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An Informational Bulletin Brought To You By Polaris Group

2017 Onsite HIPAA Audits

The Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations require health care providers and organizations, as well as their business associates, develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, verbal, and electronic.

The Office for Civil Rights (OCR) is responsible for enforcing the Privacy and Security Rules. They are currently conducting HIPAA audits that target all types of healthcare organizations. OCR is currently in Phase II of its HIPAA audit program, in which OCR identified covered entities for audit in the summer of 2016 and business associates in the fall of 2016. In early 2017, OCR is set to identify additional entities for audit.

The initial stages of Phase II focused primarily on desk audits. The audits in Phase II, set to begin in March 2017, will move to onsite audits and will examine a broader scope of HIPAA requirements than the desk audits. While OCR describes the audits as "primarily a compliance improvement activity," OCR has noted that serious issues identified in the audit process could lead to compliance reviews.

The process begins with an email from OSOCRAudit@hhs.gov that requests verification of entity contact information. Once contact information is obtained, OCR will send a questionnaire for the purpose of gathering demographic data. The demographic data collected from the questionnaire will then be complied to create a pool of audit candidates, representing a wide range of organizational sizes, types and geographic locations. Audit candidates will then be randomly selected from this audit pool. If your skilled nursing facility received the OCR questionnaire, it has been included in the audit pool and is subject to a potential audit.

Steps that covered entities and business associates can take to prepare:

- Complete a Risk Assessment to review appropriate safeguards are in place for PHI in any form (e.g. electronic, paper, and verbal)
- Ensure all action items identified in the Risk Assessment have been completed or are in the process of being complete
- Complete an inventory of business associates and their contact information
- Have document safeguards for all addressable security standards and documented the reasons why unaddressed items have not been appropriately implemented
- Implement a breach notification policy that aligns with the Breach Notification Standards
- Complete training on the HIPAA Standards that are necessary or appropriate for workforce members to perform their job duties
- Have readily available a Notice of Privacy Practices compliant with the Omnibus Final Rule
- Maintain an inventory of information system assets, including mobile devices
- All systems and software that transmit electronic PHI employ encryption technology, or that the organization has a documented risk analysis supporting the decision not to employ encryption
- Adopt a facility security plan for each physical location that stores or otherwise has access to PHI, in addition to a security policy that requires a physical security plan.

At the end of 2016, OCR had more than 200 desk audits underway with both covered entities and business associates. The audits took an in-depth look at the policies and procedures of each organization in respect to complying with the HIPAA Privacy, Security and Breach Notification Rules. OCR has indicated that the Phase 2 audits are the start of a more permanent audit program.

To read the complete HIPAA Privacy, Security, Enforcement, and Breach Notification Final Rule; http://www.polaris-group.com.

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Provider Enrollment Revalidation

The Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

To maintain Medicare billing privileges, a Skilled Nursing Facility (SNF) must resubmit and recertify the accuracy of its enrollment information. Due dates are established on their last successful revalidation or initial enrollment, approximately every 5 years for Skilled Nursing Facilities. Revalidation ensures that your enrollment information on file with Medicare remains complete and up-to-date.

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Steps for Revalidation:

- Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation; **Do not submit a revalidation application if there is not a listed due date.** The Revalidation Lookup tool is updated every 60 days and providers should periodically check the tool to identify if any new providers have been assigned a revalidation due date. The list will include all enrolled providers. Those due for revalidation will display a revalidation due date, all other providers or suppliers not due for revalidation will display a "TBD" (To Be Determined) in the due date field. This means that you do not yet have a due date for revalidation.

- Providers should receive a request to revalidate from CMS within 2-3 months prior to their revalidation due date either by email (to email addresses reported on your prior applications) or regular mail indicating the provider/supplier's due date. If you haven't received your request to revalidate make sure to check that Medicare has the correct address for your facility.

- Providers/suppliers who are within 2 months of their listed due dates on https://data.cms.gov/revalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur complete the following steps:

- Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; **or**
- Complete the appropriate CMS-855 application available at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/enrollmentapplications.html;
- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

For the complete CMS Medicare Learning Network document go to; http://www.polaris-group.com.

Clarification on Notice of Medicare Non-Coverage

The Notice of Medicare Non-Coverage (NOMNC) is a CMS required form provided to beneficiaries', to give them the opportunity to appeal the facilities decision to end their Medicare Part A skilled services. A Medicare health provider must give an advance completed copy of the NOMNC to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of Medicare Part A services. The instructions when completing the NOMNC form asks for a "member" number but the actual form asks for a "patient" number. Recently, the Quality Improvement Organizations (QIOs) have cited NOMNCs invalid

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because facilities have been using the patient's Medicare Health Insurance Claim (HIC) number for the "member" number.

The NOMNC instructions for the patient/member number says: "Providers may fill in the beneficiary's / enrollee's unique medical record or other identification number. The beneficiary's / enrollee's HIC number must not be used". If the facility decides to complete the Patient Identification Number section, which is optional, then the patient/member number should not be their HIC/Medicare number.

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

Question:
We have a resident who has exhausted their benefits. Should we provide them with a NOMNC (Notice of Medicare Non-Coverage)?

Answer:
No because the NOMNC is provided to give the beneficiary an opportunity to request an immediate independent review of the facilities proposed discontinuation of the skilled covered services. When the patient exhausts their benefits they have no further covered post-acute skilled services available under Medicare Part A.

Question:
The Medicare End of PPS assessment is not needed if a resident expires while in a SNF, correct?

Answer:
That is correct. In Chapter 3 of the RAI under Section A2400 Coding Tips and Special Populations, page A-33 it says: "If the End Date of Most Recent Medicare Stay (A2400C) occurs on the same day that the resident dies, a Death in Facility Tracking Record is completed, with the Discharge Date (A2000) equal to the date the resident died. In this case, a Part A PPS Discharge assessment is not required".

Question:
How do I show CMS that we are billing for a resident in the CJR (Comprehensive Care for Joint Replacement) demonstration project and the resident did not have a 3-day qualifying stay?

Answer:
You would put a "75" code on the UB04 in field locater 63: Treatment Authorization Codes Section.

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

	Date
New PT/OT Therapy Codes Training	
New PT/OT Therapy Codes *New Topic	3/14
MDS 3.0 Training Series	
MDS 3.0 Part 1 Basics & More	3/20
MDS 3.0 Part 2 Clinical Nursing Sections 3/22	
MDS 3.0 Part 3 Sections G, GG & O	4/17
MDS 3.0 Part 4 Interviews & More	4/19
Fall Management & Managed Risk Trainings	
Fall Management Program	3/24
Managed Risk/Event Reporting	3/28
RUG IV Training Series	
RUG IV Qualifiers & MDS Coding Part 1	3/29
COT, EOT, SOT Combinations & More Part 2	4/11
PPS Systems & Management Part 3	4/12
QAPI Training Series	
Preparing for QAPI Part 1	3/30
Quality Assurance (QA) Skill Building QAPI Part 2	4/4
Process Improvement (PI) Skill Building Part 3	4/6

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

POLARIS GROUP LTC TRAINING INSTITUTE

Comprehensive 3-day training workshops to implement a

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
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

POLARIS PULSE is an informational newsletter distributed to **POLARIS GROUP** clients. For further information regarding services or information contained in this publication, please contact **POLARIS GROUP** corporate headquarters at 800-275-6252.

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