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□ **ANOTHER ICD-10 DELAY:
USE THE EXTRA TIME WISELY**
PAGES 1 & 2

□ **STARK SELF-REFERRAL
DISCLOSURE PROTOCOL:
RECENT UPDATES AND
LESSONS LEARNED**
PAGES 3 & 4

□ **QUARTERLY CHECK-UP**
PAGE 5

Another ICD-10 Delay: Use the Extra Time Wisely

HHS considers the one-year delay a “reasonable compromise” between the incremental costs that a delay imposes on hospitals ready for compliance in 2013 and the additional time that many providers need to become compliant.

On April 17, 2012, the Department of Health and Human Services (“HHS”) published a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the International Classification of Diseases, 10th Revision, diagnosis and procedure codes (“ICD-10”).

All “covered entities,” as defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), are required to adopt ICD-10 codes for use in all HIPAA transactions with dates of services on or after the October 1, 2014 deadline. Providers who will transmit electronic claims using ICD-10 codes should have transitioned from Version 4010/4010A1 to Version 5010 of the electronic transaction standards by January 1, 2012.

HHS cites a few reasons for the delay. First, the transition to Version 5010 did not go as smoothly as expected, and the transition to ICD-10 will be much more cumbersome. Additionally, providers seemed concerned about a lack of resources due to competing statutory initiatives. Finally, several surveys showed a lack of readiness for the transition.

In announcing the delay, the Secretary of HHS, Kathleen Sebelius, stated that HHS is “committ[ed] to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system.” HHS considers the one-year delay a “reasonable compromise” between the incremental costs that a delay imposes on hospitals ready for compliance in 2013 and the additional time that many providers need to become compliant.

ABOUT ICD-10

The ICD-10 manual consists of two parts:

1. ICD-10 CM for diagnosis coding
2. ICD-10 PCS for inpatient procedure coding

ICD-10 CM is for use in all U.S. health care settings, while ICD-10 PCS is for use in the U.S. inpatient hospital setting only. **CONTINUED ON PAGE 2**



Another ICD-10 Delay: Use the Extra Time Wisely (Continued)

ICD-9

Diagnosis Codes are 3-5 characters

Inpatient Procedure Codes are 3-4 characters

Approximately 13,000 Diagnosis Codes;
3,000 Inpatient Procedure Codes

Limited capacity for new codes

Ambiguous detail in description

Code does not identify right versus left

ICD-10

Diagnosis Codes are 3-7 characters

Inpatient Procedure Codes are 7
alpha-numeric characters; all required

Approximately 68,000 Diagnosis Codes;
72,081 Inpatient Procedure Codes

Flexible for new codes

Very specific detail in description

Code identifies right versus left

The transition to ICD-10 is designed to catch up with current medical practice. ICD-9 is over 30 years old, has outdated terms and produces limited data about patients' medical conditions. ICD-10 will have the ability to grow with the medical industry, while ICD-9 limits the number of new codes that can be created. The Obama Administration believes that the ICD-10 codes provide more robust and specific data that will help improve patient care, better track the nation's health and enable the exchange of our health care data with other countries already using ICD-10.

TIPS ON HOW TO USE THE EXTRA TIME

Providers may be inclined to take a break from ICD-10 preparation. However, as the industry learned from the recent Version 5010 upgrade, there may be unanticipated challenges, and the extra time will be welcomed. Following are some recommendations for how to use the extra year productively.

1. Training and hiring billing staff.

With an extra year to prepare, providers should use the extra time to reevaluate coder training and hiring. The American Health Information Management Association estimates that, initially, it will take roughly twice as long for a coder to code under ICD-10, and providers should expect a permanent 20% loss of coding productivity. Coders should be well versed in anatomy and physiology, medical terminology and appropriate querying processes. Providers may also consider computer-assisted coding technology as a potential tactic to reduce adverse impacts of reduced productivity.

2. Expand clinical documentation improvement.

One of the biggest misconceptions about ICD-10 is that it only affects coders, billers, payers and computer systems. With the transition to ICD-10, some documentation issues will require physicians to capture new and updated information in the medical record. The extra year would be well spent educating physicians, who may have the greatest potential impact on revenue. Although physician attention may be hard to obtain, providers should consider ways to engage or otherwise incentivize physicians to learn the important role they will play in the upgrade process to ICD-10.

3. Financial plan.

Industry experts from CMS anticipate that denial rates will increase by 100%, accounts receivable days will be extended by 20-40% and claims error rates will increase by 4%. Providers should continue to analyze and prepare for the effects the ICD-10 transition will have on cash flow.

4. Talk with vendors and payers.

Although providers may feel prepared for the ICD-10 transition, payers and vendors may not be. Payers' lack of preparedness will have an impact on providers' cash flow during the beginning phase of the transition. Providers are encouraged to talk with vendors and payers to determine how they plan to handle the transition.

5. Provider-specific analysis.

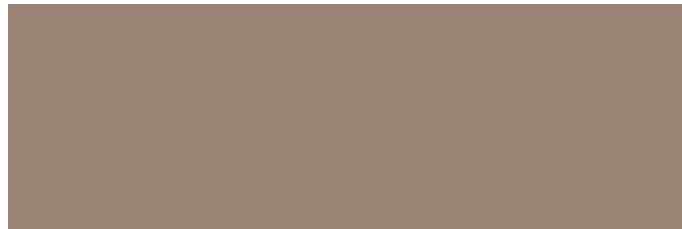
Providers should continue to analyze the impact of ICD-10 on their particular service lines and case mix. Although the ICD-10 conversion is designed to be revenue neutral, some diagnosis related groups and professional codes may become more financially attractive than others. Preparing a provider-specific analysis will help providers be more financially prepared for the transition.

6. Administrative review.

There are many administrative burdens that may have been overlooked as providers scrambled to meet the 2013 deadline. For example, provider bylaws and policies should be updated to maintain compliance with the ICD-10 requirements. Additionally, payer contracts, which may be based on older codes, may need to be updated. Providers should use the extra time to review any administrative processes that may have been overlooked.

Should you have questions, please do not hesitate to contact your regular Hall Render attorney. Please visit hallrender.com/hcr for information and resources regarding health care reform issues and regulations. ■





Stark Self-Referral Disclosure Protocol: Recent Updates and Lessons Learned

Since the creation of the Self-Referral Disclosure Protocol ("SRDP") on September 23, 2010, 150 providers have used the SRDP to disclose violations of the federal Stark Law to the Centers for Medicare and Medicaid Services ("CMS"). Although the volume and complexity of the submissions have created a significant backlog in unresolved cases, a March report to Congress and other communications and education by CMS officials, including four new frequently asked questions posted on the CMS website limiting the length of the lookback period, offer additional insight into the process for disclosing violation of the federal Stark Law to CMS.

Per Section 6409 of the Patient Protection and Affordable Care Act ("the Act"), the SRDP was developed by CMS to allow health care providers to disclose violations of the federal Stark Law. The Act also granted CMS the authority to reduce the amount due and owing for violations of the Stark Law voluntarily disclosed to the government. Prior to the enactment of the Act, CMS had limited authority to compromise overpayments associated with violations of the Stark Law, and alternative avenues to disclose violations were not appropriate for all circumstances or were foreclosed due to the nature of the violation.

In its statutorily required "Report to the Congress: Implementation of the Medicare Self-Referral Disclosure Protocol" (the "Report") issued in March, CMS described the implementation of the SRDP and the status of the disclosures to date. The Report revealed that CMS received 150 disclosures from 148 providers, including 125 hospitals, since the SRDP was first published over 18 months ago. Eight of the disclosures have been resolved through settlement, one hundred are still currently under CMS review or require additional information from the disclosing party, nine disclosures have been withdrawn by the disclosing party, three have been referred to law enforcement for resolution and twenty are in "administrative hold." The Report provides little additional information about the nature of the disclosed arrangements, other than to note that the most common violations involve a failure to comply with the Stark Law personal services exception, nonmonetary compensation exception, rental of office space exception and physician recruitment arrangement exception.

Because CMS has released only limited information about the 150 disclosed arrangements and eight settlements, it remains difficult for disclosing parties to

predict how CMS might settle other SRDP cases. The settlement amounts of the eight disclosures posted on the CMS website do seem to indicate, however, that CMS is using its authority under the Act to reduce the penalties for providers that voluntarily come forward and disclose Stark Law violations under the SRDP. In addition, the Report and other communications and education from CMS related to the SRDP reveal some best practices when disclosing under the SRDP. For instance, providers should make sure their disclosures are structured in conformance with the SRDP, include an element-by-element legal analysis of each applicable exception under the Stark Law, describe how the violation or violations were identified and describe how each disclosed arrangement was terminated or rectified. CMS has stated that submitting a well-organized disclosure that follows the outline in the SRDP will facilitate the review process.

The most significant SRDP development since its creation may be the recent guidance from CMS limiting the applicable lookback period when calculating the financial analysis.

CONTINUED ON PAGE 4



Stark Self-Referral Disclosure Protocol: Recent Updates and Lessons Learned (Continued)

Since the creation of the SRDP, CMS has taken the position that the potential overpayment should be calculated for the entire period of the noncompliance, even when that period extends beyond the time when CMS could seek recoupment.

This requirement represented a substantial burden on providers, in some cases, resulting in providers searching for financial information that may no longer exist.

In April, however, CMS posted four new FAQs clarifying that a disclosing party may limit both its disclosure of the total amount of remuneration a physician received as a result of a potential violation, and its financial analysis of the total amount potentially due and owing as a result of a potential violation, to the time frame for reopenings established in 42 C.F.R. § 405.980(b). Except in cases of fraud, this provision generally establishes a four-year reopening period for good cause. This guidance is noteworthy since, in its recent proposed rule addressing reporting and returning overpayments, CMS proposed a 10-year lookback period for returning overpayments and proposed to amend the reopening rules accordingly. CMS acknowledged the proposed rule in the FAQs and expressly stated that providers can rely on the current reopening time period when making disclosures through the SRDP until the proposed rule is finalized. At the very least, the new guidance provides temporary relief to providers disclosing Stark violations through the SRDP and may signal that CMS has heeded the industry's overwhelming objection to the proposed 10-year lookback period.

The SRDP can be an effective remedy for a provider to resolve any potential liabilities related to a violation of the Stark Law. In addition to CMS's authority to reduce the amount due and owing related to the violations, disclosing under the SRDP suspends the obligation to return identified overpayments within 60 days as required by Section 6402 of the Act. Providers should carefully analyze the facts and circumstances surrounding a potential Stark Law violation before determining the best course of action for resolving the matter. ■





Quarterly Check-Up

Regular and Dependable Attendance Is an Essential Job Function for a Nurse. The Ninth Circuit Court of Appeals determined that it was unreasonable for an employee to request complete exemption from the hospital's attendance policy as an accommodation for her fibromyalgia. <http://tinyurl.com/7ry8zz7>

OFCCP TRICARE Webinar Clarifies Some Health Care Jurisdiction Issues. The OFCCP clarified several points and positions, including their view that the National Defense Authorization Act is not retroactive, its rescission of Directive 293 and that Medicaid and Medicare Parts A and B are outside of its jurisdiction. <http://tinyurl.com/7n3v8dy>

New EEOC Age Discrimination Rule on "Reasonable Factors Other Than Age" – Effective April 30. On March 30, 2012, the EEOC published its final rule clarifying that the ADEA prohibits policies and practices that have the effect of harming older individuals, unless the employer can show that the policy or practice is based on a reasonable factor other than age (such as physical fitness tests and reductions in force). <http://tinyurl.com/88mmoyy>

We Are Being Audited by ICE – Should We Go Back and Fix Our Problems Now?! When faced with an ICE audit, it is imperative to be transparent, treat all workers fairly and to act in accordance with ICE guidelines (without requiring additional information/procedures from the employees). <http://tinyurl.com/7veulwf>

Right to Work: Now There Are Twenty-Three. On February 1, 2012, Indiana became the 23rd state to adopt a statute that prohibits private employers and unions from entering into agreements that compel union membership and the payment of dues and fees as a condition of employment. <http://tinyurl.com/86hgt73>

As Physician Acquisitions Thrive, So Do Antitrust Enforcement Actions. The FTC, DOJ and state attorneys general have taken note of the consolidation trend and are on the lookout for vertical acquisitions that could lead to market power and increased prices. <http://tinyurl.com/7mx8bt9>

Pharmacies Beware, Wholesalers May Start Closely Scrutinizing Your Purchasing Habits of Controlled Substances. The DEA alleged that the wholesaler posed an immediate danger to the public because it failed to maintain effective controls that would protect against illegitimate controlled substance distribution when four of its pharmacy clients dispensed abnormally high volumes of controlled substances. <http://tinyurl.com/73zyjpd>

Update: False Claims Exposure in Credentialing and Peer Review. In a recent settlement for \$840,000, the government alleged that, because there was evidence that a physician in the cath lab lacked the necessary training for endovascular procedures, the relevant claims submitted were false claims. <http://tinyurl.com/78hgody>

Impact of Retaliatory Motive on Peer Review Immunity. The Maryland Court of Appeals examined allegations of retaliatory peer review action against a physician who accused the hospital of providing poor patient care, concluding that the physician failed to establish a connection between the allegations and the peer review action. <http://tinyurl.com/6s4ojkh>

What's Going on with the CMS Self-Referral Disclosure Protocol? – Recent Developments. CMS recently published two additional Self-Referral Disclosure Protocol settlements, as well as its statutorily required report to Congress. <http://tinyurl.com/7uxvzww>

Federal Mandate for No-Cost Women's Contraceptive Services Continues to Receive Scrutiny. President Obama has announced that his Administration will continue to mandate that employers provide contraceptive services to female health plan participants without cost sharing, with an exception for religious employers that will be clarified in future rulemaking. <http://tinyurl.com/6r6qbrf>

New HITECH Regulations on the Horizon. It is estimated that HHS will publish the anticipated HITECH regulations addressing four separate rulemakings in mid to late June. <http://tinyurl.com/d6vqsjr>

IRS Comments on Exempt Organization Governance Study and Significant Diversion of Assets. The Director of the Exempt Organizations Division at the IRS reported findings from a study involving governance practices of exempt organizations. Good governance will continue to be a focal point for the IRS. <http://tinyurl.com/cuthyr2>

Community Health Needs Assessment: The Time to Act Is Now. Preparing and publicizing the Community Health Needs Assessment ("CHNA") documents will take extensive effort; thus, hospitals should act now. Hospitals with a July 1 fiscal year have until June 30, 2013 to complete their first CHNA and implementation strategy, whereas calendar year organizations have until December 31, 2013. <http://tinyurl.com/cqhdxe4>

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