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BUNDLED PAYMENTS

situation for orthopedic procedures, such as hip replacements. In a bundled payment compensation system, a single check would cover all patient-required care including the costs associated with the hospital, the surgical implant, the surgeon's fee, medications, nursing home or assisted living facility accommodations post-surgery, patient physical therapy and home care. It would fall to the providers to determine how to allocate the payment.

Re-engineering healthcare delivery models will increase efficiency. By keeping tabs on improved clinical outcomes, providers will be able to better understand their practices within the context of other providers who form the integrated supply chain required to deliver the patient's full experience of care. Providers should keep in mind the "Four Rs" when constructing their programs: The Right Care at the Right Place for the Right Amount of Time at the Right Cost. Late adopters will find themselves providing services at price points they did not set.

While there is no doubt the shift to bundled payments will require work, providers who move first will be able to gain market share. Additionally, they will establish reputations as value-driven, accountable care providers, ultimately leaving the patient with the largest gain from more effective, quality care.

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WHAT YOU'RE NOT HEARING ABOUT...

THE IMPACT OF THE AFFORDABLE CARE ACT ON PHYSICIANS' NEED FOR COMPLIANCE PLANS

By Laura Lovett, CPC, CPMA, CEMC, Data Integrity & Compliance Consultant, The Rybar Group, Inc.

The Affordable Care Act (ACA) will continue to evolve and morph over the coming months and years. While no one can foresee all the changes the ACA will necessitate, or predict the impact it will have on physician practices, given the anticipated magnitude of its effect on the healthcare delivery system, there are some general points of interest to consider.

While it is not within the scope of this article to present all the details, providers need to be fully aware of the fact that the ACA has granted additional powers to some governmental agencies and strengthened existing penalties in order to combat fraud and abuse. This legislation has created screening steps for new provider or supplier enrollments and requires existing providers to revalidate their enrollment. Part of this process requires providers have a compliance program. At this point in time, the specifics of what is required in those compliance programs and implementation deadlines have not yet been established. What is formally established, however, is the increased amount of civil monetary penalties.

If a provider submits a claim for services that are not supported by documentation, it is considered a false claim. Providers may be charged with the False Claims Act even though they do not have knowledge that the claim is false. It is critical for providers to have compliance plans in place to help mitigate the chance of a false claim, as well as demonstrate their attempt to be in "compliance" in case a charge is brought.

The Office of Inspector General (OIG) provided guidance for voluntary compliance plans long before the ACA, with Federal Register/Vol. 65, No. 194 dated Oct. 5, 2000, *OIG Compliance Program for Individual and Small Group Physician Practices*[1]. For a provider's own protection, it is important to develop and implement, at minimum, the auditing and monitoring portion of the OIG's recommended compliance plan. Once the official requirements for compliance programs mandated by the ACA are released, providers will need to update their existing plans to properly cover all required elements.

The best way for providers to protect themselves is to audit, identify, correct, educate and repeat. The government and other payers are continuously looking for ways to save money and identify potential fraud. One method is to stop paying for unsupported services. Reducing unnecessary and undocumented claims is a key funding source for the ACA.

On the providers' end, this means extreme due diligence and clear documentation of all services so they can be captured and submitted for correct reimbursement. If denials do occur, providers must be assertive and willing to go the extra mile by calling, sending appeals and following up with the OIG in order to receive their deserved reimbursement. The likelihood of claims denial after an appeal is reduced when the documentation is precise and accurate. The best way to do this is for providers to keep close tabs on their documentation and coding as part of their compliance plan as well as staying abreast of the ever-evolving rules that apply to their services based on their payers. Proper implementation of compliance plans are a key component to a provider's success in navigating in this process.

1 http://oig.hhs.gov/authorities/docs/physician.pdf.

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