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BRACH EICHLER

Health Law

UPDATE



FEDERAL UPDATE

OIG Identifies \$6.8 Million in Overpayments to NJ and Surrounding States

On August 17, 2011, the U.S. Department of Health & Human Services Office of Inspector General (OIG) released an audit report detailing Highmark Medicare Services overpayments. According to the OIG, providers were overpaid by approximately \$6.8 million from January 1, 2006 through June 30, 2009.

The OIG found that 68% of 1,507 selected claims processed by Highmark, the Medicare Administrative Contractor for Pennsylvania, Delaware, Maryland, New Jersey and the District of Columbia metro area, were incorrectly paid for outpatient services. Moreover, the OIG reported that providers failed to refund any of the overpayments by the start of the OIG's investigation.

Additional billing issues highlighted in the report include the following:

- Incorrect units of service
- Packaged services billed separately
- Healthcare Common Procedure Coding System (HCPCS) codes that did not reflect the procedures performed
- Unallowable services
- Unlabeled use of a drug/biological
- A lack of supporting documentation
- A combination of incorrect units of service and incorrect HCPCS codes
- Incorrectly calculated payments

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The OIG recommended that Highmark recover the identified overpayments, implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and utilize the results of the audit report in its provider education activities.

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OIG: Pay-for-Performance Payments Disbursed by Medical Home Program Administrator Will Not Implicate Anti-Kickback Statute

The U.S. Department of Health & Human Services Office of Inspector General (OIG) recently issued an Advisory Opinion (11-10) concluding that an arrangement whereby a provider of administrative services (Requestor) disburses pay-for-performance payments to physicians and dentists participating in a state's Medical Home Program on behalf of the state does not implicate the Anti-Kickback Statute (AKS).

The Requestor sells a variety of health care management services, including behavioral health administrative services and disease management and care services, and was selected through a competitive bidding process to provide administrative services to a state's Medical Home Program. The Medical Home Program was designed and approved by CMS to include a pay-for-performance component that uses payments by the state's Medicaid program to induce physicians and

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dentists to arrange for, order or recommend certain health-care services in order to reduce medical costs and improve patient care. The Requestor disburses these payments via its own bank account. The payments are funded by the state's Medicaid program and the Requestor has no discretion or control over the payments. The state and the Medical Home Program are clearly identified as the source of the payments and the checks issued identify the Requestor as the administrator of the Program.

The OIG addressed only the narrow question of whether the Requestor's role as administrator and distributor of the payments implicates the AKS. The OIG opined that it does not because: (1) the payments are funded by the state's Medicaid program; (2) the Requestor is acting as an agent of the state and has no control or discretion over the payments; (3) steps have been taken to reduce misimpression by clearly identifying the state as the payor and the Requestor as the administrator; and (4) the state supervises all payments and has the ability to audit Requestor's performance as administrator of the Medical Home Program.

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Plan to Sell Supplies Below Cost to Nursing Home Rejected by OIG

The U.S. Department of Health & Human Services Office of Inspector General (OIG) recently issued Advisory Opinion 11-11, in which it declined to approve a supplier's proposal to enter into an agreement with a skilled nursing home to provide supplies and equipment below cost for its non-Medicare business.

The supplier furnishes medical supplies and equipment to skilled nursing facilities. In connection with furnishing the medical supplies and equipment, the supplier also provides related services, including emergency delivery, inventory control, frequent visits from customer service representatives, customized resident-specific packaging and simple returns of products for credit.

The supplier bills Medicare Part B for items that are covered by the Medicare program. When they are not covered, the supplier bills the nursing home directly.

Normally, the supplier charges each nursing home a price that covers the cost of providing the related services, as well as the supplier's overhead and profit. The amount paid by Medicare also covers the costs of the related services, overhead and profit.

A nursing home has issued a request for proposals for a supplier to be its exclusive supplier of the supplies and equipment. The supplier wishes to submit a bid for non-Medicare covered supplies and services at a price that would be below its costs. The supplier stated that the amount it receives for Medicare Part B payments would more than offset any losses it would incur in furnishing the non-covered items and services at the below-cost pricing.

The OIG declined to approve of the arrangement because it was unable to conclude that the supplier would be offering improper discounts to the nursing home without the intent to induce referrals of the more lucrative federal business, stating that the arrangement poses a substantial risk of improper "swapping" of business that may run afoul of the federal Anti-Kickback Statute.

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Time to Revalidate Medicare Enrollment

Under the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) was required to implement new anti-fraud screening measures for providers and suppliers who enrolled in Medicare prior to March 25, 2011. These providers and suppliers must revalidate their Medicare enrollment information before March 23, 2013; otherwise, Medicare will suspend payment.

The New Jersey Medicare Administrative Contractor, Highmark Medicare Services, will be notifying the applicable providers and suppliers as to when they should revalidate enrollment information. Providers and suppliers should wait for their notice before revalidating, unless revalidation is necessary for other reasons, such as change of ownership. When notified, revalidation must be completed within 60 days by submitting the information online via the Provider Enrollment Chain Ownership System (PECOS) or by submitting the applicable CMS-855 form by mail.

Revalidation will not be necessary for those providers or suppliers that have revalidated their Medicare enrollment information on or after March 25, 2011.

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Insurance Exchanges – Credits to Some, Costs to Others

The U.S. Department of Health & Human Services (DHHS) and the United States Treasury simultaneously released three proposed rules for the development of “affordable insurance exchanges” authorized by the Patient Protection and Affordable Care Act. These draft rules accompany previously released draft rules released by DHHS in July, setting forth the underlying framework for crafting state-run insurance exchanges in order to offer a competitive marketplace for consumers and small businesses to compare and purchase health insurance, effective in 2014.

The proposed rules are intended to guide insurance exchanges, employers and individuals enrolling in plans sold on these exchanges with regard to eligibility, affordability programs, coordination of coverage and premium tax credits. The proposed rules include cost parameters identifying that taxpayers who purchase qualified plans on an exchange would be eligible for a premium tax credit if they have household income between 100% and 400% of the federal poverty line, when taking into account family size. Employers could be subject to an assessment if at least one employee receives a tax credit because the employer-sponsored coverage either does not provide minimum value or is unaffordable to the employee. Safe harbors from this employer assessment will be set forth in future rule proposals.

Comments to the proposed rules must be submitted by October 26, 2011.

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STATE UPDATE

New Jersey Bill Provides for Facilities to Make Health Care Decisions for Patients Without Decision-Making Capacity

On June 13, 2011, a bill sponsored by Assemblyman Herb Conaway, Jr. and Assemblywoman Valerie Vainieri Huttie reported favorably out of the Assembly Health and Senior Services Committee (A4098). The impetus behind the bill is to facilitate the making of health care decisions for patients in a general or special hospital, nursing home or assisted living facility (health care facility) who have lost decision-making capacity, and to establish a demonstration program relating to the transfer of certain patients from inpatient care to post-acute care.

Some of the major highlights of the bill include:

- A health care facility will be required to establish policies and procedures to provide for the making of health care decisions by a surrogate, to be designated by the health care facility, for an adult patient who is determined to lack decision-making capacity, who does not have a patient’s representative and who has not executed an advance directive
- The patient’s attending physician will make an initial determination (subject to a concurring determination by a health or social service practitioner) that the patient lacks decision-making capacity to a reasonable degree of medical certainty, including an assessment of the cause and extent of the patient’s incapacity and the likelihood that the patient will regain decision-making capacity
- A health care facility will be authorized to designate a surrogate to make health care decisions for an adult patient who has been determined to lack decision-making capacity, and is to provide prompt notice of that determination and designation to the patient, if the health care facility has any indication of the patient’s ability to comprehend the information, and at least one person on the “surrogate list,” which will be set forth in the final law and which will designate individuals, by order of priority, to be named as surrogates when necessary

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- A surrogate who is designated pursuant to the bill will, subject to the provisions to be included in the final law, have authority to make health care decisions on the adult patient's behalf
- A decision by a surrogate to withhold or withdraw life-sustaining treatment from the patient will be authorized if the attending physician determines, with the independent concurrence of another physician and to a reasonable degree of medical certainty and in accordance with accepted medical standards, that certain criteria to be set forth in the final law are met

If passed in its present form, the new law would establish a three-year transition authorization panel demonstration program, to be conducted at six program sites, two each in the northern, central and southern regions of the state, for the purpose of evaluating an approach to making decisions relating to the transition of eligible patients from inpatient care to post-acute care.

We will continue to monitor the progress of this bill as it continues through the legislative process.

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Safe Patient Handling and Violence Prevention Rules Adopted

The New Jersey Department of Health & Senior Services (DOH) recently approved for adoption, without change, previously proposed licensing rules governing safe patient handling and violence prevention in health care facilities.

The DOH approved for adoption N.J.A.C. 8:43E-11, which requires general hospitals, special hospitals, county and private psychiatric hospitals, and nursing homes licensed by the DOH to establish a workplace violence prevention program within three months of adoption of the rules.

N.J.A.C. 8:43E-12, which was also approved for adoption, establishes the requirements for these facilities to minimize unassisted patient handling in order to decrease the number of job-related musculoskeletal injuries suffered by health care

workers and to improve the comfort, dignity, satisfaction and quality of care for patients.

In addition to the adopted new rules set forth at N.J.A.C. 8:43E-11 et seq. and N.J.A.C. 8:43E-12 et seq., the DOH is adopting an amendment at N.J.A.C. 8:43E-3.4 that establishes monetary penalties for violations of these rules.

The final rules were published in the September 6, 2011 New Jersey Register.

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Brach Eichler In The News

Todd Brower and Lani Dornfeld presented a continuing education seminar, entitled "Responsibility, Accountability & Liability: What You Need To Know About Nursing Documentation In Home Care," at the Home Care Association of New Jersey on August 12. Brach Eichler has been general counsel to the association since 1998 and also represents numerous home health agencies, hospices and health care service firms.

On October 27, Brach Eichler will sponsor "What You Don't Know about the Board of Medical Examiners Can Hurt You: Regulations You Need to Know to Protect Your License," at the Hyatt Regency New Brunswick. Speakers will include Brach Eichler's Joseph Gorrell and Dr. Gregory Rokosz, Senior Vice President for Medical and Academic Affairs, Saint Barnabas Medical Center and former President, New Jersey State Board of Medical Examiners. For more information, contact Alan Levine at alevine@bracheichler.com

HIPAA CORNER

Notice of Privacy Practices Refresher

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), contained within the American Recovery and Reinvestment Act of 2009,

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introduced several changes to HIPAA. Although the HITECH Act on its own does not specifically direct covered entities to modify their Notices of Privacy Practices (Notices), it would be prudent for covered entities to revisit their Notices and amend and update them as necessary.

By way of background, HIPAA requires that health care providers and health plans develop and distribute to individuals a Notice that provides a clear explanation of the particular entity's privacy practices, as well as to inform recipients of their individual privacy rights with respect to their protected health information (PHI). The Notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

In July of 2010, HHS issued a Notice of Proposed Rulemaking (NPRM) in which it solicited public comments on several aspects of the new changes brought about by the HITECH Act. The NPRM provided that a covered entity

must include a description of certain types of uses and disclosures of PHI that require an authorization in its Notice (e.g., psychotherapy notes). The Notice should explicitly describe an individual's right to request restrictions on the use and disclosure of PHI, including a statement that the covered entity must agree to a request to restrict disclosure to a health plan if the disclosure is for payment or health care operations purposes and pertains solely to a health care item or service that was paid in full by a person or entity other than the covered entity. HHS recognized in the NPRM that requiring covered entities to make these changes and distribute updated Notices to individuals has the potential to be expensive and administratively burdensome, and therefore requested comments from the industry on several alternate timing proposals for informing individuals of these changes.

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