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"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE ADELMAN ADVANTAGE by Rebecca Adelman

HIPAA Guidance – *What You Need To Know About Access*

April showers bring May flowers. I hope you're enjoying the Spring and the renewal it brings. The 7TH annual National Long-Term Care Defense was an awesome experience and we enjoyed spending time together industry thought-leaders April 3-4, 2019 in Memphis. Stay tuned for details about next year in New York City.

Every day in my law firm and nearly every day in the media we are encountering issues related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a including access, security and breach. A frequent HIPAA issue that arises in healthcare litigation is the individual's right to access health information and the associated legal and regulatory considerations. As a defense attorney and for risk mitigation, my duty is to evaluate a request for health information for our provider clients, determine who is legally authorized to receive information and what information should be produced. This month, we'll explore the HIPAA Privacy Rule which provides individuals with a legal, enforceable right to see and receive copies upon request of the information in their medical and other health records maintained by their health care providers and health plans and note some answers to frequently asked questions we receive. A valuable resource for HIPAA guidance is HHS.gov.

General Right

The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice.

Information Included in the Right of Access: The "Designated Record Set"

Individuals have a right to access PHI in a "designated record set." A "designated record set" is defined as a group of records maintained by or for a covered entity that comprises the:

- Medical records and billing records;
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Other records that are used, in whole or in part, by or for the covered entity to make decisions about individuals.

NOTE: Individuals have a right to a broad array of health information, including: medical records; billing and payment records; insurance information; clinical laboratory test results; medical images, such as X-rays; wellness and disease management program files; and clinical case notes; among other information used to make decisions about individuals. *In responding to a request for access, a covered entity is not, however, required to create new information, such as explanatory materials or analyses that does not already exist in the designated record set.*

Information Excluded from the Right of Access

An individual *does not* have a right to access PHI that is not part of a designated record set because the information is not used to make decisions about individuals. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions more generally rather than to make decisions about individuals.

NOTE: For example, a nursing home or hospital's peer review files or practitioner or provider performance evaluations, or a health plan's quality control records that are used to improve customer service or formulary development records, may be generated from and include an individual's PHI but might not be in the covered entity's designated record set and subject to access by the individual.

NOTE ALSO: In addition, two categories of information are expressly excluded from the right of access:

Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record.

Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

Personal Representatives

An individual's personal representative (generally, a person with authority under State law to make health care decisions for the individual – Power of Attorney, Power of Attorney for Healthcare, Conservator, Surrogate) also has the right to access PHI about the individual in a designated record set.

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Requests for Access
A covered entity may require individuals to request access **in writing**, provided the covered entity informs individuals of this requirement Covered entities also may offer individuals the option of using electronic means (e.g., e-mail, secure web portal) to make requests for access.

Verification
The Privacy Rule requires a covered entity to take reasonable steps to verify the identity of an individual making a request for access. **NOTE:** For example, if the covered entity requires that access requests be made on its own supplied form, the form could ask for basic information about the individual that would enable the covered entity to verify that the person requesting access is the subject of the information requested or is the individual's personal representative.

Unreasonable Measures
A covered entity may not impose unreasonable measures on an individual requesting access that serve as barriers to or unreasonably delay the individual from obtaining access.

NOTE: For example, a doctor may not require an individual:
•Who wants a copy of her medical record mailed to her home address to physically come to the doctor's office to request access and provide proof of identity in person.
•To use a web portal for requesting access, as not all individuals will have ready access to the portal.
•To mail an access request, as this would unreasonably delay the covered entity's receipt of the request and thus, the individual's access.

Providing Access
The Privacy Rule requires a covered entity to provide the individual with access to the PHI in the form and format requested, if readily producible in that form and format, or if not, in a readable hard copy form or other form and format as agreed to by the covered entity and individual

NOTE: If the individual requests electronic access to PHI that the covered entity maintains electronically, *the covered entity must provide the individual with access to the information in the requested electronic form and format, if it is readily producible in that form and format, or if not, in an agreed upon alternative, readable electronic format*.

NOTE ALSO: The covered entity also may provide the individual with a **summary** of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided in addition to that PHI, so long as the individual in advance: (1) chooses to receive the summary or explanation (including in the electronic or paper form being offered by the covered entity); and (2) agrees to any fees (as explained below in the Section describing permissible Fees for Copies) that may be charged by the covered entity for the summary or explanation.

Timeliness in Providing Access
In providing access to the individual, a covered entity must provide access to the PHI requested **no later than 30 calendar days from receiving the individual's request**.

NOTE: The 30 calendar days is an outer limit and covered entities are encouraged to respond as soon as possible. Indeed, a covered entity may have the capacity to provide individuals with almost instantaneous or very prompt electronic access to the PHI requested through personal health records, web portals, or similar electronic means. Further, individuals may reasonably expect a covered entity to be able to respond in a much faster time frame when the covered entity is using health information technology in its day to day operations.

NOTE ALSO: If a covered entity is unable to provide access within 30 calendar days -- for example, where the information is archived off site and not readily accessible -- the covered entity may extend the time by no more than an additional 30 days. *To extend the time, the covered entity must, within the initial 30 days, inform the individual in writing of the reasons for the delay and the date by which the covered entity will provide access. Only one extension is permitted per access request.*

Fees for Copies
This issues of fees arises on a frequent basis in our firm. The Privacy Rule permits a covered entity to impose a reasonable, cost-based fee if the individual requests a copy of the PHI

NOTE: The fee may include only the cost of: (1) labor for copying the; (2) supplies for creating the paper copy or electronic media (e.g., CD or USB drive); (3) postage; and (4) preparation of an explanation or summary of the PHI, if agreed to by the individual

NOTE ALSO: The fee may not include costs associated with verification; documentation; searching for and retrieving the PHI; maintaining systems; recouping capital for data access, storage, or infrastructure; or other costs not listed above even if such costs are authorized by State law.

Individual's Right to Direct the PHI to Another Person
An individual also has a right to direct the covered entity to transmit the PHI about the individual directly to another person or entity designated by the individual.

NOTE: The individual's request to direct the PHI to another person must be in writing, signed by the individual, and clearly identify the designated person and where to send the PHI. A covered entity may accept an electronic copy of a signed request (e.g., PDF), as well as an electronically executed request (e.g., via a secure web portal) that includes an electronic signature.

State Laws
State laws that provide individuals with greater rights of access to their PHI than the Privacy Rule, or that are not contrary to the Privacy Rule, are not preempted by HIPAA and thus still apply.

NOTE: For example, a covered entity subject to a State law that requires that access to PHI be provided to an individual in a shorter time frame than that required in the Privacy Rule must provide such access within the shorter time frame because the State law is not contrary to the Privacy Rule.
Compliance, Breach Notification and Enforcement are beyond the scope of this Privacy Rules article, however, understanding the essentials of HIPAA and access to PHI is the first step to compliance and risk avoidance.

UPDATE ON SENATE FINANCE COMMITTEE AND CMS: Last month I reported on the March 6, 2019 Senate Finance Committee

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Getting on the Same Page by Paige Hector, LMSW

Data Driven Does Not Need to Drive You Nuts!

Is anyone else having a hard time believing that Phase 3 is almost here? In just a few short months, facilities will be expected to operationalize a myriad of new and revised regulations covering a number of different topics. Included in this phase is F866 "Program feedback, data systems and monitoring." While collecting and reporting data is nothing new to post-acute and long-term care facilities, there is a new emphasis on these tasks by way of the regulations. Facilities are expected to demonstrate that process improvement is data driven, including data collection and data analysis. But what do these things really mean?

In my experience working with facilities with data and process improvement, this is an area that people seem content to go with what they think they know. Staff compile reams of data on a variety of metrics (falls, readmissions, etc.), create some type of visual display, usually an incorrect graph (e.g. a bar graph), and then attend a QAPI meeting. Leadership compares the number of falls, readmissions and pressure ulcers from the current month to the previous month, or to the previous quarter. If they like the number, staff are congratulated (and maybe earn a pizza party). If the number is considered undesirable, staff is reprimanded and directed to "do better" next month. There is no rhyme or reason to the outcome and certainly no rationale as to what exactly the data mean and what *appropriate* action staff should take.

Do you ever wonder if there is a better way? The answer is yes, and it's all based on statistical theory. Does even reading that word conjure up horror stories of college statistics classes? I might be a little strange, but I actually enjoyed my college stats course. Unfortunately, what most of us learned in college is a type of statistics that is NOT useful in the real world. Clinical trials use a specific type of statistics called enumerative statistics. What happens in the real-world, in our nursing homes, requires a different type of statistics, analytic statistics. Or, improvement statistics which is defined as "the art and science of collecting and analyzing data to understand variation." (Davis Balestracci)

I'd like to demonstrate the importance of theory (which really comes down to *why we do things*) by using a medical analogy. Imagine a resident in your facility that has a pressure ulcer and needs a wound consultation. Would you accept just any provider, no matter their knowledge or experience with wound care, to assess the resident without following standards of practice, and then write treatment orders? Of course not! You would expect - and so would surveyors, attorneys and family members – to engage with a provider knowledgeable about the *theory* of wound care, best practices and standards, and who is capable of applying that theory and knowledge to achieve the best outcome possible for the resident.

The same is true of data and process improvement. Pouring over bar graphs (and other useless charts) and looking for rationale as to why a number is higher or lower than a previous number is NOT based in theory. Not only is it wrong, it wastes precious time and money. Consider the pressure ulcer analogy again, if the provider incorrectly assesses the wound (not using proper evidence-based medicine and *theory*) and writes incorrect orders, the resident may have a poor outcome. Or, at least no improvement. Would you accept that in your facility? Likely not. So why is leadership so apt to accept incorrect use of data, not collected and analyzed according to improvement *theory*, that also results in poor outcomes and wasted resources? I think it's because they don't know what to do differently.

It is past time for facilities to employ proper data strategies, based on improvement statistics and theory. Being an effective leader is knowing how to correctly analyze data and employ the correct strategy for improvement. Looking at data in a bar graph and making decisions that affect staff, residents and patients is wrong and it must change. Read the new regulations again and appreciate the emphasis on data analysis. In F866 it states, "Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring and evaluation." Then, "…the facility will use the data to develop activities to prevent adverse events." In F867 it states, "The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained."

Take a look at the Guidance to Surveyors for F867. It states, "The QAA committee's responsibility to identify quality deficiencies requires facilities to have a system for monitoring departmental performance data routinely in order to identify deviation in performance and adverse events." There is A LOT going on in that one sentence. Most facilities will continue to fall into the same trap of relying on incorrect graphs and opinion-based analysis to try to figure out if there is indeed a deviation. Staff will likely get blamed for outcomes outside their control, everyone will get more frustrated, more resources will be wasted and around and around everyone goes in that communal hamster wheel.

Here's what must happen instead: 1) Plot the data on run charts, 2) Use improvement statistics and theory to analyze the data, and, 3) Make the correct choice of a process improvement strategy based on the data (not your opinion of the data). This level of data analysis is going to require new learning, but the effort will pay off in actual, sustainable process improvement and better use of resources. We can no longer conduct business as usual and expect to achieve results that we're being held accountable for. Next month, I'll demonstrate simple principles of data analysis using a real facility example with falls.

So rather than let this stuff drive you nuts, take charge and grab a bowl of your favorite nutty snack and chomp away as you learn the very basics of improvement statistics!

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Discover more about her at www.paigeahead.com

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CMS has updated the PDPM website… Again!

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affairs

As we in the SNF world eagerly anticipate the 5-Star and the SNF FY 2020 proposed rule this month, the revised RAI Manual in May and the SNF FY 2020 Final Rule in July, on April 4th, CMS updated the PDPM Website… again! Things are really moving at a breakneck pace. You may feel like it is a challenge to keep up. You are not alone. It's time to pull out your running shoes and stretch your thinking muscles because the pace is not going to get any slower moving toward October.

As for the PDPM website revisions let's take a breather and have a closer look. The following are the documents have been revised to reflect clarifications that CMS has made with regard to the new payment system; PDPM FAQ, PDPM Patient Classification Walk Through, PDPM Grouper Logic, PDPM ICD-10-CM Mappings. Here is a summery of the revisions that have been made. The full documents can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PDPM ICD-10 Mapping – CMS has done us all a favor here. First, they have combined all of the mapping tools into one Excel workbook. Now we can just access that one tool to do all of our PDPM ICD-10 map searches. Next, they have updated the code sets in response to suggestions industry experts have made since the first edition of these tools. In the Clinical Categories by Dx. tab, ICD 10 codes have now been mapped appropriately.

For example, in the prior versions, there was an incomplete list of dx and some dx that should have mapped to possible surgical procedures did not. For example, dx code S72001D Fracture of unspecified part of neck of right femur, subsequent encounter, maps to a default category of Non-Surgical Orthopedic/Musculoskeletal and May be Eligible for One of the Two Orthopedic Surgery Categories. This was not the case in prior versions of the mapping tool. There are multiple similar revisions that have been made.

The SLP comorbidity map now contains 102 diagnoses. The prior version only contained 70. Multiple diagnoses have been added to Apraxia, Dysphagia and speech and language deficits categories, further enhancing the variety of diagnoses that classify under these categories. The NTA comorbidity diagnosis map continues to have 1535 diagnoses available to map to the 27 NTA comorbidity categories that use MDS item I8000.

PDPM Patient Classification Walkthrough – This document has had only a minor revision. In the prior versions of this document, the source for the NTA comorbidity, Inflammatory Bowel Disease, was noted to be I8000. However, this was a typo and has been corrected to be I1300.

PDPM FAQ – This document has had several clarifications. CMS has also been very helpful in delineating these clarifications in red so they could be easily spotted. Here is a list of the FAQ's that have been revised;

1.8 – The term primary diagnosis has been changed to Principle diagnosis as it related to the primary reason the resident is being treated in the SNF. CMS continues to indicate that MDS item I0020B and the UB-04 should match.

5.4 – The question as to whether a HIPPS code can be generated if the BIMS has not been completed has been resolved with this clarification, "*If neither the BIMS nor the staff assessment is completed, then the patient will not be classified under PDPM and a PDPM HIPPS code will not be produced for this assessment*." In other words, when the BIMS was not completed because the resident had an unexpected discharge, the staff assessment may be completed. This clarification, however, **does not** apply to situations in which the BIMS could have been completed but was not. The current rules in the RAI manual page C-2 etc. will still apply.

11.5 – CMS has clarified how the items in J2100 – J5000 will be used for payment under PDPM. They indicate, "*These items will be used, along with the patient's primary diagnosis coded in item I0020B, to classify patients into a PDPM clinical category, which is then used as part of the PT, OT, and SLP case-mix classification groups for PDPM."*

12.10 – CMS continues to reiterate the fact that under PDPM, while there is no requirement that a certain amount of therapy days and minutes are required for a rehab payment category to be generated, it is important to remember that a daily skilled service will still be required. To that point they have added a reference to Chapter 8 of the Medicare Benefit Policy Manual, specifically section 30.6. where daily skilled services are defined.

12.12 – In this FASQ entry, CMS has clarified that, under PDPM, there is no change in the way a therapy student's time can be captured. In this update they have added a reference to a section in the RAI Manual entitled "Modes of Therapy" which may be found in Chapter 3, Section O.

13.4 – Here CMS has made a substantive clarification as to how therapy data should be captured in section O of the discharge assessment when there have been one or more interrupted stays. To clarify this CMS indicates, "*SNFs should report the therapies furnished since the beginning of the Part A stay, including all parts of an interrupted stay, in section O of the MDS for each discharge assessment."* The previous FAQ indicated that only therapies that occurred since the readmission would be included.

14.10 – This FAQ has been completely rewritten. The question is, "*How long will the OSA be in place?"* To which CMS has responded,

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"*There is currently no definitive timeline for retiring the OSA. Once states are able to collect the data necessary to consider a transition to PDPM, CMS will evaluate the continued need for the OSA, in consultation with the states.*" This is good news for states who require RUG III or RUG IV HIPPS data for Medicate rate calculations.

14.13 – As CMS winds down the RUG system calculations in light of PDPM, as in 14.10, CMS here reiterates that after the implementation of the PDPM, states that will need to continue to generate RUG scores on more frequently than the 5-day PPS, OBRA Comprehensive and quarterly types of assessments, will need to use the OSA to do so. CMS added the clarification that, "*Beginning October 1, 2020, states must use the OSA as the basis for calculating RUG-III and RUG-IV HIPPS codes.*"

PDPM Grouper Logic – While CMS did not provide a document that indicates what has been revised with regard to the grouper logic, it is safe to say they have updated it with regard to the changes and clarification noted above, in particular, the multiple revisions made to the ICD-10 mapping.

CMS has updated their PDPM educational materials at least 3 times and we can expect more. As we look for the documents that will come our way in the coming months, it will be imperative that providers stay up to date on all of the changes and revisions that CMS provides.

At Broad River Rehab, we are up to date. Our PDPM Navigator® has already been updated to reflect the most recent ICD-10 mapping revisions. We provide state of the art tools and education to all our clients to help them stay current with the shifting LTC reimbursement landscape. We would love to talk with you about how Broad River Rehab can be your knowledgeable and compassionate rehab partner as you prepare for PDPM.

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(chaired by Senator Charles Grassley (R-Iowa)), hearing titled Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes. On Monday, April 15, 2019, CMS Administrator Seema Verma stated that she has directed the agency to undertake a "comprehensive review" of its regulations, guidelines and processes related to skilled nursing facilities. In her blog post, Ms. Verma wrote that along with the comprehensive review, CMS is working to increase oversight of State Survey Agencies, which have been known to deliver uneven findings and enforcement around the country. Some states have frequently identified serious issues in SNFs while others have not rooted out concerns with the same "seriousness or severity," she wrote. Her blog post also said that CMS is considering changing its organizational structure to enhance collaboration across regional staff.

Her 5 point plan is:

1. **Strengthen oversight**: CMS is intensifying its supervision of how State Survey Agencies perform, and taking a close look at how surveyors identify safety issues. It plans to set clear timelines for SSAs to review allegations, and change the Washington agency's organizational structure to allow for more collaboration with states.

2.**Enhance enforcement**: This includes strengthening policies to "hold nursing homes accountable for the care they provide." CMS has shared staffing data with state surveyors, who are [as has been previously announced] conducting unannounced, after-hours and weekend visits to focus on staffing issues, Verma wrote.

3.**Increase transparency**: By publicizing instances in which CMS terminates agreements with nursing homes due to poor quality, and making survey findings more readily accessible and digestible by the public.

4. **Improve quality**: Officials are eyeing further measures to address "serious quality issues," she said, such as healthcare-associated infections, and exploring ways to better spend Civil Money Penalty dollars on the most critical quality issues.

5.**Put patients over paperwork**: CMS also wants to ensure that it is not overburdening providers with any changes. "We will continue to think about how we can streamline processes and eliminate obsolete, unnecessary or duplicative provisions and we are interested in hearing from all stakeholders on ways to improve our programs," Verma concluded, drawing on one of the themes providers have actually liked during this administration.

The timing is complicated for CMS given the Senate probe by Sen. Grassley who questioned whether CMS was aggressively tracking nursing home quality and enforcing standards.

In a related development on the same day, the U.S. Government Accountability Office called on CMS to step up oversight of nursing home abuse investigations. The GAO found that abuse investigations and reporting in Oregon lapsed for at least 15 years. The call for action is for our healthcare leaders to emphasize how skilled nursing care operators and quality of care have improved and we need to create a force against regulatory overhaul and the changes that Ms. Verma have outlined.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation. Contact Rebecca at rebecca@adelmanfirm.com and visit www.adelmanfirm.com and www.rebeccaadelman.com.

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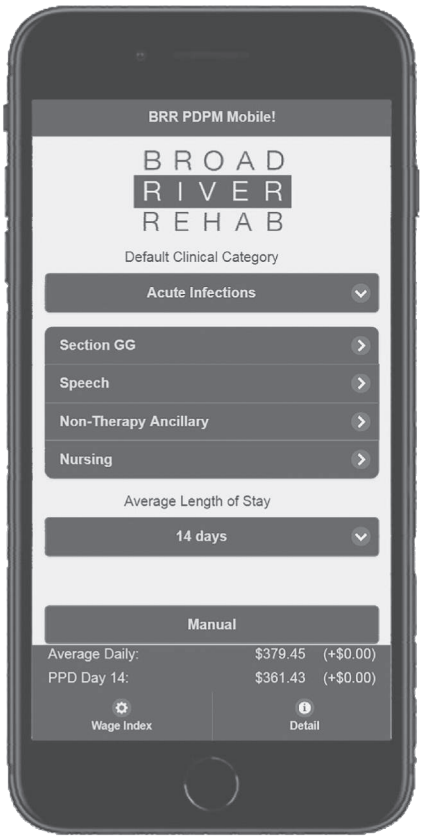

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