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News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

Nonprofit Hospitals Face Additional Regulatory Burdens in Financial Assistance and Debt Collection

by David Broyles

Roughly 60 percent of hospitals nationwide either have received or are seeking tax-exempt status under the United States Treasury Department (Treasury) and Internal Revenue Service (IRS) rules and regulations. With new final rules and regulations adopted by the Treasury and the IRS effective December 29, 2014, nonprofit hospitals (referred to in the Federal Register as "charitable hospitals") now face a number of additional requirements when attempting to collect debts owed for care provided to patients and face additional mandates related to financial assistance policies and qualification of certain low-income patients for financial assistance.

The final rules and regulations clarify the broad provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA), which added Section 501(r) to the Internal Revenue Code (Code) imposing the following four additional requirements on charitable hospitals to maintain tax-exempt status:

1. Conduct a community health needs assessment (CHN Assessment) at least once every three years and adopt an implementation strategy to meet those community health needs, or be subject to a $50,000 tax penalty.
2. Establish a written financial assistance policy which prescribes the eligibility criteria for assistance, how patients apply for assistance, and how they are charged for care under the policy, and a written emergency medical care policy requiring emergency care to individuals regardless of their eligibility for financial assistance.
3. Limit the use of gross charges and the amounts charged to those patients who qualify for financial assistance for emergency or other medically necessary care to not more than the amounts generally billed to individuals who have insurance covering such cases.
4. Make reasonable efforts to determine whether an individual is eligible for assistance under the financial assistance policy before engaging in extraordinary collection actions (EC Actions).

Additionally, the PPACA insists that a charitable hospital organization meet each of the above requirements separately with respect to each facility it operates.

Below are some requirements from the new rules and regulations that may be potential areas of focus for regulators in their review and enforcement actions against charitable hospitals.

- The CHN Assessment process requires careful documentation of each of the multiple levels of need assessment, community input and collaboration, and a hospital's plan for addressing the need with an adopted strategy for implementation.
- A hospital's financial assistance policy must contain all eligibility criteria, all financial assistance and discounts available under the policy, and methods to apply for financial assistance, as well as any actions that may be taken in the event of nonpayment under certain circumstances.
- Hospitals must continue to take certain measures to make the financial assistance policy, the policy's application form and a plain language summary of the policy available upon request, available in certain areas of the hospital for visitors and patients (e.g. emergency department and hospital intake areas), available on a website, and available to members of the community served.
- Certain additional written notices with financial assistance policy information, summaries and hospital contact information

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PLACING MEDICARE BENEFICIARIES INTO "OBSERVATION STATUS" - RECENT SECOND CIRCUIT DECISION CASTS DOUBT ON LAWFULNESS OF CMS PROCEDURES

by Wilson Hayman

The trend toward placing more Medicare beneficiaries into observation status in the hospital has come under increasing attack by patient advocates. Such patients are considered outpatients reimbursed by Medicare Part B rather than inpatients covered by Medicare Part A, even though they may receive care in the hospital for many days and nights. Classification as observation status can have significant negative financial consequences for the beneficiary, as is discussed more fully below, particularly because Part A unlike Part B provides no post-acute benefit for skilled nursing facility care.

The Secretary of the Department of Health and Human Services (the secretary, and the department, respectively), through the Centers for Medicare & Medicaid Services (CMS) in the Medicare Benefit Policy Manual, has defined an inpatient as "a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services." In 2013, CMS created the two-midnight rule, which provides that treatment is generally appropriate for inpatient admission and payment under Medicare Part A "when the physician expects the patient to require a stay that crosses at least two midnights." Consequently, if a patient fails to stay in the hospital for two nights, hospitals must list the patient as having observation status and must bill Medicare for outpatient services. Many have cited the two-midnight rule, as well as hospitals' attempts to avoid preventable readmissions and their associated penalties, as largely contributing to the current trend toward increased observation stays.

Patients who are placed into observation status may spend several days and nights in a hospital without ever being formally admitted. These patients are treated as outpatients by CMS, and their care is covered by Medicare Part B. A Medicare beneficiary receiving hospital outpatient treatment under Part B owes a co-payment for each service received, as opposed to a one-time deductible for the first 60 days in the hospital under Part A, and more importantly has no right to Medicare reimbursement for post-hospitalization care at a skilled nursing facility.

Although the Medicare statute and regulations do not define observation services, the Medicare Benefit Policy Manual contains the following definition:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

The Medicare Manual further provides that the decision to discharge a patient from the hospital can usually be made in less than 24 hours, and in a majority of cases in less than 48 hours. Only in rare and exceptional cases should outpatient observation services require more than 48 hours.

Since 2004, CMS has permitted the use of Condition Code 44 – Inpatient Admission Changed to Outpatient when the physician orders inpatient services, but upon internal utilization review performed before the claim was first submitted to Medicare, the hospital determines that the services did not meet its inpatient criteria. Utilization review requirements are established by the applicable Medicare conditions of participation found at 42 C.F.R. §§ 482.30 and 485.641. To address in part the increasing use of hospital observation services and to soften the blow imposed by this new code, 42 C.F.R. § 414.5 was adopted to permit a new rebilling option, effective October 1, 2013. This regulation permitted a hospital, after the patient's discharge, to retroactively change its decision about a patient's inpatient status that was not reasonable and necessary, and to bill Medicare for certain provided services under Part B rather than Part A, as long as the hospital outpatient services were medically necessary.

Moreover, CMS's preamble to the 2014 Hospital Inpatient Prospective Payment Systems Final Rule appears to indicate that such a beneficiary who is made an outpatient retroactively may still be eligible for the post-acute nursing stay under Part A if the hospital stay as an outpatient was medically necessary. CMS stated that "[m]edical necessity will generally be presumed to exist,

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[and] [t]he intermediary will rule the stay unnecessary only when hospitalization for three days represents a substantial departure from normal medical practice." In other words, if a hospital changes a beneficiary's status to outpatient after the patient's discharge from the hospital and submits a Part B claim for the patient, and the outpatient services are determined to be medically necessary, then the patient would still be considered a hospital inpatient for the purpose of qualifying for the post-acute skilled nursing facility benefit.

Litigation Asserts Possible New Rights of Patients in Observation Status

In the case of *Barrows v. Burwell* (formerly *Bagnell v. Sebelius*), plaintiffs filed an action in the U.S. District Court for the District of Connecticut on November 3, 2011, against the secretary on behalf of a proposed class of Medicare beneficiaries who were placed into observation status by hospitals rather than being admitted as inpatients. Unlike inpatients covered by Medicare Part A, patients placed in observation status often receive hospital care similar to that of inpatients but are covered by Medicare Part B, which generates co-payment charges for each service received and does not cover post-hospital treatment at a skilled nursing facility. Plaintiffs alleged that patients' placement into observation status caused each to pay thousands, and sometimes tens of thousands, of dollars more for medical care than they would have if they had been admitted as inpatients. Beneficiaries covered by Medicare Part B would receive a Medicare Summary Notice (MSN) often weeks or months after being discharged by the hospital. While in the hospital, they might not have even known that they were not admitted as inpatients, were covered under Part B rather than Part A, and would face the resulting financial consequences.

As a result, the plaintiffs in this litigation sought a permanent injunction on multiple grounds that would (a) prohibit the secretary from allowing Medicare beneficiaries to be placed on observation status and deprive them of Part A coverage; (b) require the secretary to ensure that the beneficiary receives expedited written notification of the fact that he or she has been placed into observation status, the consequences of such placement for Medicare coverage, and the beneficiary's right to obtain expedited review of that action; and (c) establish a procedure for administrative review of a decision to place a beneficiary on observation status.

After the district court dismissed the entire case on the secretary's motion, the plaintiffs appealed the dismissal of two of their nine claims, claiming that the secretary's failure to provide an expedited system of notice and administrative review violated the Medicare Act and federal due process clause. In its decision on January 22, 2015, the United States Court of Appeals for the Second Circuit affirmed the dismissal of the plaintiffs' Medicare Act claims but vacated the district court's dismissal of their due process claims.

The court of appeals held that the district court had erred in accepting the secretary's argument that the plaintiffs lacked a property interest in being treated as inpatients. The secretary had maintained that a hospital's decision to admit a patient is a complex medical judgment left to the treating physician's discretion. The appeals court noted that the plaintiffs had properly pleaded that there were in fact significant constraints upon physician discretion in this situation. The plaintiffs had alleged that instead of a discretionary judgment left to the treating physician, a hospital's decision to admit a patient is in practice guided by fixed and objective criteria set forth in commercial screening guides issued by CMS. The appeals court also noted the plaintiffs' argument that CMS exerts further pressure on hospitals through its billing policies and its retroactive Recovery Audit Contractor reviews to incentivize, as a cost-saving or compliance measure, placing Medicare beneficiaries into observation status for longer periods, and the plaintiffs' allegations must be taken as true on a motion to dismiss. The court concluded that the plaintiffs at this early stage of the litigation had sufficiently asserted that the admission decision was not left to the discretion or judgment of treating physicians, and the plaintiffs might ultimately be able to prove a sufficient property interest to state a due process claim.

In unusually specific instructions to the district court, the appeals court remanded the case to the lower court for limited discovery on the sole issue of whether the plaintiffs had a property interest in being admitted to hospitals as inpatients, based on a factual determination as to whether the decision to admit these patients was a complex medical judgment left to the discretion of the treating physicians, or whether in practice the decision was made by applying fixed criteria set by the federal government. If the evidence in discovery establishes that the plaintiffs have such a property interest, then the district court is directed to analyze whether the complaint would be properly dismissed on the state action and due process prongs of due process analysis. Any further appeal of a final judgment in this case by the district court must be assigned to the same court of appeals panel of judges.

Conclusion

Although the 2013 regulations may limit the problems for Medicare beneficiaries whose inpatient status is changed to outpatient while in the hospital, the "observation status" phenomenon will remain a problem for many other such patients requiring post-acute skilled nursing care. The *Barrows v. Burwell* litigation could potentially have enormous consequences for Medicare beneficiaries, hospitals, and skilled nursing facilities.

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MEDICARE RAC PROGRAM IMPROVEMENTS DELAYED UNTIL 2016

by Chris Brewer and David Broyles

The CMS had planned to award new contracts to companies that act as Medicare's recovery audit contractors (now referred to as "recovery auditors" or RAs) for operation of the Medicare recovery audit program in the hospital sector by the end of 2014, which would have concluded the procurement process for new contracts that began in May 2013. However, in familiar fashion, CMS announced recently that due to continued delays in awarding the new contracts, the existing contracts for the four private companies that currently act as Medicare's RAs (namely, CGI Federal, Connolly, HealthDataInsights, and Performant Recovery) would be extended through calendar year 2015. Along with the delay of the new contract for DME and home health and hospice providers awarded December 30, 2014, to Connolly, a post-award protest of that contract caused CMS to modify the existing RA contracts to allow the Medicare RAs to resume certain reviews that had stopped in 2014 pursuant to the old contracts' terms. The existing work under the old contracts was extended with CMS through April 2017, to finalize all appeals and reconciliation.

Unfortunately, the contract extensions and modifications granted by CMS further delay CMS's efforts to usher in the next phase of the recovery audit program, and leave hospital providers waiting at least another year for long-promised and much-needed program improvements. Looking ahead to the next phase of the recovery audit program, we have highlighted some of the program changes in the table on page five, published by CMS after evaluation of the multitude of concerns raised about the existing program, which are aimed at reducing the administrative burdens associated with the program and increasing program oversight and transparency. The new requirements will be incorporated into all new RA contract awards, and will be effective for any RA activities performed under new contracts entered into on or after December 30, 2014.

Even after the new contracts incorporating these program improvements become effective and begin to have an impact, hospitals will continue to encounter the considerable administrative burdens and related challenges that result from the current environment of aggressive auditing activities by multiple government program contractors and other payors. Past practices, trends, and approved audit issues with the recovery audit program serve as a good indicator that certain providers and service areas will continue to receive special attention from the RAs. Hospitals should closely monitor sources which reveal those trends and should continue to focus on their facilities' practices which have previously been considered high-risk areas by the RAs. One of those sources is the Connolly Consulting, Inc., website. Connolly is the primary RA with jurisdiction over Region C, which includes North Carolina providers. The Connolly website provides a complete list of issues that CMS has approved for RA audit, which may be accessed at http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx. Another valuable source is the 2015 Work Plan published by the Office of Inspector General (OIG) for the United States Department of Health and Human Services, which may be accessed at http://oig.hhs.gov/reports-and-publications/workplan/index.asp.

An analysis of past or current issues approved by CMS for RA review for North Carolina hospitals reveals that often North Carolina hospitals are included in the review of a specific billing issue because the state has the highest number of inpatient days of any of the states in Region C, its RA jurisdiction region. The RA then selects the initial claims for review based upon an analysis which identifies claims billed with the top Medicare Severity Diagnosis (MS-DRG) on the most recent Comprehensive Error Rate Testing (CERT) report. Examples of approved issues for RA review in North Carolina include minor surgery and other treatments billed as inpatient stays; esophagitis, gastroenteritis, and miscellaneous digestive disorders with or without major complications (MS-DRG-391 and 392); diabetes with or without major complications or comorbidities (MS-DRG-637, 638, and 639); and other vascular procedures without multiple complications or comorbidities (MS-DRG-254).

Maintaining an awareness of current audit issues and giving special attention to potentially vulnerable practice areas should be viewed as essential to hospitals' provider action plans to avoid being targeted for audit and to ensure an effective response if they are audited. Whether your facilities are analyzing regulatory requirements and changes, reviewing compliance policies and procedures, formulating best practices, assessing any rights and duties, or preparing a response plan post-audit notice, involvement of experienced legal counsel can be an important resource to work with hospital staff prepared and trained to deal with the burdens of auditing activity.

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Medicare RAC Program Improvements

Reducing Provider Burden	
Provider Concern	**Benefit to Providers**
Additional documentation request (ADR) limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will establish ADR limits based on a provider's compliance with Medicare rules. Providers with low denial rates will have lower ADR limits, while providers with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider's denial rate decreases, ensuring the providers that comply with Medicare rules have less recovery audit (Audit) reviews.
ADR limits are based on an entire facility, without regard to the differences in departments within the facility.	CMS-established ADR limits will be diversified across all claim types of a facility (e.g., inpatient, outpatient). This ensures that a provider with multiple claim types is not disproportionately impacted by Audit review in one claim type vs. another (e.g., all of a provider's inpatient rehabilitation claims reviewed or all inpatient).
Providers that are not familiar with the Recovery Audit Program (RAP) immediately receive requests for the maximum number of medical records allowed.	CMS-established ADR limits will include instructions to incrementally apply the limits to new providers under review. This will ensure that a new provider is able to respond to the request in a timely manner considering staffing levels at the time.
Providers must wait 60 days before being notified of the outcome of their complex reviews.	Recovery Auditors (RAs) will have 30 days to complete complex reviews and notify a provider of their findings. This provides more immediate feedback to the provider.
Upon notification of an appeal by a provider, the RA is required to stop the discussion period.	RAs will not receive a contingency fee until after the second level of appeal is exhausted. Previously, RAs were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the decision made by the RA was correct. Note: If claims are overturned on appeal, providers are paid interest calculated from the date of recoupment.
Enhancing Program Oversight CMS	
Provider Concern	**Benefit to Providers**
RAs focused much of their resources on inpatient hospital claims.	CMS will require the RAs to broaden their review topics to include all claim and provider types, and will be required to review certain topics based on a referral, such as an OIG report.
RAs are not penalized for high appeal overturn rates.	RAs will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation and claims that were corrected during the appeal process. Failure to do so will result in CMS placing the RA on a corrective action plan, which could include decreasing the ADR limits or ceasing certain reviews until the problem is corrected.
Providers are concerned with the accuracy of RA automated reviews, and RAs are not penalized for low accuracy rates.	RAs will be required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of 95% will result in a progressive reduction in ADR limits. CMS will continue to use a validation contractor to assess RA identifications and will improve the new issue review process to help ensure the accuracy of RA automated reviews.
Increasing Program Transparency	
Provider Concern	**Benefit to Providers**
Providers are unsure of whom to contact when they have complaints/concerns about the RAP.	CMS established a provider relations coordinator to offer more efficient resolutions to affected providers. This position gives providers a name and contact information when issues arise that cannot be solved by having discussions with the RA.
Providers need more information on how to prevent improper payments and bill correctly.	CMS will continue to post compliance tips to the CMS website, to be used with education and MLN Matters articles, which give information to help providers proactively prevent payment and billing errors.
Providers are unclear about the information in the RA new issue website postings.	CMS will require the RAs to provide consistent and more detailed review information concerning new issues on their websites.

SOURCE: CMS. - Full CMS table on RA program improvements can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.

Toss or Keep: Document Retention in a Hospital Setting

by Ken Burgess

Deciding how long to hold on to specific records in your hospital can be a challenging task, especially when the facility deals with so many different types of records. You may be tempted to hold on to everything indefinitely – an option we know can be space- and cost-prohibitive, especially within the hospital environment. Our reluctance to dispose of records is also driven by several critical questions: What if I need this record to defend our hospital in a lawsuit? What if a state or government agency audits or investigates our hospital for issues contained within this record?

This is why it makes sense from a compliance and risk management standpoint to have a comprehensive and consistently applied record retention policy that includes all forms of hard copy and electronic data. There are many reasons to implement a record retention policy, including compliance with statutory or regulatory requirements, maintaining control of records during litigation, improving your responsiveness and efficiency in complying with discovery demands, and avoiding the disclosure of unnecessary or obsolete records.

An effective policy will also help you avoid liability for any inadvertent destruction of evidence when litigation or a government investigation is pending or reasonably foreseeable, such as when a subpoena has been served. Generally speaking, anytime your organization is aware (or should have been aware, in the exercise of reasonable diligence) of a pending dispute like an audit, investigation, or lawsuit, you will be required to retain any record potentially related to the matter. For this reason, you'll want to make sure that your record retention policy includes procedural steps for preserving relevant evidence and instructing employees not to delete or destroy relevant records, as when a "Litigation Hold" is placed on records that are the subject of an investigation or lawsuit. As recent court decisions illustrate, organizations can be subject to large sanctions for the destruction of records when litigation, government investigations, or other disputes are, or should have been, anticipated. If you inadvertently and in good faith dispose of relevant records as part of your fully implemented, consistently applied, active records management program, you are more likely to persuade a court or government investigator that missing records were not willfully destroyed. Courts generally do not look favorably on organizations that mismanage or dispose of records on an inconsistent basis, even if there was no bad-faith motive in that inconsistency.

A good record retention policy will not only specify a record retention period for each type of relevant record (see chart at end of article for suggested general-purpose retention guidelines), but it will also establish a standard disposition policy. It may, for example, specify that the preferred method of disposition is shredding. A professional records management company or IT consultant can also assist you in managing and disposing of all records appropriately, including archived electronic files. As you develop your records disposal program, bear in mind that state and federal laws may dictate a certain type of records disposal process when certain information is included in a record. North Carolina law, for example, requires a written disposal procedure, necessitates certain diligence on records disposal vendors, and mandates a certain manner of disposal whenever "personal information" is included in your records. Finally, your record retention policy should identify a records custodian who is responsible for ensuring that the program is rigorously enforced from top management down.

The chart on the next page provides some general records categories and suggested retention periods for commonly used records within the hospital setting, and may serve as a good starting point for creating a record retention policy uniquely suited to your hospital. Please remember, however, that many different sources of law may suggest specific record retention periods for specific types of records that may not be incorporated in this list. These retention periods are provided for informational purposes only and are not an adequate substitute for legal advice based on your individual business needs and legal requirements.

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Type of Record	Suggested Retention Period
Clinical/Medical/Infection Control Records	5 years after discharge of an adult patient. If the patient is a minor when discharged, the facility shall ensure that the records are kept on file until his or her 19th birthday and then for an additional 5 years. If a facility discontinues operation, records must be stored in a business offering retrieval services for at least 11 years after the closure date.
HIPAA-Related Records	6 years from the date most recently in effect for HIPAA-mandated records such as policies or procedures, notices of privacy practices, consents, authorizations, and accountings of PHI disclosures.
Governance (board minutes, bylaws, foundation documents, etc.)	Typically retained permanently.
Quality Assurance, Safety Committee, and Abuse Investigation Records	5 years.
Finance/Accounting	Medicare specifies a retention requirement of 4 years; the recently revised Medicaid Provider Participation Agreements specify a minimum retention period of 6 years for all Medicaid finance and accounting records; it is common to retain these records for 7 years due to certain tax and financial reporting obligations at the federal level.
Employment Application, Résumé, Hire/Promotion/Demotion/Transfer Decision, Request for Accommodation, Evaluations, FMLA Records	4 years after date of termination/resignation.
I-9 Immigration Forms	3 years after hiring or 1 year after termination, whichever is later.
Wage Records (rates of pay, time earning sheets, etc.)	5 years after the calendar year in which compensation was paid.
Most OSHA/Safety Records (including inspection/training records)	5 years following end of the calendar year covered by the record (some specific types of OSHA records, such as exposure records and employees' medical files, have much longer retention periods).
Contracts with Vendors/Suppliers	For contracts valued at $10,000 or more over a 12-month period, Medicare regulations specify a retention period of 4 years after the service(s) is furnished under the contract or subcontract; state laws imposing statutes of limitation on contracts actions may be as long as 15 years, however.
Tax Records	7 years after taxes at issue were due or paid, whichever is later.
Compliance Records (committee minutes, reports to the board, internal audits, etc.)	10 years appears to be the most common retention period for these records .

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Nonprofit Hospitals Face Burdens
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for policy-related documents must be provided to patients against whom a hospital actually intends to engage in EC Action.

- Hospitals must limit the costs for any care for which financial assistance policy-eligible individuals will be personally responsible to not more than amounts generally billed (AGB), and the criteria and method for calculating the AGB must be clearly defined by a hospital in its financial assistance policy.
- Reasonable efforts, as defined in the new regulations, must be followed and carefully documented by hospitals during each step of an EC Action assessment application, including notification and further billing and collection communication(s) with financial assistance policy-eligible individuals. The regulations define EC Action as including, among other things, reporting adverse information about the individual to credit bureaus; requiring or deferring medically necessary care because of nonpayment of bills for previously provided care; and instituting legal process such as liens, foreclosure, attachment of property, or garnishing wages.

The full Treasury and IRS rules and regulations related to the additional requirements on charitable hospitals contain specific regulatory changes and other nuances not touched on in the "big picture" points mentioned above. The full text of the new regulations can be found at: http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf.

Charitable hospitals may lawfully bill for and collect funds they are owed for patient care. However, the new rules and regulations in this area mean hospital leadership and experienced legal counsel should closely review all related policies, procedures, and facility practices to ensure all billing and collection policies and practices fully comply with the law.

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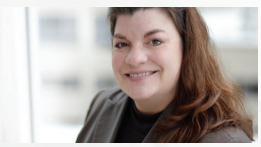

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