

Radiology Administrator's

Compliance & Reimbursement Insider

JANUARY 2005

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Barrier falls for use of out of state radiologists

In November, CMS announced that it is changing its billing regulations to allow imaging centers to submit bills through their local carriers when they use out-of-state radiologists to interpret images.

“This is a big development that will create major business opportunities for teleradiology companies,” says **Thomas Greeson, JD**, an attorney with Falls Church, VA–based law firm Reed Smith.

Prior to this announcement, using out-of-state radiology services was highly impractical because bills had to be submitted to the local carrier in the state where they were provided, says Greeson. For example, if a Massachusetts imaging center used a California radiologist, it would have been forced to accept reassignment and to bill for that service in California.

Under the revised billing regulations, the center will now be able to submit the bill in Massachusetts, provided that it includes the ZIP code of the locale where the radiology services were provided. This allows the government to ensure that the imaging center receives the proper reimbursement rate for the services, as reimbursement rates vary across the nation.

The change, which takes effect April 2005, will likely spur competition among radiologists. “I think there is going to be growth in the number of diagnostic radiologists with multiple state licensure who are able to provide professional services that can be billed as official interpretations throughout the country,” says Greeson.

Until next April carriers will operate under transitional instructions, which allow them to accept claims without regard to the location where the service was provided. Carriers will adjudicate the claims using the data provided, says Greeson. However, although many imaging centers will benefit from this change in the billing requirements, physician group practices that are subject to the Stark self-referral prohibitions will not be afforded the same luxury of using out-of-state radiology services or independent contractors to provide those services.

Under the Stark law, group practices cannot bill for the use of independent contractors unless they provide the service on-site, says Greeson. For example, a Massachusetts group practice could contract with a radiologist from California, but that radiologist would be required to bill Medicare or Medicaid for the service separately. The same would be true for any radiologist who did not provide interpretation services while on-site at the group practice, says Greeson. ■

Insider source

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Radiology Administrator's Compliance & Reimbursement Insider is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$227/year; back issues are available at \$25 each.

Postmaster: Send address changes to **Radiology Administrator's Compliance & Reimbursement Insider**, P.O. Box 1168, Marblehead, MA 01945

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Regulators interested in administrative services agreements

With radiologists in short supply, many hospitals are turning to innovative retention strategies, including offering to compensate their radiologists for the administrative services they provide. And some radiology groups looking to benefit from this situation are demanding extra compensation for administrative duties that were previously considered part of the job. Before you give too much back to your radiologists, understand that this extra compensation may get you into trouble with the Office of Inspector General (OIG) and the Internal Revenue Service (IRS). We'll explain the protections that your hospital—and your practice—should have in place to ensure that your administrative services agreement passes legal muster.

Regulators have increasingly turned their focus onto the compensation of department heads and hospital-based physicians, says healthcare attorney **Ralph DeJong, Esq.**, of Gardner Garton & Douglas, LLC, in Chicago.

You may think that this doesn't affect your practice—after all, radiologists generally don't admit patients to the hospital, so relationships between hospitals and radiologists don't raise the same anti-kickback concerns as relationships between surgeons and hospitals. But that doesn't mean radiologists get a regulatory pass, warns **Joseph Truhe Jr., Esq.**, general counsel for Eisenhower Medical Center in Rancho Mirage, CA.

Interventional radiologists refer patients to hospitals, and those referrals are often lucrative for the facility. Many hospitals maintain good will in the community and increase surgical referrals by offering services for which they need radiologists, such as mammography. Also, joint ventures between hospitals and radiologists to offer high-end services such as PET are becoming more common, and government regulators are increasing scrutiny in this area—as evidenced by the numerous OIG alerts and opinions concerning joint ventures for radiology services.

The status of radiologists is changing, Truhe says, and the OIG is examining payments to them more carefully to determine whether the compensation is an attempt to induce or reward referrals or to encourage the use of hospital facilities for high-end procedures.

'Excessive' compensation can lead to IRS sanctions

The IRS keeps an eye on any arrangement in which a not-for-profit or charitable institution—such as a hospital—pays “excessive” compensation to an individual, says DeJong. (The IRS has not, as of presstime, defined “excessive.”) When a hospital pays a physician to provide administrative services, if the parties can't prove that the physician performed valuable services in return, the IRS may determine that the payment is an improper benefit. That is, it's being paid for the benefit of the individual rather than to further the hospital's charitable purpose. The IRS calls this an “excess benefit transaction,” and although the hospital is likely to bear the brunt of any action by the IRS, the radiologist who accepts the excessive compensation is also

subject to penalties.

For example, if the IRS determines that a physician's compensation arrangement constituted an improper benefit, that physician could be fined anywhere from 10% to 200% of the benefit that the IRS determines he or she received improperly, DeJong says.

So if a physician received \$50,000 a year for five years from a hospital for services the IRS determines were worth only \$10,000 per year, the IRS could impose fines—called interim sanctions—on the physician, in an amount ranging from \$20,000 to \$400,000, depending on the circumstances.

Define duties

If your hospital pays—or plans to pay—a radiologist in your practice for administrative duties, it is important to be able to articulate and defend precisely what he or she is being paid for. To do this, Truhe suggests discussing with the hospital what duties the radiologist would perform. Ask yourself the following eight questions:

1. If the radiologist doesn't perform these duties, will the hospital hire a consulting radiologist to perform them?

If the answer is no, the hospital should reconsider having the radiologist perform the duties, and the radiologist should carefully consider all risks before accepting the position, says **James Unland**, president of The Health Capital Group in Elgin, IL. That's because if the hospital wouldn't hire someone to perform the duties, it raises a legitimate question about whether the duties to be performed are necessary—or whether the position is an improper benefit masked as an administrative job.

If the answer is yes, conduct more analysis to determine whether the job requires your radiologist's particular skills.

2. Must a radiologist perform these duties?

3. Must the radiologist performing these duties be a radiologist?

If the answer to either or both of these questions is no, that raises at least a perception that the administrative job is being offered for nonlegitimate business reasons. It may actually be what the IRS considers an improper benefit, Unland says.

So if you decide to go forward, have solid objective reasons that explain why your radiologist was the best person for the job. Truhe says that if you answered yes to questions two and three, or if both you and the hospital feel comfortable that the radiologist has particular, nonmedical skills that support his or her candidacy for the position, continue to analyze the scope of the administrative duties the radiologist

would perform for the hospital by asking the following:

4. What is the value of the service(s) in furthering the hospital's charitable purpose?

5. What sort of time commitment will the duties require?

6. What results are expected—such as increased efficiency, productivity, or market share, or perhaps development of new markets and technology?

7. How will the results be evaluated and the quality assessed?

8. Who will verify the time and tasks being compensated?

Document results

Once you've answered the questions above and determined what administrative duties the position requires, the results that the hospital expects, and the procedure for verifying, monitoring, and evaluating the radiologist's duties, Unland suggests creating a document that contains

- a job description
- goals for the position
- reporting mechanisms
- benchmarks

Documentation can help both the radiologist and the hospital in several ways, says Truhe. It helps the hospital articulate the need for the administrative position should it ever be questioned. It benefits the radiologist to know exactly what's expected and protects the radiologist in the event of an inquiry by the OIG or IRS. A document that shows a well-defined set of responsibilities and goals and a method of tracking performance and quality will go a long way toward showing that the job is necessary and is being performed in accordance with the parties' expectations, Truhe says.

Such a document is particularly important if the physician holds a number of positions, Truhe says, because one person with roles in several corporations, departments, and institutions can attract regulators' attention. Regulators may wonder whether the administrative position carries real duties if the physician's other time commitments seem excessive, Unland explains.

Note: It is crucial for the hospital to follow through on monitoring the physician's (continued on p. 4)

ADMINISTRATIVE SERVICES AGREEMENTS

(continued from p. 3)

performance and documenting the results, DeJong says. The hospital should have documentation of the hours that the radiologist worked on the administrative tasks, the radiologist's performance goals and whether they were met, any quantifiable results of the radiologist's administrative work, and performance reviews and evaluations.

These records will be useful to the hospital and to the physician if regulators ever question the legitimacy of the compensation, DeJong says. If your radiologist has an administrative position with a hospital and doesn't receive periodic objective and subjective performance reviews, he or she should pressure the hospital to begin them, DeJong advises.

Set reasonable compensation

An administrative services agreement with well-defined duties won't help much if payment for those services seems out of line, says DeJong. Although it's difficult to assess the reasonableness of compensation, he says there are ways parties can ensure that compensation isn't excessive and to steer clear of trouble.

Compensation for administrative duties is often calculated on a straight-time basis. For

example, if a radiologist earns \$300,000 in her practice and the hospital expects the radiologist to spend 20% of her working time on hospital administrative duties, then the hospital pays her \$60,000 for these duties.

But DeJong advises against this approach, because each element of the equation—the physician's annual income, time spent, etc.—is based on assumptions. Instead, DeJong suggests that compensation be calculated from the actual value of the duties performed. Determine this value by asking what the hospital would pay someone with no relationship to the hospital, its patients, or its referral sources.

He also advises the parties to look at the total compensation paid for the total bundle of services provided, rather than to compartmentalize the services and pay separately. The latter approach risks the aggregate of the radiologists' compensation being so out of line that it attracts unwanted regulatory attention.

Unland emphasizes the need to assess the radiologist's commitments both inside and outside the hospital to determine whether the time and effort the radiologist has available to devote to hospital administrative duties justifies the compensation. ■

HIPAA COMPLIANCE

HIPAA compliance and PACS: Can it happen?

Many picture-archiving communication system (PACS) vendors claim that their products are HIPAA compliant, and others say they will be by January. One compliance area to watch is the HIPAA requirement for authentication. You must ensure that actual imaging results are signed (e.g., x-ray, mammo, CT, MR, etc.) once you acquire or generate the result.

Make sure the information does not change at this point. Your capital equipment vendors' products should be able to sign images before they enter your PACS. Check whether the image is stamped at the point of ori-

gin by the modality.

There are also requirements on the PACS system itself. Double check that the following occur:

- Signatures of original images are generated at the first generation point of imaging
- Additional information is signed, such as info generated at a PACS station (i.e., a three-dimensional reconstruction or a particular magnification of the image)
- Each signature must be by user, not by workstation (this

ensures authenticity of the user)

Action steps

Set a timeline for your vendors' compliance and documentation with these standards. Arrange testing times, but ensure that you have a business associate agreement in place. Leave plenty of time to address the inevitable areas of non-compliance before April 2005. ■

Insider source:

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New G-code for bone marrow aspiration and biopsy

The CMS announced November 15 in the *Federal Register* that it has approved a new add-on G-code—G0364—for bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service. The physician must use the CPT code for bone marrow biopsy (38221) and G0364 for the second procedure (bone marrow aspiration).

In making its ruling, CMS said there was minimal incremental work associated with performing the second procedure through the same incision during a single encounter. It estimated that the time associated with this G-code is approximately five minutes based on a comparison to CPT code 38220 (i.e., bone marrow aspiration), which has 34 minutes of intraservice time and 1.08 work relative value units (RVU) when performed on its own.

Several radiologists disagreed with this finding. For example, one group urged CMS to increase to 15 minutes the practice expense input for the nurse assisting with the procedure. Others noted the extra time needed for the

actual aspiration procedure, approving the quality of the aspiration, collecting flow cytometry and chromosome studies, among other duties.

But CMS said the proposed five minutes of physician time, five minutes of registered nurse time, and two minutes of lab technician time reflect the additional effort involved when a bone marrow aspiration is performed in conjunction with a bone marrow biopsy through the same incision during a single encounter.

“It is our understanding that some of the activities attributed to the additional 15 minutes of physician work generally are performed by ancillary staff [e.g., preparing slides]. We believe that the majority of the effort and specific tasks discussed are accounted for in the CPT code for bone marrow biopsy [i.e., 38221], which is the primary code being billed,” according to CMS.

CMS also finalized 0.16 work RVUs for this new add-on G code and malpractice RVUs of 0.04 (current malpractice RVUs assigned to CPT

code 38220). For practice expense, CMS proposed the following practice expense inputs:

- Clinical staff time: Registered nurse—five minutes
- Lab technician—two minutes
- Equipment: Exam table

CMS also confirmed it will use a ZZZ global period (i.e., code related to another service that is always in the global period of the CMS-1429-FC 184 other service) for this add-on code because this code is related to another service and is included in the global period of the other service.

CMS also stated that if the two procedures—aspiration and biopsy—are performed at different sites (e.g., contralateral iliac crests, sternum/iliac crest, or two separate incisions on the same iliac crest), the -59 modifier, which denotes a distinct procedural service, is appropriate to use and Medicare's multiple procedure rule will apply. In this instance, the CPT codes for aspiration and biopsy are each being used. ■

Final regs and changes for LOCM

Payments for low osmolar contrast media (LOCM) will be consistent with the payment rate for the majority of drugs administered by physicians, according to changes CMS announced in the physician fee schedule November 15. Payment will be based on average sales price plus 6% in accordance with the drug pricing established by the Medicare-reform law. The rates take effect April 1, 2005, as CMS collects the final data from LOCM manufacturers.

RACRI will report the data in

Imaging Weekly as soon as it becomes available. (Go to www.hcpro.com to sign up for *Imaging Weekly*, a free weekly e-zine.)

And though it was pressed, CMS won't issue new LOCM codes in 2005. Continue to use the three current HCPCS codes (A4644–A4646) in the reporting of low osmolar contrast agents. However, a CMS spokesperson confirmed that the agency is exploring the possibility of additional codes to accurately capture the cost differences among all con-

trast agents as well as the differing clinical uses, concentration, and dose administrations. Send CMS comments if you have suggestions.

Lastly, CMS says it's not able to determine accurately the degree of duplicate payment that might occur when both the imaging procedure and LOCM are billed. Therefore, it will not, as originally reported, apply an 8% reduction to the LOCM payment. The payment for LOCM will be consistent with the payment rate for the majority of drugs administered by physicians. ■

Radiologists disagree in digital debate

In November, one radiologist told **MRR** that there was no scientific evidence favoring digital mammography over analog and that the perceived advantage of digital (i.e., greater detail) could be a drawback—particularly when calcium deposits are involved.

The radiologist did not want to be identified because his facility is using digital equipment while national studies continue. Although digital mammograms find more suspicious items, many of those turn out to be benign, says the radiologist. In his experience, the threshold for suspicion should be a spot big enough to be able to be seen by ultrasound (6 mm–8 mm), but digital scanning picks up everything down to 4 mm. “Regarding calcium, digital mammography would not be that meaningful,” he says. “It would show up a lot of noise that would necessitate a six-month follow up—with all the anxiety in the interim.”

Rather than chasing everything at 4 mm, he says, consider that radiologists “can be equally criticized for workups that lower the bar for false positives.” He believes current national studies will show that for masses, digital is “a little better, but for calcium deposits, it’s not as good” as analog mammography.

Officially, the jury is still out. The results of national trials are due this spring, says **Dr. Etta Pisano**, chief of breast imaging at the University of North Carolina School of Medicine in Chapel Hill, who coordinates the tests. Nonetheless, radiologists who have used the digital systems cite pros and cons.

Wende Logan-Young, MD, director of the Elizabeth Wende Breast Clinic in Rochester, NY, says her facility has used the General Elec-

tric, Hologic, and Fischer systems, putting her in a good vantage point to gauge the equipment.

“Every day, we do online evaluations with the manufacturers,” says Logan-Young, “and if something needs fixing, they fix it. No one unit is just right, but they’re all working to get theirs to be just right. It’s a work in progress.”

At presstime, four manufacturers had six full field digital mammography systems approved for use in the United States. They include

- GE Senographe 2000D and DS
- Fischer Imaging SenoScan
- Lorad/Hologic Selenia and Digital Breast Imager
- Siemens Mammomat Novation DR

Fujifilm Medical Systems also makes a system, about 1,500 of which are in use worldwide. The FDA has yet to approve Fuji Computed Radiography for use in the United States. The FDA did recently approve the workstation built by the Swedish company Sectra. The workstation is an accessory used to carry data from a mammography unit.

Pisano does not think the machines changed much during or since the clinical trials. “The detectors are substantially the same,” she says, “but the image processing may be different. That’s why we’re running reader studies up to the last minute.”

Pisano constantly asks the manufacturers for the latest and greatest in softcopy display, using the same cancers and noncancers to test the reading accuracy.

The Wende clinic, which performs about 75,000 mammograms a year,

has used the Fischer and Hologic systems since fall 2003, and it received the Sectra Workstation and GE unit this summer. Although she could not single out one system as the overall best, Logan-Young did pinpoint some difficulties and advantages. GE, the first system brought to market in the United States (in 1999), “has eliminated a lot of its problems,” she says, noting that “its software is good.” However, she points out, GE uses a 100 micron pixel image, enabling sharper image resolution, whereas others use smaller pixels.

However, GE comes with a smaller film tray, “so you can’t do [the whole] breast. If you have a large-breasted patient, you have to have multiple exposures,” says Logan-Young. Siemens and Hologic promote their large (24 cm x 29 cm) image areas. All the systems tout their compatibility with CAD, paddle comfort, and networking components.

Hologic uses 70-micron pixels, whereas Fischer and Sectra have 50-micron panels, affording “the best resolution, but they’re harder to work with” than GE and Hologic, says Logan-Young. She says she has a good deal of experience working with photographic equipment, “and with the grain size it now has, film is about as good as it’s going to get,” she says.

“Digital is definitely the future. But the potential has not yet been realized. If there is a difference between digital and traditional imaging, it’s minimal,” says Logan-Young. And then there’s the problem of how to pay for it.

Mark Segel, MD, chief of breast imaging at St. Joseph’s Mercy Hospital in Macomb, MI, echoes Logan-Young’s opinion that the cost-benefit ratio is dubious at this stage. He

believes that “if you’re looking at digital v. analog, you have to look at value-oriented healthcare. It may be smarter to replace aging analog equipment that invest in digital.”

Manufacturers emphasize the assets of digital mammography, saying the systems, which cost about \$450,000, are medically and financially valuable because

- they enable the physician to electronically manipulate (e.g., enlarge, contrast, shape, lighten, or zoom in on) the breast images (much like a digital camera allows the photographer to optimize the picture) by putting the film in a computer and adjusting the light and size

- fewer callbacks are needed because the detailed digital images are more precise than film

- the facility and the patient

save time

- consultations and access are more efficient because the images can be electronically beamed to another site

- lower-radiation doses may be used, especially on large-breasted women

- higher volume is possible, which is especially important when screening large numbers of healthy women

Read times

Another shortcoming mentioned by a physician who did not want to be named was that it took significantly longer to read digital pictures on the screen. “At one point, we were printing out hard copies to read, which defeats the purpose” of the GE digital system his facility uses, he says. “We have to figure out a way to cut back on the time” entailed in digital readings, he

adds, because “in modern medicine, you have to increase your throughput. And anything that makes you less efficient is a problem.”

Conversely, another concern is that the technology available with digital screening and CAD could lead to an over-reliance on the systems.

“If the computer doesn’t say anything is suspicious, you stop searching. The computer does the work for you. But the computer is not perfect,” said one radiologist.

Pisano’s verdict is still out. “I’m a proponent of whatever helps women,” she says, “and if it turns out digital is more expensive but not any better than film, then I’m not for it. That’s what we’re waiting to see.” ■

Insider source:

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Vessel mapping G code

A new G code for vessel mapping for hemodialysis access placement will be available starting in January and will help CMS track its use for quality improvement purposes.

Operating surgeons as well as clinicians who provide care to end-stage renal disease (ESRD) patients will have the opportunity to bill for this service, contrary to an earlier Medicare proposal. Vessel mapping requires the assessment of the arterial and venous vessels to provide the information necessary for the creation of an autogenous conduit. As a result, CMS revised payment for vessel mapping and announced November 15 in the *Federal Register* that it would “crosswalk it to CPT

code 93990” for work, malpractice, and practice expense relative value units (RVU). The G code and descriptor will be G0365—vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow).

“These RVUs more appropriately reflect the work and resources of this new G code,” a CMS spokesperson said.

This code can only be used in patients who have not had a prior hemodialysis access prosthetic graft or autogenous fistula. Providers may

use the code no more than twice a year per patient.

“We will not permit separate payment for CPT code 93971 when this G code is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region,” the CMS spokesperson said.

Other imaging studies may not be billed for the same site on the same date of service unless an appropriate KO modifier, indicating the reason for the second imaging study, is provided on the claim form. ■

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ASK THE INSIDER

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Sharing T1 lines

Q Our radiology group provides night and weekend coverage to two area hospitals. These two hospitals have installed a T1 line that they use to transmit information between them. Sometimes our radiologists are located at Hospital A, and Hospital B will want them to look at a film. Hospital B transmits the image over the shared T1 line to our radiologist at Hospital A for interpretation. We worry that this may violate the HIPAA privacy regulations because the patient didn't consent to give Hospital A access to his protected health information (PHI) and probably doesn't even know that Hospital A could have access to it. Is this a legitimate concern?

A It's a legitimate concern but not a problem in the scenario you describe, says Washington, DC, healthcare attorney **Anna L. Spencer**. The first issue is whether the HIPAA privacy regulations permit

Hospital B to disclose the patient's PHI to the radiologist located off-site for interpretation. The HIPAA privacy regulations make it clear that a covered healthcare provider in a direct treatment relationship—in this case, Hospital B—may disclose a patient's PHI for the purpose of treating that patient. And the HIPAA privacy regulations don't require patient consent to this disclosure.

Therefore, Hospital B's disclosure of the patient's x-ray to the radiologist for the purpose of treating the patient isn't a HIPAA violation. The other issue is whether the use of the T1 line to transmit the image violates the HIPAA privacy regulations because it's a disclosure of the image by Hospital B to Hospital A, which doesn't have a direct treatment relationship with the patient. In this case, Hospital A isn't acting as a hospital, says Spencer. Instead, Hospital A is acting only as a conduit of the PHI—that is, Hospital A is facilitating the transfer of the information from Hospital B to the radiologist by letting Hospital B send it via

the T1 line. HHS defines a conduit as "an entity that transports information but does not access it other than on a random or infrequent basis as may be necessary for the performance of the transportation service or as required by law," and conduits aren't covered entities for HIPAA purposes. Spencer says although Hospital A isn't a covered entity when it acts only as a conduit, any random disclosure that occurs in the process of transmitting the PHI over the shared T1 line won't violate HIPAA. But the HIPAA security regulations still require the provider to protect access to PHI, Spencer notes. Although there's no inherent security risk in transmitting PHI over a dedicated T1 line, she advises her clients to implement access controls—such as passwords assigned specifically to radiologists—to limit the possibility of disclosure. ■

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