



How reform law integrity provisions impact your practice: What you need to know and implement now

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, signed into law by President Obama, contain a number of key provisions intended to increase the government's ability to:

1. Ensure only legitimate health care providers and suppliers are enrolled in federally funded health care programs
2. Reduce improper payments
3. Curtail activities that undermine the financial integrity of Medicare, Medicaid and the State Children's Health Insurance Program.

The following enrollment, referral and ordering, and payment provisions in the new law may have an immediate impact on your practice and your patients. The AMA is actively seeking clarifications from the Centers for Medicare and Medicaid Services on how it intends to implement these provisions. Ongoing updates providing clarifications and information on other provisions that may have a longer timeframe before they take effect will be provided as information becomes available.

Effective Jan. 1, 2010

Although the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act became law in March, the following program integrity provisions are effective as of Jan. 1. It is essential that your practice take immediate steps to comply with them, including consulting with legal counsel (as appropriate), since failure to implement these provisions can result in denial of payment, civil or criminal liability, and/or exclusion from federal health programs:

- Physicians who rely on the in-office ancillary services exception to the prohibition on physician self-referral are now required to inform patients in writing at the time they order magnetic resonance imaging, computed tomography, and positron emission tomography that the patient may obtain these services elsewhere. They must also provide the patient with a written list of those who furnish such services in the area where the patient resides. The new law specifies that this requirement may also apply to any other designated health services that the Health and Human Services (HHS) secretary determines appropriate. The HHS secretary has not yet specified additional services, and the AMA is seeking clarification on how physicians can comply with this provision for referrals made prior to the new law's enactment.
- The maximum period for submitting Medicare claims is reduced to no more than one calendar year from the date of service, subject to exceptions yet to be specified by the HHS

secretary. Also, all bills and requests for payments for services furnished before Jan. 1, 2010, must be filed by Dec. 31, 2010.

- Physicians must conduct a face-to-face encounter with a patient within six months prior to certifying their eligibility for Medicare Part B home health services. A similar requirement applies to durable medical equipment certifications and Medicaid, but an effective date has not yet been specified. In addition, clarification is being sought on how to comply with this provision for certifications made prior to enactment of the new law.
- Physicians are required to maintain and provide access to documentation for seven years relating to written orders or requests for payment for durable medical equipment and certifications for home health services. The HHS secretary has the authority to expand this requirement to other items or services. Failure to maintain and provide access to such documentation could result in a permissive exclusion from the Medicare program for up to one year.

Effective March 24, 2010

- A physician who has received a Medicare or Medicaid overpayment is required to report and return that overpayment to the HHS secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, at the correct address. As part of the notification, the physician is required to specify in writing the reason for the overpayment. An overpayment must be reported and returned within 60 days after it was identified. The statute defines the term “overpayment” to mean any funds that a person receives or retains under Medicare or Medicaid to which the person, “after applicable reconciliation,” is not entitled. Clarification has not been provided by the HHS secretary on the process for returning overpayments or on the meaning of the statute’s phrase “applicable reconciliation.” However, failure to comply with this provision could result in significant liability. As a result, physicians should consult with legal counsel, if appropriate. Those who believe they have received an overpayment should, at a minimum, immediately contact their contractor to obtain additional guidance, preferably in writing.
- The anti-kickback statute has been amended to remove the “intent” standard, so it is no longer necessary to prove that an individual knew of the prohibitions contained in the statute and intended to violate it. Also, the new law provides that a violation of the anti-kickback statute constitutes a false or fraudulent claim under the False Claims Act. The AMA will continue to work with Congress to address its concerns with this change and others made to the “intent” standard of other health care-related fraud statutes.
- The health care provisions of the mail fraud statute (a criminal statute) have been amended so that it is no longer necessary for prosecutors to prove an individual had actual knowledge of the health care fraud statute or had the specific intent to violate the statute for liability to be established. The definition of health care offense has been amended to include violations of the anti-kickback statute, the Food Drug and Cosmetic Act, and certain Employee Retirement Income Security Act provisions.