

MEDICARE AUDIT

A Medical Care Audit is one of the most important audits in Medical Education. This audit will conclude to the government the amount of reimbursement for your institution and for each individual program. This audit will have an impact on your program, training, and budgets for the coming years.

In an audit the most important part will be verification and certification of residency status for all residents in your program and any past programs since the resident has graduated from medical school. No matter how many programs they may have joined, the first program will have an impact on how your program is reimbursed. The resident decision to join a training program will be one of the most important decisions that impact your facilities reimbursement. With this in mind, the importance of selecting a program by the resident and the actual hiring of the resident for a residency program will intersect and will make a final decision regarding the amount of reimbursement for each resident in your program(s).

ECFMG Certification

ECFMG certification and verification is absolutely necessary for all International Medical Graduates (IMG's) in a Medicare Audit situation. All IMG's must be certified before beginning a residency program. Each IMG will become circumspect as an audit is completed. IMG's must be tracked for each residency program they have entered whether they have finished the program or not. Their first program will be the basis for the number of years of full reimbursement versus lesser amounts of reimbursement. Your residency files will be reviewed by the auditor for discrepancy in previous residency programs entered, ECFMG certification, and date of issue of the certification.

Verification of Residency

By ACGME guidelines all residents should have a letter from their program director of any program they joined for however long and that letter should evaluate the number of rotations by name, amount of time spent in each rotation, and whether that resident was competent or did not pass the rotation. In addition, the number of procedures should be outlined as well. This would be an ideal situation or document to attach with every resident who have completed any other residency program in addition to yours or their current program. Also, upon completing your program the residency program should have a brief synopsis of what rotation were completed for board certification. These documents are very important for future recommendation or review by auditors or even newly appointed program directors.

There are several disciplines that require a resident to spend time in general training prior to immersing themselves in the specialty, for example, radiology

and anesthesiology, this clinical base year training is a requirement for approval of these programs. Residents can satisfy this clinical base year requirement in several ways, but the two most common ways to satisfy the requirement are through enrollment in a transitional year program or a in a preliminary year of an internal medicine program. Residents often match for the base year training and specialty training at the same time. If a resident is in a transitional year program his/her initial residency period is determined in the resident's second year of training. When a resident obtains general training in an internal medicine, however, CMS policy is that the initial residency period is the three-year period for internal medicine. CMS insists that this is the proper interpretation of the statute despite the fact that:

1. The resident has no intention of becoming certified in internal medicine and is already matched for specialty training
2. The resident is accepted into an internal medicine program only for the first year of training and not for the full three years of such programs; and
3. The result is inconsistent with how CMS treats transitional year programs.

Most intermediaries are not familiar with CMS' policy and have not applied it, but that is likely to change since the issue arose in a few Department of Health and Human Services Offices of Inspector General (OIG) audits of GME resident counts.

Congress made clear in the legislative history of MMA that it has never intended for the initial residency period to be determined on the basis of the clinical base year training. Congress directed that the initial residency period should be determined in the resident's second year of training. CMS has ignored this provision, at least for now, and did not address the issue in this one-time notification.

Effective in 1999, CMS changed its interpretation of the law, determining that a hospital would have to compensate the supervising physician in a non-provider setting in order for the hospital to claim the resident while on rotation to that setting. Many hospitals have not paid the supervising physicians' as those physicians are pleased to volunteer their time. While there are instances when CMS accepts this, for example CMS appears not to require a hospital to compensate the supervising physician when that physician is an owner of the practice, CMS has generally not accepted the concept that a physician can volunteer his/her time.

Congress addressed this problem in 713 of MMA by requiring that residents rotating to non-provider settings be counted without regard to whether the supervising physician is compensated by the hospital during calendar year 2004. The law was ambiguous as to whether reference to 2004 meant when the resident was engaged in the rotation or when a cost report was being settled. CMS has resolved this ambiguity by interpreting the law as applying to both

rotations occurring in 2004 and cost reports settled in 2004. This 2004 exception applies only to:

1. Resident in family practice programs;
2. Family practice programs in existence as of January 1, 2002;
3. Residents who spend time in patient care activities;
4. When there was a written agreement in place; and
5. the hospital actually incurred the cost for the resident's compensation.

CMS' interpretation gives teaching hospitals an incentive to have cost reports settled in 2004. CMS has anticipated this and directs its intermediaries to schedule cost report audit and settlement activities during 2004 "in accordance with normal procedures."

CMS has also directed that intermediaries should not reopen cost reports settled before 2004 to allow a hospital to count family practice residents previously disallowed because of CMS' interpretation on volunteer physicians. The One Time Notification is silent on whether it applies to pending appeals heard or decided in 2004.

Program Positions and Institutional Caps

The amount of program positions for each program is different. University programs are the biggest programs and most diverse, but they can be harder to maintain since there can be numerous rotations for residents depending on their residency or fellowship program requirements. The number of positions of each program greatly increases the revenue for each program and facility. The number of residents each institution is "capped" at generates this revenue.

The Department Chairs and program directors must negotiate with hospital administrators to secure resources for resident and fellow training, but they have limited leverage in these negotiations. This problem is only exacerbated by the fact that Medicare GME funds are not paid to hospitals in any relationship to what the institutions actually extend on medical education. Variable and idiosyncratic reimbursement of house staff positions by Medicare further complicates this negotiation. The Balanced Budget Act 97 cap on the number of resident funded by Medicare also diminishes the flexibility of program directors and chairs in adapting to new technological, community and clinical trends. For example, this regulation complicates shifting resident or fellow positions between institutions to best meet the needs of the educational program.

References

CMS implements MMA Provisions on GME and IME, notification details changes. Reimbursement Advisor, May 2004, p. 10-11.

Rich, EC et al. (2002) Medicare financing of Graduate Medical Education: intractable problems, elusive solutions. Journal of General Internal Medicine, 17, 283-292.