

AmeriChoice False Claims Act Settlement and Impact on Future Medicare/Medicaid Managed Care Contracting by Health Care Providers

On June 30, 2005, United States Attorney Patrick L. Meehan announced a civil settlement with AmeriChoice of Pennsylvania, Inc. in which AmeriChoice agreed to pay the government \$1.6 million and enter into a corporate integrity agreement to resolve allegations relating to Medicare and Medicaid claims processing and coverage determinations. AmeriChoice participated as a contractor in the Medicare managed care program, Medicare+Choice, and as a contractor to the State of Pennsylvania in its Medicaid managed care program. In addition to other issues, the government alleged that from September 1995 through June 1998, AmeriChoice violated the federal civil False Claims Act (“FCA”) by failing to process or pay health care provider claims in a timely fashion, or at all. The federal civil FCA only applies to claims in federal health programs and providers may not use the FCA to challenge the processing or payment of commercial health insurance claims.

The AmeriChoice settlement potentially offers health care providers model contract provisions to ensure Medicare and Medicaid managed care company prompt claim processing and payment, transparency of reimbursement policies and procedures, and the reduction of downcoding, improper bundling and computerized denial practices. The AmeriChoice settlement establishes the expectations of the federal government for operation of a managed care company that participates in Medicare or Medicaid managed care programs. In preparing for contract negotiations, amendments and renewals with Medicare and Medicaid managed care companies, it would be prudent for health care providers to understand the following key provisions of the AmeriChoice settlement affecting claims processing and reimbursement and to include these changes in managed care contracts and provider manuals:

Claim Receipt and Status. Requires a verifiable and auditable claims system to ensure timely receipt and recording of all claims submitted to the managed care company. Requires hardcopy claims to be entered into the claims system within 96 hours of receipt and electronic claims within 24 hours. Requires an automated query system for providers to monitor the status of all claims submitted, paid, denied or pended in the past 120 days. Requires a system for providers to determine the reason for pended claims submitted in the previous 120 days. Requires weekly audits of the system to verify full functionality.

Claim Data Elements. Requires at least the following data elements when the claim is initially entered into the claims system:

- Information relating to member identification, plan membership, eligibility, preauthorization and known secondary payors;
- Information relating to inconsistent or overlapping claims which have the potential to reduce or prevent payment; and
- Information relating to the participation status of the provider.

Claim Payment. Requires a verifiable and auditable claims system to ensure timely payment of claims including the following claim payment data elements: patient identity, date of service, the claim number, the CPT or procedure code, the provider, the date and amount of payment and identifying information such as the check number, electronic transfer number, and the address or bank to which the payment was made. Defines “timely payment” as paying 95% of clean claims within 30 calendar days of claim receipt by issuance of check or electronic funds transfer.

Denials and Appeals. Requires a verifiable and auditable claims system to ensure that providers whose claims are improperly denied or delayed are made whole with the payable amount of the claim and interest as allowed by law. Requires a verifiable and auditable claims system to ensure appropriate handling and resolution of all denied or pended claims, including notice of denial within 30 days of decision, timely notice of appeal rights and written policies and procedures for denying or pending a claim.

Transparency and Accessibility. Requires the complete physician fee schedule to be available to participating physicians. Requires the acceptance of paper or electronic claim forms. Requires the development and posting on the managed care company's website of all written policies and procedures for appropriate claim submissions and requests for additional information and all written policies for codes and procedures related to covered services that are bundled or paid at a discounted rate.

Prohibited Practices.

- Automatically reducing a billed evaluation and management code level without proper review of the clinical record and compliance with written policies and procedures.
- Not recognizing modifier codes when applying Multiple Procedure Logic to a claim that contains more than one procedure.
- Applying global periods for surgical procedures longer than periods designated on a national basis by CMS.
- Automatically changing a code to one reflecting a reduced intensity of the service.
- Using claim-editing software that has not been updated in the past year.

Texas insurance laws and rules governing PPOs, HMOs, submission of clean claims, contracting requirements, required contract provisions, preauthorization and verification do not apply to Medicaid managed care contracts, and may not apply to Medicare managed care contracts if preempted by Medicare laws or rules. In order to create the obligation for managed care companies to comply with such Texas laws and rules, health care providers must negotiate such compliance in their Medicare and Medicaid managed care contracts. The AmeriChoice settlement provides additional provisions for health care providers to consider including in these contracts.

Please contact one of the Haynes and Boone Health Care Practice Group members listed below with any questions you may have or for guidance in using these settlement provisions in future Medicare and Medicaid managed care contract negotiations.

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