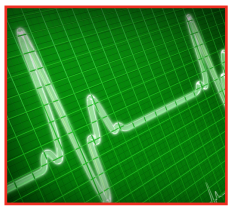
BAKER DONELSON

# BAKER'S DOZEN


## Thirteen Things Every Physician and Medical Practice Needs to Know About Health Care Reform

*Katherine Forseth, 404.443.6711, kforseth@bakerdonelson.com*

There are certain provisions in the Patient Protection and Accountable Care Act (PPACA) that directly and most immediately affect physicians and their medical practices. There are many more provisions that affect physicians and still more that have a more universal application, but below are a Baker's dozen provisions that specifically, and most immediately, affect physicians and medical practices.

**1 New Stark Law Disclosure Requirement for Diagnostic Tests.** Effective January 2010, physicians who provide MRI, CT or PET tests in their offices pursuant to the In-Office Ancillary Services Exception to Stark self-referral prohibitions are required to provide patients with written notice at the time of the referral informing the patient that he or she is not required to receive the diagnostic service in the physician's office. The notice must also include a list of suppliers who furnish such services in the area where the patient resides. Currently, only MRI, CT, and PET tests require the notice, but PPACA authorizes the Department of Health and Human Services (DHHS) to include additional designated health services.

**2 New Deadline for Returning Overpayments.** Any overpayment that is discovered must be repaid within 60 days from the date the overpayment was identified. Additional civil monetary penalties may be assessed for late returns of overpayments.

**3 Reduced Period for Submission of Medicare Claims.** Effective January 1, 2010, all Medicare claims must be submitted within 12 months of the date of service in order to receive reimbursement. Claims for all services provided before January 1, 2010, must be submitted by December 31, 2010.

**4 No Co-Pays for Preventive Services.** Beginning September 23, 2010, some third-party payors will no longer be able to require (and consequently, physicians will no longer be able to collect) co-pays, co-insurance, or deductibles on certain preventive services. Beginning January 1, 2011, Medicare beneficiaries will no longer have co-pays on preventive services. Preventive services include (among others) routine vaccines, well baby and well woman exams, high cholesterol and high blood pressure screenings, smoking cessation and weight loss counseling, and hearing and vision tests for children. Managing this requirement becomes more difficult for physicians when the office visit includes additional services as well as preventive services.

**5 Medicare Incentive Payments.** From 2011 through 2016, primary care providers (physicians, nurse practitioners and physician assistants practicing in family medicine, internal medicine, geriatrics and pediatrics) whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for up to a 10 percent bonus payment for these services. Similarly, general surgeons who perform certain procedures in a health professional shortage area will be eligible for a 10 percent bonus payment for such services.

**6 Changes in Reimbursement Methodology.** In an effort to reduce costs, CMS will begin to experiment with new payment methodologies. There are opportunities for physicians to participate in demonstration projects including participation in Accountable Care Organizations, Health Homes for individuals with chronic conditions, and bundled payments for integrated care around a hospitalization.

*continued*

# Thirteen Things Every Physician and Medical Practice Needs to Know About Health Care Reform

**7 Face-to-Face Meetings Required for Home Health, Hospice and Durable Medical Equipment (DME).**

***Hospice.*** Effective January 1, 2011, hospice physicians or nurse practitioners must have a face-to-face encounter with the patient to determine continued eligibility of the individual for hospice care before the 180th day re-certification and each subsequent recertification. In addition, DHHS will establish, by regulation, a required medical review process for approving hospice stays over 180 days when a hospice provider reaches a certain percentage (to be determined and set by regulation) of patients exceeding that time frame.

***Home Health.*** In the case of certifications made after January 1, 2010, physicians must document face-to-face encounters (including through use of telehealth and other than with respect to the encounters that are incident to services involved) with the individual within a reasonable time frame preceding the physician's certification for home health (currently six months for Part B services). What constitutes a "reasonable time frame" will be determined through regulations.

***DME.*** Orders for DME must have documentation that the physician, physician assistant, nurse practitioner, or a clinical nurse specialist has had a face-to-face encounter (including through the use of telehealth and other than with respect to the encounters that are incident to services involved) with the individual during the six-month period preceding the written order, or such other reasonable timeframe as determined through regulations.

**8 Stark Violation Self-Disclosure Protocol.** Before November 2010, the DHHS Office of Inspector General (OIG) will establish a protocol for providers to disclose an actual or potential violation of the Stark law. Previously, providers were not permitted to use the self-disclosure protocols for Stark violations. Self-disclosure will be taken into account when determining any amounts owed for Stark violations. While self-disclosure will not eliminate civil monetary penalties, the total amounts should be reduced for providers who self-disclose violations.

**9 Ordering Physicians Must Be Medicare Enrolled.** Medicare will only pay for home health services and DME if the *ordering* physician (to be distinguished from the provider or supplier who actually *provides* the ordered item or service) is a Medicare-enrolled provider. Future regulations may apply this requirement to items or services in addition to home health or DME.

**10 Enhanced Fraud Provision.** Several changes to fraud and abuse enforcement are included in the statute. Included in these changes is specific authorization to suspend Medicare and Medicaid payments to providers pending an investigation of a "credible action of fraud" against the provider. This statutory change is not new in practice, however, as CMS has long taken the position that it could suspend payments before any conviction or final determination was made. In addition, civil monetary penalties may be imposed against providers for (a) making false statements that are material to false or fraudulent claims for payment or (b) for failure to grant timely access (upon request) to the OIG for audits, investigations, evaluations, and other functions. These civil monetary penalties can be up to $50,000 for each false statement and $15,000 per day for failure to grant timely access. Finally, for anti-kickback violations, the statute changes the knowledge requirement clarifying that there is no need for a person to have actual knowledge of the anti-kickback statute or intent to violate it for a conviction to occur. Again, this change in the knowledge requirement does not change the conduct that is prohibited by the anti-kickback statute (generally, to offer or receive anything of value in cash or in kind for the referring or arranging for an item or service payable by Medicare or Medicaid), it simply makes enforcement of the prohibition easier. Additional clarifications regarding "inducements" were made relating to conduct that poses a low risk of harm to patients and federal health programs. For example, offering coupons or rewards from a retailer for transferring or filling a prescription at the retailer, when offered to the general public regardless of payor status and without being tied to the provision of other services or items

*continued*

# Thirteen Things Every Physician and Medical Practice Needs to Know About Health Care Reform

payable by federal or state health programs, is not conduct prohibited by the anti-kickback statute.

**11 Compliance Programs.** DHHS and the OIG will be establishing "core elements" of an effective compliance program for additional industries and categories. Going forward, the adoption of a compliance program that contains the core elements may become a requirement for continued enrollment as a provider in the Medicare program. Physicians and physician groups should consider adopting a corporate compliance plan appropriate to their size and continue to monitor requirements for continued enrollment. Physicians can refer to the OIG Compliance Program for Individual and Small Physician Group Practices for current guidance on compliance programs.

**12 Documentation of Referrals to Programs at High Risk of Waste and Abuse.** As of January 2010, physicians must maintain, and provide DHHS with access to, documentation relating to written orders or requests for payment for DME, certifications for home health services, or referrals for other items or services written or ordered by the physician.

**13 Physician Hospital Ownership.** There are new restrictions to qualify for the "rural provider" and "whole hospital" exceptions to the Stark ownership or investment prohibitions. Please see the Baker's Dozen article "Thirteen Things Providers Should Know About Stark Law and Physician Ownership Changes Under Health Reform" for more information.

*Baker Donelson's Health Law group is consistently ranked as one of the top in the nation, representing leading hospitals and health systems, academic medical centers, medical device manufacturers, pharmaceutical companies, physician organizations, payors and specialty care providers. Our professionals recognize the sheer scope and complexity of the changes effected by health care reform and welcome the opportunity to help your organization navigate these uncharted waters. For more information, visit www.bakerdonelson.com/healthreform.*