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An Informational Bulletin Brought To You By Polaris Group

OIG Issues Final Rule On Exclusion Authority

On January 11, 2017, the U.S. Department of Health and Human Services Office of Inspector General (OIG) published its Final Rule establishing new standards for excluding individuals and entities from participation in federal health care programs.

Healthcare providers who interfere with audits risk being barred from the Medicare and Medicaid programs, under the final rule. The rule, which was first proposed in 2014, updates HHS' exclusion authority to include individuals and organizations found guilty of obstructing audits. That authority was previously limited to those convicted of obstructing criminal investigations; the update was called for within the Affordable Care Act. This final rule will become effective February 10, 2017.

Key items in the final rule include:

- **Imposition of 10 Year Limitation on Exclusion Actions**. In accordance with the Final Rule, exclusions will only apply to misconduct from the past ten (10) years. The OIG had, in its proposed rule, suggested that its authority to exclude under the exclusion statute did not require a limitations period, but, with the Final Rule, the OIG may only take action to revoke billing privileges up to ten years from the date of the actual violation.
- **Changes to Certain Definitions.** The Final Rule revises certain definitions to account for new payment methodologies, allowing that a provider has "furnished" an item or service not only when the individual or entity "submits a claim" to a federal health care program but also when they "request or receive payment" by other means. This, therefore, allows providers to request or receive payments in ways other than traditional fee-for-service claims, such as, for example, shared savings payments and performance-based payments.
- **Expansion of Permissive Exclusion Authority**. The OIG expands its authority to exclude individuals or entities from participating in federal health care programs based on: (i) convictions related to obstruction of an investigation or audit, (ii) failure to provide payment information, and/or (iii) making false statements or misrepresenting material facts in provider/supplier applications. The OIG maintains that compliance with audit processes is "integral to fraud prevention and detection."
- **Exclusion of Individuals with Ownership Interests in Excluded Entities**. The OIG will also be permitted to exclude individuals who maintain a direct or indirect ownership or control interest in excluded entities for the same time period as that of the sanctioned entity.
- **Establishment of an Early Reinstatement Process.** The Final Rule establishes procedures for an early reinstatement process for providers that were excluded due to a loss of their healthcare license for reasons related to professional competence, professional performance, or financial integrity. Individuals may apply for early reinstatement if they obtain, or are permitted to retain, a healthcare license in another state, or retain a different healthcare license in the same state, or if they can otherwise demonstrate that they would no longer pose a threat to Federal healthcare programs and beneficiaries of such programs. Early reinstatement is not available to individuals who lost their health care licenses related to patient abuse and neglect until the lost license is restored in the state in which it was lost.

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Recommendations to Providers Regarding Cyber Security

The Centers for Medicare and Medicaid Services (CMS) published a Survey and Certification Memo on January 13, 2017 reminding providers and suppliers to keep current with best practices regarding mitigation of cyber security attacks.

The Cybersecurity Act of 2015, required the Department of Health and Human Services (HHS) to develop a report on the preparedness of HHS and health care industry stakeholders in responding to cybersecurity threats. This report is known as the U.S. HHS Preparedness Report and outlines the HHS components responsibilities for cyber security. However, the report does not outline mechanisms for States and facilities regarding procedures to take to protect themselves from adverse cyber events.

While the new Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers regulation does not specifically address elements of cyber-security, the regulation requires providers and suppliers to have an emergency plan and risk assessment based on an "all-hazards" approach. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters.

Potential Adverse Outcomes
The primary areas of concerns are the disruption to patient care that occur when a cyber-attack is successful. These attacks can lead to a series of adverse events, including incomplete discharge instructions, missing patient information or orders, potential compromise of Public Health Information (PHI), personal identifiable information (PII), which ultimately could lead to violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, depending on the facility's ability to provide patient care, such as loss of electronic health records or other critical computer based systems, the facility may need to close or temporarily suspend operations.
The Conditions of Participation most impacted for facilities faced with cyber incidents are:

- Governing Body
- Medical Records/ Patient Records
- Nursing Services: due to lack of knowledge of alternate methods such as the medication administration record (MAR), etc.

CMS recommends that facility leadership review current policies and procedures to ensure adequate plans are in place in the event of an attack. Per the CMS memo, some providers have shared best practices and mitigation methods, which include retraining of staff to include use of non-electronic methods, such as written discharge instructions, care planning and medical records. Some providers have pre-printed discharge instructions based on common or reoccurring patient care, such as influenza and common cold, and a blank area for additional information which can be hand written by the medical staff. Providers have also encouraged staff to familiarize themselves with the knowledge of the paper medication administration record (MAR) process, and the transmission of laboratory and radiology orders on paper-based requisition forms that are hand delivered to departments for processing.

For the complete CMS Memo go to: http://polaris-group.com/news_releases.asp

Staffing Data Submission Reminder

As of July 1, 2016, electronic submission of staffing data through the Payroll-Based Journal (PBJ) is mandatory for all Long Term Care Facilities. You have up to 45 days after the end of the quarter to submit data for Federal Fiscal Quarter 1 (October 1, 2016-December 31, 2016.) The final submission file for this quarter is due on February 14, 2017.

PBJ website link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

For the updated PBJ policy manual and FAQ go to: http://polaris-group.com/news_releases.asp

Revised SNF PPS Fact Sheet

CMS revised the SNF PPS Fact Sheet, this is an educational tool that explains the basics of SNF PPS and consolidated billing. It includes a flow chart for determining whether consolidated billing applies to services provided to residents in institutional settings. In addition, it discusses both the SNF VBP and SNF QRP programs.

For the complete SNF PPS Fact Sheet go to : http://polaris-group.com/news_releases.asp

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
Could you tell me what the CMS Federal requirements are for physician visits?

Answer:
The Federal requirement is at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Question:
I had a resident that was on a Medicare Part A stay whose last covered day was 1/6/17, then she discharged the next day. What date would I code under A2300 (ARD date) and what date would I code underA2400C (Medicare end date)?

Answer:
The A2300 (ARD date) would be 1/7/17; the same as the discharge date. The Medicare end date would be the last covered day which in this case would be 1/6/17.

Question:
If we have a resident that is on a Medicare Part A stay for twenty days, then admits to long term care for a week and then decides to go home a week later; would I have to complete a NPE item set when Part A stay ends and an OBRA Discharge assessment when goes home a week later?

Answer:
The NPE item sets purpose is to track the functional assessment of the resident from a skilled level of care to a non-skilled level of care. If the patient is on a skilled level of care, then discharges off Medicare Part A but remains in the building greater than one day after the last covered day then decides to discharge home, then the RAI rules for completing a regular discharge assessment does not change. Both would be required to be completed.

2017 WEBINAR TRAININGS
Polaris Group is pleased to offer the following ***CEU approved*** live Webinars

	Date
Final Regulations Impacting LTC Training	
Overview of Final Regulations Impacting LTC *New Topic	2/9
5 Star & Coding Tips for GG Training Series	
Overcome 5 Star Anxiety	2/9
Section GG Coding Tips	2/10
Pain & B&B Management Training Series	
Pain & Management in LTC	2/15
Bowel & Bladder Management	2/22
Writing a Plan of Correction Training	
Writing a Plan of Correction	2/21
ADL Coding Training	
Master ADL Coding - Improve Your CMI & ADL Scores	2/23

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

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Training Workshops for LTC Current 2017 Dates & Locations:

Medicare & PPS Compliance for SNFs
May 16-18 Orlando, FL
July 18-20 Las Vegas, NV

Surviving MAC/RAC/ZPIC Audits
February 8-9 Las Vegas, NV
November 8-9 Orlando, FL

SNF Billing - Basics & More
March 21-23 Las Vegas , NV
June 13-15 Chicago, IL
September 19-21 Orlando, FL

Advanced Billing for SNFs
April 18-20 Dallas, TX
August 22-24 Las Vegas, NV
November 14-16 Tampa, FL

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