department.

Model Language

The Director shall:

a. Chair regularly scheduled Department meetings; and

b. Establish and maintain coverage schedule assuring that Group complies at all times with the minimum staffing

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INCLUDE SEVEN PROTECTIONS
(continued from p. 3)

three hours per week, the hospital should pay the director fair market value for them, he advises.

❑ Make Chain of Command Clear

Schaff says that your agreement should make clear whom the director reports to for administrative matters and clinical matters. It may be the same person or different people. In the following Model Language we assume that the director reports to the same person for clinical and administrative matters.

Model Language

The Director shall report to the Executive Director of the Hospital for both clinical and administrative matters.

❑ Get Opportunity to Correct Defaults

Sometimes a hospital that's experiencing a change in administration, or trying to cope with financial pressures, will point to some failure on the part of the department director or the practice and use it to try to replace the department director. This is often a first step toward terminating the practice's contract with the hospital. To improve your odds of surviving a situation like this, require the hospital to give you notice of any problem and sufficient time to remedy it, before the hospital can take action. In legalese, this is called an "opportunity to cure." Here's the language Schaff uses:

Model Language

The Director shall be removed from that position by the Hospital's Executive Director or his designee only if there is a:

a. Material failure of either the Director or Group to fulfill the responsibilities under this Agreement after receipt of written notice;

b. Thirty (30)-day opportunity for the Director or Group to cure such failure; and

c. Failure to cure in accordance with Paragraph (b) hereof.

***Insider* Says:** In return for getting the opportunity to cure, you may need to agree to waive any appeal rights you or the director may have under the hospital staff bylaws. ■

Insider Source

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ASK THE *INSIDER*

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Referrals from Family Member

Q The daughter of a local family practitioner recently completed her residency in radiology. She's interested in coming back to the area, and our group is interested in hiring her. But one radiologist says that if we hire her we could get into trouble because her dad refers patients to our practice. This seems far-fetched. Is it true?

A Yes, says Long Island health care attorney Jay Silverman, and there may not be a way to get around it. The federal anti-referral law (known as *Stark II*) bars a physician from making any referrals for designated health services reimbursed under federally sponsored health care programs to an entity in which the physician, or the physician's immediate family member, has a financial interest. Radiology services are "designated health services" under Stark II. And your state law may also bar this type of referral, regardless of who's reimbursing them, Silverman points out.

In this case, the family practitioner might refer a Medicare patient for a designated health service to your radiology practice. Your practice would be considered an entity in which the family practitioner's immediate family member has a financial interest because his daughter works for your practice. If such a referral occurred, it would be considered a violation of Stark II, and it could lead to serious penalties.

There are a few exceptions to Stark II that may make this kind of arrangement permissible, but they're narrow. For example, if the practices are in a rural or medically underserved area, the family practitioner could refer Medicare patients to his daughter's practice for covered radiology services as long he disclosed the relationship to the patient. He would also have to give the patient the names of other practitioners able to perform the service.

The bar on such referrals applies whether or not the parties intended to do anything improper, Silverman notes. So, to be safe, he suggests contacting an experienced health care attorney to see whether any exception to Stark II applies in your case. If not, you should pass on hiring the family practitioner's daughter, he says. Or you can just stop accepting referrals from the family practice. ■

Insider Source

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Use New CMS Transmittal to Get Paid for Certain Pre-Op Exams and Tests

In a revision to the Medicare Carrier's Manual dated May 31, 2001, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) added a new section 15047—"Preoperative Services Paid Under the Physician Fee Schedule." Although the new section doesn't represent a change in policy, it's significant because it clarifies that certain preoperative services performed outside of the global surgical period are payable. (The "global surgical period" is a period of time during which all medical services a patient receives are included as part of the surgical fee unless they are clearly meant to treat a separate and distinct condition.)

We'll tell you what the new section says and how it may affect whether you get paid for preoperative examinations and diagnostic tests performed outside the global surgical period. We'll also describe CMS instructions to carriers about how to evaluate claims for preoperative services to determine whether to pay them. And we'll tell you how to document these services and bill your claims so that you maximize the possibility of getting paid.

Why Clarification Was Necessary

Physicians sometimes have a hard time getting paid for some preoperative services performed outside of the global surgical period, says Washington, D.C., health care attorney William A. Sarraille. Before the CMS transmittal, some carriers simply assumed that preoperative examinations and diagnostic tests weren't covered and denied the claims across the board, he says. Other carriers set these claims aside for manual review, which would delay payment for the services.

The new section in the Carrier's Manual clarifies that certain preoperative examinations and diagnostic tests performed for medically necessary reasons such as to determine a patient's risk of complications and to properly address significant patient care issues during and after surgery may be reimbursable under Medicare rules (although they may be denied on a case-by-case basis).

Two Steps for Assessing Which Claims Are Reimbursable

The new section in the Carrier's Manual describes a two-step analysis the carrier should make when it decides whether to reimburse a claim for a preoperative exam or diagnostic test performed outside of the global surgical period. Understanding this analysis can help you to get paid, Sarraille notes.

1) Not 'routine.' First, the carrier must determine that the test isn't a screening test or that the exam isn't a routine physical checkup—that is, it isn't a diagnostic test or physical examination performed in the absence of signs or symptoms consistent with an illness or injury. Medicare doesn't cover screening tests and routine exams.

To prove that the exam or test isn't routine, you should carefully note the patient's signs and symptoms, and list the possible surgical complications that the patient may experience. Sarraille suggests that you also include a brief remark indicating how the exam or test you perform relates to the patient's complaint and likelihood of complications, and what you expect the exam or test to tell you.

2) 'Medically reasonable and necessary.' Once the carrier has decided that the exam or test wasn't part of a routine physical checkup, it must consider whether it was "medically reasonable and necessary" under Medicare rules. A service that meets this medical necessity requirement must help the physician diagnose or treat the patient's illness or injury.

To establish medical necessity, you must document that the preoperative exam or test will help to assess a patient's risk of complications or aid in the patient's treatment during or after surgery, Sarraille advises.

Billing for Pre-Op Exams and Tests

The new section in the Carrier's Manual says that when billing for preoperative exams or diagnostic tests performed outside of the global surgical period, you must use the appropriate ICD—9 code for preoperative services (V72.81 - V72.84). You must include other ICD-9 codes, too—the code that describes the condition that led to the recommendation for surgery, as well as the codes for any other conditions that the patient may suffer from. Including codes for other conditions the patient suffers from is especially important if these secondary conditions increase the patient's risk of complications, Sarraille says, because it helps you to establish that the claim meets the medical necessity requirement. For example, a preoperative exam or test that would be medically unnecessary in an otherwise healthy patient may be crucial if the patient suffers from, say, a clotting disorder, autoimmune disease, or diabetes, he explains. ■

Insider Source

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GETTING PAID

Take Two Steps to Complain About Unpaid Claims

Many plans are slow when it comes to paying claims. If you don't get paid on time, you may have a hard time paying your own bills. For instance, one provider we spoke to had to cut his staff's salaries because unpaid claims had hurt his cash flow. But complaining to plans about late payments can be tricky. If you don't handle your complaint the right way, you won't get paid. You could also ruin your relationship with the plan.

There are steps you can take to get a plan to pay you, say the experts. We'll give you a rundown on their advice. And we'll give you a Model Letter (see p. 7) to show you the right way to demand payment.

Lawsuit Is Last Resort

Why not just sue? If your claims haven't been paid by a plan, you may have grounds to sue the plan for violating your contract or state law. But that's not an effective way to get paid, says Thomas P. Gordon, former director of network development for a large regional HMO. It's a last resort. A lawsuit is time consuming and expensive, and it escalates the conflict between you and the plan, rather than resolving it. So before you go to court, try to work with the plan on getting paid.

Step #1: Call Plan

As a first step, call and speak to a plan representative about the unpaid claim, say plan insiders. "The squeaky wheel gets oiled," counsel for a national plan told us. Calling the plan will often work to dislodge a late payment. Often one call will be enough to get a claim processed, according to Gordon.

When to call. Be prompt about contacting the plan. Most contracts set a deadline for the plan to pay claims—for example, 30 days after the submission of the claim. Call the plan about an unpaid claim within two months of this deadline. If you wait too long after the deadline to complain, your unpaid claims may pile up and your cash flow will suffer.

***Insider* Says:** You'll have more leverage with the plan if you complain about unpaid claims when the plan wants something from you, notes Gordon. "For example, if a plan is renegotiating a contract with a provider and the provider brings up unpaid claims, they'll usually look right into it and pay up," he says.

Whom to call. To make an effective complaint, you must contact the right plan representative. Several plan experts told the *Insider* that a provider shouldn't complain to the plan's claims department. Claims staffers typically don't have authority to respond to a complaint. Instead, contact a plan executive who will be interested in making sure that you have a good working relationship with the plan.

This person's title will vary from plan to plan. In some plans, the person to contact will be the director of network development. In others, it might be the provider relations representative. You also might try speaking with the plan's medical director. The *Insider* learned of one case where an HMO's medical director arranged for a provider to get paid promptly after learning about his unpaid claims.

If the plan owes you more than several thousand dollars, call the plan's chief financial officer (CFO), experts recommend. The CFO will be sensitive to serious financial issues and will probably help you get paid.

What to say. Give the plan representative identifying information about the unpaid claim. Tell him or her the amount you're owed, the date you submitted the claim, and the name of the member you treated. Ask when you can expect to be paid and whom you should contact if you don't get paid by that time. Also, make sure you get the name of the person you're speaking to.

It's important to use the right tone when you speak to the representative. You want to be factual and matter-of-fact, not insulting, warned one source. After all, the person you're complaining to probably didn't cause the payment delay personally. Make it clear that you want to work with the plan to resolve the problem. Don't threaten to sue the plan or to terminate your contract if you don't get paid immediately. You don't want to bite the hand that feeds you—at least not while there's a chance that you'll get paid.

It also may be helpful to offer to meet in person with the plan representative to discuss unpaid claims—especially if the plan owes you a lot of money. Some plan representatives prefer to conduct business this way. Others don't like spending time in meetings and will prefer to talk to you by phone.

The plan representative may ask you to resubmit copies of your claims. She may tell you she needs to research your complaint and get back to you before committing to a payment deadline. If that happens, make sure you set a date by which the rep-

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resentative should contact you, and find out whom you should contact if you don't hear from her by then.

Step #2: Send Letter

If you don't get paid after speaking with a plan representative, send a letter demanding payment. A well-written demand letter will support your claim and help you get paid. The letter should be firm but polite. Send it to the person the plan representative told you to contact if you didn't get paid by the deadline you set during your phone complaint. Send the letter promptly after that deadline passes.

Like the *Insider*'s Model Letter, your letter should do the following:

Give identifying information. Give the plan identifying information about the unpaid claim. State the amount you're owed, when you submitted the claim, and the name and identification number of the member you treated [Ltr., par. 1]. Some contracts require plans to pay interest on unpaid claims. If your contract does, be sure to specify that you're owed interest on the unpaid claim. Also, many state laws require the payment of interest on unpaid claims that have been filed on time. If your state has such a law, cite the law and the deadline it sets. Ask your attorney if there's a state law you can rely on.

***Insider* Says:** If you have more than one unpaid claim, "bundle" them into a single complaint letter. Spell out the identifying information for each claim in a schedule, and attach the schedule to the letter.

Say that claim is uncontested. Let the plan know that it hasn't notified you about any problem with the claim, such as missing information or lack of preauthorization. Otherwise, the plan may assume that's why it hasn't paid the claim [Ltr., par. 1].

Cite contract deadline. If your contract sets a deadline for paying claims, cite the deadline and the contract clause that sets it [Ltr., par. 2].

Detail previous attempts to collect. Tell the plan that you've already spoken to plan representatives about the claim. Be specific. Identify the individuals you spoke to, when you spoke to them, and what they told you [Ltr., par. 3].

Give deadline. Give the plan a deadline for paying you. A reasonable deadline is 14 days from the date of the letter, say the experts [Ltr., par. 4].

Warn plan of consequences. Tell the plan that if your claims aren't paid on time, you may have to take "further action." While this threat may seem wishy-washy, you must be careful. If you threaten to sue the plan or go to the press, you may antagonize the person you're writing to and not get paid, plan insiders say. This vague threat shows that you take the matter seriously, but aren't being difficult [Ltr., par. 4].

(continued on p. 8)

MODEL LETTER

Get Plan to Pay Claims

Here's an example of a letter you can send to a plan to complain about unpaid claims. It's based in part on one prepared by the California Medical Association.

The letter demands payment and gives identifying information about the claim. It points out that the plan hasn't notified you that it's contesting the claim and cites the deadline set out in the contract for paying claims. The letter also details your previous efforts to collect payment. It gives the plan a new deadline to pay and warns the plan that you may have to take "further action" if the plan doesn't pay.

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

Sept. 21, 2001

Re: John Patient (Member #00000)

Dear Mr. Poe:

1. I am writing to demand payment from XYZ Health Plan for a claim in the amount of $1,200. The claim relates to services provided to the above-referenced patient on July 12, 2001. The claim was sent to XYZ on July 16, 2001. To date, XYZ has not notified me that it is contesting this claim. Additionally, Section 35 of the Anystate code requires the payment of interest on any claims not contested or paid within 60 days of timely claim submission.
2. Section 12 of our contract states that XYZ must pay uncontested claims within 30 days of receiving the claim.
3. I have already spoken to a representative of XYZ about this matter. On Aug. 27, 2001, I spoke to Jane Roe, XYZ's Provider Relations Representative. She told me that my claim would be paid within seven days. However, I have not yet received payment.
4. If I do not receive payment of this claim by Oct. 3, 2001, I may have to take further action to protect my interests.
5. Please feel free to call me at 555-5555 to discuss this matter. I am also available to meet with you in person if you prefer.

Thank you for your cooperation.

Yours truly,
John Provider, MD

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GETTING PAID (continued from p. 7)

Offer to meet with plan. Give the person you're writing to your phone number, and offer to discuss the unpaid claim either over the phone or in person.

If Plan Doesn't Pay

If the plan still doesn't pay, it may be useful to lodge a complaint about unpaid claims with your local or state medical society or trade association. If your association learns that several of its members are having payment problems with a particular plan, the association will probably complain to the plan on the providers' behalf, according to a representative in the California Medical Association's legal division. This may help get your claims paid.

Another place to report a complaint is your state's department of insurance, but only after you've contacted the plan directly and gotten nowhere. Going to the department of insurance can be very effective, but use it as a last resort, since that escalates the matter. Also, the department will be more receptive to your case if you can show that you already tried to recover the money yourself.

If all else fails, talk to your attorney about suing the plan to get paid. ■

Insider Sources

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Offer Incentives to Attract New Radiologists to Your Practice

Many radiology groups are having trouble attracting new radiologists, especially interventional radiologists, to join their practices. But for a radiology practice to thrive and take full competitive advantage of the opportunities in the health care marketplace, it must be able to offer the latest technology and a full range of services to patients. And one great way to do this is by bringing new radiologists on board. But to do this successfully, radiology practices must be creative and change some of the ways they're used to handling their arrangements with new radiologists, says health care attorney Thomas W. Greeson.

Greeson has surveyed radiology practices to get an idea of the incentives they offer to attract and sign up well-qualified young radiologists. We'll tell you about these incentives, some or all of which might help your practice to recruit and retain new young radiologists. And if you're a hospital-based practice, we'll let you know about some potential pitfalls and how to steer around them.

Recruiting New Radiologists Is Tough

It's a tight market for new radiologists, Greeson says. Advances in technology mean that radiologists trained in the latest methods using the most modern equipment can pretty much write their own tickets. So practices have to offer more than a nice salary, a good reputation, and the latest equipment as enticements. "These newly minted radiologists are very business savvy—they understand their value in the marketplace, and they expect to benefit from it, not only in the financial sense," Greeson says. "To recruit successfully, the modern radiology practice has to address not only the long-term financial needs of young radiologists but also their quality of life concerns," he explains.

Five Incentives to Consider

Here are five incentives Greeson has seen radiology practices offer:

Cash. Greeson is aware of several radiology practices that offer new radiologists a cash bonus as a "signing incentive." These bonuses can be thousands of dollars—one group practice offers an initial $10,000 bonus and another $10,000 bonus when the radiologist has put in 90 days. Given the relatively low salaries radiologists earn during their residencies and the enormous debt burden they may carry, cash bonuses may be irresistible to a recruit.

Other financial incentives. Not all practices can afford large cash incentives. And some practices are leery of getting into bidding wars for new radiologists. In those practices, other financial incentives such as paying relocation expenses, professional society dues, continuing medical education costs, and licensing fees may help.

Paying the expenses for continuing medical education classes and professional meetings held in resort areas can also be an attractive incentive. Offering a young radiologist the opportunity to spend an expense-paid week in Hawaii can pay off in a big way, especially since much of the expense of a legitimate CME program or conference may be tax deductible, Greeson adds.

Some practices are experimenting with productivity or other merit-based bonuses. The idea is to present the new radiologist with an opportunity to earn extra compensation without committing your practice to it before you're sure the new radiologist will work out, Greeson says.

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Better working hours. The old school of physicians understood that they were on duty 24/7, at least in the beginning of their careers. Today's young radiologists may not be willing to make that sort of commitment, Greeson says. So creating on-call requirements for new radiologists—especially during the evenings, weekends, and holidays—can be a strong incentive to them. Some practices also offer substantial additional compensation for off-hours on-call duty, Greeson points out.

More vacation. Some practices are increasing the amount of vacation they offer, or permitting their radiologists to buy unused vacation time from each other. "Extra time away from the pressures of the office can mean more than money to a young radiologist," remarks Greeson. Allowing more flexible vacation arrangements can be a very effective recruitment tool, and especially useful for practices that lack the cash to pay big bonuses.

Fast track to partnership. Most young radiologists hope—and expect, eventually—to hold an equity position in a practice. In the past, radiologists fresh from training expected to spend four to six years on the road to partnership. No longer, says Greeson. Some of his clients have shortened to as little as two years the time they require a radiologist to work for the practice before being offered an equity position. Greeson has heard of some immediate partnership offers being made to interventional radiologists, something unthinkable a decade ago.

***Insider* Says:** Watch out for the impact that these fast-track partnerships can have on your practice's overall morale, Greeson cautions. A radiologist hired several years ago, but not yet a partner, may resent today's hire being offered a shorter partnership track, Greeson explains. You may have to offer the radiologist already working for you some of the other incentives such as bonus payments and reduced on-call time, to make her want to stay. Also, make sure she understands the business imperative of bringing in new talent and the importance of offering incentives.

Special Concerns for Hospital-Based Practices

Hospitals need to be careful about the incentives they offer to physicians who refer patients to their hospitals, Greeson explains. The federal *antikickback law* bars hospitals from directly or indirectly paying for or offering to pay for referrals. This may also be a concern for hospital-based practices that are recruiting radiologists who may be in a position to refer patients to the hospital.

So if you're a hospital-based radiology practice and you (or your hospital) are offering special incentives to interventional radiologists, you should proceed with caution, says Greeson. That's because, unlike most radiologists, interventional radiologists may be a source of referrals to the hospital. If the hospital provides services and support to your radiology practice, and your radiology practice offers any special incentive to interventional radiologists, the arrangement could be construed as an indirect payment in return for referrals to the hospital—a violation of the antikickback law.

To prevent this problem, make sure that the total compensation package represents fair market value for the interventional radiologist's services, Greeson advises. To do this:

- Document your attempts to fill the position—this will help you show that interventional radiologists are in short supply;
- Establish that any special incentives you (or your hospital) offer to get the interventional radiologist to join your practice aren't out of line with the incentives other (non-hospital based) practices offered interventional radiologists; and
- Make sure that any incentives you (or the hospital) offer aren't based directly or indirectly on the volume or value of the referrals the interventional radiologist may generate for the hospital. ■

Insider Source

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DOS & DON'TS

✓ Create Separate Documentation for Each Internal Audit Issue

When conducting an internal audit, consider creating separate documentation (including separate reports and files) for each issue covered by the audit, advises attorney Nancy Lynn Roberts of Crowe & Dunlevy's Tulsa, Okla., office. Then, if the government later subpoenas documents concerning a specific audit issue, you can limit the documentation you disclose to the files and reports relevant to that issue. Otherwise, you could end up being forced to disclose documentation about other, unrelated issues. And that could place your practice in greater jeopardy.

Suppose you discover an inadvertent error involving ICD-9 coding. To investigate, you conduct an audit of a random sample of charts before submitting claims for them—and find other inadvertent billing errors that are

(continued on p. 10)

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DOS & DON'TS (continued from p. 9)

unrelated to ICD-9 coding. You then take corrective action to prevent these errors from occurring again. As you prepare memoranda and other internal documents throughout the audit, you should address each error you identify separately, along with the corrective action you take. Keep the documentation for each issue in separate files.

If you conduct the audit after submitting the claims for reimbursement, and you're returning overpayments to your carrier, you should issue separate checks for each type of error, advises Roberts. You should also prepare a memo to your files in connection with each check that identifies the nature of the error, the charts showing the error, the nature of the investigation you conducted to determine that the error was inadvertent, and any corrective actions taken to deter future errors.

Having separate documentation should help if the government decides to investigate one type of billing error to determine whether any crime was committed. When the government requests all records relating to any internal investigations or audits for that particular type of error, you can disclose your internal reports and other documents without disclosing any of the other types of errors you identified. If you have just one general audit report to turn over, you may be forced to give the government a detailed road map to every other risk area in your organization, warns Roberts.

✗ Don't Set Specific Audit Schedule in Your Compliance Program

When creating a compliance program for your practice, don't include an audit schedule or say how often you intend to audit. You may set yourself up for failure by committing to an audit schedule you're unable to keep. Although the OIG says that a compliance program should include the use of audits, it doesn't specify how often or when a practice should conduct them. In its September 2000 compliance guidance for physician practices, the OIG advises "regular" compliance audits. So it's sufficient for your compliance program to state in general terms that you'll conduct audits on a regular and ongoing basis.

Making a commitment in your compliance program to conduct a specific number of audits or to follow a specific auditing schedule is risky because down the road you may not be able to comply with the audit program you designed. Budget constraints or other unexpected circumstances may prevent you from performing as many audits as you said you would or from performing them when you said you would. This could be used as evidence to show that you failed to enforce your compliance program. And if the OIG thinks you don't enforce your own compliance program, it's likely to think you don't follow HCFA rules, either. ■

Insider Source

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SHOW YOUR LAWYER

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

- Antikickback law: 42 USC §§ 1320a-7b(b)
- HCFA-Pub.14-3, Transmittal 1707, Medicare Carrier's Manual Part 3—Claims Process, 5/31/2001.
- Stark II: 42 USCA § 1395nn.

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