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Change is the one constant that physicians, health systems and other providers face in 2014 as the ACA and its myriad regulations become effective along with increasing review and scrutiny from not just state and federal regulators, but also private companies with state and federal contracts to review and audit claims, cost reports, and billing practices. So, listed below are the top ten areas that physicians and other providers should watch in 2014.

Meaningful Use Audits: Physicians, hospitals, and others that have received incentive payments to integrate electronic medical records into their practices will likely be subject to an audit from either Medicare or Medicaid to assess whether the providers have actually made meaningful use of these funds and systems. Auditors are likely to demand evidence of meaningful use of incentive monies and repayment when providers cannot back up the attestations made for Stage 1 compliance. Providers should be on the lookout for audit request letters sent via email by the contracted auditor. Make sure that whoever has the email address registered with CMS checks for an audit letter. In addition, providers should make sure that all meaningful use attestations are backed up and documentation is maintained for the six years that CMS requires. Some of the required evidence includes EHR vendor agreements, attestation reports on clinical quality measures, statements from EHR vendors, information used to generate numerator and denominator values for reporting, et cetera. If an audit letter is received, contact should be made immediately. Providers need to pay attention to these responses; a failure to respond adequately could result in more than just a request for repayment.

Assuring and Measuring Compliance with HIPAA and HITECH: Increased audit and enforcement activities related to HIPAA and HITECH are coming and providers should ensure that they have implemented required changes such as identifying business associates and executing compliant business associate agreements as well as implementing security standards and testing for patient information and reporting breaches. Also, expect increased enforcement activities from Kentucky’s Attorney General as HITECH granted enforcement authority to the Attorney General along with the opportunity to seek damages.

Stark Law Application to Medicaid Claims: While the Stark Law on its face applies only to Medicare, recent court decisions have found that a Medicaid claim filed in violation of the Stark Law also constituted a false claim. Courts have now found False Claims Act liability for Medicaid claims filed in violation of the Stark Law. Historically, the federal government had focused enforcement efforts on Medicare claims. Carving out Medicaid referrals and claims in health care transactions is no longer prudent. All contracts and transactions should be reviewed for compliance with the Stark Law even if the contract only applies to services for private pay or Medicaid patients.

Medicaid Integrity Contractor Audits: As the Medicaid review auditors are finalizing their review of the big data to identify providers who fall outside billing standards, these reports are being released to Medicaid for provider audits and collection of overpayments. Challenging overpayments must be made through Kentucky’s Medicaid appeal process, which establishes important deadlines for requesting a dispute resolution meeting when an overpayment is identified. If a DRM is not requested, then repayment is due in 30 days. Providers should pay close attention to these deadlines and exercise their ability to challenge overpayments.

Measuring Quality: As CMS’ Physician Compare website joins the nursing facility and hospital compare websites, physicians must be ever mindful that quality scores will ultimately impact reimbursement for all payors, not just
Medicare and its incentive payments. Physician groups as well as all providers should carefully develop their quality measures. As ACOs, hospital systems and payors develop their own quality measures, individual physicians must be aware of those measures and how they affect them. Participation in networks, ACOs, and even Medicaid may become tied to performance. All physicians, even those who are employed by health systems, should be careful in their contracting and knowledgeable about their individual quality and performance.

Medical Staff Membership and Credentialing: Changes in Joint Commission for Accreditation of Health Care Organization’s requirements for medical staff credentialing have made evaluation of a physician’s quality of care an element of the credentialing and recredentialing process. How this evaluation takes place and the factors that are considered are left to the medical staff, which, in reality, usually means administration. The information about this evaluation becomes a permanent part of a physician’s records. Every physician should be aware of this, find out about evaluation results, and challenge them if necessary. A challenge does not mean that a physician impairs his/her privileges, but rather seeks to maintain an accurate credentialing file.

Retention of Overpayments: Retention of a Medicare or Medicaid overpayment can create false claims liability and treble damages recovery when the overpayment is not returned within 60 days. The ACA created the duty to report and return known overpayments. While the law sounds simple, its application is anything but simple and creates a host of issues for providers including determining when an overpayment is known to the provider. For example, is the billing clerk’s knowledge imputed to the physician owner of the practice? Also, when reporting an overpayment, does a provider have a duty to look back to see if there are other overpayments?

Expansion of Medicaid Beneficiaries: With Kentucky’s successful rollout of its Health Insurance Exchange and the possibility of 308,389 new Medicaid beneficiaries, what is the health care provider’s duty to take on more Medicaid patients? Should a provider establish express limits on the number of Medicaid patients that a practice will accept as patients? Does this create liability under provider agreements with Medicaid Managed Care payors? These issues will become even more important as the number of beneficiaries increases.

Prescribing Controlled Substances in Kentucky: The war on prescription drug abuse has taken a terrible toll on physicians as House Bill 1 and the implementing regulations issued by the Kentucky Board of Medical Licensure have forever changed how and when a physician may prescribe controlled substances. While the regulations have been slightly tweaked, physicians must take extraordinary efforts to build the procedures and processes required for prescribing into their day-to-day practice. Physicians should be aware that the Drug Control Branch of Kentucky’s OIG routinely reviews KASPER data and reports the highest prescribers of controlled substances to the KBML for investigation. Physician responses to these investigations must be careful and complete with the understanding that there is little recourse if a violation is found.

Getting Paid: All providers must take active steps to assure that they are paid, which includes keeping abreast of a myriad of payment issues and policies. A provider’s staff must be diligent in following up with insurance companies, Medicaid, and Medicare to seek payment. The squeaky wheel gets oiled first. Providers also need to be aware that preventive benefits such as cholesterol screenings and vaccinations are now free of charge through all Marketplace plans and many other insurance plans, including Medicare, Medicaid, and private insurance plans. Providers should be prepared that they will no longer be able to collect a copay from any member of these plans, regardless of whether that member has met his or her deductible. A list of preventive benefits covered by most plans under the ACA can be found at https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Providers, particularly physicians, should pay attention to proposed federal legislation that will finally repeal the sustainable growth rate and replace it with a methodology that ties payments to quality and efficiency, incorporates alternative payment models and improves the fee for service system by including value-based performance measures. This bill has the support of both Senate and House committees. We will see…….

In conclusion, 2014 promises to be anything but boring.

[i] Small Area Insurance Estimates 2010 US Census Bureau

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