COMPLIANCE ROUND-UP

RAC, Compliance, HIPAA, CMS

January 10, 2012

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Today's Faculty

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(Final) Reformatting for Compliance Round-Up

- When we introduced RAC Subscription Service, we:
  - Anticipated more RAC activity
  - Responding to lack of organization and structure from RACs in regard to the presentation of newly approved issues

- Circumstances have changed. Most notably, RACs are now presenting approved issues in a more organized fashion

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(Final) Reformatting for Compliance Round-Up

- As such, we are revamping the Compliance Round-Up and the RAC Subscription Service
- We will NOT charge for the Compliance Round-Up or the RAC Subscription Service
- We will make the RAC resource page and material available on our public webpage
- Starting this month, we will no longer host two webinars per month; rather, we will host a single webinar per month on the second Tuesday of every month
- May supplement monthly calls will special sessions

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Compliance Round-Up: Webinar Overview

- Each session will continue be 60-75 minutes in duration, including a question and answer session
- Each session will begin at 12:00 PM CT
- If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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Continuing Goals

- The goals of the Compliance Round-Up Webinars:
  - Teaching/knowledge transfer
  - Keep you up to date on compliance rules
  - Practical points
  - Assist organizations to develop in-house methods of managing

- Please share your thoughts, suggestions (and criticisms)

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Today's Topic and Agenda

- RAC
  - CMS postpones Prepayment review demonstration project
  - Newly approved issues
- Compliance
  - OIG Solicitation of New Safe Harbors
  - US v. Chavez
- HIPAA
  - HHS publishes standards for Electronic Funds Transfers
  - Loma Linda University Medical Center reports possible breach
  - 2012 Predictions
- CMS
  - Proposed Rule—Physician Payments Sunshine Act
  - Interpretive Guidelines for Rehab CoPs

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RAC Update—Prepayment Review Demo

- As we previously reported, CMS had announced a new prepayment review demonstration project for RACs in certain states
- On December 29, 2011, CMS announced that it will postpone implementation of the Recovery Audit Prepayment Review demonstration that was scheduled to begin January 1, 2012.
- Implementation has been delayed in order to allow CMS to carefully consider the “many comments and suggestions” it received on the program, which was announced in November.
- While the start date is still unknown, CMS has said it will provide at least 30 days’ notice before the demonstration begins.
- Noteworthy development given the potential implications of prepayment review on provider cash flow

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RAC Update—Newly Approved Issues

- Region A (DCS) posted over 100 new issues since December 1, 2011, most involving medical necessity reviews for DRGs.

- Region C (Connolly) has posted two new issues since December 1, 2011. One involved DME and the other involved outpatient hospital services

- Region D (HDI) has posted 17 new issues since December 1, 2011, all involving acute inpatient hospitalization

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Compliance—OIG Solicitation of New Safe Harbors

- On December 29, 2011, the OIG published a Federal Register notice regarding its intent to develop new safe harbor regulations
- Annual notice as required by HIPAA
- Nonetheless, may be indicative of 2012 action by OIG regarding Safe Harbors and Special Fraud Alerts.

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Compliance—US v. Chavez

- Dr. Armando Chavez, MD, was recently sentenced in the Southern District of Texas to nearly **six years in prison** after pleading guilty to defrauding private insurance companies, including Aetna and Cigna, through false and fraudulent billing practices.

- Case is a reminder that private payor fraud is not beyond federal criminal prosecution; in this particular case, under 18 U.S.C. Section 1341 (mail fraud) and 18 U.S.C. Section 371 (conspiracy).

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Compliance—US v. Chavez

- According to the plea agreement, Dr. Chavez added Endovenous Laser Vein Ablation (ELVES) to the scope of medical services offered at his Houston, TX, clinic. According to the criminal information filed in his case, Dr. Chavez billed private insurance companies $14 million over a two-year period for the ELVES procedure.

- Dr. Chavez allegedly targeted members of the Hispanic community who had private health insurance. Dr. Chavez reportedly directed members of his staff to discourage interested patients who were covered by Medicare or Medicaid, or who wished to pay cash for the procedure.

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Compliance—US v. Chavez

- In connection with securing coverage eligibility, his practice prepared template pre-operation evaluation reports which allegedly often contained false or misleading statements that were then submitted to the insurance companies.

- In April 2011, the U.S. Attorney for the Southern District of Texas charged Dr. Chavez with one count of conspiracy to commit mail fraud and three counts of mail fraud under 18 U.S.C. Sections 371 and 1341.

- After his guilty plea, Dr. Chavez was sentenced to sixty months of incarceration for conspiracy and seventy months of incarceration for mail fraud (to run concurrently), and was ordered to pay restitution in the amount of $3,821,082.

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HIPAA—Electronic Funds Transfers

- HHS recently published an interim final rule with new standards for electronic funds transfers that the department says will reduce provider paperwork and save billions in administrative costs.

- Mandated by the Affordable Care Act

- According to a CMS Press Release, the rule (in conjunction with a rule published earlier this year that set industry-wide standards for how health providers use electronic systems to quickly and easily determine a patient's eligibility for health coverage and check on the status of a health claim), will save the health care industry more than $16 billion over the next 10 years.

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HIPAA—Electronic Funds Transfers

- The rule adopts streamlined standards for the format and data content of the transmission a health plan sends to its bank when it wants to pay a claim to a provider electronically (through an electronic funds transfer) and to issue a Remittance Advice notice.

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HIPAA—Loma Linda University

- According to published reports, a Loma Linda University Medical Center worker was been fired following a security breach.
- The medical records of 1,336 patients were endangered sometime around December 19, after the worker took home documents. All of those documents have since been secured.
- The records included birth dates, addresses, medical record numbers, driver's license numbers, and in some cases, Social Security numbers.
- The medical center said it will pay for a year of credit-monitoring services for those affected by this incident to determine if there is irregular activity on their accounts.

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HIPAA—Top 2012 Predictions in Healthcare Data

1. Healthcare organizations will not be immune to data breach risks caused by the spread of mobile devices in the workforce;
2. Class-action litigation firestorms are imminent;
3. Social media risks in healthcare will grow;
4. Cloud computing is not a panacea; technology is outpacing security and creating unprecedented liability risks;
5. Growing reliance on business associates will create new risks;
6. Organizations risk reputation fallout;
7. Mobile will explode in healthcare;
8. Increased emphasis on willful neglect leads to increased enforcement of HIPAA;
9. Privacy and security training will be an annual requirement;
10. Rise in fraudsters will increase fraud risk education; and
11. Healthcare organizations will turn to cyber liability insurance.

http://www.darkreading.com/insider-threat/167801100/security/news/232301377/top-11-trends-for-2012-in-healthcare-data-according-to-industry-experts.html

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CMS—Physician Payments Sunshine Act

- On December 19, 2011, CMS published a proposed rule implementing the Physician Payments Sunshine Act, a law designed to increase public awareness of financial relationships between drug and device manufacturers and certain healthcare providers.

- The Sunshine Act, which was signed into law as Section 6002 of the Affordable Care Act, requires public disclosure of the financial relationships between physicians and the pharmaceutical, medical device, and biologics industries.

- CMS was required under the law to establish reporting procedures for applicable manufacturers to submit information, as well as procedures for making that information available to the public, by October 1, 2011.

- Under the rule, CMS is proposing to delay the beginning of data collection from January 1, 2012 until after a final rule is published. CMS said in a fact sheet that it is considering whether to require applicable manufacturers and GPOs to submit partial year data for calendar year 2012.

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CMS—Interpretative Guidelines for Rehab Hospitals' Conditions of Participation

- Conditions of Participation (CoPs) are regulations which a hospital must agree to comply with in order to participate in the Medicare Program. While hospitals have general CoPs, there are additional CoP if the hospital is approved for providing special services, such as rehabilitation services, then there are additional CoPs.

- The Rehab Services CoPs are found 42 CFR 482.56

- 42 CFR 482.56 entitled "Delivery of Services" states:

  - "Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws."

- However: new Interpretative Guidelines seem to stretch the regulation farther than the plain language of the rule.

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CMS—Interpretative Guidelines for Rehab Hospitals' Conditions of Participation

- On November 18, 2011, CMS issued new interpretative guidelines which state in part:

  – *Rehabilitation services must be ordered by a qualified and licensed practitioner who is responsible for the care of the patient. The practitioner must have medical staff privileges to write orders for these services. (emphasis added)*

  – *Review medical records of patients receiving rehabilitation services. Determine who wrote the orders for the rehabilitation services. Determine if the practitioner is responsible for the care of the patient and privileged to write orders for rehabilitation services. Verify the practitioner meets hospital medical staff policies and procedures as well as State law for ordering rehabilitation services.*

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CMS—Interpretative Guidelines for Rehab Hospitals' Conditions of Participation

- The interpretative guidelines raise questions:
  - Can a hospital accept orders for rehab services from a physician who is not on the medical staff?
  - Can a hospital accept orders for rehab services from a physician who is on the medical staff but does not have privileges to provide rehab services?
  - Does the hospital have a process which reevaluates the patient before performing rehab services, thus rendering the new guideline moot?
- Several trade associations have objected to the new guidelines in arguing that the guideline departs from the wording of the rule. The rule focuses on the delivery of services and does not regulate how the patient gets to the hospital. The interpretative guideline appears to regulate the order coming from outside the hospital.
- Aegis comment: The regulation is the law, not the guideline.

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Follow-Up

- Questions?

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- Next Lecture:

Tuesday, February 14, 2012

12pm CT/1pm ET

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