STATLAW® New York

Volume XXIV Number VIII – August 15, 2016
Single Issue Price: $5.00

Late breaking news on medical-legal development affecting physicians and health care professionals

MACRA Model Forcing Physicians to Evaluate Risk: Practices are now in the process of deciding which of the two possible reimbursement paths they will take under the Medicare Access and CHIP Reauthorization Act (MACRA). The shift from the much maligned sustainable growth rate formula (SGR) to MACRA is forcing physicians to think about issues typically reserved for the financial industry, such as the balancing of upside and downside risk and capitation. Under MACRA, providers can choose to be reimbursed either through the Merit-based Incentive Payment System (MIPS) or the existing alternative payment model. Currently, about 90% of physicians are expected to choose MIPS as their method of reimbursement, although it has less to do with the merits of MIPS and more to do with the increased risk the alternative payment model brings with it. Under MIPS, providers will be rated on quality, resource use, clinical practice improvement and meaningful use of certified EHR technology. Medicare revenue would be affected by as much as 4% in 2019 and increase to up to 9% in later years. The relatively few groups planning to use the alternative payment model have to first agree to accept more than nominal financial risk. In return, those groups and practices will receive a lump sum incentive payment and higher annual provider payment as benefits. Providers choosing to be reimbursed under the alternative payment model also benefit from being exempt from the MIPS reporting measures. MACRA is a particular challenge for small and rural providers who lack the capital, infrastructure and flexibility to quickly adapt to MACRA's requirements. In fact, the proposed rule included a table that estimated about 60% of practices with between two and nine eligible clinicians would be subject to a negative payment adjustment in 2019 with the rate for solo practitioners a massive 87%. In response, the CMS has stated that solo practitioners and small groups will be able to join "virtual groups" and report their MIPS information together. The CMS will also offer them technical assistance and impose fewer reporting requirements on them.

Federal Court Finds that a Medical Staff Hearing Satisfies Federal Due Process: In the case of Buchheit v. Lakeland Health Systems, the United States District Court for the Western District of Michigan granted Lakeland Health Systems' motion for summary judgment on a physician's claims asserting violations of his Federal Constitutional right to due process. In the underlying matter, Lakeland Health Systems terminated Dr. Buchheit's clinical privileges. In response, he sued based on the premise that his Federal Constitutional right to due process was violated. The physician argued that the health system failed to follow its own bylaws during the proceedings, he was not allowed to have an attorney present at the Medical Executive Committee (MEC) meetings, and the decision-makers were biased. The court rejected these arguments and concluded that the physician had a meaningful opportunity to be heard at numerous points in the process, he had an attorney present at the fair hearing, and there was no evidence that the hearing committee was biased. As for the allegations the hospital failed to follow its own bylaws, the court also cited Sixth Circuit precedent, noting that "compliance with organizational bylaws is not a mandatory requirement of due process."

HHS Audit of New York-Presbyterian Alleges $14.2 Million in Medicare Overpayments: An audit conducted by the Department of Health and Human Services (HHS) of claims submitted by New York-Presbyterian Hospital found sufficient billing errors to conclude the hospital may have received more than $14.2 million in Medicare overpayments over two years. The OIG audit looked at 285 inpatient and outpatient claims submitted to Medicare in 2011 and 2012. After concluding that 123 of the claims reviewed did not fully comply with all Medicare billing requirements, an overpayment of $819,000 was calculated. Thereafter, the OIG extrapolated that overpayment demand and determined the total Medicare overpayments are approximately $14.2 million. As part of its findings, the OIG's report notes that almost half of the 102 improperly billed inpatient claims did not qualify as inpatient services. The report also notes that a significant portion of the other improperly billed claims stemmed from services that had been included in other Medicare claims. New York – Presbyterian, a teaching hospital for the Columbia University College of Physicians and Surgeons, disputed 91 of the alleged 123 overpayments in the audit findings and agreed that 32 of the audited inpatient and outpatient claims resulted in incorrect billings. New York-Presbyterian Hospital also challenged the audit's veracity, objecting to the fact that the majority of the highlighted payments could no longer be recouped by the CMS since the statute of limitations had expired. The hospital further disputed the OIG's findings, arguing that its review misapplied Medicare requirements and that the massive overpayment estimate was "improper and statistically unsound."

For more information on the above items, contact Kern Augustine, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.