



Vague and Confused: The OIG on Transcription Cost Ownership

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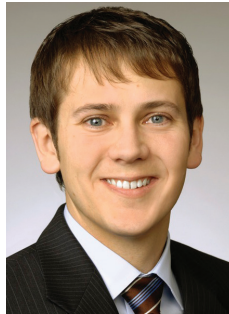
For the second time, the HHS Office of Inspector General has issued a confusing advisory opinion on payment of transcription costs by radiologists, concluding once again that such a financial arrangement would not violate the federal anti-kickback statute. OIG Advisory Opinion No. 15-15 relates to a proposed arrangement in which a hospital would bill a radiology group for transcription of the radiology group's reports for patients who are not hospital patients, but rather patients of a third-party clinic which purchases the technical component of radiology services from the hospital for its patients.

Under the proposed arrangement, the hospital sells technical component services to the clinic, which in turn bills all payors, including Medicare and Medicaid, for the technical component services. The radiologists perform interpretation services and bill the same payors separately for the professional component. The hospital provides the transcribed report. At issue is whether the radiologists—rather than the hospital or the clinic—should pay for the cost of transcription.

OIG issued a similar, equally controversial, opinion on this topic in 2007. In OIG Advisory Opinion 07-19, the OIG determined that a rural Critical Access Hospital (CAH) would not violate the anti-kickback statute if it charged the radiology group for transcription services. In both opinions, OIG based its conclusion on what appeared to be very loose and unsupported views on how the cost of transcription is allocated between the technical and professional components of the Medicare Physician Fee Schedule (MPFS) payment.



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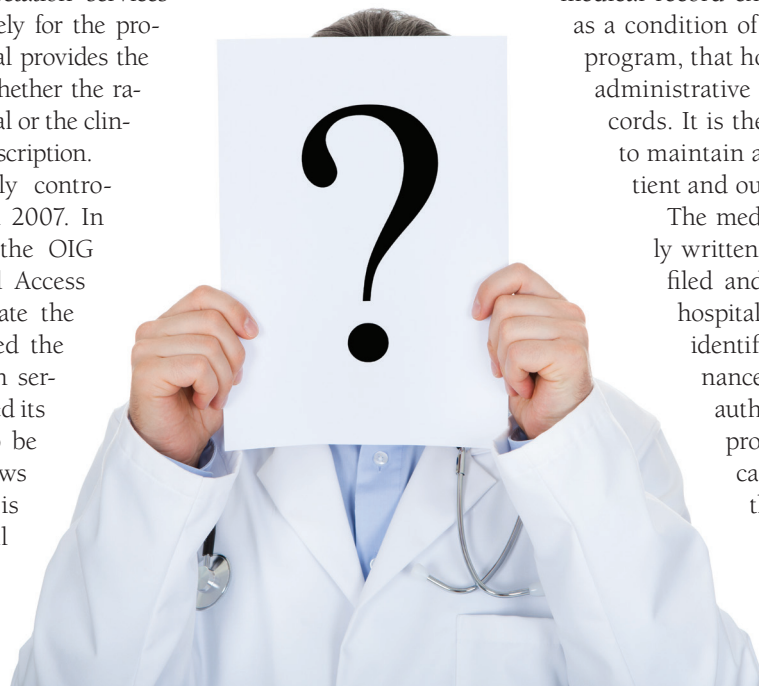
In the past

Historically, transcription costs have not been considered part of the professional component of a radiology service. For a radiology group to pay for the cost of transcribing reports for tests performed at a hospital or at a referring clinic's office creates risk that the radiologists were incurring costs properly allocated to the technical component provider and the assumption of this obligation could risk scrutiny under the anti-kickback statute

as illegal remuneration to induce the referral of Medicare patients. This has been true regardless of the place of service.

In the hospital setting, the Medicare regulations have long vested with hospitals the responsibility to provide transcription based on the obligation of the hospital to assure that written medical record exists. 42 CFR 482.24 requires, as a condition of participation in the Medicare program, that hospitals have a service that has administrative responsibility for medical records. It is the responsibility of the hospital to maintain a medical record for each inpatient and outpatient.

The medical records must be accurately written, properly completed, properly filed and retained and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity and authentication of the record, while protecting the security of all medical records. In fact, hospital costs that support Hospital Outpatient Prospective Payment System payments have included the costs of transcription as a hospital expense.





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In the freestanding setting like a multi-specialty clinic, transcription costs have long been considered part of the technical component payment made to the clinic. It is telling that the total RVUs for physician work, practice expense and malpractice values for the professional component of a radiology procedure are the same for both a facility (i.e., hospital) and non-facility (i.e., multi-specialty clinic).

Consequently, it's hard to see how the professional component values support transcription, whether in a hospital (where the conditions of participation seem to mandate that the hospital pay for all medical record costs) or in a physician office setting, where the professional component values are the same as in the hospital setting.

Stirring the confusion pot

In its recent opinion, the OIG correctly noted that because the clinic is a referral source to the radiology group, if transcription costs were reimbursed as part of the Medicare payment for the technical component, these costs would be the responsibility of the clinic, and the payment of the transcription fees by the radiology group could be viewed as an improper kickback to the clinic.

However, according to the OIG recent opinion, CMS informed the OIG that when the technical and professional components of a test are performed by different parties, the parties may determine who will pay the transcription costs. According to the OIG, CMS is taking the position that under the MPFS, transcription costs are considered to be part of indirect expenses (e.g., non-clinical administrative expenses) under the methodology for establishing resource-based practice expense RVUs.

Under this approach, indirect expenses (including transcription costs) are not separately identifiable but are included in both the professional component and the technical component of each service. Thus, according to CMS, when the professional component and technical component for a radiology service are billed separately, the radiologist is paid some amount for transcription costs through the PE-RVU.

The OIG concluded that because some part of the indirect expense included in the professional component is the expense of the transcription, then such fees by the radiology group would not be an improper inducement and, therefore, that the arrangement would not violate the anti-kickback statute.

Erring on the side of vague

Unfortunately, it appears no effort was made by CMS or the OIG to quantify what percentage of the overall transcription costs is attributable to the professional component. It

is our view that a more nuanced and thoughtful cost analysis would conclude that the transcription may well be a shared cost, but that the MPFS payment methodology should not permit the technical component supplier/provider to impose the entirety of the cost on the interpreting physician—particularly when the anti-kickback law is a potential issue.

It is undisputed that radiologists must review and authenticate the written report. With the widespread adoption of voice recognition, these costs are more and more part of the radiologists' share of the expense. But widespread adoption of new technology should not justify shifting to radiologists the entire cost of transcribing the written radiology report.

CMS told the OIG that Medicare payment rules do not preclude that arrangement where the radiologists pay for transcription. The flaw in CMS's guidance to OIG is that it fails to consider that a radiology group is not reimbursed through the professional component for the entirety of such costs. It thus remains a leap of logic to shift this financial burden on the referral-dependent radiologists.

If asked to modify one's arrangements for the cost of transcription with a hospital based on this opinion, a radiology group should understand that OIG Advisory Opinion No. 15-15 is advisory only, and it should also understand this opinion is not definitive guidance regarding CMS payment policies. ■

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