

Radiology Administrator's

Compliance & Reimbursement Insider

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Setting up a solid PET/CT program takes planning and forethought

Adding new technology can help you bring in new customers and additional revenue. But if you don't move carefully, it can also cause major headaches and unanticipated problems.

When Moncrief Cancer Center in Fort Worth, TX, decided to add PET/CT, it established a task force that meets weekly to discuss the project, according to **Ed Townley**, the manager of patient financial services.

The group, led by the center's information technology director, considered several points before it began, said Townley:

- The need—will the area and referral base support the new technology?
- The physical site—where could the machine be located and could it fit all the necessary components?
- Reimbursement—will carriers pay for the new services and when will they pay?
- Referrals—will physicians be willing to refer patients to you and how will you educate the physicians about the new technology?

Making the decision

The first step toward adding a PET/CT program involves determining whether you have the patient volume to support one. Consider the following:

- Are you planning tap into an existing referral base?
- Will it be enough to get you off the ground?

Finding the answers to these questions is critical, said Townley.

Also consider your competition—or potential competition. “Keep in mind that you will have competition,” said Townley. “It's only just a matter of when.”

Then ask yourself these questions:

- Do I have an existing referral base for diagnostic scans and oncological applications or will I be primarily oncology-related? (Moncrief falls into the latter category.)
- Will I conduct many diagnostic scans with oncology as a second market?
- Am I building strictly for profit modes? Move ahead carefully if that is what you are doing, said Townley.

Moving ahead

After you decide that you are going to move ahead in the process to add PET/CT, consider the physical site. Make sure it meets your needs:

- Can it accommodate a hot lab?

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PET/CT PROGRAM

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- Does it have adequate storage?
- Will it have separate bathrooms and waiting areas for patients to use after they receive the radioactive infusion?

Plan ahead, because it's not easy to make changes later on if you find the site is insufficient, said Townley.

Reimbursement and contracts

It's also important to plan ahead when it comes to billing to ensure that you can collect on your investment. Examine your contracts and verify that they will allow you to add new services in the middle of a contract period. Moncrief had many contracts that were a mix of annual and two-year agreements. Most pacts allowed for adding the new services as an addendum, but others were insistent that new services not be added until the end of the contract period, when it was up for negotiation, Townley said.

Hammering out codes

Moncrief also had to settle with carriers what codes they would use. "We had some carriers that were not enthusiastic about adding G-codes," said Townley. At that time there was only one code for PET—CPT Code 78810. "They weren't interested in HCPCS codes at all." However, other carriers were interested in the HCPCS codes because they provided a higher level of specificity, Townley recalled. Once some of the carriers understood the level of specificity, they approved the use of the G-codes.

Since Moncrief began its PET/CT program, CPT codes have been added for use with PET (although the timeline for use of these codes is still uncertain). "We're trying to ensure that [the payers will] accept the new CPT codes, and we're still in negotiations with them about that," said Townley.

Because different carriers have different preferences, it was critical for Moncrief to set up billing systems that recognized those differences, said Townley. For example, one carrier wanted them to use CPT code 78810, which did not include the cost for FDG. (FDG is the radioactive sugar that makes the scan work.) That was an additional cost, according to the billing codes. Other carriers, however, allowed them to use the G-code, which included the FDG dose. "We had to set up our procedures a little bit differently to flag that FDG dose as a separate line item on the charge," said Townley.

Be proactive when working with Medicare. "If you have a new technology coming, get in touch with your local Medicare carrier to let it know it's coming and discuss it. If they understand the technology they are less likely to deny first and pay on appeal," says Townley.

Be certain to set time limits

Townley said the problems didn't end even though the coding issues were settled. Some carriers neither had the codes to existing contracts nor made them billable by the time the PET/CT machine was ready for use. The contracts failed to specify a timeline for this process, which left Moncrief at the mercy of the carriers.

"We were open, and had fixed expenses," said Townley, but they could only see patients with certain carriers. Fortunately for Moncrief, the physi-

cians who were referring patients for the new PET/CT scans understood the problem and helped by sending patients who could be processed, Townley said. There were times when patients had to be rescheduled because of delays in precertification, but they tried to avoid this whenever possible.

Insider says: To avoid problems with carriers, make changes to your contracts now to ensure that you can add technology in the future. Specifically, add a paragraph in your contracts that limits the length of time a carrier has from when the contract is signed to when all codes are uploaded into the system and approved for billing (e.g., 30 days), said Townley. Also be certain that the contract explicitly states that those same time limits apply to any outside precertification firm that the carrier uses.

Troubleshooting once you are in business

Once your PET/CT operation is up and running, set up a plan to flag diagnoses that will be problematic from a billing standpoint and those that will require additional supporting documentation. Townley has written up checklists for areas about which Medicare is particular to ensure that all necessary information is collected to support reimbursement requests. (See the related checklist on p. 4.)

"We have a state Medicaid carrier that will not pay for PET or PET/CT under any circumstances," said Townley. Some versions of TRICARE will also deny reimbursement for these scans, he added. "You need to let your scheduler know which [insurance] carriers are problematic [so that they can] let you know when a patient with one of these carriers is in the pipeline."

In addition to taking steps to ensure that the procedures you perform will be covered, decide ahead of time what you will do if something is not covered, said Townley.

Structuring your department

It's a good idea to separate employees handling scheduling and precertification. It is too difficult to have the scheduler handle precertifications, said Townley. He or she probably won't have time to sit on the phone and wait for an answer on a case.

Also ensure that appropriate staff members review appointments to prevent denials, said Townley.

"At our facility, the reading radiologist reviews for medical necessity and makes certain the scan will give the referring physician the information he or she needs," said Townley. A coder also looks at the information to assign the proper diagnosis and procedure codes.

Having both the radiologist and coder review the information at the same time can flag potential problem areas,

such as whether additional pathology or clinical information is needed to justify the scan.

"We do a lot of work on the front end and, as a result, we've never had a denial in a year or more of operation," said Townley.

Insider says: Medicare now conducts post-payment reviews with PET scans. This means you must collect all the documents you need to substantiate medical necessity at the time of the exam, said **Stacie L. Buck, RHIA, LHRM**. Trying to get that information later will prove problematic, she predicted. When you receive this information, keep it accessible with other medical records for the patient, she said. A documentation checklist is helpful in this process.

Be certain to reevaluate periodically

Although it's important to establish solid systems upfront, remain flexible.

"Whatever process you put in place out in the trenches, you will find that it changes," Townley said. "If you have any process or procedure in place at the beginning of your program, don't think it will be equally valid eight months or a year down the line. My suggestion would be to reevaluate regularly. Come back after three months and examine everything from the top down." ■

Editor's note: Townley and Buck spoke during a recent audioconference, "PET/CT: Strategies for setting up an effective program," sponsored by HCPro, Inc., the company that publishes RACRI. To order a copy of the tape, call our Customer Service Department at 800/650-6787.

Insider sources

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Sample PET/CT for Alzheimer's disease

The following criteria must be met and documented for approval of a PET/CT scan for Medicare.

- [X] Service date on or after 09/15/2004
- [] Covered ONLY for the differential diagnosis of frontotemporal dementia [ICD9 code 331.19] versus Alzheimer's disease (AD) [331.0]. Specifically NOT covered for "possible" or "probable" AD, clinically atypical FTD, dementia of Lewy bodies, or Creutzfeld-Jacob disease.
- [] Recent diagnosis of dementia [294.8] with a documented cognitive decline [294.9] of at least six months.
- [] a. The patient's onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline.
 - * Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD.
- [] b. The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology [AAN]) encompassing a medical history from the patient and a well-acquainted informant including the assessment of activities of daily living, physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or CT.
- [] c. The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia.
- [] d. The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.
- [] e.
 1. The FDG-PET scan is performed at a facility that has all the accreditation necessary to operate nuclear medicine equipment.
 2. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience in interpreting such scans in the presence of dementia.
- [] f. A brain single-photon computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication.
- [] g. The referring and billing providers have documented the appropriate evaluation of the Medicare beneficiary. Providers establish medical necessity by ensuring that the following information is collected and available in the patient's medical record:
 - [] 1. Date of onset of symptoms
 - [] 2. Diagnosis of clinical syndrome (normal aging; mild cognitive impairment [MCI]; mild, moderate, or severe dementia).
 - [] 3. Mini-mental status exam or similar test score
 - [] 4. Presumptive cause (possible, probable, or uncertain AD)
 - [] 5. Any neuropsychological testing performed
 - [] 6. Results of any structural imaging (MRI or CT) performed
 - [] 7. Relevant laboratory tests (B12, thyroid hormone)
 - [] 8. Complete list of number and name of all prescribed medications.

If all of the above have not been met and documented in the record, Medicare will not approve. In a few cases, a secondary insurance will cover even if Medicare does not, but in most cases the secondary follows Medicare's lead.

If Medicare will not cover the scan, or if all documentation is not received, patients will be asked to sign an advance beneficiary notice, stating that they have been notified that Medicare would possibly not pay, and that they assume responsibility for any charges incurred if this is the case. This is also required if Medicare will not cover the scan but a secondary insurance states upon verification that they will cover.

We will make this service available to the beneficiary even if noncovered, but they will be expected to pay according to a sliding scale based on financial need.

Source: Adapted from Moncrief Cancer Center, Fort Worth, TX. Reprinted with permission.

New Medicare billing rules for LOCM

By Jackie Miller, RHIA, CPC

In a move welcomed by providers, CMS expanded its coverage of low osmolar contrast material (LOCM) in the nonhospital setting, effective April 1. However, the agency has also given nonhospital providers a new set of HCPCS codes that must be used to bill for the contrast.

In the 2005 final rule for the Medicare Physician Fee Schedule (published in the November 15, 2004, *Federal Register*), CMS announced it would eliminate its long-standing coverage restrictions for LOCM. In the past, Medicare covered LOCM only for intrathecal use, or when the patient had one of several risk factors, including previous allergic reaction to contrast. Those rules were instituted in the early 1990s, at which time CMS believed that high osmolar contrast—which is less expensive than LOCM—could be safely used for most Medicare patients. Since then, however, LOCM has become the standard of care and is used by many providers for all contrast exams, even when the patient does not have risk factors. For this reason, CMS decided to begin allowing unrestricted coverage of LOCM. In the final rule, the agency noted that this “would make Medicare payment for LOCM consistent across settings since, under [the hospital Outpatient Prospective Payment System], there is no longer a payment difference between LOCM and other contrast materials.”

As of April 1, payment for LOCM is made under the mechanism prescribed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for drugs and biologicals. Providers will be paid 106% of the average sale price (ASP) for the contrast. CMS will calculate the ASP quarterly using data submitted by drug manufacturers. The current ASP file can be found at www.cms.hhs.gov/providers/drugs/asp.asp.

CMS originally proposed to deduct 8% from providers' payments for LOCM because the technical component payment for the exam already includes payment for high-osmolar contrast. The agency initially believed that this reduction was necessary to avoid duplication of payment for LOCM. However, CMS announced in its final rule that it would pay providers the full amount for LOCM (i.e., 106% of the ASP). CMS noted that it was unable to accurately determine the amount of duplicate payment that might occur under the new policy.

The final rule also indicated that CMS was exploring the possibility of establishing new HCPCS codes for LOCM in order to “accurately capture the cost differences among all contrast agents, as well as the differing clinical uses, concentration, and dose administrations.” As a result, CMS on March 11 issued Transmittal 502/Change Request

3748 (www.cms.hhs.gov/manuals/pm_trans/R502CP.pdf), which establishes 13 new codes for contrast agents, including LOCM. (See the table below for the new LOCM codes and their abbreviated descriptions.)

Note: These new codes are not for use by hospitals. Hospitals will continue to report LOCM on outpatient Medicare claims with the “A” codes that are currently used by all providers.

Code	Definition
Q9945	Less than 149 mg/ml iodine
Q9946	150–199 mg/ml iodine
Q9947	200–249 mg/ml iodine
Q9948	250–299 mg/ml iodine
Q9949	300–349 mg/ml iodine
Q9950	350–399 mg/ml iodine
Q9951	Greater than 400 mg/ml iodine

Just as with the A codes, providers will select the new code for LOCM based on the concentration of iodine in the contrast agent, not on the dosage of contrast that was administered. For example, contrast with 350 mg of iodine per ml (e.g., Omnipaque 350) will be reported with code Q9950, “Low osmolar contrast material, 350 mg/ml–399 mg/ml iodine concentration, per ml.”

The units will be reported based on the volume of contrast that was used. For example, if the patient receives 200 ml of an agent with 350 mg of iodine per ml, the provider will report 200 units of Q9950.

The transmittal also includes new codes for contrast agents for magnetic resonance imaging:

Code	Definition
Q9952	Gadolinium-based contrast, per ml
Q9953	Iron-based contrast, per ml
Q9954	Oral contrast, per 100 ml

Please see the transmittal for full descriptions. As of press time, CMS had not announced any changes in its current payment policies for these agents.

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BILLING LOCM (continued from p. 5)

Finally, the transmittal includes new codes for contrast agents used in echocardiography:

Code	Definition
Q9955	Perflexane lipid microspheres (for example, Imagent)
Q9956	Octafluoropropane microspheres (for example, Optison)
Q9957	Perflutren lipid microspheres (for example, Definity)

Code A9700 will continue to be used for echocardiography contrast agents that do not meet the description for the new Q-codes.

Nonhospital providers who bill for LOCM should watch for instructions from commercial payers and managed care plans as to whether LOCM should be billed to these payers using the new codes or the old "A" codes. ■

Insider source

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ASK THE INSIDER

Clearing up confusion with PET/CT billing while awaiting the final word from CMS

Q: If you perform a PET/CT scan and a diagnostic CT using the PET/CT machine on the same date of services, is it permissible to bill for both exams?

A: Yes. You can bill for both without "double dipping." While everyone is still waiting for official guidance from CMS on PET/CT billing and coding, it appears, from the existing information published by the Society for Nuclear Medicine and other interested parties, that this is allowed, says Stacie Buck.

In this case The PET/CT codes (78814–78816) designate that the CT portion of a procedure is for attenuation correction and anatomical localization. A standard PET scanner performs both emission and transmission scans, with the transmission scan producing an anatomic image. In simple terms, The CT portion of a PET/CT scan replaces the transmission scan of a traditional PET scan.

These new nuclear medicine PET/CT codes are not designated to

represent the performance of a diagnostic CT procedure. The PET/CT codes specifically describe the CT portion of the scan as "with concurrently acquired CT for attenuation correction and anatomical localization." When a separately ordered and medically necessary diagnostic CT scan is ordered and performed (on a PET/CT scanner) on the same date of service as the PET/CT, the appropriate CT site-specific CPT code should be billed with the -59 modifier in addition to the PET/CT code.

Q: Should FDG be billed separately in addition to the codes for PET or PET/CT?

A: Unlike the G-codes, the new CPT codes for PET do not include FDG. The correct code for billing FDG depends on setting. FDG is billed with A4641 for those receiving reimbursement under the Medicare Physician Fee Schedule and C1775 for those receiving reimbursement under the outpatient prospective

payment system

Q: Can I bill for the fusion of PET/CT images?

A: Although there are currently no specific codes for PET fusion, if you are using a dedicated PET scanner and manually fusing a diagnostic CT with PET images, some payers may allow reimbursement for code 76375 or 78999. Check with you individual payers as to whether they allow additional reimbursement and which code they want reported. If you are performing and billing for diagnostic CT procedures on your dedicated PET/CT system and the fusion data is automatically reconstructed by your software, then there is no need to bill any additional codes. ■

Insider source

Stacie Buck, RHIA, LHRM, president of Health Information Management Associates, Inc., in North Palm Beach, FL.

Designated coders can perk up your bottom line

Getting appropriate Medicare reimbursement for the services you perform is a challenge for all radiology practices, but it may be even more difficult if yours is a hospital-based department that depends on the facility's general billing and coding department to code and submit your department's claims.

Because of the uniqueness of radiology claims and the importance of reimbursement to cover the expensive procedures you provide, hire a billing and coding professional to specialize in handling your claims. Whether the person works for the radiology department or in the hospital's billing and coding department, his or her services can be beneficial to your practice's financial health in the following ways:

▪ Reduce claim denials.

Many claims for radiology procedures are denied because they don't show medical necessity, says radiology department administrator **Karol Handrahan**. This often is the case because the billing and coding department looked only at the patient's admission information when it assigned a diagnosis code. However, a radiological procedure may have been performed because of a subsequent event (e.g., the patient fell out of bed) or because of a condition that wasn't apparent upon admission to the hospital. In such situations, the procedure doesn't relate to the patient's admitting diagnosis, so the claim would be denied for lack of medical necessity. A designated radiology coder would be aware of such possibilities, Handrahan says, and would make sure that the diagnosis code and the procedure code refer to the same condition, which may differ from the patient's admitting diagnosis.

▪ Increase familiarity with new codes and procedures.

There are so many new procedures and codes in radiology that improper coding is frequent, notes Handrahan. Even when a procedure is coded correctly, the hospital billing and coding department's office software may cause a procedure code or diagnosis code to fail an edit. Or the payer's software may not be up to date and may initially deny legitimate, properly coded claims. A designated coder would be familiar with all the radiology codes and procedures and could correct any of those problems. Equally important, the designated coder could suggest changes to the software that would prevent the initial failure of proper claims, Handrahan advises.

▪ Educate others.

Betty Roakes, a radiology department director from South Carolina, says a designated coder could serve other

functions as well.

"He or she could attend our physician-office manager luncheons to educate those managers on the importance of having the right diagnosis code to bill and get reimbursed," she says. Roakes says a designated coder also could be responsible for responding to claims denials and questions from insurers and patients. This is currently Roakes' task, which takes away from her other managerial duties.

▪ Increase cost-effectiveness.

Many radiology departments may find a designated coder to be cost-effective, Handrahan says. A designated coder means fewer denials or write-offs. A designated coder may also handle claims that are initially denied through to conclusion, relieving the radiology manager of that task.

▪ Reduce audits.

Finally, a designated biller/coder can have important compliance benefits because his or her efforts can reduce the likelihood of audits. That in itself can make a designated coder worth the cost, says Handrahan.

Whom to hire?

There's not much specific training available for radiology coders, and the radiology learning curve is steep, says radiology administrator **Roberta Miller**. She says your hospital's medical records department may be one of the best places to look for a coder. Medical records coders already have familiarity with radiological procedures and overall coding expertise. Using coders from the medical records department may be a way of shifting at least part of the expense away from the radiology department. However, if part of the coder's anticipated function is to review clinical signs and symptoms in order to code appropriateness, you may need the radiology technologist's interview notes, as well as the coder/radiologist's report. The technologist's interview notes hold the key to the appropriate code. Access to this information will be helpful to the coder no matter which department he or she works for. ■

Insider sources

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Dispose of confidential records appropriately

Despite the growing use of computers and electronic storage, most practices still generate a lot of paper. In fact, some probably have tons of paper records—literally. Although you may want to free up space, disposing of patient records can be tricky. Here are two tips on how to proceed with compliance:

Tip #1: Check laws that govern how long you must keep records

Be familiar with all laws that apply to record retention, says New York health-care attorney **Matthew Kupferberg**. Many states require you to keep patient records for a certain number of years—usually five to 10—after a patient's last visit. If the patient is a minor, state laws may require you to keep records for a certain time after the minor has reached age 18 or 21.

Mammograms also present special concerns for record retention. Federal law requires practices to keep copies of patients' most recent mammograms for 10 years. Some states may require you to try to get in touch with the patient before you dispose of medical records.

Call your medical society or your specialty society, Kupferberg says. Someone there should know the laws in your state and be aware of any particular rules that might apply to your specialty.

Another consideration: Don't get

rid of financial and billing records too soon. Never dispose of a financial record that's less than seven years old, as that's how far back a Medicare, Medicaid, or IRS audit may request information. Also find out the statute of limitations for lawsuits involving contracts in your state. If the statute deems more than seven years, keep all financial records for the longer period, Kupferberg says. Your local bar association or public library should be able to tell you the statute of limitations in your state.

Tip #2: Use a disposal method that protects confidentiality

State and federal laws, as well as your state's professional conduct rules, require you to protect patient confidentiality. Be careful about how you dispose of your patients' identifiable medical information, Kupferberg says. Otherwise you could be in trouble with your patient, state medical board, or local law enforcement officials.

Removing records from your office and storing them in a "safe" place is usually a bad idea, Kupferberg says. It's too easy for the records to fall into the wrong hands in a warehouse or—even worse—the physician's attic, basement, or garage. Be careful with your practice's financial records, too, Kupferberg says. Such records may contain confidential medical informa-

tion about your patients, such as insurance coverage information. Even if the records don't contain confidential patient information, you don't want to make the details of your practice's financial affairs available to anyone who happens to go digging in your Dumpster.

A method that permanently destroys records to prevent them from being read after disposal is best. Kupferberg recommends incineration or shredding to his clients. In general, shredding is the preferred method because incineration doesn't always completely destroy records. Many companies offer shredding services at reasonable rates. They provide you with a locked box in which you place the documents you want destroyed, and then they pick up the box and shred the contents. Afterward, they'll give you a "certificate of destruction" so you can prove the documents were destroyed. If you generate a lot of paper, many document destruction companies will leave you a shred box and pick it up every few weeks to destroy its contents. Local hospitals and clinics, your professional society, and your local chamber of commerce are all good sources of information about reputable shredding companies. ■

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