Readmissions
Legal & Compliance Issues
from a Home Health Perspective

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Agenda

• History
• Importance
• Current Information
• Legal and Compliance Issues
• Proactive Steps
Overview

- History
- PPACA
- Post-PPACA
- Penalties
The Problem – for Medicare and Patients

- In 2005, 6.2% of hospitalizations among beneficiaries resulted in readmission within 7 days, 11.3% within 15 days, and 17.6% of hospitalizations resulted in readmission within 30 days.

- 84% of 7-day readmissions, 78% of 15-day readmissions, and 76% of 30-day readmissions were flagged as potentially preventable.

- Medicare spending on these potentially preventable readmissions is substantial: $5 billion for cases readmitted within 7 days, $8 billion for cases readmitted within 15 days, and $12 billion for cases readmitted within 30 days.

“Focusing on readmissions is a great way to tackle inappropriate use of hospital stays,” …[Readmissions are] “the intersection of three things we care about: cost, quality, and patient safety.”

Jane Brock, M.D., Colorado Foundation for Medical Care
Readmissions

Where are we today?

Recent Statistics

Recent Studies
Hospital Root Causes

Where does the Home Health Agency fit in?
Readmissions

Let’s talk about best practices for addressing avoidable readmissions.

What does that mean from a legal and compliance perspective?
Some Legal Issues to Consider:

- Patient confidentiality and privacy
- HIPAA
- Conditions of Participation
  - Medical Records
  - Discharge planning
  - Patient Choice
- Anti-Kickback Statute
Some Legal Issues to Consider:

- Civil Monetary Penalties Law
- Reimbursement
- Anti-trust
- Integration with other payment models
- State licensure
- Florida Laws

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A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.
(1) Covered entities: Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows: [ ]

(ii) For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506;

[ ]
A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

A covered entity may disclose protected health information for treatment activities of a health care provider.
The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
The treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.
The relationship between an individual and a health care provider in which:

- The health care provider delivers health care to the individual based on the orders of another health care provider; and
- The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.
A covered entity may disclose protected health information for the treatment activities of any health care provider (including providers not covered by the Privacy Rule). For example:

- A primary care provider may send a copy of an individual’s medical record to a specialist who needs the information to treat the individual.
- A hospital may send a patient’s health care instructions to a nursing home to which the patient is transferred.
HIPAA

Standard: Authorizations for uses and disclosures — (1)
Authorization required: General rule. Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section.

When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization.
Implementation specifications: Core elements and requirements — (1) Core elements. A valid authorization under this section must contain at least the following elements:

(i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
(ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
(iv) A description of each purpose of the requested use or disclosure.
(v) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
(vi) Signature of the individual and date.
In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of certain matters, including, without limitation, the individual's right to revoke the authorization in writing, the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, and the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.
HIPAA Business Associate Agreement:
iv. Exceptions to Business Associate. “. . . the HIPAA Rules currently describe certain circumstances, such as when a covered entity discloses protected health information to a health care provider concerning the treatment of an individual, in which a covered entity is not required to enter into a business associate contract or other arrangement with the recipient of the protected health information. We proposed to move these provisions to the definition of ‘business associate’ itself as exceptions to make clear that the Department does not consider the recipients of the protected health information in these circumstances to be business associates.”
Confidentiality

Medicare Conditions of Participation (Hospitals)

The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records.

Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.
Confidentiality

Interpretive Guidelines:

The hospital has sufficient safeguards to ensure that access to all information regarding patients is limited to those individuals designated by law, regulation, and policy; or duly authorized as having a need to know. No unauthorized access or dissemination of clinical records is permitted. Clinical records are kept secure and are only viewed when necessary by those persons having a part in the patient’s care.

The right to confidentiality means safeguarding the content of information, including patient paper records, video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the individual, parent of a minor child, or legal guardian. Hospital staff and consultants, hired to provide services to the individual, should have access to only that portion of information that is necessary to provide effective responsive services to that individual.
Confidentiality

State Law Provisions: Certain Florida law provisions:

Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(A) Licensed facility personnel, attending physicians, or other health care practitioners and providers currently involved in the care or treatment of the patient for use only in connection with the treatment of the patient.

(B) Licensed facility personnel only for administrative purposes or risk management and quality assurance functions.

(C) The agency, for purposes of health care cost containment.
Confidentiality

State Law Provisions: Certain Florida law provisions:

If the content of any record of patient treatment is provided under this section, the recipient, if other than the patient or the patient’s representative, may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose.
Confidentiality

State Law Provisions: Certain Florida law provisions:

Patient records shall have a privileged and confidential status and shall not be disclosed without the consent of the person to whom they pertain pursuant to Section 395.3025(4), F.S., but appropriate disclosure may be made without such consent to:

(A) Hospital personnel for use in connection with the treatment of the patient

(B) Hospital personnel only for internal hospital administrative purposes associated with the treatment, including risk management and quality assurance functions

(C) The Agency for Health Care Administration
Confidentiality

Certain additional Considerations

- Substance Abuse
- HIV/AIDS
- Mental Health
Anti-Kickback Statute

- Prohibits whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind: (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under Federal health care program.
Anti-Kickback Statute

- Prohibits whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person: (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.

- Remuneration includes kickbacks, bribes, or rebates
  - May be in cash or in kind
  - May be direct or indirect
Civil Monetary Penalties

- Statute
- Regulation
- Interpretative Guidance
Other Issues to Consider

- Reimbursement
- Anti-trust
- Florida laws
- State licensure
- Integration with other payment models
Certain Proactive Steps to Consider

- Are the people with the right expertise analyzing the issues? and at what point in time?
- Are Readmissions part of your compliance program?
- Are Readmissions part of your quality program? (Link between quality and compliance)
- What are your policies and procedures?
- How is your training and education?