Health Care Legislation Alert

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Health Care Reform: It's Finally Here.
Now What Does It Mean And How Does It Affect You?

by Sandy Teplitzky, Chair of Ober|Kaler's Health Law Group

The debate over health care reform reaches as far back as 1975, when I began practicing health law, and perhaps even back to the inception of Ober|Kaler's health law practice 40 years ago. Even then, discussions were already underway in an effort to address concerns about access to, the delivery of, and reimbursement for, health care services for Americans. Over the years, little substantive progress was made and the issues became more politicized. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, the President signed the Health Care and Education Affordability Reconciliation Act of 2010. Whatever one's political views, health care reform has now truly arrived.

Immediately after the signing of those laws, newsletters blanketed the country, webinars were held, and other educational programs were scheduled. In the meantime, we here at Ober|Kaler have been busy doing what we have always done for our clients: analyzing the practical effect of the new provisions on daily operations and overall health system goals. Our entire Health Law Practice Group, comprised of over 40 lawyers, is currently reviewing and analyzing the new laws, speaking with government officials, and preparing analyses that we hope will be helpful to you.

Many of the provisions of the health care reform legislation do not take effect for an extended period of time and most will require the publication of implementing regulations and/or the issuance of programmatic guidance. Thus, no one has all of the answers at this time. In fact, many of us are still struggling to understand the questions that must be asked.

We have prepared this publication, the first in a series that we plan to issue over the coming weeks, to help you prepare for the future and to provide analyses of the most important elements of health care reform. We will issue additional analyses as more information becomes available. You will note that the format for each article is a summary of the specific issue, followed by "Ober|Kaler Comments." In analyzing new developments, our goal is to provide a meaningful context, so that our clients and friends not only know what the developments mean, but more importantly, what the developments mean to them. We trust that you will find this approach helpful in understanding the implications and applications of each provision.

Please do not hesitate to contact us with any comments, questions, or suggestions regarding health care reform.

New 60-Day Time Limits for Reporting and Returning Overpayments

by Joshua J. Freemire

Reporting and returning overpayments is now an obligation of providers and suppliers. As part of the enhanced program safeguarding provisions in PPACA, providers and suppliers are required to report and return overpayments within 60 days of the date the overpayment has been identified. Failure to meet this deadline may result in liability under the False Claims Act. This obligation, based on the plain statutory language, appears to be effective immediately. PPACA, however, does not define *identified*.

Under section 6402(d) of PPACA, a person (defined to include providers, suppliers, Medicaid Managed Care Organizations, Medicare Advantage organizations, or PDP sponsors) must report and return identified overpayments to, as appropriate, HHS, the State, an intermediary, a carrier, or a government contractor by the later of:

- 60 days from the date the overpayment is identified; or
- The date any corresponding cost report is due.

Overpayments that are not both reported and returned by the statutory deadline become *obligations* as that term is used in the False Claims Act as amended by the Fraud Enforcement and Recovery Act (FERA). Obligations, under FERA's amendments, are actionable as so-called reverse false claims and subject persons to the False Claims Act's standard treble damages and penalty provisions.

This "new" deadline is not precisely new. CMS has tried twice before to require the return of identified overpayments within 60 days (once in a 1998 proposed rule, and again in 2002) and it abandoned both efforts in the face of broad industry criticism. That criticism was well-founded then, and is even more so now. Providers and others subject to the law will need to determine when to deem an overpayment identified. Is it when the potential overpayment is discovered? When an overpayment is confirmed? When it is both confirmed and quantified? No guidance is given in the previous proposed rules or in the new statutory provision.

Ober|Kaler's Comments: It seems likely that CMS will issue additional implementing guidance to answer some of providers' questions. Until then, however, providers must assume that the new law is effective as of the date of the enactment of PPACA. Accordingly, suspected overpayment situations (which include suspected Stark or antikickback violations) must be investigated immediately and vigorously and repaid as quickly as possible. In preparation, providers should familiarize themselves with the applicable repayment policies and procedures for their Medicare Administrative Contractors (MACs) so that repayment, when necessary, can be made as quickly as possible. Not all MACs accept paper checks or electronic fund transfers,

and may lack the ability to offset an overpayment within the 60-day time limit. In essence, the new law offers providers more questions than answers, and threatens significant penalties for those who guess incorrectly.

CMS Gets Expanded Authority to Recoup Overpayments from Related Entities

by Thomas W. Coons and Mark A. Stanley

Providers and suppliers now may find themselves on the hook for debts owed to Medicare by related parties. In section 6401(a) of PPACA, Congress has granted CMS the authority to adjust payments to providers and suppliers on the basis of their federal tax identification numbers. Under the new program, CMS now may reduce funds due to any provider or supplier, regardless of provider number, as long as the entity shares a federal tax identification number with a provider or supplier with a past-due obligation under Medicare. This change to permit "cross-provider" recoveries is a departure from prior recoupment rules, which only allowed for recoupment on the basis of individual provider numbers.

Ober|Kaler's Comments: The new recoupment rules go into effect immediately, and may come as a surprise to health care organizations with multiple providers and suppliers under the same federal tax identification number. The law does not apply retroactively, nor does it prevent an organization from seeking separate tax identification numbers for each billing entity. Therefore, providers and suppliers that wish to avoid the impact of the cross-recoupment law still are able to establish a separate federal tax identification number for each entity that bills Medicare.

Check the Clock: Claims Filing Deadline Reduced to One Year from Date of Service

by Thomas W. Coons, Donna J. Senft and Lisa D. Stevenson

Section 6404 of PPACA reduced the time period for filing Medicare fee-for-service claims to one calendar year after the date of service, effective for services furnished on or after January 1,

2010. Moreover, PPACA mandates that claims for services furnished between October 1, 2009 and December 31, 2009 be filed no later than December 31, 2010.

Prior to this change, providers and suppliers had anywhere from 15 months to as long as 27 months, depending on when the service was furnished, in which to file a claim with Medicare.

Ober|Kaler's Comments: With the shorter claims filing deadlines, providers and suppliers may need to devote additional staff to ensure that all outstanding patient claims are timely submitted.

The new shorter claims-filing period also may create problems for new enrollees or previously enrolled providers and suppliers. For new enrollees, to the extent that delays in processing the enrollment application occur, the timely filing deadline must be closely tracked while the new enrollee awaits approval of the enrollment application. Enrollment application processing delays may occur for a variety of reasons, many of which, such as application backlogs, are due to no fault of the provider/supplier. A delay in enrollment means a delay in claim submission, since these claims must be held until the enrollment is approved, a Provider Transaction Access Number (PTAN) is issued, and the National Provider Identifier (NPI) is cross-walked allowing billing to occur. For existing enrollees, claims submission may be interrupted as a result of updates to NPI data, updates to enrollment data, or computer systems back-ups causing cross-walk problems resulting in an inability to submit claims. In these situations a timely fix of the problem will be essential to avoid claims filing timeliness issues.

PPACA gives HHS the authority to "specify exceptions to the one calendar year period." It is uncertain whether any exceptions will be granted to providers and suppliers whose time limits for filing claims are linked to enrollment status issues such as those mentioned here.

You Can Go Elsewhere… But Where?
Imaging Services and the In-Office Ancillary Services Exception

by Julie E. Kass and Kristin C. Carter

In an apparent attempt to require more transparency under the in-office ancillary services exception to the Physician Self-Referral Law (Stark Law), 42 U.S.C. § 1395nn, section 6003 of PPACA amends the in-office ancillary services exception to require referring physicians to provide written notice to patients being referred for specified imaging services that the patient can obtain such services from suppliers other than the physician. The disclosure must be made at the time of the referral, and the referring physician also must provide the patient with a list of other suppliers who furnish such services in the area where the patient resides. The amendment expressly applies to magnetic resonance imaging (MRI), computer tomography (CT), and positron emission tomography (PET) services provided pursuant the in-office ancillary services exception. HHS, however, is authorized to expand the requirement to other designated health services (DHS) provided pursuant to the exception.

Ober|Kaler's Comments: Interestingly, the law states that the effective date is January 1, 2010. Obviously, physicians could not possibly have complied with the requirements as of that date, having had no notice of them. CMS has yet to issue any guidance regarding this notice requirement, including when such requirements will be enforced; however, the law clearly states that the amendment "shall apply to services furnished on or after January 1, 2010." Therefore, it is prudent for physician practices to immediately implement procedures to comply with the written disclosure requirements for MRI, CT and PET services provided pursuant to the in-office ancillary services exception to ensure continued compliance with the Stark Law exception.

The amendment leaves open some questions regarding what types of entities should be included on the written list of other suppliers providing the services near the patient's residence. For example, it is unclear whether hospitals providing MRIs, CTs, and PETs should be included, because the amendment specifically requires the list to include other suppliers.

Hospitals are defined as *providers* and not *suppliers* as the term is defined under the Medicare Act. However, nothing in PPACA prohibits identifying hospital resources on a list of other imaging service providers. At a minimum, we suggest that the written list of suppliers provided by physicians at the time of referral include imaging centers near where the patient resides. *Supplier* is defined in the law to include physicians, which raises another issue as to whether the list must include other physician practices (including competing practices) which provide such services. Finally, PPACA requires the notice to list other entities where the patient resides. This raises the question of whether a physician's office must have various lists depending on a patient's address. Clearly, CMS will need to issue guidance to address all of these issues. In the meantime, it is prudent for physicians to develop reasonable disclosure protocols and notices that give their patients choices in imaging services.

About Ober|Kaler
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