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Legislation: Providers Win Regulatory Relief in Medicare Bill

You can correct minor errors without pulling your own teeth

If you're drowning in Medicare paperwork, you can rejoice. Buried in the hundreds of pages of the newly signed Medicare Prescription Drug, Improvement and Modernization Act of 2003 lie regulatory reform provisions that could ease your administrative burdens.

The provisions, gathered under the "Regulatory Reform" heading under Title IX of the bill, were signed into law by President Bush on Dec. 10 along with the rest of the bill. Probably the most helpful provision will be the one allowing you to correct minor technical errors on claims without going through the timely and costly full-blown appeals process.

Technical errors that you can correct through this new quick process include missing referral documentation, incorrect dates, beneficiary addresses that change, and unexpected hospital stays.

The Department of Health and Human Services will work with both its Medicare contractors and provider representatives to develop a process that will allow those simple corrections to take place, according to Section 937 of the bill. The new process should be in place by December 2004, the bill indicates.

The new law also restricts Medicare from recouping overpayments until a reconsideration decision on the matter is rendered - in other words, until the provider has exhausted the first level of appeals. It also lets providers appeal a claims determination when a patient dies and there's no other party to take up the appeal.

Also, Medicare will be prohibited from extrapolating overpayment amounts from a small statistical sample, unless the provider has a high level of payment errors or "educational intervention" fails to correct the problem, the bill says.

But opponents of extrapolation are likely to think the provision doesn't go far enough in limiting the controversial practice, in which a small number of claims are reviewed and the error rate is projected out to the provider's universe of claims for the same time period to generate an overpayment amount. "It doesn't go to the core of the problem," says attorney **Bill Sarraille** with Sidley Austin Brown & Wood in Washington, D.C.

The new law gives intermediaries and carriers a 45-day limit to respond in writing to written inquiries they receive from providers and beneficiaries. And it protects providers from penalties if they follow Centers for Medicare & Medicaid Services or contractor written guidance that ends up being wrong.

Starting a year from now, carriers may conduct random prepayment review only if they are developing system-wide error rates or are working under other narrow circumstances, the bill mandates. And CMS must publish regulations spelling out the requirements for terminating nonrandom prepayment review.

The law prohibits CMS from applying "substantive changes" retroactively. There are two loopholes that would allow retroactive application, however: if the change complies with a statutory requirement, or if it's in the "public interest."

CMS can't drag its feet any longer when it comes to issuing regulations, at least not without a good excuse. The agency can't let three years elapse from proposed rule to final regulation unless it justifies publicly the reason for the delay. And new material can't be introduced in a final rule unless it is a "logical outgrowth" of what was originally proposed, the provision says.

CMS has taken a "kinder, gentler approach" to regulating healthcare providers under the Bush administration, Sarraille

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says. That more reasonable attitude has lessened some of the urgency attached to the regulatory relief provisions.

Editor's note: The full bill text is at http://thomas.loc.gov/cgi-bin/bdquery/z?d108:h.r.00001:.

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