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

Open Payments Physician Review and Dispute Period Began on April 6 and will last for 45 days: As part of the Open Payments program ("Sunshine Law") physicians and teaching hospitals can review payments attributed to them beginning on April 6, 2015. Drug and medical device makers ("Applicable Manufacturers") are required to report certain payments made to physicians and teaching hospitals on an annual basis. Physician and teaching hospital participation in the program is voluntary, but it is encouraged that physicians and teaching hospitals review, and if necessary, dispute payments that are attributed to them before the information is made public on June 30, 2015. After the review and dispute period ends, physicians and teaching hospitals can continue to register and initiate disputes, but resolutions of disputes will not be publicly displayed until the next reporting cycle. To review data, physicians and teaching hospitals must register in both the CMS Enterprise Portal and the Open Payments system. This is the second reporting cycle for Open Payments and it covers payments made by Applicable Manufacturers in 2014. Last year, CMS published information about 4.45 million payments valued at $3.7 billion for the last five months of 2013. For more information, practices should visit www.cms.gov/openpayments/.

CMS Imposes Record Number of Medicare Advantage Fines in Q1: During the first quarter of 2015, the CMS has fined Medicare Advantage plans at a record pace. The CMS fined practices to the tune of almost $2.5 million in civil monetary penalties. In comparison, there was a single $50,000 fine in the first three (3) months of 2014. The CMS also lifted enrollment sanctions on three (3) companies that had fallen far out of compliance, saying their deficiencies had been rectified. Civil monetary penalties are the most common and lowest-level enforcement actions the CMS takes. Intermediate sanctions, such as immediately suspending a health plan from marketing or enrolling members, are considered to be more damaging to the insurer's business. Although the monetary amount of fines pales in comparison with the billions of dollars Medicare pays private Advantage health plans every year to cover beneficiaries, it is a clear sign of the heightened level of scrutiny and auditing by the CMS.

New Law in Effect Protects Consumers from Surprise Bills and Emergency Services: As of March 31, 2015 a new law went into effect protecting consumers from bills for out-of-network emergency services in a hospital if the patient is covered through an HMO or insurer subject to NY law (coverage that is not self-insured). The patient is not required to pay the non-participating physician charges for emergency services that are more than what the patient would pay for out of pocket costs for a participating physician, such as the in-network co-payment, coinsurance or deductible. The health plan must pay the physician an amount it determines is reasonable for the emergency services, or negotiate with the physician. If the physician and health plan do not agree on the amount that is reasonable for the emergency services, either the non-participating physician or the health plan may submit a dispute to the dispute resolution process. The law also provides a dispute resolution process for "surprise bills." If a patient has coverage through an HMO or insurer subject to NY law, a physician's bill to the patient will be considered a surprise bill if the patient receives services from a non-participating physician at a participating hospital or ambulatory surgical center and: (1) a participating physician was not available; or (2) a non-participating physician provided services without the patient's knowledge; or (3) unforeseen medical circumstances arose at the time the health care services were provided. A bill is also a surprise bill if a patient is referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan. If an insured receives a surprise bill, the insured may make an assignment to the non-participating physician, and then the non-participating physician must bill the insured's health plan for the services.

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