

Health Law ADVISORY

Current legal insights for health care executives

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RAC SERIES: Vulnerability Issue: An Example – Chest Pain-Related One-Day Stays

This article is the fifth in the series on Recovery Audit Contractor (RAC) Audits. In the first parts of this series, we covered the basic facts and history of the RAC program, the key steps in preparing for RAC audits, strategies for defending RAC denials and RAC identification of “vulnerability issues” and medical records requests. This article focuses on one likely vulnerability issue: cardiac-related one-day stays.

As indicated in the prior article, the RACs were required to identify vulnerability issues as a part of their Project Plans for the base contract year. Those vulnerability issues will be announced at Provider Outreach meetings which are currently being scheduled for Iowa and Nebraska. The Iowa programs will be held on August 25, 2009, at Iowa Methodist Medical Center, with alternative morning and afternoon sessions. Information is available through the Iowa Hospital Association and Iowa HFMA. The Nebraska Hospital Association reports that RAC outreach meetings will occur in late August, but the dates and times have not yet been confirmed by CMS. NHA is negotiating for two meetings, one in Eastern Nebraska and another in Greater Nebraska.

Based on experience in the demonstration states and those states that have had early RAC implementation, it is anticipated that cardiac-related one-day inpatient stays will be an identified vulnerability issue. Vulnerability issues will be identified by RACs based on groundwork laid by fiscal intermediaries and quality improvement organizations, as well as the Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG) and other federal agencies and programs evaluating the efficiency of the Medicare program from time to time. In the demonstration states, RACs targeted inpatient rehabilitation facility admissions, respiratory with ventilator coding, excisional debridement documentation, three-day admissions as prequalification for skilled nursing, and chest-pain related one-day stays. For purposes of example, this article addresses chest-pain related one-day stays and the evidence relied upon by the RACs to identify overpayments.

Under the Prospective Payment System (PPS), one-day stays have long been a concern for enforcement by the OIG, because PPS hospitals receive the full DRG payment for Medicare regardless of whether the inpatient was present for one

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day or for many days, and because inpatient reimbursement is higher than that for outpatients. In 2001, the OIG reported that the number of one-day stays increased 57% from 1990 to 1997. In 1990, 6.8% of Medicare inpatients were one-day stays, increasing to 10.7% by 1997.

It has been reported that 4.4 million patients present to the emergency department with chest pain each year and are admitted to inpatient care. CMS contracted with the Arizona and Florida Quality Improvement Organizations (QIOs) to design and implement special projects to reduce unnecessary hospital admissions for Medicare patients with chest pain using a 2004 case management protocol (CMP) to assign the proper admission status. Of these short stay admissions, admissions under DRG 143-chest pain were the least likely to meet medical necessity for an inpatient level of care (81% denial rate). After that initial step in the project, the two QIOs proceeded to conduct baseline analyses of 2005 Medicare admissions for DRG 143-chest pain using nationally recognized criteria to screen samples of medical records of short-stay admissions to hospitals with high numbers of DRG 143 discharges. The Arizona QIO found a 93.5% error rate. The Florida QIO implemented a two-level review, including physician chart review. Sixty-nine percent of the admissions reviewed failed both levels of review. These QIOs recommended chest pain admission criteria for use within their states. Among participating hospitals in Florida, there was a reported 67% reduction in projected admission denials and a 48% overall reduction in chest pain discharges.

It is anticipated that RACs will use this evidence-based analysis to identify hospitals with high levels of DRG 143-chest pain discharges, and request medical records for short stays to determine whether they should have been admitted to outpatient observation rather than acute inpatient

care. The Tennessee Hospital Association has published national data on total discharges per DRG and the percentage of one-day stays under those discharges. Of 194,086 total Medicare discharges for DRG 143-chest pain during FYE 2007, 45% were one-day stays. Hospitals exceeding that percentage can expect a high level of medical record requests for chest pain discharges. These cases will likely be viewed as low-hanging fruit by the RACs for denial and processing as overpayments.

The seriousness of these cases is underscored by a 5-year Corporate Integrity Agreement (CIA) between the OIG and Saint Joseph's Hospital of Atlanta, Inc., dated December 2007, and available on the OIG Web site. We understand that the CIA was one component of a settlement that included payment in lieu of penalties under the False Claims Act, based on a whistleblower claim relating to one-day stays. The CIA requires extensive training of billing, clinical, and case management personnel, and professional accreditation or certification of case management personnel. Monitoring will be internal and external. Admissions are required to be handled pursuant to an Admit to Case Management/Utilization Review Protocol, presumably similar to the case management protocols described above with regard to chest pain cases. The Hospital is required to retain an Independent Review Organization to carry out annual Inpatient Medical Necessity and Appropriateness Reviews, the standards of which are set out in detail, including definitions of varying lengths of stay. The CIA contains many OIG oversight and reporting obligations common to CIAs.

What is the difference between a hospital's experience with one-day stays that precipitate RAC attention as opposed to whistleblower and OIG attention? Presumably, it is all a measure of the degree of error, which is in turn interpreted for purposes of determining whether there was

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evidence of intent to defraud the Medicare program.

In anticipation of RAC audits of PPS hospitals' chest-pain related one-day stays, some hospitals have engaged external consultants to review medical records and Medicare claims to determine their preparedness and exposure. Some such consultants have recommended repayment in advance of the RAC audits to show the hospitals' good faith and to reduce risk of whistleblower claims. In some instances, administrators may be motivated to repay marginally defensible claims for one-day stays in order to deprive the RACs of the contingent fees they would receive by auditing this "low-hanging fruit."

Not surprisingly, these external audits conclude with recommendations that hospitals adopt case management protocols similar to those implemented in Florida, Arizona and under the Saint Joseph Hospital CIA, described above. PPS hospitals which have not analyzed their exposure for denial of DRG 143-chest pain should do so.

The evidence-based approach taken by the RACs on chest-pain inpatient admissions changes the enforcement strategy of CMS from a clinical case review conducted by the QIOs to a statistical approach more consistent with a collections agency mentality. That shift will necessitate a shift in providers' defensive strategies, which must be proactive in the form of statistical analysis.

An analysis similar to that of the DRG 143-chest pain cases will be applied by the RACs to determine the medical necessity of three-day hospital inpatient stays as prequalification for Medicare skilled nursing benefits. This vulnerability issue will apply to non-PPS hospitals just as to PPS hospitals.

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The "Five Principles" of Health Care Reform

In June 25, 2009 testimony before the House Energy and Commerce Committee Subcommittee on Health, Inspector General of the Department of Health and Human Services (DHHS) Daniel R. Levinson announced a "comprehensive strategy to combat fraud, waste, and abuse to ensure that the Federal health care programs remain solvent and best serve the need of beneficiaries."

The testimony included a description of the Health Care Fraud Prevention and Enforcement Team (HEAT), a joint task force launched May 20, 2009 as a collaboration between DHHS and the Attorney General's Office. One of the activities of HEAT is to expand the OIG-Department of Justice (DOJ) "Strike Force" in South Florida to other metropolitan areas of the country. Levinson explained that the Strike Forces use "advanced data analysis" techniques to "identify criminals operating as health care providers and to detect emerging or migrating fraud schemes." Strike Force activities will also expand to preventive strategies including site visits to DME suppliers to be sure that the suppliers are "legitimate businesses and not criminals."

Inspector General Levinson identified the following "program vulnerabilities:" durable medical equipment, home health/ personal care services, prescription drugs, Medicaid-specific services, *e.g.*, school-based health services, case management services and disproportionate share payments, other outpatient services, including diagnostic

In FY 2008, OIG investigations resulted in 455 criminal actions against individuals or entities that engaged in crimes against departmental programs and 337 civil and administrative actions, which included the False Claims Act and unjust enrichment lawsuits filed in Federal District Court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. Also in FY 2008, OIG excluded from Federal Health Care programs 3,129 individuals and entities for fraud or abuse that affected Federal health care programs and beneficiaries.

services performed in physical offices and inpatient services.

The keystone of the testimony was the unveiling of the Five Principle strategy to combat health care fraud, waste and abuse which will be followed to develop a national health care strategy:

1. Enrollment. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.
2. Payment. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
3. Compliance. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.
4. Oversight. Vigilantly monitor programs for evidence of fraud, waste, and abuse.
5. Response. Respond swiftly to detected fraud, impose sufficient punishment to deter others and promptly remedy program vulnerabilities.

The testimony strongly indicates that there is increasing sophistication, organization and collaboration among key government agencies in aggressively identifying program fraud and abuse in high risk areas, targeting both specific program vulnerabilities and geographic areas in which higher incidence of illegal activities occur.

Julie A. Knutson

Amended Iowa County Hospital Statutes

Iowa House File 260, which was recently signed into law, makes substantial revisions to the Iowa county hospital rules. These changes go into effect on July 1st. The amendments made some minor changes regarding the composition of the board, but generally speaking, the amendments are intended to modernize the powers and duties of county hospital boards to make them more closely resemble the powers and duties of other private non-profit boards. Below are some summary comments addressing the major changes to the powers and duties of county hospital boards.

1. Fiduciary Duties.

The amendments expressly impose fiduciary duties on county hospital trustees. While there has always been an assumption that county hospital trustees owe a duty of loyalty and good faith to the hospital, county hospital trustees are now specifically required to act in the same fiduciary capacity as non-profit board members. Accordingly, each member must discharge his or her duties as a trustee in good faith and in a manner the trustee reasonably believes to be in the best interests of the county hospital exercising the care that a person in a like position would reasonably believe to be appropriate under similar circumstances.

In discharging these duties, a trustee is entitled to rely, to some extent, on the information, opinions, reports or statements, including financial statements and other financial data, of officers or employees of the hospital, legal counsel,

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public accountants or other persons with similar skills or expertise. When a trustee so relies upon the opinion of an “expert,” the trustee must have a reasonable belief that the matter is within that particular person’s professional competence or is one in which the particular person merits confidence. Of course, a trustee is not entitled to rely on the advice of “experts” if he or she has actual knowledge that would make such reliance untenable.

2. Investment of Hospital Funds.

The amendments also permit county hospital boards broader discretion in investing county hospital funds, including the hospital’s depreciation fund. Specifically, county hospital funds must be managed and controlled under what is essentially a “prudent person” standard.

The amendments also explicitly enumerate which types of investments are permissible. Most importantly, county hospitals are now permitted to invest funds in common stock. Prior to these amendments, the Attorney General had opined that county hospitals were not permitted to take ownership interests in private organizations, thus prohibiting the ownership of common stock. In addition to allowing the purchase of common stock, county hospitals are now also legally authorized to invest in the following:

- (1) U.S. Bonds;
- (2) certain certificates of deposit;
- (3) prime bankers’ acceptances that mature within 270 days and that are eligible for purchase by a federal reserve bank, provided that, at the time of purchase, no more than 10 percent of the investment portfolio shall be in investments authorized by this subparagraph and that at the time of purchase no more than 5 percent of the investment portfolio shall be invested in the securities of a single issuer;

(4) commercial paper or other short-term corporate debt that matures within 270 days and that is rated within the two highest classifications, as established by at least one of the standard rating services approved by the superintendent of banking by rule adopted pursuant to Iowa Code chapter 17A, provided that, at the time of purchase, no more than 5 percent of all amounts invested in commercial paper and other short-term corporate debt shall be invested in paper and debt rated in the second highest classification, and provided further that at the time of purchase no more than 10 percent of the investment portfolio shall be in investments authorized by this subparagraph and that at the time of purchase no more than 5 percent of the investment portfolio shall be invested in the securities of a single issuer;

(5) repurchase agreements whose underlying collateral consists of U.S. Bonds if the political subdivision takes delivery of the collateral either directly or through an authorized custodian. Repurchase agreements do not include reverse repurchase agreements;

(6) open-end management investment companies registered with the federal securities and exchange commission;

(7) joint investment trusts organized pursuant to Iowa Code chapter 28E prior to and existing in good standing on the effective date of this Act or a joint investment trust organized pursuant to chapter 28E after April 28, 1992, provided that the joint investment trust shall either be rated within the two highest classifications by at least one of the standard rating services approved by the superintendent of banking by rule adopted pursuant to chapter 17A and operated in accordance with 17 C.F.R. § 270.2a-7, or be registered with the federal securities and exchange commission under the federal Investment Company Act of 1940, 15 U.S.C. § 80(a), and operated in

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accordance with 17 C.F.R. § 270.2a-7. The manager or investment advisor of the joint investment trust shall be registered with the federal securities and exchange commission under the Investment Advisor Act of 1940, 15 U.S.C. § 80(b); and

(8) warrants or improvement certificates of a levee or drainage district.

Not surprisingly, futures and options contracts continue to be impermissible investments.

3. Proceeds from the Sale of Property Acquired by Gift.

Property received by a county hospital board via gift, devise or bequest, if sold, is no longer required to be sold pursuant to a public sale. Likewise, the proceeds from such a sale are no longer required to be used for the retirement of hospital bonds, repairs or improvements of property or the purchase of equipment. The proceeds of any such sale may be applied towards any lawful purpose so long as the use is explicitly approved by the board.

4. Sale or Lease of Property and Public Vote.

A county hospital board is no longer required to obtain the vote of residents in order to sell or lease hospital sites or buildings, unless such a sale or lease will result in the county hospital being operated as a private hospital or a merged area hospital. The board must only provide public notice of such a sale and hold a hearing pursuant to the rules set forth in Iowa Code § 347.30.

5. Additional Lines of Service.

If the board determines that the hospital should offer additional lines of health care services, the statute explicitly grants the board “all of the powers and duties necessary for the management, control, and government of the institution, including

but not limited to any applicable powers and duties granted boards of trustees under other provisions of the Code relating to hospitals, nursing homes, assisted or independent living services, and other ancillary services irrespective of the chapter of the Code under which such an entity is established, organized, operated, or maintained, unless such provisions are in conflict with this section and section 347.13.” This language gives the board broad powers to operate other lines of business so long as those powers do not conflict with the powers and duties specifically granted to county hospital boards of trustees under the county hospital statutes.

The amendments also repealed many other outdated provisions such as those dealing with tuberculosis sanatoriums and other contagious diseases. Overall, these provisions are intended to improve the governance of county hospitals by updating the powers and duties of hospital trustees given the current times and bring them in line with current requirements of non-profit boards. Due to the wide variety of amendments, it may be necessary to amend organizational bylaws to ensure that they comport with the amended statutory language.

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Do You Have a Contract with an HMO? You May be a Federal Subcontractor with Affirmative Action Obligations

In recent years, the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP), the agency which enforces affirmative action regulations, has grown increasingly aggressive in its attempt to expand its jurisdiction over health care employers. Generally, the OFCCP enforces regulations that require employers with at least 50 employees, who hold a single contract or subcontract of at least \$50,000 to provide services to the federal government, to comply with certain affirmative action obligations, including maintaining an affirmative action program (AAP).

What is an AAP?

An AAP requires employers to track the gender, race, and veteran status of each individual who applies for a particular job, as well as analyze other employment practices, such as transfers, promotions,

and terminations, to ensure their practices reflect race- and gender-neutral employment processes. The OFCCP focuses intently on these employment practices, and holds that ignorance of the requirement to maintain the data is not an excuse for non-compliance.

The OFCCP also analyzes an organization's compensation practices to see whether they have a disparate impact on women and minorities. A few years ago, the OFCCP issued a guidance on employer compensation practices, that, among other issues, "recommended" that employers self-evaluate their practices to determine the existence of any current or potential disparate compensation concerns. While compensation analyses technically are not part of an AAP, the OFCCP is now training its compliance officers to conduct detailed evaluations of employer compensation practices during all AAP compliance reviews.

Does Your Organization Have Affirmative Action Obligations?

Many health care organizations have a direct contract with the federal government, and therefore have affirmative action obligations by nature of that contract. For instance, a hospital may be a covered contractor as a result of a contract with the Department of Veterans' Affairs or the Department of Defense, requiring the provision of medical services to active or retired military personnel.

At the same time, a health care provider may have affirmative action obligations by nature of being a *subcontractor* to someone with a federal contract. In relevant part, a "subcontract" is any agreement between a contractor and any person for the purchase, sale, or use of non-personal services (1) that in whole or in part, are necessary to the performance of any contract, and/or (2) under which any portion of the contractor's obligation under

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any contract is performed, undertaken, or assumed. Whether a health care provider's subcontracts bring it under the OFCCP's jurisdiction is a difficult inquiry, as it depends upon the nature of the underlying prime contract and the terms of the subcontract.

In a 2003 case entitled *OFCCP v. Bridgeport Hospital*, the DOL's Administrative Review Board ("Board") held that a hospital's contract with Blue Cross did not make it a subcontractor for affirmative action purposes. The Board held that because (1) the prime contract between Blue Cross and the agency was for *medical insurance*, and (2) the hospital was not in the business of providing insurance, the hospital was not a subcontractor because it did not perform work necessary to the performance of the prime contract to insure federal employees. Based on this decision, the consensus was that the OFCCP generally could not claim subcontractor coverage for hospitals, pharmacies or other medical care providers based solely upon the existence of a contract with Blue Cross or other Federal Employee Health Benefits Program (FEHBP) providers.

The OFCCP, however, did not give up its attempts to assert jurisdiction over health care providers, and began focusing on health care providers that have contracts with *health maintenance organizations* (HMOs). In May 2009, the OFCCP succeeded in its efforts. In *OFCCP v. UPMC Braddock*, the Board held that a hospital was a subcontractor by nature of its contracts with an HMO. In that case, the OFCCP sent a letter to three affiliated hospitals requesting a copy of their AAPs as part of a compliance review. The hospitals denied that the OFCCP had jurisdiction because they claimed they were not federal subcontractors. The Board disagreed. In finding that the hospitals were federal subcontractors, the Board made a distinction between an HMO and an insurance arrangement like the one at issue

in Bridgeport. Specifically, it held that, because the prime contract between the HMO and federal agency was to provide medical services to the federal employees, and the hospital provided medical services, the hospital was performing work necessary to the performance of the HMO's federal contract, which made them a subcontractor with affirmative action obligations.

The hospitals nevertheless argued that, even if they were federal subcontractors, they were never notified by the HMO of the HMO's federal contractor status, and therefore they did not agree to take on the obligations that come with being federal subcontractors. The Board rejected the argument, stating that the HMO's failure to notify the hospitals of their affirmative action obligations did not excuse the subcontractors' noncompliance. In other words, even if an organization does not know it is contracting with a federal contractor, the organization may nevertheless be bound by the affirmative action regulations.

What Does this Mean?

The *Braddock* decision suggests that any hospital or medical practice that has contracts with HMOs may have affirmative action obligations. The determining factor is whether the HMO has contracted with a federal agency to provide medical services to the agency's employees. Health care providers should review their contracts to determine whether the goods or services being provided might make them federal contractors who must implement an affirmative action plan. In this way, health care providers can be better prepared should the OFCCP contact them for a compliance review.

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Hospital Visitation for Same-sex Couples

Recent lawsuits have brought a lot of media attention to the hospital visitation rights of same-sex couples. The story of Janice Langbehn appeared in the *New York Times* on May 18, 2009. Ms. Langbehn was denied access to the room of Lisa Pond, Ms. Langbehn's partner for 18 years, after Ms. Pond collapsed from an aneurysm. Ms. Pond passed away while Ms. Langbehn tried to persuade hospital officials to let her visit, along with the couple's adopted children. A similar lawsuit is taking place in Washington state where Sharon Reed was denied access to her partner of 17 years, Jo Ann Richie, who was dying of liver failure.

The Nebraska legislature has adopted a provision that clarifies individuals' hospital visitation privileges. "A hospital patient who is nineteen years of age or older or an emancipated minor may designate, orally or in writing, up to five individuals not legally related by marriage or blood to the patient whom the patient wishes to be given the same visitation privileges as an immediate family member of such patient. The individual so designated shall have the same visitation privileges as an immediate family member of such patient." Neb. Rev. Stat. § 71-20,120 (Reissue 2003). The hospital is responsible for noting any designation or recession made by a patient in the hospital's record of the patient's health history and treatment. The couple must only express, orally or in writing, that the other be given the same visitation

privileges as an immediate family member. This Nebraska law is more favorable to the patient than are the more permissive terms found in HIPAA which allow, but do not require, hospitals to permit friends and family to have access to the patient.

Unlike Nebraska, Iowa does not have a statute outlining hospital visitation privileges. However, the same Iowa Supreme Court ruling that made national news for allowing same-sex couples to marry may have an impact on hospital visitation rights in Iowa. In many cases, hospital visitation privileges are extended to family members related by either blood or marriage. Because same-sex couples can legally marry in Iowa, these visitation privileges should extend to all married same-sex couples. Under HIPAA, hospitals may still rely on their professional judgment of what is in the best interest of the patient when the patient is unable to consent to allow visitation by friends and family beyond those related by blood or marriage.

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