

Physician Organizations

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Physician Practices as Employers under Federal Health Care Reform: The Employer Mandate and Related Requirements and Opportunities

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It is no secret that the Affordable Care Act (ACA)¹ provides physician practices with plenty of information to digest and tasks to accomplish. On a daily basis, physician practices strive to understand and implement a plethora of requirements they need to satisfy in order for them to thrive as providers of health care under new payment and delivery models, which increasingly focus on value (i.e., quality and efficiency) in addition to the volume of services provided. As business owners, many physician practices realize, for example, that they will need to inspire their workforce to strengthen clinical integration efforts, implement a robust and living compliance program, and overcome challenges related to electronic health record meaningful use implementation. That being said, physician practices also must stay abreast of their legal obligations as *employers* during this time of change under the ACA.²

This article provides a broad overview of the obligations of certain physician practices to offer a minimal level of health insurance coverage to their employees, as well as certain carrots and sticks that the federal government has promulgated in hopes that employers do indeed provide such benefits.

Employer Mandate and Its Application to Large Employers

To advance its goal of increasing health insurance coverage and affordability, and as a counterpart to its general requirement that individuals maintain a minimum level of health insurance,³ the ACA requires, in general, that large employers either: (1) provide affordable minimum value health coverage to their employees and their dependents; or (2) risk being responsible to the federal government for an assessable payment for not doing so (Employer Mandate).⁴ Generally stated, large employers who do not provide affordable minimal essential coverage that meets the minimum value standard to substantially all of their full-time equivalent (FTE) employees (and their dependents) may be subject

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—from a declaration of the American Bar Association

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to a payment requirement if at least one of its FTEs receives a premium tax credit for purchasing individual coverage on the health insurance marketplace (also often referred to as the individual exchanges).⁵ The amount of the payment depends on the specific circumstances but will in no case exceed \$2,000 per year per FTE (subject to an inflation adjustment). According to the American College of Physicians and other organizations, many physician practices already offer such coverage and will remain largely unaffected by the Employer Mandate.⁶

Generally stated, employers that employed an average of at least 50 FTEs on business days during the preceding calendar year are referred to as “applicable large employers” or “large employers” and are subject to the Employer Mandate.⁷ The regulations implementing the Employer Mandate define “employee” as an individual who is an employee under the common law standard, and not including a leased employee, sole proprietor, partner in a partnership, 2% S corporation shareholder, real estate agent, or a direct seller. Full-time employees are defined as employees that, with respect to a calendar month, average at least 30 hours of service per week.⁸ Internal Revenue Service (IRS) guidance includes the following example: an employer that employs 40 employees employed for 30 or more hours per week on average and 20 employees employed 15 hours per week on average has the equivalent of 50 FTEs and would be a large employer.⁹

As stated above, when the Employer Mandate is implicated (i.e., when an employer is an “applicable large employer”), the employer must offer affordable health insurance meeting

the minimum value standard in order to avoid the risk of otherwise-assessable payments described above. In order to be “affordable,” the employee share of the self-only premium must be no more than 9.5% of household income to FTEs. The IRS has clarified that employers are permitted to use the wages they pay, their employees’ hourly rates, or the federal poverty level in determining whether employer coverage is affordable as required under the ACA.¹⁰ The minimum value standard means providing coverage with an actuarial value of 60% (i.e., it must cover at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan) or more.

Impact of Employer Mandate on Small Physician Practices

Under the ACA, small employers (including without limitation physician practices) with less than 50 FTEs are not subject to the Employer Mandate and do not need to provide minimal essential coverage (or any other type of health insurance coverage) to their employees. Guidance from the U.S. Department of Treasury recently stated that “[a]pproximately 96 percent of employers are small business and have fewer than fifty workers and are exempt from the employer responsibility provisions.”

That being said, those small employers with 50 or fewer FTEs that elect to provide health insurance coverage to their employees will be able to shop for health insurance products to offer to their employees through state or federal Small Business Health Options Program (SHOP) marketplaces.¹¹

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Further, small employers with fewer than 25 FTEs, with an average annual employee salary of less than \$50,000 (adjusted for inflation) and who pay at least 50% of their FTEs' premium costs are eligible for a tax credit to purchase health care coverage through the SHOP marketplace for their employees.¹²

Final Rule Provides Transition Relief

Although the ACA provides that the Employer Mandate was set to become effective during 2014, the IRS Final Rule on the Shared Responsibility for Employers Regarding Health Coverage (i.e., the Employer Mandate), which was published on February 12, 2014, provides for a more-gradual phasing in of such requirements.¹³ Briefly stated, the Final Rule provides that, starting in 2015, the Employer Mandate will generally apply to businesses with 100 or more FTEs and, starting in 2016, will apply to employers with 50 or more FTEs. In order to take advantage of the extension to 2016, employers with at least 50 but fewer than 100 FTEs will need to provide an appropriate certificate on a prescribed form with respect to workforce size, maintenance of workforce, aggregate hours of service, and maintenance of previously offered health coverage as described in the Final Rule. Further, in order to otherwise avoid the risk of being assessed a payment for failing to offer health insurance coverage, the Final Rules provides that large employers only need to offer coverage to 70% of their FTEs during 2015 (instead of the 95% threshold that will apply during and after 2016).¹⁴

We also note that, in conjunction with the Final Rule, the federal government has promised “to simplify and streamline the employer reporting requirements” that are set forth in the ACA and that are designed to demonstrate and ensure compliance by employers with the Employer Mandate. Employers will be required to make and provide such reports annually to the IRS and their employees. Such reports will include whether the employer offers health care insurance to the employees, and if so, details including plan participation, waiting periods, coverage, premiums, and other information.¹⁵

Conclusion

In general, physician practices that constitute large employers (i.e., those with 50 or more FTEs) will need to either provide a minimal level of health insurance to their FTEs or risk having to pay certain assessments to the federal government as described above. Although small physician practices (i.e., practices with less than 50 FTEs) are not subject to the Employer Mandate, they should be aware of potential tax credits and cost savings available through the SHOP marketplaces. Now that the Final Rule and additional guidance have been issued with respect to the Employer Mandate, health care attorneys and consultants have an opportunity to work with their physician practice clients to develop a definitive strategy for assessing whether the practice is subject to the Employer

Mandate and, if so, complying in the most advantageous manner possible.

- 1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended. See 26 C.F.R. § 54.4980H-1(a)(3).
- 2 Physician professional organizations are often invaluable sources of guidance for physician practices with respect to the Employer Mandate and related requirements. See, for example, “Questions & Answers about Physician Concerns on Affordable Care Act Implementation,” available on the American College of Physicians website at www.acponline.org/advocacy/state_health_policy/aca_enrollment/faq_physician_concerns.htm. Additional helpful websites also include, for example, www.healthcare.gov/ and www.dol.gov/ebsa/healthreform/index.html.
- 3 Beginning January 1, 2014, individuals who do not have minimum essential health coverage will be required to pay an annual penalty when they file their federal tax return. See www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.
- 4 26 U.S.C. § 4980H. See also 26 CFR § 54.4980H-0, *et seq.* Accordingly, the Employer Mandate is not an explicit mandate and is referred to in the law and elsewhere as the “employer responsibilities” or the “employer responsibility provisions.” The Employer Mandate also is often described as offering employers the option to “pay or play.”
- 5 For additional information regarding the potential employer penalties under the ACA, see Janemarie Mulvey, Congressional Research Service, “Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)” (July 22, 2013).
- 6 See www.acponline.org/advocacy/state_health_policy/aca_enrollment/faq_physician_concerns.htm.
- 7 26 C.F.R. § 54.4980H-1(4).
- 8 See 26 C.F.R. § 54.4980H(21). Also note that the Final Rule clarifies that employers may use either a monthly method to determine FTE status or a look-back period to determine whether an employee is considered a FTE and provides additional guidance on such calculations. This guidance is especially important to those employers who have employees with varying hours, on-call hours, and seasonal employees.
- 9 See www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act.
- 10 79 Fed. Reg. 8544, *et seq.* (Feb. 12, 2014).
- 11 By way of clarification, these SHOP exchanges are separate and apart from the individual health insurance marketplace. For additional information regarding the SHOP marketplace, see <http://marketplace.cms.gov/getofficialresources/publications-and-articles/key-facts-about-shop.pdf>. Also note that, beginning no later than January 1, 2016, the SHOP marketplaces will be available to employers with 100 or fewer FTEs.
- 12 An abundance of additional guidance regarding the small business health care tax credit is available at www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers. See also 26 U.S.C. § 45R and IRS Notices 2010-44 and 2010-82. When determining whether a physician practice has exceeded the \$50,000 threshold, consider that the definition of employee often does not include physicians who own their own practices.
- 13 79 Fed. Reg. 8544, *see supra* note 10.
- 14 See www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%2020121014.pdf.
- 15 See 26 U.S.C. § 6056, available at www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%2020121014.pdf. IRS Notice 2013-45 provides that “no penalties will be applied for failure to comply with these information reporting provisions for 2014.”

Chair's Column

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Well, it looks as though the winter snow has finally gone, and spring is here. We enjoyed visiting with everyone at the Physicians and Hospitals Law Institute in New Orleans in February. For those who could not attend, you can still [purchase](#) the materials and sessions through modern technology. Modern technology also helps our Practice Group bring you tweets on the latest news of interest to lawyers who represent physicians. We hope you sign up to follow us on Twitter [@AHLA_PhysOrgs](#), and let us know if you are interested in tweeting.

As it turns out, the government is using new technology, too. It is data mining and comparing physicians and their patterns more than ever. What's more, the government has settled a lawsuit by agreeing to provide their claims data about physicians to anyone who requests it. In April, following voluminous reimbursement data record requests, the Centers for Medicare & Medicaid Services released its Medicare physician payment data en masse. The data catalogues \$77 billion in payments to more than 880,000 professionals in 2012. With this data now public, greater physician False Claims Act scrutiny is inevitable, whether through enhanced government scrutiny, media reports that prompt government investigations, or whistleblowers. Accordingly, physicians should be aware that the information they submit to Medicare for reimbursement may ultimately be scrutinized by more than just the government.

With all of the changes in health care, the Physician Organizations Practice Group strives to keep you in the know by sharing the experiences of our members through email blasts, webinars, tweets, newsletters, and more. No one person can make this happen, so I continue to request your support and effort to write, speak, and get involved in the Practice Group.

Feel free to reach out to any vice chair directly if you are interested in their area of leadership. The current vice chairs and their positions and contact information are available on page 2.

Any one of these folks would be happy to talk more about our Practice Group and would welcome additional member involvement.

Once again, thanks to all of the volunteers who submitted email alerts and executive summaries for electronic distribution. We always are looking for volunteer authors, so if you have an idea to share with colleagues please contact Nancy Gillette (Gillette@osma.org). Dan Shay, Vice Chair of Research and Website, is actively working on an active Twitter feed for the Practice Group. He also welcomes contributors and followers.



Upcoming Webinars:

Wednesday, May 21, 2014

[Personalized Medicine Bootcamp, Part IV: Privacy and Security Issues in Personalized Medicine](#)

Thursday, May 22, 2014

[Acute and Post-Acute Relationships in an ACO World: The Devilish Details](#)

Thursday, June 19, 2014

[The ABCs of Antitrust in Health Care, Part IX: Introduction to the Enforcers](#)

Wednesday, June 25, 2014

[Personalized Medicine Bootcamp, Part V: Reimbursement Issues](#)

How Long Must We Wait? Repercussions for Health Care Providers and Suppliers of ALJ Adjudication Delays

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The Social Security Act, implementing regulations, and the Centers for Medicare & Medicaid Services (CMS) sub-regulatory guidance all require adjudicators to timely process Medicare Part A and Part B claim appeals. Despite these mandates, adjudicators routinely fail to meet their adjudication timeframes, to the financial detriment of Medicare Part A and Part B claim appellants. Effective July 15, 2013 the U.S. Department of Health & Human Services, Office of Medicare Hearings and Appeals (OMHA) “temporarily suspended the assignment of most new requests” for administrative law judge (ALJ) hearings, resulting in an anticipated delay of approximately 2.5 years from the time an appellant makes a request for a hearing until an ALJ hearing takes place.¹ The appeals backlog is significant, and will continue to grow exponentially unless the underlying causes for the backlog are addressed. Recent updates to recovery auditor activity may ultimately prove to provide near-term relief to Medicare Part A and Part B claim appellants awaiting appeals adjudication.

ALJ Adjudication Timeframes

Section 1869 of the Social Security Act (42 U.S.C. § 1395ff) created the five-stage uniform Part A and Part B Medicare appeals process. Implementing regulations are codified at 42 C.F.R. Part 405 Subpart I, and CMS sub-regulatory guidance is set forth in the Medicare Claims Processing Manual (CMS Internet-Only Manual 100-04), Chapter 29.² An ALJ hearing is the third stage in the five-stage³ Medicare Part A and Part B appeals process.

The Social Security Act expressly requires that an ALJ “conduct and conclude a hearing . . . and render a decision on such hearing *by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.*”⁴ If the ALJ fails to abide by this timeframe, a party may “escalate” its appeal to the Departmental Appeals Board’s Medicare Appeals Council for review;⁵ however, as a practical matter this means that the party waives the opportunity for oral argument in the vast majority of cases.

The 90-day adjudication timeframe does not apply to the following situations:

- When an appeal escalates from the reconsideration stage of appeal to the ALJ stage of appeal, the ALJ is granted a 180-day period to issue its decision;⁶

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- When CMS or its contractor participates in an ALJ hearing as a party, and a party requests discovery, the 90-adjudication period is tolled;⁷
- When an appellant fails to submit all evidence within ten days from receipt of a “notice of hearing,” the 90-day adjudication period is tolled for the period between when evidence should have been submitted and when it was received;⁸
- When an appellant fails to send a notice of its ALJ hearing request to all other parties, the 90-day adjudication period is tolled until all parties receive notice of the request for an ALJ hearing;⁹ and
- When a party’s request for an in-person ALJ hearing is granted, the party should expect an extension of the 90-day adjudication timeframe. The CMS website indicates that a request for an in-person ALJ hearing will lead to an extended timeframe for decision.¹⁰ However, note that federal regulations explicitly state, “When a party’s request for an in-person hearing . . . is granted, the ALJ must issue a decision within the adjudication timeframes specified in §405.1016 . . . unless the party requesting the hearing agrees to waive such adjudication timeframe in writing.”¹¹

Effect of Failure to Adhere to Statutory, Regulatory, and Sub-regulatory Guidelines

Citing an “exponential growth in requests for hearing,” by way of memorandum issued on December 24, 2013 OMHA announced that, effective five months earlier (i.e., as of July 15, 2013), it “temporarily suspended the assignment of most new requests” for ALJ hearings.¹² To illustrate this “exponential growth,” OMHA noted the following statistics:

- In January 2012 OMHA received an average of 1,250 appeals per week; in November 2013 this number increased tenfold to an average of 15,000 appeals per week; and
- At the time OMHA issued its Memorandum to OMHA Medicare Appellants, 357,000 appeals in queue were awaiting adjudication.¹³

Presently the OMHA website projects a 20-24 week delay (i.e., a 140-168 day delay) in docketing new requests for ALJ hearing; projects a delay of up to 28 months before assignment to an ALJ; and projects an additional six-month delay before a hearing will be held.¹⁴

Medicare Part A and Part B claim appellants, however, must strictly adhere to their appeals timetables. In very limited situations, CMS will grant a party the opportunity to continue with its appeal if it misses an appeals filing deadline, but only if “good cause” is established. CMS recognizes serious illness, death, natural disaster, and circumstances beyond the control of the appellant as examples of “good cause” for late filing.¹⁵ Despite OMHA repeatedly citing lack of business resources to account for its inability to meet its statutory obligations (seemingly without repercussion from CMS), an *appellant’s* lack of business resources has been expressly noted as insuff-

icient to establish good cause for missed deadlines: “The contractor does not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused late filing.”¹⁶

Impact on Appellants

Delays in processing appeals violates the Social Security Act (as noted above), and clearly results in a violation of appellants’ procedural due process rights. In addition, adjudication delays have very real financial consequences for Medicare appellants.

Significantly, delayed ALJ adjudication results in cash flow issues for appellants. While awaiting an ALJ hearing and decision, Medicare administrative contractors (MACs) are authorized to begin withholding an alleged overpayment. Section 935 (f) (2) (A) of the Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173) amended Section 1893 of the Social Security Act (42 U.S.C. § 1395ddd) to prohibit Medicare contractors from recouping an alleged overpayment until after issuance of a reconsideration (second stage) decision.¹⁷ CMS does not withhold or recoup an alleged overpayment during the first two stages of the Medicare appeals process, provided that expedited appeals timeframes are satisfied;¹⁸ however, interest accrues against the alleged overpayment.¹⁹ Following issuance of a partially favorable or unfavorable reconsideration decision, CMS will begin recoupment activities.

Appellants’ likelihood of success in the Medicare appeals process has historically been greatest at the ALJ stage of appeal. A November 2012 Report by the Office of Inspector General reported that qualified independent contractors issued fully favorable results in just 20% of cases decided at reconsideration.²⁰ In contrast, fully favorable ALJ decisions were issued in 56% of cases, and partially favorable ALJ decisions were issued in an additional 6% of cases.²¹ Health care provider and supplier appellants waiting years for an ALJ hearing to take place suffer the consequences of cash flow interruptions associated with CMS recoupment of alleged overpayments (which may or may not be ultimately upheld).

Impact of Today’s Audit Landscape—Recovery Auditors

OMHA is considering several initiatives that may help to resolve the backlog of appeals in queue for adjudication, including adding a fifth OMHA field office and permitting “alternate adjudication models.”²² However, these initiatives may fail to address the underlying cause of the appeals backlog. Numerous auditing bodies review health care providers’ and suppliers’ Medicare claims. Although OMHA cited the “[c]ontinuing expansion of *all* post-payment audit programs”²³ as one reason for the increase in appeals in queue, the role of recovery auditors has clearly been significant.

Over the past few years, recovery auditors have focused ever-increasing medical review efforts on Part A inpatient



hospital claims. CMS has increased the additional documentation request (ADR) limits imposed on recovery auditors over time,²⁴ and the recovery audit contractors (RACs) have reported a correlated increase in collections.²⁵ RACs nationwide have focused a majority of their attention on Part A inpatient hospital claims, and in correlation, OMHA has experienced an exponential growth in Medicare Part A claim appeals.²⁶ As hospitals have reported an approximate 70% success rate contesting Part A claim denials in the Medicare appeals process,²⁷ hospitals will likely continue to appeal, contributing to a “back log” of appeals in queue. The American Hospital Association has called on CMS²⁸ and Congress²⁹ to address issues associated with the ALJ backlog as tied to audit activities of the RACs.

CMS recently announced “pauses” in certain recovery audit activity, which will likely reduce the overall number of claim denials and by extension, the number of appeals submitted. During these “pauses” in recovery audit activity, OMHA will have the opportunity to adjudicate many of its pending appeals. Recovery audit activity pauses include the following:

- On January 31, 2014 CMS announced an extension of its “probe and educate” medical review program.³⁰ Presently, the probe and educate program plans to cover inpatient claims with dates of admission between October 1, 2013 and September 30, 2014, although this timeframe may be extended.³¹ During the probe-and-educate time period, Medicare review contractors are generally prohibited from conducting medical reviews of hospital stays spanning zero to one midnight for the purposes of determining the medical necessity of admission to inpatient status. Recent legislation has prohibited RACs from conducting patient status reviews with dates of admission October 1, 2013 through March 31, 2015.³² During the probe-and-educate time period, MACs, rather than RACs or supplemental medical review contractors, will conduct pre-payment reviews of a limited sampling of inpatient hospital claims to determine whether the provisions of the 2014 Inpatient Prospective Payment System Final Rule were satisfied,

including whether admission to inpatient status was medically necessary; and³³

- In addition, on February 18, 2014 CMS announced a pause in recovery audit complex audit activity in general, while CMS procures the next round of recovery audit contracts. However, automated reviews may continue through June 1, 2014.

Important dates for this recovery audit pause include the following:

- February 21, 2014 was the final date a RAC was permitted to send a post-payment ADR;
- February 28, 2014 was the final date a MAC could send a pre-payment ADR for the Recovery Audit Prepayment Review Demonstration Program; and
- June 1, 2014 is the final date a RAC may send information regarding an unfavorable determination to a MAC for adjustment.³⁴

Conclusion

The financial viability of many health care providers and suppliers depends on a resolution to the extensive ALJ adjudication delay. This issue is high priority for health care providers and suppliers, industry stakeholders, OMHA, and CMS. Health care attorneys representing providers and suppliers in the Medicare appeals process should monitor the OMHA and CMS websites for announcements regarding new adjudication initiatives as well as updates to recovery audit activity as these areas continue to evolve.

- 1 See Memorandum from Nancy J. Griswold, Chief Administrative Law Judge (ALJ) for the Department of Health and Human Services (HHS) to OMHA Medicare Appellants issued December 24, 2013, available at www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf.
- 2 Medicare Claims Processing Manual (MCPM) (CMS Pub. 100-04), Ch. 29, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 3 Generally, the five stage appeals process is as follows:
 - **Stage 1: Redetermination.** Following receipt of an initial determination, a party may file a request for “redetermination.” This first-level appeal must be submitted in writing to the Medicare administrative contractor (MAC) that issued the initial decision within 120 days following the party’s receipt of the initial determination. The MAC must conclude its redetermination within 60 days from the date it receives a request for redetermination. See Section 1869 (a) of the Social Security Act (42 U.S.C. § 1395ff (a)), 42 C.F.R. § 405.920 *et seq.*, and Medicare Claims Processing Manual (CMS Internet-Only Manual 100-04) (MCPM), Ch. 29 § 310 *et seq.*, available at www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/clm104c29.pdf.
 - **Stage 2: Reconsideration.** If a party is dissatisfied with a redetermination decision, it may file a request for “reconsideration.” This second-level appeal must be in writing to the qualified independent contractor (QIC) identified on the redetermination decision within 180 days from the date the party receives the redetermination decision. The QIC must conclude its reconsideration within 60 days from the date it receives the request for reconsideration. If the QIC fails to abide by this adjudication timeframe, an appellant may “escalate” its appeal to the ALJ stage. See Section 1869 (b) and (c) of the Social Security Act (42 U.S.C. § 1395ff (b) and (c)). See also 42 C.F.R. §§ 405.960-405.970 and

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- MCPM (CMS Pub. 100-04), Ch. 29, §320 *et seq.*, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- *Stage 3: ALJ.* A party is required to submit its request for ALJ hearing within 60 days from the date it receives a reconsideration decision. See Section 1869 (b) (1) (E) of the Social Security Act (42 U.S.C. § 1395ff (b) (1) (E)). An amount in controversy requirement applies (\$140 in 2014). See also 42 C.F.R. § 405.1006 and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf. See also 78 Fed. Reg. 59702 (Sept. 27, 2013) and www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ALJ.html.
 - *Stage 4: Medicare Appeals Council (Council) Review.* If a party is dissatisfied with an ALJ's decision, it may file a request for Council review. A request for Council review must be submitted within 60 days of the date a party receives the ALJ decision. The Council is required to conduct and conclude its review within 90 days. If the Council fails to issue its decision within this timeframe, a party may “escalate” its appeal to federal district court. See Section 1869 (b) and (d) of the Social Security Act (42 U.S.C. § 1395ff (b) and (d)). See also 42 C.F.R. § 405.1100 *et seq.* and MCPM (CMS Pub. 100-04), Ch. 29, § 340 *et seq.*, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - *Stage 5:* If a party is dissatisfied with the Council decision, it may file a request for federal district court review. An amount in controversy requirement applies (i.e., \$1,430 in 2014). See 42 C.F.R. § 405.1002 and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf. See also 78 Fed. Reg. 59702 (September 27, 2013) and www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html.
- 4 See Section 1869 (d) (1) (A) of the Social Security Act (42 U.S.C. § 1395ff (d) (1) (A)) (emphasis added). See also 42 C.F.R. § 405.1016 and MCPM (CMS Pub. 100-04), Ch. 29, § 330.1, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 5 See Section 1869 (d) (3) (A) of the Social Security Act (42 U.S.C. § 1395ff (d) (3) (A)). See also 42 C.F.R. § 405.1104 and MCPM (CMS Pub. 100-04), Ch. 29, § 340, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 6 42 C.F.R. § 405.1016 (c).
 - 7 42 C.F.R. § 405.1016 (d).
 - 8 42 C.F.R. § 405.1018.
 - 9 42 C.F.R. § 405.1014 (b) (2).
 - 10 See www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html.
 - 11 42 C.F.R. § 405.1020.
 - 12 OMHA advised that it would continue to assign and process ALJ hearing requests submitted directly by Medicare beneficiaries. See Memorandum to OMHA Medicare Appellants issued December 24, 2013, available at www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf.
 - 13 *Id.*
 - 14 See “Administrative Comments,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html. See also www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.
 - 15 See 42 C.F.R. § 405.940 (b) (2). See also MCPM (CMS Pub. 100-04), Ch. 29, § 240 *et seq.*, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 16 MCPM (CMS Pub. 100-04), Ch. 29, § 240.3, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 17 See also 42 C.F.R. § 405.379.
 - 18 In order to avoid recoupment during the redetermination and reconsideration stages of review, an appellant must abide by expedited appeals timeframes. Specifically:
 - A request for redetermination must be submitted within 40 days of the date of demand letter (rather than within 120 days); recoupment commences on day 41 if no appeal is filed. See MLN Matters Number MM 6183, available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf.
 - A request for reconsideration must be submitted within 60 days of the date of redetermination decision (rather than within 180 days); recoupment may commence on day 61 if no appeal is filed. Of significance to appellants, this expedited timeframe could create challenges to those appellants attempting to compile additional documentation. Federal regulations require all evidence to be submitted at the reconsideration stage of review. If an appellant fails to do so, absent good cause, new evidence may not be submitted at subsequent stages of appeal. See 42 C.F.R. § 405.966 and MLN Matters Number MM 6183, available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf.
 - 19 See Medicare Financial Management Manual (MFMM) (CMS Pub. 100-06), Ch. 3 § 200.6, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf. Notably, in order to avoid assessment of interest to an alleged overpayment, many providers and suppliers have requested immediate offset of the alleged overpayment, resulting in immediate recoupment of the alleged overpayment. In these cases, the recoupment is considered “voluntary” and the appellant does not receive Section 935 interest if the overpayment is reversed as part of the appeals process. See www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-MattersArticles/downloads/MM7688.pdf.
 - 20 OIG Report, *Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals* (OEI-02-10-00340) at p. 12, November 14, 2012, available at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.asp>.
 - 21 *Id.* Notably, this number has declined significantly in FY 2013 and to date in FY 2014. However, this could be the result of ALJ hearings not being held (for various reasons), which impacts the data. For example:
 - In FY 2013, fully favorable ALJ decisions were issued in 34% of cases, and an additional 3.99% of cases were partially favorable. However, 23% of cases were remanded (compared with 4.12% of cases in FY 2012).
 - In FY 2014, fully favorable ALJ decisions have been issued in 34.55% of cases, and an additional 2.97% of cases were partially favorable. 32% of cases have been dismissed (compared with 19.19% in FY 2013 and 11.99% in FY 2012).
 - 22 See “Policy Update,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
 - 23 See “Welcome and Update ALJ Hearing Process,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html (emphasis added).
 - 24 The maximum number of requests per 45 days effective November 2, 2010 was 300. On March 15, 2012, the maximum number of requests per 45 days increased to 400. However, providers with more than \$100 million in MS-DRG payments will have a cap of 600.
 - 25 In the fourth quarter of 2012, CMS reported that the RAC fiscal year (FY)-to-date corrections totaled more than \$2.4 billion. Part A inpatient hospital claims were the “top issue” audited in each recovery audit region. See Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter (4th Quarter 2012), available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-4th-Qtr-2012.pdf.

In the fourth quarter of 2013, CMS reported that the RAC FY-to-date corrections totaled more than \$3.8 billion. Part A inpatient hospital claims remained the “top issue” audited nationwide. *See* Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter (4th Quarter 2013), available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-4th-Qtr-2013.pdf.

26 OMHA reported receiving approximately 50,000 Part A claim appeals in FY 2012 and approximately 225,000 Part A claim appeals in FY 2013. *See* “Welcome and Update ALJ Hearing Process,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.

27 *See* Letter from Rick Pollack, Executive Vice President of the AHA, to Marilyn Tavenner, Administrator of CMS, January 14, 2014, available at www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf.

28 *Id.*

29 *See* Letter from Rick Pollack, Executive Vice President of the AHA, to Member of Congress, dated January 14, 2014, available at www.aha.org/advocacy-issues/letter/2014/140114-pollack-congress-rac.pdf.

30 *See* <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>.

On August 2, 2013 CMS released its 2014 Inpatient Prospective Payment System Final Rule (Final Rule), which became effective on October 1, 2013. 78 Fed. Reg. 50496 *et seq.* (Aug. 19, 2013) available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html?DLPage=1&DLSort=0&DLSortDir=ascending. The Final Rule revised CMS’ reimbursement criteria for Part A inpatient hospital claims, creating new guidelines to establish the medical necessity of inpatient hospital admissions (i.e., establishing the “2-midnight rule”) and clarifying CMS’ documentation requirements related to physician inpatient admission orders and certifications. Following implementation of the Final Rule, CMS created a medical review program, known as the “probe and educate” medical review program, designed to provide education to hospitals implementing the requirements of the Final Rule. *See* cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

31 Section 111 of the Protecting Access to Medicare Act of 2014 (H.R. 4302) permits the extension of the probe-and-educate medical review program through March 31, 2015, and prohibits RACs from performing patient “status” reviews for inpatient claims with dates of admission October 1, 2013 through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care. *See* www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf.

32 *Id.*

33 *See* cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/SelectingHospitalClaimsForAdmissionsForPosting02242014.pdf.

34 *See* www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html.

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AHLA Connections



Access *AHLA Connections*, the monthly membership magazine devoted to health-related legislative and regulatory activity at both state and federal levels, and includes detailed legal features and analyses written by members. The magazine reports on the professional activities of AHLA members and also highlights educational and job opportunities available in the health and life sciences legal world.

NYG In-House Counsel Program & Annual Meeting

June 29-July 2, 2014 | New York Hilton Hotel



As the culmination of AHLA's educational year, the Annual Meeting provides a forum for networking and interaction with colleagues, friends, and family as well as an outstanding educational event. Every year, the Annual Meeting offers an array of sessions that will appeal to anyone practicing in health law. We're excited to announce this year's Keynote Speakers, Senator Claire McCaskill (D-MO) and Marty Makary, MD, New York Times best-selling author and CNN and FOX News Medical Commentator.

New York is one of the most-exciting cities in the world with museums, sporting and cultural events, restaurants, shopping, and amazing energy, all of which are hard to match. This year, Monday night's off-property reception is being held at the historic Ellis Island! There is no shortage of social events and fun during these three days—receptions, happy hours, breakfasts, luncheons. You won't be disappointed!

This year the Physician Organizations Practice Group is co-sponsoring its luncheon with the Health Information and Technology and Teaching Hospitals and Academic Medical Centers Practice Groups, and the Accountable Care Organization Task Force on **Monday, June 30**.

The Annual Meeting begins Monday at 8:00 am and will end on Wednesday at 3:45 pm. Learn more about the 2014 [Annual Meeting](#).

We hope you can join us!





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AHLA and GC Metrics will publish a series of four reports in survey year 2015. The reports allow both in-house counsel and outside counsel representing hospitals and health systems to review industry-wide benchmark data.

Physician Organizations

AHLA

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