Compliance Programs Proof of Good Faith

Fully document policies and procedures for federal reimbursement, physician groups are advised.

BY MARY ELLEN SCHNEIDER
Senior Writer

LAS VEGAS — Proper documentation is key to an effective corporate compliance program and can serve as evidence of a good-faith program to investigators, one compliance expert said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Documentation should include the group's compliance policies and procedures, training, and any compliance issues and the resolution, said Edward R. Gaines III, senior vice president for compliance and general counsel for Healthcare Business Resources Inc. of Durham, N.C.

But documentation can be a double-edged sword if it's inaccurate when it's created or if it has been manipulated to pass an audit, Mr. Gaines said.

The Health and Human Services Department Office of Inspector General outlines seven elements of an effective corporate compliance program:

► Compliance standards and policies
► Oversight
► Education and training
► Effective lines of communication
► Monitoring and auditing
► Enforcement and discipline
► Response and prevention

Another important element of a compliance program is the ability to prevent and detect fraud and abuse, Mr. Gaines said.

Implementing a corporate compliance program will mitigate the risk of potential liability, Mr. Gaines said.

Penalties under the Federal False Claims Act are possible as well. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) expanded the federal False Claims Act to all payers including commercial claims. And the government does not need proof of intent to take action. Physicians are liable for knowingly allowing or encouraging false claim submission, being deliberately ignorant, or having a reckless disregard for the truth, according to the HIPAA law.

In addition, even if the physician is not responsible for performing the billing and coding, he or she is liable if the claim is submitted in the physician's name.

The stakes in compliance are high, Mr. Gaines said. For example, in a two-hospital system with 100,000 annual visits and a 30% Medicare/Medicaid mix, if 0.1% of the claims from those 30,000 Medicare/Medicaid visits have compliance issues, that translates into a minimum of $16.5 million in penalties. If there was a finding of intentional bad conduct, that penalty is closer to $33 million.

Don't forget to account for attorney's fees, bad press, a loss of contracts, poor employee morale, and private payer audits, he said. And commercial payers do pay attention to what happens on the government side, he said.

Mr. Gaines advised physicians to start at the top by getting a commitment to the compliance program from senior level executives in the organization.

Groups should create an environment where physicians and staff members are free to ask questions without fear of retribution or retaliation.

"One of the [places] where compliance programs frequently fail is that they don't have clear leadership from the top," he said.

Create an environment where physicians and staff members are free to question without fear of retribution or retaliation. And groups should be willing to bring issues to resolution even if it takes years, Mr. Gaines said.

Some of the risk areas to address when creating a comprehensive compliance program include the role of nonphysician providers; teaching physicians and residents; coding for critical care, x-rays, and EKGs; and computer programs that provide instantaneous feedback for coding or billing purposes.

On the back end, discounts or copay waivers and secondary payer issues also must be taken into account, Mr. Gaines said.

Medicare contractors and other auditors will use data analysis to detect aberrant billing practices.

The auditors tend to rely on comparative billing reports that examine providers of the same specialty in a given area. The auditor might also look at increases in critical care utilization versus historical trends for the group, for example.

But physician groups can be prepared, Mr. Gaines said, by considering why their E/M coding and billing data might be different from CMS national or Medicare carrier data.

For example, higher coding could result from features such as the presence of urgent care facilities or clinics in close proximity to the emergency department, admission criteria, emergency medical service preference, or the presence of a nursing home nearby or on the hospital campus, he said. ■

New Five-Step Process Is Available To Appeal Medicare Part B Denials

BY MARY ELLEN SCHNEIDER
Senior Writer

LAS VEGAS — On Jan. 1, Medicare officials implemented a new five-step process for appealing Medicare Part B claims.

The changes apply to Part B initial claim determinations issued and mailed on or after that date, Edward R. Gaines III, senior vice president for compliance and general counsel at Healthcare Business Resources, Inc. of Durham, N.C., said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

The new process includes some significant procedural differences that could benefit physicians, including an opportunity for an independent review earlier in the process, Mr. Gaines said in an interview. The new process includes these steps:

► **Step 1.** The process begins with a "redetermination" of the initial claim decision made by the Part B carrier. The redetermination is also made by the Part B carrier but the appeals decision is made by an employee who was not involved in the initial determination. This is the only step that involves the Part B carrier that made the original decision, Mr. Gaines said.

Physicians have 120 days from the receipt of the notice of initial determination to file an appeal. Mr. Gaines recommended filing all documentation with the letter requesting a redetermination, including case summaries explaining your code selection. Otherwise, the carrier automatically receives up to 14 additional days to its 60-day decision deadline.

► **Step 2.** Providers can appeal the redetermination decision in a step called reconsideration. Physicians have 180 days from the date of receipt of the redetermination to file this appeal with the Qualified Independent Contractor (QIC) indicated in the Part B carrier letter. The redetermination step replaces the old "fair hearing" process. The old process was frequently criticized since the fair hearing officer usually had close ties to the Part B carrier that made the original decision, Mr. Gaines said.

He recommended submitting all relevant evidence in support of the claim when the notice of reconsideration is submitted because this is a new review and the QIC will not consider the previous ruling.

QICs are bound by Medicare national coverage decisions, CMS rulings, laws, and federal regulations. But they are not bound by other documents including local coverage decisions, program guidance, or manual instructions, he said. The reconsideration decision is rendered within 60 days under the appeals process.

► **Step 3.** A hearing with an administrative law judge is held in person, by video, or by telephone. Otherwise, the administrative law judge (ALJ) will base his or her decision on the written record. To have an ALJ review the appeal, submit a written request within 60 days of the reconsideration notice. At this level of the appeal, at least $110 must be in dispute.

In order to get an in-person hearing, physicians must make that request before the hearing date is set and explain why a telephone or video hearing is not acceptable, Mr. Gaines said. Consider obtaining legal counsel at this point in the process, Mr. Gaines advised.

► **Step 4.** If still not satisfied, a provider may appeal to the Medicare Appeals Council. This must be done within 60 days from the receipt of the ALJ decision. The Medicare Appeals Council is another addition to the process. Previously, physicians who wanted to appeal a decision beyond the ALJ would have to go to federal district court, and few physicians took that step, Mr. Gaines said.

There is no right to a hearing before the council but physicians can request an oral argument. In addition, parties to the appeal can file briefs.

► **Step 5.** The final appeal is to the federal district court. This must be filed within 60 days of the Medicare Appeals Council decision. The case may be filed in the U.S. District Court where the appealing physician resides. At this step in the process, at least $1,090 must still be in dispute.

Since the new process applies only to initial claims determinations issued and mailed on or after Jan. 1, it will take several months to evaluate how the new process works for physicians, Mr. Gaines said. ■

DATA WATCH

Health Plans Voted the Best in 2005

Rank	Plan Name	State
1	Harvard Pilgrim Health Care	MA, ME
2	Harvard Pilgrim Health Care of New England	NH
3	Preferred Care	NY
4	Tufts Health Plan (HMO)/Tufts Health Plan (POS)	MA, NH, RI
5	Independent Health Association (HMO)	NY
6	ConnectiCare	CT
7	Care Choices (HMO)	MI
8	Blue Cross and Blue Shield of Massachusetts	MA
9	Capital District Physicians' Health Plan (HMO)	NY
10	Health Alliance Medical Plans	IL, IA

Notes: All plans are combined HMO/Point of Service (POS) plans, except where indicated. Audited data submitted by plans were ranked by access to care, overall member satisfaction, prevention, treatment, and customer service.

Sources: U.S. News & World Report, National Committee for Quality Assurance

ELSEVIER GLOBAL MEDICAL NEWS