

MEDICARE COMPLIANCE

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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Increased Scrutiny Is Coming for Necessity Of Skilled Nursing, Qualifying Hospital Stay

The medical necessity of both the three-day hospital stay that propels a skilled nursing facility admission and the services provided at the SNF are under Medicare scrutiny. It's a kaleidoscope compliance issue, with the acute-care hospital stay, the entire SNF stay and the level of service during justified SNF admissions facing potential challenges by Medicare watchdogs.

Theresa Edelstein, vice president for continuing care services at the New Jersey Hospital Assn., says it appears some recovery audit contractors (RACs) will review hospital stays that are three days or less. "If any of those days are denied as a result of the audit, then it could put a SNF stay for that patient in jeopardy as well," she tells RMC.

Medicare pays for up to 100 days in a SNF if patients are first in an acute-care hospital for three days and need rehabilitative services to recover from strokes, hip replacements and other conditions.

While RACs and other Medicare contractors may not deny the entire SNF stay because that could shift the financial burden to the patient, they may pursue SNFs for upcoding and other abuses. "Medicare is really ramping up scrutiny in this area," says Peter Hughes, compliance officer for Meridian Health System in Neptune, N.J.

There are three interrelated compliance risks:

(1) *The medical necessity of the three-day stay*, which has been a compliance risk since the beginning of time. Some hospitals are pursuing a CMS waiver from the three-day qualifying stay for SNF admission to free up emergency department resources in

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Providers Weigh Two Options for Financing EMRs Within Fraud and Abuse Exceptions

With their Medicare reimbursement to rise or fall depending on whether electronic medical record (EMR) systems are adopted, hospitals and physicians are weighing their options within the confines of fraud and abuse exceptions.

Hospitals are permitted to subsidize the cost of physicians' EMR systems as long as physicians kick in 15% of the cost (among other criteria), but getting the 15% is easier said than done. *Two options are being considered:* The first involves financing through a vendor or bank. The second — a more legally controversial idea — envisions having physicians signing over to the hospital the small boost in Medicare reimbursement the physicians collect for adopting EMRs.

Regardless of how they make the change to interoperable EMR systems, hospitals and physicians better act soon, since the 2009 American Recovery and Reinvestment Act (ARRA), signed by President Obama in February, includes disincentives for providers who fail to make the conversion.

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they amortize it over a period, that still counts as long as they're not borrowing from the hospital," he says. "Even if physicians use the same financial institution that's financing the whole deal for the hospital, which means the debt is implicitly linked, that still meets the Stark and OIG exceptions."

Whatever compliance arrangement hospitals dream up, "it must be put in a written agreement," Fitzgerald says. "It can be a series of agreements that cross-reference each other rather than a single overarching agreement." The regulations say agreements that cross-reference each other are OK. He doesn't perceive a regulatory obstacle with one master agreement between the hospital and financial institution that also shows the terms between the lender and physicians, as long as it cites the terms between all other lenders.

Another Possible Path to Follow

There's another way to get the EMR ball rolling and help hospitals and physicians qualify for ARRA funds. It's conceivable physicians could meet the 15% contribution aspect of the Stark exception and anti-kickback safe harbor by writing an IOU to hospitals for their share of future stimulus payments for adopting EMRs, says Washington, D.C., attorney Robert Hudock, with Epstein, Becker & Green. But physicians shouldn't sign away their future interest in ARRA funds without first contacting an attorney, Hudock cautions. "I don't know if a physician would have the legal right to sign away his or her stimulus payments," he says.

If this were legal from an anti-kickback and Stark perspective and under traditional contract law, the IOU approach would light a fire under EMR adoption. But there are still problems. "Removing the 15% funding block and allowing physicians to sign away a portion of their stimulus payments may not yield the solution physicians want in the end. We want to push out EMRs that are useful to physicians in private practice. If physicians use solutions designed for hospitals" but they don't translate well to the office setting, then physicians may not be able to meet the "meaningful use" criteria, Hudock notes. In other words, he says, the Stark exception and OIG safe harbor might prevent kickbacks and therefore promote EMR adoption, but what good will this do if the benefits of EMRs aren't accomplished?

According to Hudock, all this EMR stuff will be held up as the industry awaits final definitions of "meaningful use" and "interoperability," which are due at the end of the year. "

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With New Authority, OCR to Conduct Security as Well as Privacy Audits

The following story is excerpted from the September issue of AIS's Report on Patient Privacy. For more information, go to www.AIShipaa.com.

HIPAA covered entities (CEs), as well as business associates, should expect stepped-up federal enforcement of both the privacy and security rules now that the HHS Office for Civil Rights (OCR) has been granted authority for investigating alleged violations of the HIPAA security rule, complementing its role as the enforcer of the privacy rule.

Since 2005, the HIPAA security rule had been enforced by CMS, while privacy has been OCR's job. That changed in August when HHS Sec. Kathleen Sebelius re-delegated that authority to OCR.

In an interview with AIS, Susan McAndrew, OCR's top privacy (and now security) official, repeatedly made the point that OCR — "public perception aside" — has been a tough overseer, and will bring a similar approach to its security rule efforts. She also raised the prospect that more CEs could see fines for violations of both rules in the future.

"Having the rule transferred to OCR actually puts us in an excellent position for more cases going forward with us seeking a resolution agreement on both the privacy rule and security rule side," McAndrew says.

A "resolution agreement" is the term OCR and CMS use to describe a contract a CE signs with HHS after an investigation and, according to OCR's Web site, "likely would include the payment of a resolution amount."

Two Agreements Signed So Far

There have been two such agreements, for \$100,000 in 2008 against Providence Health System, an Oregon health care system, and against pharmacy giant CVS, in January, for \$2.25 million. Both were the result of joint OCR-CMS investigations.

In addition to describing the impact of OCR taking over security enforcement, McAndrew outlined a series of changes at OCR that are also likely to enhance enforcement, including an increase in manpower and funding and better positioning of security investigative staff in regional HHS offices. McAndrew is OCR's deputy director for health information privacy, and reports to Georgina Verdugo, who began as the new director of OCR on Aug. 31.

Another reason for staying on top of compliance efforts: McAndrew says the HITECH Act gave