

## Critical Care: Meeting the Challenges in Health Care Bankruptcies

In 2005, a number of dramatic – and controversial – changes were made to the way health care businesses are treated under the Bankruptcy Code. Most of these modifications under the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) became effective on October 17, 2005, but even after the passage of three years, many questions remain unanswered for health care businesses facing financial challenges.

### What Is a Health Care Business?

One of the fundamental changes brought about by BAPCPA was the introduction of the concept of a “health care business.” Bankruptcy Code Section 101(27A) defines a “health care business” as “any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of injury, deformity or disease; and (ii) surgical, drug treatment, psychiatric or obstetric care.”

Specific examples of a “health care business,” as delineated in the statute, are: (i) a general or specialized hospital; ancillary ambulatory, emergency or surgical treatment facility; hospice; home health agency; and any other similar health care institution; and (ii) any long-term care facility, including a skilled nursing facility; intermediate care facility; assisted living facility; home for the aged; domiciliary care facility; and related “health care institutions” if they primarily provide room, board, laundry or personal assistance with activities and incidentals of daily living. This rather broad definition has raised a number of questions, such as what was intended by restricting health care businesses

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to only those entities that offer facilities and services to the general public? A group of doctors operating a private practice likely would be excluded, but can the same be said of the many diagnostic testing centers throughout the country? In one decision, the Bankruptcy Code's definition of a “health care business” was unsuccessfully challenged as ambiguous by related debtors in the medical imaging business. The court deemed them to be “health care businesses” regardless of the fact that they had no patients and that the legislative history had references to “new protections for patients of hospitals and HMOs and nursing homes.” *United Radiology Associates, Inc., et al.* (Jointly Administered Case No. 05- 95014, Southern District of Texas, Docket No. 13, November 21, 2005).

The ruling in *In re 7-Hills Radiology, LLC*, 350 B.R. 902 (Bankr. D. Nev. 2006), excludes health care providers who accept patients by way of referral, as so many health care providers do. The *7-Hills Radiology* debtor sought to undo an earlier claim of being a health care business, alleging that: (1) it saw patients on a referral-only basis; (2) it “[did] not advise the patients” but, instead, advised physicians; and (3) the physicians, not the debtor, maintained the patient records. The court concluded that the debtor did not meet the Code's definition of “health care business,” because, by limiting itself to referral-only patients, the debtor did not meet the “general public” requirement of

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Section 101(27A). The Bankruptcy Court wrote that: “[no] member of the general public [could] walk in and request an X-ray or any other procedure [the debtor] perform[ed].” The *7-Hills Radiology* court’s narrow construction of “general public” eliminates from the Code’s protection a vast number of patients, including patients of businesses explicitly mentioned in the definitional provision. Ironically, no member of the general public may walk into a facility and request a surgical procedure. The rationale of *7-Hills Radiology* would eliminate surgical facilities – explicitly set forth in the list of examples – from the scope of the amendment’s protection.

It is noteworthy that the “patient” concept is not limited to individuals receiving traditional health care services. “Patient” is defined in Code Section 101(40A) as “any individual who obtains or receives services from a health care business.” The “services” referred to in the definition are not limited to medical services. Thus, for example, if a pharmacy is determined to be a health care business, then all of its customers, not just the customers who obtained pharmaceuticals, are arguably “patients.” Similarly, “patient records” are defined in new Section 101(40B) as “any written document relating to a patient...” This definition does not appear to be limited to traditional medical records. Similarly, the catch-all example of related “health care institutions” is equally broad and fraught with ambiguity.

### **Preservation of Patient Records**

In the event of bankruptcy, a “health care business” may have new and costly obligations regarding the handling of patient records and transfer of patients upon the cessation of operations. Changes to the Bankruptcy Code establish a notification procedure that must be followed before any patient records can be destroyed. A health care business must store patient records in the manner required by state or federal law for at least one year, and must notify the patient and the insurance carrier of any planned destruction. These costs, including any cost of preserving or destroying patient records or transferring patients, are now afforded priority administrative expense status in bankruptcy by virtue of Code Section 503(b)(8). Yet, how will this priority aid the estate if no funds are available to cover these expenses? Will lenders be required to furnish carve-outs from their collateral to fund such additional costs of administration in the event there are no funds to do so? One should fairly expect that the costs of winding down a health care business in a bankruptcy proceeding will increase as a result of these modifications.

### **Another Player at the Negotiating Table - Appointment of a Patient Ombudsman**

Prior to enactment of BAPCPA, patients had limited input in a bankruptcy case and the Bankruptcy Court had little, if any, involvement in the patient care aspects of a distressed health care business. Instead, the focus of the bankruptcy proceeding was on the financial aspects of the business enterprise and the reorganization, or liquidation, of the business. This, too, has changed with the introduction of a new player at the health care reorganization table, in the form of a patient care ombudsman “to monitor the quality of patient care and to represent the interests of the patients.” The scope and responsibility of the patient care ombudsman are, in large measure, undefined. The health care ombudsman must (i) monitor the quality of patient care, which may include interviewing patients and physicians; (ii) report to the court regarding the quality of patient care provided to patients of the debtor, not later than 60 days after appointment, and not less frequently than at 60-day intervals thereafter; and (iii) alert the court immediately if the ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised. Appointment is mandatory unless the court finds that the appointment of the ombudsman is not necessary for the protection of patients under the specific facts of the case. Notably, the ombudsman is to be compensated by the bankruptcy estate pursuant to amended Code Section 330.

As a result, there may be enhanced cost-shifting efforts associated with complying with BAPCPA’s new requirements and paying for the patient care ombudsman. Debtors will seek to impose those costs on lenders and vendors, who in turn will undoubtedly seek to pass them on to patients and insurers. Typical negotiations between a lender and a debtor regarding the use of cash collateral or for post-petition lending may be complicated by these new obligations. Health care business advisors will have to be cognizant of these new cash requirements in terms of budgets, forecasts and other financial reporting requirements submitted to lenders, parties in interest and the court.

### **Sale Restrictions**

A number of nonprofit health care institutions are regulated by state laws that are enforced by attorneys general. In this connection, BAPCPA limits the ability of nonprofit health care institutions to use the Bankruptcy Code to transfer assets without also complying with applicable

non-bankruptcy law. Section 363 of the Bankruptcy Code generally provides that a debtor-in-possession in a Chapter 11 case may use, sell or lease assets of the debtor with court permission. However, BAPCPA added Subsection 363(c)(4)(d)(1), which permits a sale only in accordance with applicable non-bankruptcy law governing the transfer of property by a nonprofit entity. Accordingly, applicable state law has become a primary consideration in terms of structuring the strategic disposition of assets for a nonprofit health care business.

In addition, Code Section 1129(a)(16), dealing with Chapter 11 plans of reorganization, contains a similar limitation on the transferability of assets. As part of the plan confirmation process, the Bankruptcy Court must find that all transfers of property under the plan will be made in accordance with applicable provisions of non-bankruptcy law that govern the transfer of property by a nonprofit institution. The wave of consolidation in the health care industry, through acquisitions, mergers and the like, mandates that health care acquirers and sellers alike carefully review their transactions and possibly involve regulators before the plan confirmation stage, in order to avoid a potential objection to a proposed transaction on the basis of non-compliance with applicable non-bankruptcy law.

### Implications for Health Care Businesses

The impact of BAPCPA is far-reaching and poses new challenges for both health care businesses and their advisors. Many of the statute's changes in the health care arena are not free from ambiguity. It is therefore critical that a troubled health care business be vigilant in seeking advice and guidance from experienced health care and insolvency professionals early in the process. The complexity of the bankruptcy option occasioned by BAPCPA's relevant amendments compels a higher level of strategic deliberation and planning to ensure a maximum degree of flexibility in navigating the restructuring process.

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## Getting Ready for the RACs: CMS Begins Nationwide Rollout of Medicare Audit Program

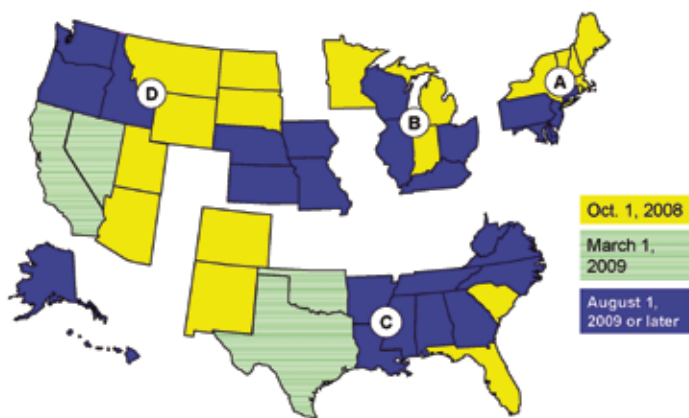
This month the Centers for Medicare & Medicaid Services (CMS) implemented a nationwide expansion of the three-year pilot program designed to identify fraud and abuse in the Medicare system. The aim of the agency's Recovery Audit Contractor (RAC) program is to identify and correct improper Medicare payment through the use of independent auditors.

Under §306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the RAC demonstration program was launched in March 2005 in the three states with the highest Medicare utilization rates per capita (California, Florida and New York). The scope of the demonstration program was later enlarged to include Arizona, South Carolina and Massachusetts.

On July 11, 2008, CMS released an evaluation of the three-year demonstration program, which showed that RACs allegedly corrected more than \$1.03 billion in improper Medicare payments, over 95 percent of which were overpayments (see <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf>). After accounting for underpayments, overpayments overturned on appeal and administrative costs, CMS reported \$693.6 million was returned to the Medicare Trust Funds.

Following the conclusion of the demonstration program, CMS has begun to implement auditing on a rolling basis.<sup>1</sup>

## RAC Expansion Schedule



Reflecting the concerns of Congress that providers needed to be treated more fairly, CMS has made a number of changes to the RAC program since the demonstration was initiated. These changes include establishing a “sliding scale” limit for the number of medical records a RAC can request from a provider; not performing a review in excess of 10 medical records without CMS approval and having a third party entity review a random sample of overpayment claims from each RAC. Additionally, each RAC will be required to post an online portal allowing providers to track medical records and review the status of their respective audits.

CMS recently awarded contracts to four companies to execute the auditing: Diversified Collection Services, Inc. (Region A), CGI Technologies and Solutions, Inc. (Region B), Connolly Consulting Associates, Inc. (Region C) and HealthDataInsights, Inc. (Region D). These companies will be paid contingency fee basis, causing critics of the program to express concern that the contractors will have a financial incentive to aggressively identify and pursue errors.

### RAC Review Process

The four RACs will rely on data analysis and OIG, CMS and GAO reports to identify Medicare claims that contain improper payments for which payment was made, or should have been made, under Medicare Parts A and B. Examples of improper payments include incorrect payment amounts, payments for-covered services, incorrectly coded services and/or payments for duplicate services. RACs are not permitted to identify improper payments arising from other Medicare programs (such as the Medicare managed

care or drug card programs) or claims paid earlier than October 1, 2007. Additionally, the RAC program uses a three-year look-back period; accordingly, RACs may not identify claims more than three years past the date the claim was originally paid.

The RAC program uses two types of review:

- *Automated review* occurs when a clear improper payment is determined by the RAC’s proprietary software program. The RAC may contact the provider without evaluating the medical records associated with the claim.
- *Complex review* occurs when the RAC has identified a high probability that an improper payment has occurred. The RAC may request from the provider copies of relevant medical records to assist in its claim review. All RACs must employ a physician medical director to oversee the medical review process.

Complex reviews must be completed within 60 days of receipt of the requested medical record documentation. The RAC may classify the overpayment as either 1) a “full denial” if no service was provided, or if the service provided was not reasonable and necessary and no other service would have been reasonable and necessary; or 2) a “partial denial” if the service provided was not reasonable and necessary and another level of service was reasonable and necessary.

Upon identification of an overpayment, the RAC will notify the appropriate Medicare Fiscal Intermediary and send a findings letter to the provider listing the relevant coverage, coding or payment policy or article that was violated. Overpayments are recouped by reducing the provider’s present or future Medical payments and applying the amount withheld to reduce the amount owed. Providers may opt to repay overpayments through an installment plan and may attempt to negotiate a settlement directly with CMS.

### RAC Appeals Process

Within 15 days of receiving notice of recoupment of an overpayment, a provider may dispute the RAC’s determination via an informal rebuttal statement. The RAC may consider the rebuttal statement in its decision to maintain the recoupment. Should the provider desire to further contest the RAC determination, any RAC appeals

will follow the customary Medicare appeals process, which may take 12-24 months:

- *First Level of Appeal.* The provider must request redetermination in writing to an independent Medicare contactor within 120 days of the initial determination. The RAC responsible for the initial determination must respond within 60 days.
- *Second Level of Appeal.* Within 180 days of the redetermination, the provider must request a reconsideration, to be provided to a Qualified Independent Contractor (QIC). The reconsideration must be processed by the QIC within 60 days.
- *Third Level of Appeal.* Within 60 days of the QIC's reconsideration, the provider may request a hearing before an Administrative Law Judge (ALJ). The minimum amount in controversy for this level of appeals is \$120.
- *Fourth Level of Appeal.* Within 60 days of the ALJ's decision, a provider may escalate the case to the Medical Appeals Council (MAC). The MAC may modify, reverse or remand the ALJ's decision.
- *Fifth Level of Appeal.* Within 60 days of the MAC's decision, the provider may file suit in federal district court. The minimum amount in controversy for this stage is currently \$1,180.

### How to Prepare for the RACs

Providers should begin to prepare for the implementation of the RAC program in their states by taking the following steps:

- *Develop Best Practices for Responding to RAC Requests.* An effective RAC plan should be developed to ensure ongoing compliance with a provider's administrative practices. Each provider should staff a team of employees to address all RAC-related issues. Members should include representatives of compliance, financial and medical staff. The team leader should keep both the CFO and the Board of Directors aware of its RAC initiatives.
- *Educate the Staff.* A provider's staff should be aware of any updated coverage and care documentation requirements and coding, billing and payment rules. Employees should be given an overview of the RAC audit process, including what to expect from the process and how to respond. The RAC team also should be familiar with the appeals process.

- *Conduct an Internal Assessment.* A proactive self-review can help a provider identify any procedural deficiencies before an RAC audit is initiated. An internal assessment also may help a provider improve its operations and policies.
- *Engage Outside Counsel to Assist with Appeals Process.* A provider should conduct a cost-benefit analysis to determine whether an aggressive appeal of an RAC determination is worthwhile. Given the short deadlines for each level of appeal, consider enlisting an attorney experienced in such matters and tracking key dates to handle appeals.

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### Endnotes

- 1 Chart available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>.

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