

MEDICAL/LEGAL NEWSLETTER



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THE EXCELLUS SETTLEMENT

Shouldn't you expect the same business practices from your other payors?

On May 23, 2005 a Settlement Agreement was signed that will, subject to final court approval, settle the class action lawsuit known as Dolan, et al. v. Excellus et al. and a companion case, Medical Society of the State of New York v. Excellus et al. A hearing to consider final approval the settlement has been scheduled for November 1, 2005. It is expected that the settlement will be approved at this hearing.

The Settlement Agreement delivers some modest financial benefits to physicians. However, its real benefit lies in the over 50 business practice changes that Excellus is required to make. Unlike an increase in the fee schedule – which most physicians

Agreement that could easily be adopted by other payors in Onondaga County.

Fee Schedule Disclosure. Within a year, physician fee schedules will be made available to all participating physicians on Excellus' provider website. Upon approval of the settlement, Excellus will provide, on request, the fee schedule for up to 50 CPT high volume codes by e-mail or hard copy. Although already obligated to do so under New York's Public Health Law, payors have been reluctant to disclose their complete fee schedules.

Pre-Certification Requirements. In addition to reducing the number of procedures requiring pre-certification, Excellus will post its pre-authorization requirements on its website within six months and update this listing at least annually.

Limitation on Fee Schedule Reductions. Excellus may not reduce fee schedules more than once a year. Any reduction in fee schedules will trigger the right of participating physicians to terminate their participation in the product lines affected by the fee schedule reduction.

Prompt Payment Requirements. After one year Excellus must pay electronic claims in 30 days and paper claims in 45 days. This time frame is reduced after two years to 15 days for electronic claims and 30 days for paper claims. These timeframes are superior to New York's Prompt Payment Law which requires all claims to be paid in 45 days.

“Unlike an increase in the fee schedule – which most physicians certainly would have preferred – the business practice changes are not designed to increase revenues. Instead, they should reduce administrative costs and administrative burdens, resulting in a financial benefit to physicians.”

certainly would have preferred – the business practice changes are not designed to increase revenues. Instead, they should reduce administrative costs and administrative burdens, resulting in a financial benefit to physicians. Excellus is required to keep these changes in place for four years, after which some or all may be modified or discontinued. Similar business practice changes have been adopted by Aetna and CIGNA in connection with the settlement of the national physician class action lawsuits against them.

This Article will highlight certain provisions of the Settlement

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No Automatic Downcoding of E&M Claims. Excellus will not automatically downcode any evaluation and management CPT code for covered services.

Bundling and Other Computerized Claim Editing. Excellus will process and make eligible for payment *all* physician claims pursuant to and consistent with the current version of CPT Codes guidelines and conventions as interpreted in AMA CPT.

Disclosure of Claim Payment Practices. By December 2006 Excellus must make available on its website a pre-adjudication tool that provides information regarding the manner by which Excellus' claim system adjudicates claims for specific CPT codes or combinations of such codes. Certain medical payment policies, code editing policy and claims adjudication logic will be disclosed to physicians. Finally, except under limited circumstances, Excellus will no longer routinely require submission of clinical records before or after payment of claims.

Recovery of Overpayments. Excellus will provide 30 days written notice before seeking overpayment recovery. For the first 18 months, Excellus will not initiate overpayment recovery efforts more than 24 months after the original payment. For the next four years, Excellus will not initiate overpayment recovery efforts more than 12 months after the original payment. The time limit does not apply if there is reasonable suspicion of fraud or other intentional misconduct.

Notice of and Right to Terminate Upon Material Adverse Change. Excellus must provide at least 90 days prior notice of all Material Adverse Changes to its policies and procedures that affect performance under contracts with participating physicians. A Material Adverse Change is any change that could reasonably be expected to have a material adverse impact on (1) the aggregate level of payment to a significant number of physicians (includes *any* reduction in fee schedule), (2) practice administration for a significant number of physicians or (3) physicians in any specialty or subspecialty. Following such notice, physicians will have the right to terminate their participation in Excellus or in one or more product lines affected by the change as of the date the Material Adverse Change takes effect.

Policy Issues Involving Clinical Judgment. In adopting clinical policies, Excellus will rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community and will take into account physician specialty society recommendations and the views of physicians practicing in relevant clinical areas

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All Products Clause. At the time a contract is initially signed, a physician may decline, without financial penalty, to participate in any Excellus product line. Physicians may later terminate participation without financial penalty in any product line if there is a Material Adverse Change affecting the product line. Physicians may opt out of new product lines under certain circumstances.

Accelerated Credentialing of New Physicians. Excellus agrees to begin to process credentialing applications prior to the time a physician formally changes or begins employment or changes location.

Copies of Contract. Upon request, Excellus will provide a physician with a copy of his or her contract with Excellus. Sounds simple, but have you requested a copy of a contract with a payor lately?

Over the years physicians and their counsel have tried, generally without success, to negotiate many of these same changes to provider contracts. Physicians were never in a position to collectively negotiate these changes with Excellus, or any payor, because such conduct would be illegal under the antitrust laws. As with Aetna and CIGNA it took a class action lawsuit to encourage Excellus to "rethink" its business practices. Under current law this may be the only viable way – short of legislative action – to force system-wide change. However, it is not unreasonable for physicians to expect – and, perhaps, insist – that many of these business practices be offered and adopted by other commercial payors and become industry standards.

ALL IN THE FAMILY

Several Medicare carriers around the country have recently reminded physicians that when it comes to treating family members “love and affection” should be sufficient payment.

In 1994, CMS (then HCFA) instituted a ban on billing for services rendered to “immediate relatives”, including those furnished incident to the physician. The intent of the ban was to bar Medicare payment for items and services which would ordinarily be furnished gratuitously because of the family relationship. Immediate relatives include spouses, parents, children, stepparents and stepchildren, in-laws, and grandparents. A step relationship and an in-law relationship continue even if the marriage upon which it is based terminates through divorce or death of one of the parties.

“In 1994, CMS (then HCFA) instituted a ban on billing for services rendered to immediate relatives, including those furnished incident to the physician.”

Some commentators have said that it isn’t clear whether the ban also applies to services furnished to a relative by another member of the physician’s group practice. However, in the author’s opinion because the CMS rule is written to apply to the physician who ordered or furnished the services, it should not apply to treatment by another member of the physician’s group practice.

Since Medicare reimbursement is statutorily excluded for items and services furnished to immediate relatives, the local carrier says that an advance beneficiary notice (ABN) – a notice that the carrier is expected to deny payment – is not required in these instances. An ABN is more commonly used where services are usually denied for lack of medical necessity (e.g., acupuncture) or because the service or procedure is experimental or frequency limits have been exceeded.

NEW CHANGES AFFECT MEDICARE APPEALS

On March 1, 2005, the CMS published a new rule overhauling the process for appeal Medicare denials and overpayments. The rule implements certain legislative provisions from the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Under the new regulations, physicians will continue to have the right to appeal an initial determination to the Medicare carrier. This first level appeal is now called “redetermination”. The carrier must process the appeal in 60 days.

An appeal from the carrier’s determination (known as a “reconsideration”) will be handled by an entity known as the Qualified Independent Contractor (QIC). The QIC must be independent of the Medicare carrier and include panel members with sufficient medical, legal and other expertise, including knowledge of the Medicare program. For these second-level appeals, there is no minimum dollar amount in controversy. There is no dollar threshold. The QIC has 60 days in which to issue its written decision unless additional evidence is submitted after the request for reconsideration is filed. The QIC process will apply to all carrier redeterminations issued after January 1, 2006.

The reconsideration of the QIC may be further appealed to an administrative law judge (ALJ). The ALJ must render its decision within 90 days, otherwise the provider will have the right to escalate the appeal to the next level (Medicare Appeals Council). Perhaps the most significant change in the appeals process is that all administrative hearings before an administrative law judge will be conducted by videoteleconference unless the technology is unavailable or if special or extraordinary circumstances exist.

In the past, Medicare appeals were essentially one-sided matters pursued by the provider. But the new rules also give the ALJ the right to request CMS, or its contractors, including carriers and QICs, to file position papers or to give clarifying testimony. And on its own motion, CMS can seek full party status. These changes increase the possibility that appeals will become more like real litigation, thus resulting in the investment of more time, resources and money by providers.

INFORMATION SECURITY BREACH AND NOTIFICATION ACT

Over the past five years, the medical profession has adapted to the 21st century and the maze of confidentiality regulations known as HIPAA. Now the State of New York has gotten into the act with the recent enactment of the Information Security Breach and Notification Act. The Act follows a string of identity thefts affecting the banking and insurance industries on a national scale.

The new law is intended to give State residents the right to know when personal confidential information has been misappropriated or wrongly disclosed. It covers all state agencies, as well as any business in New York which owns or licenses computerized data which includes private information, such as social security numbers, driver's license ID numbers, and account numbers or passwords. Thus it would cover virtually every medical practice in the State.

If there is a breach of the security of a system resulting in an unauthorized disclosure of private information, the medical practice must disclose the breach of security "without unreasonable delay" to the person whose private information was breached. The notification can be delayed only if a law enforcement agency notifies the practice that notification would impede a criminal investigation.

The notification can be in writing or by phone. If there is a major security breach – for example the computer system is hacked resulting in unauthorized access to all patients' private information – the cost of notifying all of the patients and the resulting bad press could be catastrophic to the medical practice.

At the same time as notification is given to the patient, the State Attorney General, the Consumer Protection Board, and the State Office of Cyber Security and Critical Infrastructure Coordination must be notified as to the timing, content and distribution of notices and the approximate number of affected persons. If

more than 5,000 patients are affected, the practice must also notify consumer reporting agencies (the Attorney General keeps a list of them).

If a medical practice fails to give the required notices, the State Attorney General can take legal action seeking injunctive relief or monetary damages; however, much like under HIPAA, it doesn't appear that affected patients are given any private right to sue for damages they might suffer as a result of the theft of their personal information.

Physician should update their compliance policies and procedures to cover these new requirements. The new law becomes effective on December 8, 2005.

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Wood & Smith, P.C. represents physicians, physician organizations and other health care providers on regulatory, business, real estate and tax matters. Our mission is to help our clients plan for and respond to the challenges and opportunities that exist in the health care industry.

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