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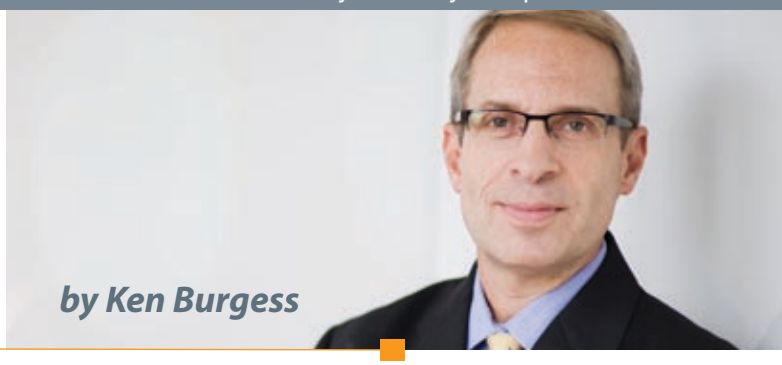
SHORTS ON LONG TERM CARE
for the North Carolina LTC Community from Poyner Spruill LLP

A Sign of the Times: Nonpayment of Resident Accounts, Transfer/Discharge and Related Issues



by Ken Burgess

It's surely a sign of economic times that Poyner Spruill's long term care lawyers have seen a marked increase in the number of clients calling us for assistance with nonpaying residents. While providers have seen facility-based reimbursement shrink from Medicaid and Medicare, and the number of private paying residents decline, residents too are feeling the pinch of devalued retirement investments, families are less able to help pay for their care, and other financial strains. Add to that the aggressive efforts of federal officials to "audit" and recoup dollars already paid to providers from RAC audits, ZPIC audits, and a host of other "look back" and recoupment efforts, and you have the perfect storm.

Given all that, we thought it would be a good time to review with providers and hopefully dispel some common notions about provider options for dealing with nonpaying residents.

"I HAVE A NONPAYING RESIDENT I CANNOT DISCHARGE BECAUSE NO OTHER FACILITY WILL TAKE THEM." We hear this one a lot, and it comes from federal OBRA requirements allowing a facility to discharge a resident who has failed to pay for care and services provided to a resident and the corresponding requirement that facilities ensure a "safe and orderly" discharge for the resident. Many providers interpret this to mean that they are responsible for finding a new location for the resident (whether an adult care home for residents who no longer need SNF care; home health services, or another SNF) and for working out the payment arrangements for that care and/or assuring the receiving provider of a payment source. Many elder care attorneys who represent residents appealing a notice of discharge also make this argument. However, it's legally incorrect. The Interpretive Guidelines to Surveyors published by CMS define a "safe and orderly" discharge as one in which the provider has made arrangements for safe travel to the resident's new location, and coordinates delivery of necessary records and paperwork to the new facility or care provider. *This requirement does not require the discharging facility to guarantee payment to the new provider for services provided to the resident.* In fact, legally a discharging provider has met its burden if and when it finds a new location, with the appropriate level of care, that will take the resident, **assuming** payment terms are met. It's very important in a discharge appeal before a hearing officer (these are handled by six or seven hearing officers from the Division of Medical Assistance) to remind him or her of this meaning of "safe and orderly" discharge and that working out payment arrangements is the responsibility of the resident, legal surrogate or family.

"I HAVE A RESIDENT I CAN'T DISCHARGE BECAUSE SHE DOESN'T LIKE THE DISCHARGE LOCATION I FOUND." This is also **not** a valid legal reason to appeal a notice of discharge. The resident, her legal surrogate or her family is free to select another location for discharge if they choose, but the discharging facility has met its legal burden by finding one facility or service provider of the appropriate care level that will accept the resident. Beyond that, competent residents, their surrogates or their families are

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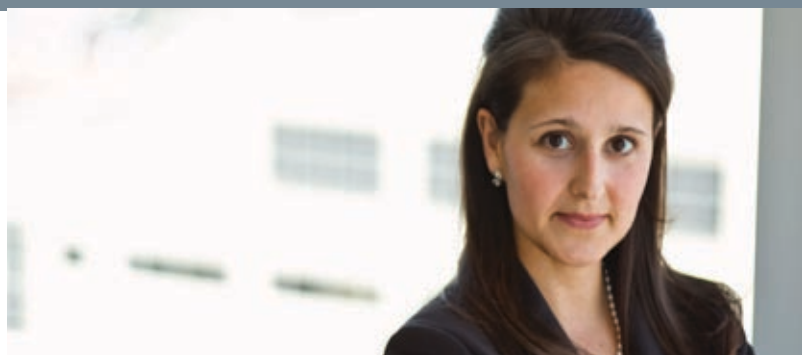
Responding to an Audit? Be Prepared!

by Jessica Lewis



As a health care provider, you're probably aware of the efforts by the state and federal governments to identify and recover overpayments made by the Medicare and Medicaid programs. The Medicare Modernization Act of 2003 and subsequent legislation CMS dramatically expanded CMS' authority to detect and recover overpayments made by the Medicare and Medicaid programs. CMS has engaged a number of contractors to audit health care providers to identify and recoup overpayments. Chances are high that your facility has been or will be subject to an audit by one of the many CMS or NC Division of Medical Assistance (DMA) contractors, and the best way to come out ahead is to be prepared now.

The audit contractors use sophisticated data mining techniques to identify providers for audit, and many use statistical processes to extrapolate an overpayment amount that is exponentially higher than the overpayment identified in the sample of claims the audit contractor actually reviews. Historically, billing issues like high claim rejection rates, higher utilization than neighboring providers and unusually long lengths of stay have been red flags for auditors looking for targets. Avoiding these types of issues can help decrease the chance that your facility will trigger an auditor's interest, but complaints from beneficiaries and utilization screens might also trigger an audit.

No matter what type of audit and auditor you face – ZPIC, RAC, MIC or other – some common principles apply to preparing and responding.

What can you do to prepare now?

- Develop, implement and maintain an updated compliance program.
- Develop and implement policies and procedures for handling correspondence from auditors and responding to requests for records.
- Assign a point person for receipt of audit request letters, and make sure that person knows what to do with those letters and when (immediately!).
- Make sure that your Medicare administrative contractor (MAC) and DMA have the correct mailing address for your facility to improve the chances that an audit letter requesting records will end up in the right place for a timely response rather than languishing in a PO Box for days or weeks.
- Implement a mode for tracking and documenting each audit process, and assign roles and responsibilities for each stage of the process.
- Educate key personnel within your facility – billing personnel, clinicians and administration. Be sure your billers know what pieces of documentation must be in place prior to billing for a service, and have a fail-safe in place to make sure that the documentation exists before billing. Be sure your clinicians understand the appropriate components of documentation, including the need for legible signatures.
- Monitor material posted by CMS, DMA and their contractors to gain insight into the types of issues that trigger audits and the focus of the audits.
- Perform an internal audit of your organization and address any identified weaknesses.

What do you do when you receive notice that you are being audited?

- Pay careful attention to the timelines for response set forth in the initial letter, and respond in a timely manner.
- Pay careful attention to the records requested. Be sure to provide all records that are pertinent to the dates of service set out in the letter. Some of these records may predate the actual dates of service listed in the letter. For example, the certification covering the dates of service requested with regard to one resident may be dated earlier than the dates of service for which medical records were requested. Be sure to provide the certification and any other documents that demonstrate why it was appropriate for the payor to pay the amounts that it did for those dates of service.
- Provide records in an organized, comprehensive manner and ensure copies are legible. This will make it easier for the auditor to conduct the audit and to conclude that payment was proper.
- Involve experts. These may be your clinical or billing staff or external consultants who can help you identify the appropriate records and prepare a response.
- Maintain a copy of everything – correspondence, emails and records that you provide or receive – and log it.

- Try to get information from auditors in writing. If you can't, write it down yourself. Make notes of telephone calls you have with an auditor, inclusive of the date, time, persons involved and subject matter.
- Cooperate. The more organized and responsive you are, the better the chances that the process will move along smoothly.

Depending on the type of audit, the provider will have an opportunity to appeal unfavorable results. But the best defense really is a good offense when it comes to appealing audit results, so it makes sense to expend time, energy and resources now to best position your facility to avoid overpayments and to defend itself in the event of an overpayment determination.

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free to select a different receiving provider, and the actual physical location to which the resident will be discharged can be changed from the place you designated on the notice of discharge right up to, and even during, a discharge appeal before DMA. As a practical tip, we always advise clients who are issuing a notice of discharge to 1) identify one location for the discharge that has agreed to accept the resident and that offers the appropriate level of care; and 2) include with the discharge notice a printout of every other SNF, adult care home, and/or home health or home care agency in the county or vicinity. This allows the resident or family to select a different location and prevents them from saying the facility gave them only one choice that they found unacceptable. You are not legally required to do this, but it's very effective in shutting down that argument, which residents, their lawyers and/or their families nearly always raise in discharge appeals.

"I ISSUED A DISCHARGE NOTICE THAT WAS NOT APPEALED, BUT THE RESIDENT WON'T LEAVE THE PREMISES." This is a tough one. Federal law presumes, often incorrectly, that a resident who has been properly "discharged" – e.g. the notice of discharge was proper, a permissible reason for discharge was given, a new location was found and no appeal filed – will simply leave the facility. Increasingly, we see residents, often on the advice of their counsel, who simply refuse to go. State laws often do not directly address what to do in such cases. In North Carolina, we have landlord/tenant laws that apply to any residential lease or rental, but in some counties, local judges or magistrates are reluctant to order an "eviction" of a senior from a nursing home or adult care home. Legally, once that proper notice of discharge has been issued and no appeal filed or appeal won by the provider, the resident is then illegally on your premises. A couple of options are available: 1) seek a summary eviction under North Carolina landlord/tenant laws (there is a defined process, some time frames and some defenses available to the resident under these laws that can be frustrating), 2) seek a criminal warrant for trespass or 3) do both. In tough cases, we usually commence both actions simultaneously. One of the drawbacks to either procedure is that at the end of the day, assuming the provider prevails, local police have to enforce the eviction order or trespass warrant. This means arresting a resident who won't leave, and many providers are understandably reluctant to take this course of action. Often, respectfully informing the resident, his or her surrogate or family that this will occur resolves the issues, but not in every case. Providers need the advice of experienced counsel, and some patience.

"I HAVE A RESIDENT WITH AN UNPAID BALANCE WHO HAS NOW QUALIFIED FOR MEDICAID. CAN I STILL DISCHARGE THEM FOR NON-PAYMENT?" Yes, absolutely. The fact that a resident has found a source of payment going forward for future care and services does not prevent you from discharging a resident with a past unpaid balance, and the size of that balance is irrelevant. Increasingly, we are seeing residents, families, surrogates and counsel simply asking providers to "write off the back balance" and be satisfied getting paid for future services. First, most providers are not in a position to do this these days. Second, doing so creates a possible expectation on the part of other residents or families that they'll receive the same special treatment. Ultimately, the call belongs to the provider. Legally, you are permitted by federal and state law to discharge any resident with an unpaid balance who is unwilling or unable to pay it, regardless of the amount and regardless of whether a future payment source has been identified, such as Medicaid.

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"My facility just lost a discharge appeal based on nonpayment. Now what do I do?" When we get this call, we know immediately that the provider tried to handle a discharge appeal on its own. Please, don't do this. Residents, family members and local attorneys are increasingly getting better at these appeals. In addition, local ombudsmen with no clinical or legal training often appear at these hearings and give "testimony" about the resident's clinical condition, "unsafe discharge" or other issues designed to help the resident by persuading the hearing officer the resident shouldn't be discharged. Your best chance to win these appeals is the first time, and you should go into the hearing prepared. Most of these hearings are handled by DMA hearing officers via telephone and last about an hour. Five days before the scheduled hearing you have to have in the hands of the hearing officer, the resident, and the resident's family or legal representative a complete packet of **all** documents you plan to rely on at the hearing. Particularly important are financial records showing nonpayment and recent updated clinical or social work records showing clinical condition and social services issues, if applicable. If you lost a discharge hearing based on nonpayment, for whatever reason, you can appeal that to the superior court in your county. But this is time-consuming, expensive and rarely done. You can also issue a new discharge notice and start the entire process again. Especially in nonpayment cases, each new dollar that is billed to the client and goes unpaid is a new "nonpayment" that authorizes you to discharge the resident. But you'll have to go through the same 30-day notice; wait for a possible appeal; and wait for that to be scheduled, heard and decided while the resident's unpaid balance continues to increase. The DMA hearing officers who hear these cases are bright, dedicated and committed. But they hear many other types of cases. It's important for providers to have legal counsel at the hearing to help keep the hearing officers focused on the legal requirements as opposed to the many irrelevant issues residents, family members or their counsel raise in an attempt to block the discharge. There are also important strategies for dealing with any witness – ombudsman, family friend, etc. – who brings up issues that are irrelevant or tries to offer testimony he or she is not qualified to give.

"How soon should I begin a discharge for nonpayment?" Most providers want to keep their residents and don't want to discharge them. So many providers wait for months in nonpayment situations to start discharge proceedings, hoping the resident will qualify for Medicaid or the family will sell some property that is blocking Medicaid eligibility or otherwise find a way to pay. This is laudable. But it often backfires. Many clients come to us with unpaid bills in the tens of thousands, frantically needing to resolve the situation. Our advice is not to wait. If you see balances starting to grow, and you've made every effort to help the resident or family find a solution, start the discharge process now. This may seem like cold advice, but it's important. Remember, discharge for nonpayment requires a 30-day notice. If an appeal is filed, you cannot discharge that resident until the hearing is over and the hearing officer has ruled (which can take up to 10 days after the hearing). Also, hearing officers often ask in these hearings, "Why did you wait so long to start this process and allow the bill to grow?" The notice of discharge will usually bring the resident's representatives to the table faster than your phone calls or pleas for help. In cases where there are available assets or means for payment that a resident or his representative simply won't pursue (like failing to file a **completed** Medicaid application), the discharge notice can get things moving.

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Ken's Quote of the Month

"Be the person you would like to know."

Ken's daddy

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