Making a Difference

Baker Donelson Long Term Care Newsletter

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Mandatory Reporting Requirements: Reporting Delayed

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As we have reported in previous client alerts (see links below), many long term care facilities are required by law to report to the Medicare Program any payments or settlements for liability insurance (including self-insurance), no-fault insurance and workers' compensation benefits made to a Medicare beneficiary.

On February 17, the Centers for Medicare and Medicaid Services (CMS) extended the reporting deadline from April 1, 2010 to January 1, 2011. This extension is a welcome relief to all Responsible Reporting Entities (RREs) which are required to report non-group health plan (NGHP) claims. Many RREs have been reporting significant problems with test files, including reported instances of CMS losing data files transferred.

The statement from CMS reads in part:

" . . . the date for first production NGHP Input Files is changed from April 1, 2010 to January 1, 2011, effective immediately.

- NGHP File data exchange testing will continue. All NGHP RREs should now be registered with the COBC, and either in or preparing for file testing status. NGHP file data exchange testing may continue during 2010, as needed.

- All NGHP file data exchange testing will be completed by December 31, 2010. NGHP RREs that have completed file data exchange testing at any time are encouraged to proceed to production file data exchange status."

On February 25, CMS officials announced they modified the dates for required reporting. Previously, RREs were required to report any total payment obligations for claimants (TPOCs) made after January 1, 2010. The new reporting requirement is for all TPOCs after October 1, 2010. Furthermore, RREs were previously required to report ongoing responsibilities for medicals (ORMs) entered into as of July 1, 2009, but this date has now been extended to January 1, 2010.

CMS published the next version of the "Section 111 NGHP User Guide" and a number of alerts relating to particular NGHP policy issues on February 25. The alerts include a policy change on who must report and are required reading for all long term care facilities, as reporting obligations related to deductibles and self-insured retention have changed.

CMS also posted an alert for NGHP RREs describing the steps those RREs can take to assure their ongoing compliance with the Section 111 reporting requirements. The alert focuses on compliance efforts including (1) ensuring that if you

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In This Issue:

In the Trenches

In December, members of our Nashville office signed and delivered more than 380 holiday cards to the Bordeaux Long Term Care residents. From left to right below are Nashville staff members Melissa Holloway, Pat Allard and Sherry Kuykendall.

In January, **Jennifer Keller** was invited to present "Documentation – It All Comes Down to This" at the Network Health Care Winter Weekend Escape in Atlanta, Georgia. Ms. Keller covered

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are an RRE that you are registered appropriately, (2) the exchange of test data and (3) the filing of production data.

See below for links to prior alerts:
http://www.bakerdonelson.com/Content.aspx?NodeID=200&PublicationID=682
http://www.bakerdonelson.com/Content.aspx?NodeID=200&PublicationID=632
http://www.bakerdonelson.com/Content.aspx?NodeID=200&PublicationID=696

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The Payroll Risk From Within

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At a time when Medicare reimbursements and other sources of revenue are threatened to be frozen or even reduced, a recent trend has been noticed that provides for an additional threat to long term care facilities and other health care providers – the risk of employee suits for unpaid wages. Fortunately, this is one risk that can be well managed and largely eliminated through effective preventive measures.

The Fair Labor Standards Act (FLSA)

The FLSA sets a minimum wage for employees in the United States and also ensures the payment of overtime (one and a half times the regular rate) for all non-exempt employees. Virtually all businesses in the country are covered by the FLSA, and both the United States Department of Labor and individual employees have a right to sue for unpaid wages.

The FLSA's payment provisions are intentionally written broadly and are designed to encompass all time that employees work for the benefit of an employer. Employers should be very cautious about standard or otherwise automatic deductions from time worked using payroll systems that account for meal breaks, other breaks or automatic work stoppages. For instance, some payroll systems provide for an automatic deduction of 30 minutes or one hour for a meal break or other 15 or 20 minute breaks or coffee breaks for time that employees are supposed to receive as time off. However, if the employee in fact works all or a portion of that time period (whether because of an emergency situation, understaffing needs or because the employee is not able to finish his or her work during a prescribed time period), that time is compensable under the FLSA.

The Exposure Can Be Great

Under the FLSA, workers are entitled to sue for all amounts of unpaid wages owed for a three-year period (a two-year period can be applied in certain limited situations). Further, if some amount is determined to be owed by the court, the

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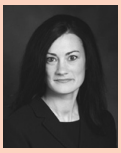
In the Trenches, *continued*

the importance of documentation and its impact on litigation.

In February, **Christy Crider** attended the American Health Lawyers Association Long Term Care and the Law Conference in Miami, Florida. The conference covered important legal issues facing long term care, skilled nursing and assisted living facilities.



On March 30 at 1:00 p.m. Eastern, **Christy Crider** and **Sonya Smith** will present the webinar "Health Care Decisions Acts, Surrogates and Arbitration: Save Money, Save Time, Save a Life" for The Bureau of National Affairs, Inc. Attendees can expect to take away: (1) An understanding of the purpose and benefits of health care decisions acts; (2) An understanding of surrogate forms and how to use them; (3) Examples of surrogate forms that can be modified to use in your state; and (4) An understanding of how surrogate forms and arbitration agreements relate.

The Payroll Risk from Within, *continued*

employee is entitled to an additional liquidated penalty equal to the unpaid wages, as well as all attorneys' fees and expenses associated with the suit. It is typical in these cases for individual worker claims to be far eclipsed by the amount of attorneys' fees and costs awarded by a court, and it is not uncommon to find different cases in which employees are alleged to have been docked five to ten minutes of work per day.

Recent Trends for Health Care Providers

Several plaintiffs' firms have targeted long term care providers for FLSA suits. The reality is that many workers in this industry find themselves unable to take lunch breaks or other meal breaks as a consequence of their position, such as when a patient has an incident requiring immediate attention. Suits have recently been filed against health care providers in the South, and employers need to understand how to prevent FLSA suits against their facility. The plaintiffs' firms are relying upon their own publicity via the Internet and mass mailings to attract more suits. Because registered nurses are licensed by the state and the records are open to the public, they are easy for plaintiffs' firms to identify. Also be aware that once a suit is filed, then FLSA provides a mechanism for a plaintiff's lawyer to contact existing and former employees of a defendant employer.

Risk Areas and Preventive Measures

As noted above, many employees in the long term care industry miss meal or other breaks as a consequence of high work loads, limited staffing and resource availability or other emergencies that arise during their shift. Consequently, the highest risks to employers exist when they utilize payroll systems that automatically deduct or assume certain uncompensated time exists during the work day – whether it is for personal break, meal break or otherwise. The following are some preventive measures long term care employers might consider:

- Provide training to your supervisors to monitor employees and know how to spot those who might not take their required breaks.
- Encourage your supervisors to remain open to employees who might need to adjust their documented hours.
- Review payroll records to ensure adjustments to employees' time are entered accurately.

Baker Donelson's attorneys have extensive experience in reviewing and auditing employment manuals and procedures to ensure compliance with the FLSA and companion state statutes requiring payment of wages. It also has teams dedicated to the defense of lawsuits filed under the FLSA and similar laws – whether class actions or individual actions. Should you need help in any of these areas, do not hesitate to contact any member of the Long Term Care Industry Service Team.

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The HEAT is On: The Government's Fight Against Waste, Fraud and Abuse

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With increased funding and focus on combating Medicare and Medicaid fraud and abuse, the long term care industry should be aware of risk areas which are the subject of government investigation and which could result in fraud and abuse, or improper claims submission. Through increased transparency, oversight and enforcement activities, the government is stepping up efforts to stem the loss of federal and state health care program dollars to fraud and abuse. Congress, the President, the Department of Justice (DOJ), the Health and Human Services (HHS) Administration and state enforcement authorities continue to raise the stakes by providing increased and expanded enforcement tools, resources and focus by senior leadership to recover Medicare and Medicaid funds lost to fraud.

This past year, the President signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA), which passed both the House and Senate with overwhelming majorities. FERA made significant changes to the federal False Claims Act (FCA) applicable to the health care industry. These changes expanded the scope of FCA liability for health care providers, extended the FCA statute of limitations, provided new whistleblower rights and enhanced the ability of enforcement agencies to pursue health care fraud cases.

A new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), was also created to combat Medicare fraud. HEAT is composed of senior-level officials from the DOJ and HHS who are charged with coordinating the fight against Medicare and Medicaid fraud. HEAT's anti-fraud efforts include: (i) creating "Strike Force" teams in major cities; (ii) assisting state Medicaid offices with provider audits; (iii) strengthening monitoring activities; (iv) analyzing electronic data to find patterns of fraud; (v) training to help providers and law enforcement identify fraud; and (vi) improving citizen access to fraud hotlines.

On January 28, 2010, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder joined private sector leaders, law enforcement personnel and health care experts for a landmark National Summit on Health Care Fraud, the latest initiative of HEAT. The National Summit focused on developing ways to eliminate fraud and abuse in the health care system, including (i) the use of state of art technology to prevent and detect health care fraud and improper payments; (ii) increased support to state Medicaid officials to allow them to conduct targeted activities to fight fraud in their states; (iii) a renewed commitment to expanded data sharing and improved information sharing procedures between HHS and the DOJ; and (iv) increased provider site visits.

In addition, the President's FY 2010 Budget makes fighting health care fraud a top priority. The President called for increased funding for programs with a proven record of preventing fraud, reducing payment errors and returning funds to the Trust Funds. Highlights from the President's budget include a request for $1.7 billion for fraud fighting at the Department of Health and Human Services (DHHS), funding to allow expansion of the HEAT Strike Force Teams, and funding to support better data sharing among investigators, increase oversight and improve data analysis.

The OIG (Office of Inspector General) Work Plan for FY 2010 describes the OIG's planned activities with respect to HHS programs and operations in the next year through audits, evaluations and investigations.

With respect to nursing homes, the Work Plan identifies the following areas for targeted review:

- Medicare Part B payments for psychotherapy services provided to residents during non-covered Medicare Part A SNF (Skilled Nursing Facility) stays;
- Medicare requirements for quality of care in SNFs, to include
  - a review of SNFs' use of standardized Resident

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The HEAT is On: The Government's Fight Against Waste, Fraud and Abuse, *continued*

Assessment Instrument to develop residents' plans of care,
  - a determination of whether SNFs provided services to beneficiaries in accordance with these plans of care, and
  - a determination of whether SNFs planned for beneficiaries' discharges;
- Accuracy of Resource Utilization Groups coding;
- SNFs emergency plans and emergency preparedness deficiencies cited by state surveyors to determine sufficiency of plans and implementation of plans;
- Criminal background checks for employees;
- Survey and certification reviews of poorly performing nursing homes;
- Medicare Part B services provided to residents whose stays are not paid for under Medicare's Part A SNF benefit; and
- Residents aged 65 or older receiving antipsychotic drugs in absence of conditions approved by the Food and Drug Administration (FDA).

The OIG Work Plan also identifies areas relating to nursing facilities and their residents which have and will be the subject of OIG scrutiny. The Work Plan reports on an OIG investigation of and an agreement by nursing home chain to pay $4 million plus interest to resolve potential FCA liability for violations allegedly committed at 10 of its nursing facilities. The allegations included submitting claims to Medicare and Medicaid for skilled services that were not medically necessary and/or were for patients that did not qualify for the claimed services.

The Work Plan also reports on investigations of substandard care at nursing homes based on alleged failures which put residents at risk for harm which included the failure to maintain adequate staffing levels, properly administer medication, provide adequate hydration and nutrition and prevent accidents. Allegations of a nursing home's failure to monitor and assess a resident or to provide the care and services the resident needs can also result in civil money penalties due to violations of 41 C.F.R. 483.10(b)(11), causing immediate jeopardy to the resident. For example, the Fourth Circuit Federal Court of Appeals recently upheld a determination by HHS that a skilled nursing facility failed to comply with Medicare participation requirements related to its residents' well being and safety (Universal Healthcare/King v. HHS, 4th Cir., No. 09-1093, 1/29/10), and affirmed CMS's (Centers for Medicare & Medicaid Services) imposition of civil money penalties.

With respect to the Medicaid program, the Work Plan lists plans to review Medicaid payments made to continuing day treatment providers, community residences for persons with mental illness, personal care facilities, home health agencies and home and community-based services provided in assisted living facilities. Also, the OIG plans to review Medicaid data to identify nursing facilities that may have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions, including those for diagnoses of pressure sores, infections or both. Finally, the OIG intends to examine how states administer and use civil monetary penalties imposed on nursing homes that failure to meet Medicare and Medicaid health and safety requirements.

With these increased oversight and enforcement activities of the government, it is imperative for long term care providers to operate their facilities in compliance with Medicare and Medicaid laws, rules and regulations. The OIG Compliance Program Guidance for Nursing Facilities identifies specific compliance components and risk areas and offers guidelines for nursing facilities to consider when developing and implementing a new compliance program or evaluating an existing one. As a compliance program can significantly reduce the risk of unlawful conduct and corresponding sanctions, long term providers should either develop and implement a new compliance program or revisit and update existing compliance programs to assist in their compliance with the laws applicable to their operations.

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Social Media and Long Term Care Facilities: Considerations for Employers and Employees

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Long term care facilities should consider implementing a social media policy to establish clear guidelines for appropriate use, prevent and mitigate facility-damaging postings and clearly delineate patient information protected by Health Insurance Portability and Accountability Act (HIPAA). The policy, and the consequences of violating it, should also be clearly communicated to all employees. At a minimum, a good social media policy should include the following:

- If a facility chooses to allow employees personal use of the Internet at work, its policy should limit usage to: checking personal email, handling personal business via the Internet or passive reading of news or other informational websites. Employees can and should be prohibited from blogging or posting on sites while at work, unless such usage is for sanctioned, work-related activities.

- The policy should emphasize that employees remain responsible for the content of texting and Internet postings done outside of work. For example, employee posts should not violate any policies including the Code of Ethics or Anti-Harassment/Nondiscrimination policies. Employees should also be encouraged to use good judgment and discretion when posting information. For example, if a profile can link someone to their place of employment, the employee should not post anything that could potentially embarrass or otherwise reflect poorly on the facility. Moreover, if an employee posts information to a posting site that could impair or injure the reputation of, or otherwise harm the facility, the policy should reserve the company's right to demand that the employee remove the information from the posting site and discipline the employee.

- The policy should strictly prohibit the dissemination of, posting, or reference to patient information, unless done via encrypted communication and for work purposes only. Willful violations of this rule should result in immediate termination.

- All policies should also emphasize that employees should have no expectation of privacy with respect to any information communicated via the company's electronic communication systems; and that the company reserves the right to monitor, review and inspect all e-media use conducted through its networks and the contents of it.

The policy should be communicated in writing to every employee immediately upon hire, and it should be re-emphasized periodically so the provisions stay fresh in employees' minds. As discussed earlier, companies should also consider implementing a social media monitoring program. The company's monitoring program should be communicated to employees so that employees know that online postings will be reviewed by the company. This will help ensure employees are complying with the policy and it will alert the company to any content on social media sites involving the company. Several companies offer monitoring services for a charge, and others offer free services. For example, Google Alerts provides email updates of the latest relevant Google results on the search terms of your choice.

A facility should also consider establishing a team tasked with responding to disparaging uses of social media that threaten to go, or have already gone, viral. The team should be comprised of employees from corporate communications (specifically people well-versed in social media), senior management and people in the legal and marketing departments. Doing so now will save time later if the facility needs to respond quickly in order to mitigate potential damage.

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RAC Audits: CMS Approved Audit Issues Published

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A listing of topics approved by the Centers for Medicaid and Medicare Services (CMS) for RAC (Recovery Audit Contractor) review was recently published and can be found at http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx. The list is notable primarily in its focus on "automated reviews." This means billing errors should be detected by looking at data on the claims forms and on Medicare data bases, without evaluating medical necessity. The take-away point is that providers and suppliers can encounter RAC denials on some rather technical aspects of medically necessary services.

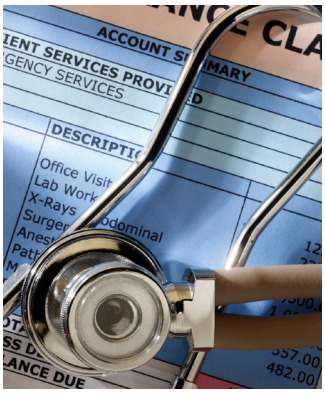
The largest category of audit activity is "DRG (Diagnosis Related Group) Validation." The audit will ensure that diagnostic and procedural information and the discharge status of the beneficiary as coded and reported by the hospital on its claim, matches both the attending physician description and the information in the beneficiary's medical record. At this time, the RAC auditor will compare principal diagnosis, secondary diagnosis and procedures affecting or potentially affecting the DRG to see if the assigned DRG is a fit with the diagnosis and procedure codes. These are data elements available to an auditor based on a filed claim.

Another large category for audit is for "bundled or consolidated items and services." Where an item or service is included in a prospective payment – such as the DRG payment (hospital) or the resource utilization group rate (skilled nursing facility), separate claims should not be filed for those items. These can be identified by the RAC by comparing line items on a facility bill to Part B claims by outside suppliers.

Also of interest is the "Medically Unlikely Edit List." A Medically Unlikely Edit (MUE) applies to all Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes that are billed above the maximum units of service that a provider would report for the same beneficiary, on same date of service and same provider.

These RAC Audit topics edits should inspire providers to pay attention to claims detail, and carefully note dates of service, units of service and definitions in billing codes relating to quantity or volume. For example, where a PT procedure is an untimed code, the provider should enter a one in the units billed column per date of service. If there is a dosage specified in a code, the units billed should represent the number of multiples of that dose administered, not the total number of milligrams, for example.

Going forward, it will be good policy to print out the definition of the codes used on a quarterly or semi-annual basis to ensure that there are no changes and that your billing is in accord with the definition. Be sure time and (a false sense of) familiarity are not dulling the sharpness of your coding compliance.



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Upcoming Events

Please check out the events page on the Baker Donelson website for a comprehensive list of events on a variety of topics that may be of interest to you: www.bakerdonelson.com.

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