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Health Care News

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New York Has New Medicaid Anti-Fraud Law

In the waning hours of the latest legislative session, the New York State Senate and Assembly succeeded in compromising on a Medicaid fraud bill, adopting a consensus package which includes wins and losses for both sides. The Senate was able to eliminate the Assembly-proposed "whistleblower" program that would have permitted individuals to bring Medicaid fraud charges, then share in any financial recoveries. The Assembly secured a reinvigorated Medicaid Inspector General (IG), who serves at the pleasure of the Governor, with the consent and advice of the Senate.

Certain elements of the new law are noteworthy. Regulated health care facilities, including those governed by Articles 28 and 36 of the Public Health Law (hospitals, ambulatory surgery centers and home care providers) and Articles 16 and 31 of the Mental Hygiene law must implement compliance programs. The IG is charged with issuing regulations for those programs. The law contains certain Sarbanes-Oxley-type elements and favorably references programs that comply with the existing federal guidance. While the law takes effect on January 1, 2007, penalties for failure to institute the required compliance programs will not be imposed until 90 days after the IG issues the regulations.

The new law also establishes a process for requesting advisory opinions from the Commissioner of Health on whether certain billing approaches or other arrangements are consistent with Medicaid and other related laws. It creates five new Medicaid fraud criminal offenses and a new defense. The new defense permits employees to argue that they were simply "following orders" when they engaged in billing activity alleged to be criminal. Governor Pataki signed the compromise bill into law on July 26, 2006.

Compliance Corner

Deficit Reduction Act of 2006 Employee Education Requirements: The Time to Act is Now!

Effective January 1, 2007, the Federal Deficit Reduction Act of 2006 will require health care providers that receive or make Medicaid payments of at least $5 million annually to have the following in place as a condition to continuing receipt of Medicaid funds:

1. written policies for all employees (including management), contractors and agents providing detailed information on the role of the Federal False Claims Act, State civil and criminal false claims act laws, administrative and civil remedies for false claims or statements (such as qui tam recoveries) and whistleblower protections, as these laws aid in the prevention and discovery of fraud, waste and abuse in federal health care programs;

2. written policies explaining the provider's policies and procedures to avoid and detect fraud, waste and abuse; and

3. a discussion, in the provider's employee handbook, of such laws, the employee's rights as a whistleblower and the provider's policies and procedures to detect and prevent fraud, waste and abuse.

Due to the impact providing this information may have on employee relations and the internal functionality of your compliance program, care should be taken in developing and implementing these required policies and employee handbook provisions.

1500 Tower I, P.O. Box 4976, Syracuse, New York 13221 • P: (315) 471-3151 • F: (315) 471-3167
www.hancocklaw.com

New Stark Exceptions and Anti-Kickback Safe Harbors Issued for Electronic Prescribing and Electronic Health Records Arrangements

The Centers for Medicare & Medicaid Services and the Department of Health and Human Services' Office of the Inspector General recently published final rules detailing (respectively) two new exceptions to the federal physician self-referral prohibition (or "Stark" law) and two new safe harbors under the anti-kickback statute for certain electronic prescribing and electronic health records arrangements. The rules, which become effective on October 10, 2006, were created in response to a Congressional mandate that an exception and safe harbor be developed that would allow entities to provide non-monetary assistance to physicians to encourage the use of electronic prescribing. As part of this effort, the federal agencies also established the exception and safe harbor for certain electronic health records arrangements.

The exception and safe harbor for e-prescribing allows hospitals and certain other entities to provide physicians with hardware, software, or information technology and training services that are necessary and used solely for electronic prescribing. The exception and safe harbor for electronic health records allows entities furnishing designated health services to donate interoperable electronic health records software, information technology and training services that are necessary and used predominantly to create, maintain, transmit or receive electronic health records. It is important to note that the standard for electronic health records assistance is that such support must be "necessary and used predominantly" for such purposes, while the standard for e-prescribing assistance is that the support be "necessary and used solely" for e-prescribing.

Governor Signs Pro-Physician Law Affecting Claims Payment, Recovery of Overpayments and Credentialing

On August 16, 2006, the Governor signed into law new physician-friendly mandates for claim payment practices of New York insurers and HMOs. The law requires payors to process physician claims that are filed consistent with the American Medical Society's Current Procedural Terminology ("CPT") rules and to identify any claims-editing software used to evaluate claims.

The new law also places limits on such payors' ability to recoup money from physicians for alleged overpayments, requiring them to give physicians at least 30 days prior written notice before taking action to recoup, or offset against future payment, such alleged overpayments. The written notice must state the patient's name, date of service, original payment amount, adjustment (recoupment) that will be taken and a reasonably specific explanation of the proposed adjustment. Perhaps most importantly, the law prohibits payors from recouping funds more than 24 months after the initial payment of a claim unless (1) the payor has a "reasonable belief" that fraud, other intentional misconduct or a "pattern of abusive billing" was involved; (2) such recovery is required by or initiated at the request of a self-insured health plan sponsor; or (3) the recoupment is required by the state or federal government. The law takes effect on January 1, 2007 but the limits on recoupment of overpayments will not apply to claims paid to physicians prior to that date as long as the payor has notified the physician that such claims are under consideration for possible recoupment. The law also permits physicians to bring action against a payor for underpayment, in which case the payor may defend by asserting overpayment as far back as the date of the physician-alleged underpayment.

As to physician credentialing by health plan networks, the law mandates speedy time frames within which a health plan must complete consideration of a physician's credentials, except in circumstances beyond the plan's control or for other "non-routine or unusual circumstances".

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COUNSELORS AT LAW

Health Care Practice Group Attorneys:

Raymond R. D'Agostino, Catherine A. Diviney, Peter V. White, Marguerite A. Massett, Laurel E. Baum, Nancy M. Belkowitz, Jennifer M. Reschke, Cora A. Alsante, Michael J. Sciotti, Mark J. Schulte, Steven R. Shaw & Wendy A. Marsh