The Quarterly

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NEW FEDERAL REGULATIONS AND PENALTIES EMPHASIZE PROVIDER RESPONSIBILITIES TO ENSURE PROPER MEDICARE PAYMENT CLAIMS

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New Medicare participation requirements present additional challenges for provider compliance programs with respect to responding to claims denials, whether as a result of claims processing, RAC Audits, or appeals. Providers should update their compliance programs to reflect these new requirements. On December 5, 2014, 79 F.R. 72500, the U.S. Department of Health and Human Services adopted a Final Rule that included adding new criteria for the revocation of Medicare billing privileges (42 CFR § 424.535(a)(8)(ii)) when CMS determines that the provider or supplier "has a pattern or practice of submitting claims that fail to meet Medicare requirements," considering the following:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

The Final Rule emphasized, 79 F.R. 72517, that:

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> "while we recognize that providers sometimes rely on physicians for certain information, the provider remains ultimately responsible for ensuring that the claim and the supporting documentation meet Medicare requirements."

The Final Rule notes, 79 F.R. 72514) that:

> "Medicare billing privileges come with a responsibility for the provider to diligently seek and obtain clarification of Medicare policies should there be a misunderstanding or confusion." The Final Rule expressly notes, 79 F.R. 72513, that the Medicare requirements involved include "that the service be reasonable and necessary."

The Final Rule does not require a finding of fraud or any specific intent (79 F.R. 72514).

In the Final Rule, there are repeated statements that the focus of the new requirements is not on sporadic or occasional claim denials, including, at 79 F.R. 72516:

> "We recognize the possibility that a single inadvertent error on similar electronic claim submissions could result in multiple claim denials. As we stated earlier, we recognize that Medicare has many rules and requirements regarding billing and coding, and that claims are sometimes submitted in error due to a provider's honest misunderstanding of these policies. It is not our intention to revoke billing privileges under § 424.535(a)(8)(ii) for such sporadic misinterpretations."

The Final Rule states, 79 F.R. 72519, that the focus of the penalty "should be reserved for only the most serious of abuses;" that it is "not targeted toward honest providers and suppliers that make occasional billing mistakes;" and, that "our sole focus is on providers and suppliers that engage in a systematic, ongoing, and repetitive practice of improper billing notwithstanding the public availability of CMS educational materials or guidance and CMS issuance of claim denial notices to the providers."

Nevertheless, the Final Rule identifies events that may give rise to concerns to include the results of RAC Audits and denials that have not been overturned in the appeal process (79 F.R. 72513). The Final Rule advises (79 F.R. 72518) that:

> "We believe that frequent claim denials should alert the provider that there may be an issue with its claim submission and that remedial action may be required. We do not believe that an interim notification from CMS (for example, a "warning letter") should be a prerequisite for taking action under § 424.535(a)(8)(ii). Further, if the provider has questions regarding CMS's billing and coding requirements, it should review CMS's manuals, educational articles, and other informational documents at CMS's Web site (www.cms.hhs.gov); the provider may also contact its local MAC if it has additional questions."

While the Final Rule confirms that providers can appeal any revocation of Medicare billing privileges under 42 CFR Part 498 (79 F.R. 72518), the Final Rule reflects the compliance guidance from the OIG that providers must take steps to ensure submission of accurate claims, 73 F.R. 56832, 56839 (September 30, 2008). The monitoring and auditing elements of a provider's effective compliance program must include methods to learn from claim denials to avoid submission of inaccurate claims. The Final Rule reminds providers to seek and document guidance received from CMS, but also presents the risk that letting an incorrect RAC Audit finding slide by without appeal can lay a foundation for future loss of billing privileges if the provider does not incorporate that finding into future claims submissions, including cases where documentation supporting "reasonable and necessary" is involved. And – yes, providers do win some of those RAC appeals and demonstrate that their claims are properly documented and meet Medicare requirements.

If your facility has concerns about the effectiveness of its compliance program to deal with this new risk area or about how to substantiate your claims in the appeals process, you may contact Bruce G. Baron, Esq. or Nicholas J. Luciano, Esq. at our Firm.

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FEDERAL COURT UPHOLDS THE CONFIDENTIALITY OF CORPORATE INVESTIGATIONS

Attorney – Client Privilege Protects Internal Investigation Reports

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Businesses today face a variety of regulatory requirements from a host of state and federal agencies. Medical, insurance, and financial industries are particularly burdened with extensive and complex regulations. Consequently, most corporations have adopted internal compliance policies and programs to assist them in navigating this highly

regulated environment. When compliance issues arise, it is often advisable for a corporation to conduct an internal investigation to locate the problem before the government initiates its own investigation. If the source of the problem is determined to be the misconduct of a corporate officer, employee or agent, steps can be taken by the company to address the situation in advance of official government involvement. If a corporation is perceived by the government as acting promptly and responsibly with respect to a compliance issue, there is less likelihood that enforcement action will be taken or, if enforcement action occurs, the penalties imposed will likely be less severe.

Most corporations utilize legal counsel, in-house or outside, to assist with the internal investigation process. Typically, the results of an internal investigation will be memorialized in a report prepared for management. Most internal investigation reports contain information of a highly sensitive and private nature, including statements of employees, that may not necessarily reflect favorably on the company. Consequently, these reports need to be maintained with the utmost confidentiality. Can a claim of attorney-client privilege be asserted by a corporation to protect the contents of an internal investigation report? A recent U.S. Court of Appeals' opinion provides a qualified "yes." In the matter of United States ex rel. Barko v. Halliburton Co., the United States Circuit Court of Appeals for the District of Columbia held that internal communications are privileged "if one of the significant purposes of the internal investigation was to obtain or provide legal advice." Notably, the court ruled that the privilege applies whether the investigation is conducted by in-house counsel or outside counsel, and that communications made by and to non-attorneys serving as agents of attorneys, e.g. investigators, paralegals, etc, are also protected by the privilege.

The Barko decision affirms the principal that corporations should not be penalized for acting responsibly and in a manner consistent with best management practices. As long as legal counsel is involved in an internal investigation for the purpose of providing legal advice, corporations can remain confident that the contents of any report will be protected from third-party disclosure by the courts. Corporations should be aware that if counsel is not involved in the internal investigation process, the contents of any report may not be deemed privileged by the courts.
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NLRB DECISION CALLS INTO QUESTION EMPLOYER POLICIES ON E-MAIL USE

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In December of last year the National Labor Relations Board issued a decision that has employers double checking their employee handbooks, policies, and procedures. In Purple Communications, Inc., the Board held that employees who have already been granted access to an employer's e-mail system for work purposes have a right to use the e-mail system to engage in Section 7-protected communications about their terms and conditions of employment during non-working time.

The e-mail policy in Purple Communications prohibited employees from using their employer's e-mail system to engage in "activities on behalf of organizations or persons with no professional or business affiliation with the Company" or send "uninvited email of a personal nature." The union filed an unfair labor practice charge alleging that the policy restricted employees' rights to engage in protected concerted activity under Section 7 of the National Labor Relations Act.

In reaching its decision, the Board overturned a previous decision in Register Guard that had condoned similar policies, calling that decision "incorrect" and noting that it undervalued the significance of communication as the cornerstone of Section 7 rights while placing undue emphasis on employer's property rights. The Board also found that the Register Guard decision failed to recognize e-mail as a "critical" mode of communication in the workplace, stating that the modern-day pervasiveness of e-mail has rendered it a natural "gathering place" for employees to communicate with one another, including about the terms and conditions of their employment. The Board stressed that its holding is limited to e-mail only, and does not prohibit the employer from monitoring its e-mail systems in furtherance of legitimate management objectives or enacting uniform and consistently enforced constraints on its use. The decision also applies only to employees who already have access to their employer's e-mail system in the course of their work.

The Board remanded the matter to an Administrative Law Judge for additional findings. It remains unclear whether the decision will be appealed after the ALJ's determination is rendered, but given strong dissents from two members of the Board who disagreed with the ruling, an appeal is likely. Until Purple Communications is finally resolved, employers should exercise caution in enforcing similar e-mail policies. Contact Brandon Williams at BrandonW@capozziadler.com or (717) 233 4101 with questions regarding this issue or other employment related questions.

MANAGING AND COLLECTING YOUR ACCOUNTS RECEIVABLE - *Notice of Intent to Discharge a Resident for Nonpayment*

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This is the 12th installment of our firm's series known as "Take Control of your Resident Accounts Receivable". As you are already aware, the financial survival of most nursing facilities in Pennsylvania depend on how aggressively and effectively their business office managers administer their accounts receivable. This series is devoted solely to the design, management, and improvement of your accounts receivable program and collections efforts. Also, here we share with you tips, legal updates, personal observations, and "lessons learned" to help you improve the effectiveness of your accounts receivable management program.

I am frequently asked by NHAs or Business Office Managers about the requirements and enforceability of the Notice of Intent to discharge a resident for non-payment. In other cases, I may refer to this Notice when discussing various options to deal with a resident's aging account. On many occasions, however, the facility's staff is not familiar or comfortable with the planning for and preparation of the 30-Day Notice of Intent to Discharge.

The primary purpose of the Notice is to comply with regulatory requirements to notify the resident and family of a pending discharge for non-payment when the discharge can be achieved safely. Its secondary purpose is to notify the resident and family that the facility is serious about forcing payment and/or compliance with Medicaid application requirements. I have found that the Notice frequently, but not always, gets the attention of the family or Legal Representative when it receives the Notice. Here are several important considerations in the use of the Notice of Intent as part of your Accounts Receivable Management Program:

(1) **Admission Agreement.** Your Admission Agreement should refer to your right to involuntarily discharge a resident for non-payment or for non-compliance with the Medicaid application process. I have observed numerous facilities with an Admission Agreement form that fails to adequately protect the facility in the event a resident or family refuses to cooperate in financial matters.

(2) **Internal Policy.** Your facility should have an internal written policy to address the timing of the use of the Notice of Intent to Discharge a resident for non-payment. Normally, a facility will have a policy, but it has either never used it or the current staff members are not familiar with the policy. In many cases, the policy directs the staff to research alternative care for the resident and to issue a Notice of Intent to Discharge after its third demand letter. Some facilities aggressively implement this policy and others are reluctant to resort to this option. I recommend that you review your policy and procedures.

(3) **Review of Aging Accounts.** The NHA, BOM and/or CFO should consider the Notice as an option while reviewing the facility's Aging Accounts Report. Most facilities will review its Aging Report at least once weekly to ensure its receivables remain manageable.

(4) **Authority for the Notice.** Section 483.12 of Title 42 of the Code of Federal Regulations provides specific regulatory guidance to nursing facilities. 42 C.F.R. §483.12 (Admission, Transfer, and Discharge Rights).

(5) **Key Provisions of 42 C.F.R §483.12.** Although each facility is required to have a complete copy of the regulation, a summary of the key provisions follows:

(a) **What is a "Transfer and Discharge"?** Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(b) **What qualifies as "non-payment"?** The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

(c) **What are the steps to notify a resident or Legal Representative of a pending discharge for non-payment?** At least 30 days before a facility transfers or discharges a resident, the facility must:

(d) **What information must the Notice include?** The written Notice must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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RECENT AND UPCOMING EVENTS

Jan. 8 Louis J. Capozzi, Jr. presented a National Labor Relations Board (NLRB) Update for the Jersey Shore Association for Human Resources at the Jumping Brook Country Club in Neptune, New Jersey. The Jersey Shore Association for Human Resources (JSAHR) provides members with local access to services and programs dedicated to the advancement of the Human Resources profession in New Jersey. There were over 100 companies in attendance for Lou's presentation.

Jan. 20 Louis J. Capozzi, Jr. had the distinguished honor of attending the President's State of the Union Address before the U.S. Congress as the guest of U.S. Representative Louis J. Barletta. Representative Barletta's hometown is Hazelton, Pennsylvania and he represents the people of Pennsylvania's 11th Congressional District. Fundraising events were held at the Capozzi Barn in support of Rep. Barletta in 2013 and 2014. Mr. Capozzi is personally involved in supporting those in State and Federal offices who advocate for healthcare companies and nursing facilities in Pennsylvania. During the State of the Union Address, Mr. Capozzi was seated between a 105-year old woman who marched with the Rev. Dr. Martin Luther King, Jr. over the Selma Bridge in 1965 and a 101-year old admiral who fought in the Pacific during World War II. Mr. Capozzi noted that: "It was amazing to me the acrimony and partisanship displayed before, during and after the President's Address – no wonder nothing ever gets done in Washington!"

Apr. 17 Capozzi Adler, P.C. Semi-Annual Continuing Education Seminar – "Current Issues in 2015 for Nursing Facilities in Pennsylvania" – at the Allegheny Ballroom in Rivers Casino in Pittsburgh (8:00 a.m. – 5:30 p.m.). Admission is free along with 7 continuing education credits for NHA's, lawyers, and CPA's. For a brochure and registration information, email Gabriella Marchi at our Firm: Gabriella-M@CapozziAdler.com.

June 11 18th Anniversary of the Founding of Capozzi Adler, P.C. and Annual Cook Out at the Firm's Office in Camp Hill.

Nov. 5 (8:30 a.m. – 5:00 p.m.).
Bruce G. Baron, Esq. will present a full-day seminar as part of Penn State Greater Allegheny's licensing program for nursing home administrators on "The Government's Role in Health Care Policy, Regulation and Reimbursement" at the campus in McKeesport

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(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

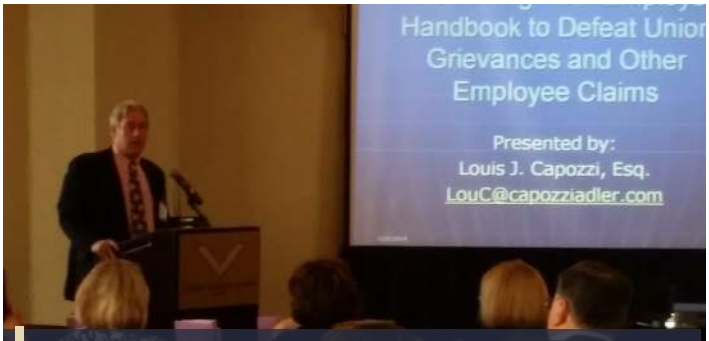
(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(e) **What other steps must a facility take in addition to the Notice?** A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(f) **What are the practical challenges to the use of this Notice?** Obviously most facilities have difficulty in locating a new facility to transfer the resident when the resident or Legal Representative is unwilling to pay or cooperate with the CAO in the Medicaid application process. Or, in some cases a discharge to home would not be "safe and orderly". Your staff or attorney must handle these situations on a case-by-case basis, which cannot be addressed adequately in this article.

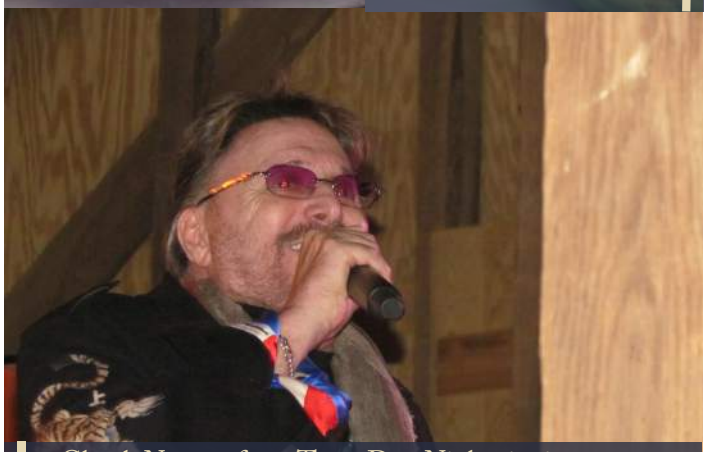
Questions? Please call or email me if you have any questions or concerns about the legal rights of your facility as a creditor under the terms of your Admission Agreement or under Medicaid law, or if you if require legal assistance with your "Medicaid Pendings". My email address is andrewe@capozziadler.com. In our next newsletter, I will focus on residents' social security and pension income issues.



Presenting at the FREE Semi-Annual Seminar

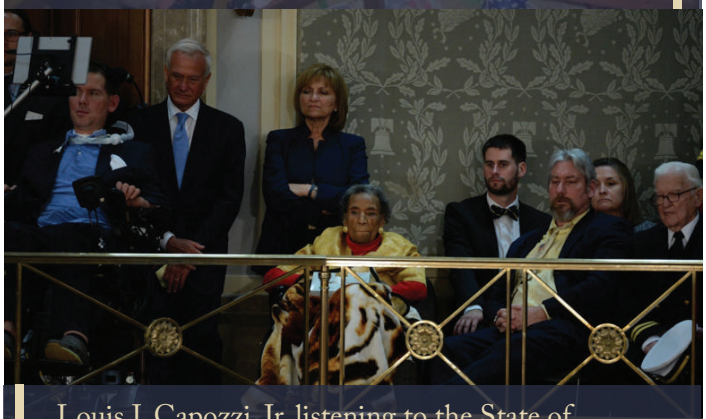
Celebrating St. Patrick's Day at the Office

Matthew Thomsen getting in the St. Patty's Day Spirit



Chuck Negron from Three Dog Night singing at our Annual Holiday Party

Everyone Enjoying the Annual Holiday Party



Louis J. Capozzi, Jr. listening to the State of Union Address