G2 Compliance Advisor

For Clinical and AP Laboratories and Pathology Practices

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Inside this issue

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Compliance Perspective of the Doc Fix Law's Section On Laboratory Payment Reform

Clinical laboratories may face substantial penalties for failure to submit complete and accurate data in the latest government move to revise the Clinical Laboratory Fee Schedule (CLFS).

Section 216 of H.R. 4302, the Protecting Access to Medicare Act of 2014, implements a new approach to setting payment under the CLFS that will tie lab fees to commercial market rates paid by private and third-party payers for laboratory services. However, the new law also includes important potential liabilities for labs should they make errors or omissions when they provide data during mandated reporting periods included in the measure.

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Fraud and Abuse Implications of the CMS Data Dump

Whistleblowers and their lawyers are likely already poring over the data contained in the data set released by the Health and Human Services Centers for Medicare and Medicaid Services (CMS) on April 9, as are others looking for ways the data can be used to attach some kind of legal liability for individual providers.

CMS touts the release of the data as part of the Obama administration's efforts to make the health care system more transparent, affordable, and accountable; however, the data contain no information about quality or outcomes. Released as raw data that include services sorted by providers and procedure codes and include charges and reimbursement, the data have as much chance of being misinterpreted as being useful. Providers may soon find themselves spending already scarce resources produced by CMS's relentless reductions in reimbursements defending themselves against unfair and inaccurate accusations because of misinterpretations of the data.

Other potential risks of the data dump include damage to a health care provider's reputation or public image if data are misused or misinterpreted. There are already examples of this in newspaper articles and blogs concerning the data. For instance, two pathologists are named as among the top 10 recipients of Medicare payments in 2012 when,

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in fact, they simply head large group practices and as a result they are identified as the claim submitter when that is not the case.

While the data release creates more legal risks for providers, it also has many other uses that can be beneficial to both patients and providers. For example, patients can use the information to make better choices, at least as far as cost is a consideration, when choosing a provider.

Access by the Public

The data were published by CMS in the form of public use files or PUFs and include information on the kinds of services furnished by health care providers to Medicare beneficiaries. The files are provided in various formats, one of which is a series of Microsoft Excel spreadsheets that consumers are likely familiar with and can manipulate. The spreadsheets are embedded with a tool that allows the user to sort the data in several different ways so they can be viewed from different perspectives.

For instance, the data can be sorted by Healthcare Common Procedure Coding System codes, Medicare's code set for identifying services which includes, in part, the American Medical Association's Current Procedural Terminology codes. This can be used to determine what kinds of physicians or suppliers file the most claims for a certain procedure and what each charges for that particular service. An outlier provider, a provider who files claims for a significantly higher number of a particular procedure than other similar providers, may receive extra scrutiny from both the government and patients.

From the government perspective, that physician may be gouging the system or ordering the procedure unnecessarily, while from a patient perspective, a physician who has performed a procedure many times may indicate expertise.

Limitations on the data that must be considered by the user in order to correctly interpret information in the data set include the fact that they represent only a part of the physician or supplier's overall practice. Another issue to be considered is that health care providers serving Medicare beneficiaries face a myriad of regulations and claims submittal requirements that they do not face when filing claims to other payers. In some cases these requirements can alter the choice of which test or service is ordered or performed. Patients may not be aware of these factors and their influence on a physician's decisions.

Other ways the information can be used include public scrutiny of physician office practices when the services are provided by, and paid directly to, a physician when the tests or services are performed in their own office as opposed to one who refers for services. A laboratory can use the data to construct a fairly accurate picture of another competing lab's patient fee schedule and what their volumes are, at least for Medicare beneficiaries.

What Is Missing

The data release does not include any information about the quality of services provided or information about patient outcomes related to the numbers and types of services provided. Without such information, it is nearly impossible to use the data to help choose one particular laboratory provider over another. However, as the government continues on its quest to make the health care system transparent, it becomes more and more possible that a diligent patient could assemble a more

complete picture of a provider using data collected by one or more of the quality reporting requirements for physicians and hospitals. That will be more difficult when it comes to laboratories because as yet no such quality reporting requirements exist.

Takeaway: The release of such a huge amount of data in a raw format like the recent release of data by CMS is more likely to create problems for laboratories and other health care providers then to create opportunities, at least in the short term.

Think That Internal Investigation Is Protected? Think Again

A recent district court ruling that documents produced during internal compliance investigations are not protected could have important implications for laboratories and other health care providers.

A March 6 ruling in the U.S. District Court of the District of Columbia concerning a discovery request by a qui tam plaintiff relator compelled the defendants in the case to produce documents related to an internal Code of Business Conduct (COBC) investigation that the defendants considered protected under attorney-client privilege and work product doctrine.

The defendants in the Department of Defense (DOD) False Claims Act case include Kellogg Brown & Root Services Inc., KBR Technical Services Inc., Kellogg Brown & Root Engineering Corp., Kellogg Brown & Root International Inc., and Halliburton Co. (KBR). The relator is Harry Barko.

Barko sought documents related to internal audits and investigations into the alleged misconduct by KBR that were conducted as part of the organization's compliance program, which requires internal controls such as the COBC. Compliance programs are mandatory for companies contracting with the DOD.

In its written response to the request for documents, KBR said it was withholding documents related to the request by Barko. The court, after opposition was filed, ordered KBR to produce the documents for an in-camera review, meaning that the court would review the documents in private. After said review, the court labeled the COBC reports as "eye-openers."

Mandatory Compliance Program Investigations

The important aspect of this case for health care companies is that the case concerns investigations conducted as part of a compliance program. The investigations that were conducted, including interviews of employees, were conducted as part of KBR's compliance program, which includes similar elements as are included in all health care compliance programs. The court ruled that since the investigations were routine ongoing corporate compliance investigations required by regulatory law and corporate policy they were not protected. They would have been conducted in any case, whether or not legal advice was being sought.

The COBC investigations were a result of KBR's need to comply with government regulations. The interviews with employees were carried out by a nonattorney. Similar arguments were made by the court to overcome the work product protections. As a result, the relator Barko was granted access to all 89 documents relating to the COBC investigation.

Takeaway: This case changes the climate for health care companies required to implement compliance programs. Laboratories and other providers should carefully consider how to react to findings of internal audits and investigations conducted as a result of the requirements of those programs.

OIG Looks Unfavorably on EHR Fee Arrangements Involving Labs

Laboratories that work directly with physician offices for the electronic exchange of test orders and results but that do not charge the physicians for the service will not be affected by a recent advisory opinion (AO) from the Health and Human Services Office of Inspector General (OIG).

Opinion 14-03, issued April 1, concludes that certain fee arrangements between labs and EHR service providers could potentially violate the anti-kickback law. The AO concerns the kind of information exchanges using electronic health record (EHR) vendors where the laboratory pays a fee to the vendor for each test order transmitted to the laboratory. The fees decrease as the volume of referrals increases. The new AO addresses similar issues raised in a prior opinion (11–18), which the OIG rescinded April 1. Previously, the OIG had issued a favorable opinion on proposed fee discounts. However, the OIG now says that such arrangements potentially generate prohibited remuneration under the anti-kickback statute.

The arrangements described in these AOs include some kind of connection between the physician practice, the vendor, and the laboratory where the vendor, as the middle entity, charges a fee to both or either party in exchange for using the service. The laboratory in the arrangement would be designated as an in-network laboratory and would have the availability of a bidirectional interface between its computer and the office EHR. The laboratory would pay a fee to the vendor in exchange for that designation and the service.

The laboratory indicated in the request for an opinion that it has the ability to provide the service on its own but that in order to receive the in-network designation it had to participate. The requestor said it believes that the physician practice does not have to pay any fee when using an in-network laboratory or that the fees decrease as volume increases. The requestor also stated that some practices indicated they might change to another laboratory designated as in-network if the lab refused to participate in the arrangement. The OIG found fault with the arrangement in three main areas:

1. The physicians previously had the ability to order and receive results electronically from the requestor laboratory without a fee. Under this arrangement, they now must pay a fee to the vendor if they use an out-of-network lab. The choice of paying a fee or not paying a fee may influence their referrals.
2. The fee structure itself could influence referrals because the more tests they order, the less they pay.
3. There appears to be no other reason for the requestor to pay fees to the vendor except as a means to secure referrals.

Any laboratory participating willingly in such an arrangement may find itself in trouble with the OIG since the issuance of this AO. The vendor may also have a problem if it is using the arrangement to direct referrals in exchange for participation in its network.

Takeaway: Laboratories should end any similar arrangements with an EHR vendor or any physician practice that uses such an arrangement to coerce a laboratory to participate in a program where the physician receives a benefit in exchange for referrals of laboratory services. G2

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COMPLIANCE PERSPECTIVES

Direct Patient Access to Laboratory Test Reports: 10 Things a Lab Should Know About the Final Rule

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On Feb. 6, 2014, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, and the Office for Civil Rights finalized the Patients' Access to Test Reports final rule (79 FR 7290).

The rule amends provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to require clinical laboratories covered under CLIA to make available to patients, upon request, completed test reports. The rule also amends the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to grant individuals the right to access such reports directly from laboratories without the ordering provider's approval. The rule became effective on April 7, 2014; however, HIPAA-covered entities have until Oct. 6, 2014, to comply. These changes to the CLIA regulations and the HIPAA Privacy Rule provide individuals with a greater ability to access their health information and empower them to take a more active role in managing their health and health care.

This article discusses key provisions of the rule and highlights 10 things a clinical laboratory should know.

Background

The objective of the rule, which became effective on April 7, 2014, is to formalize an additional mechanism through which individuals may obtain test reports in order to reduce the instances of patients not being informed of test results. Hopefully, greater access to test reports will reduce the number of patients who fail to seek appropriate care and will further reduce unnecessary duplicate testing. To this end, the rule applies "broadly and uniformly" to all HIPAA-covered laboratories, including primary laboratories, reference laboratories, and hospital laboratories.

Prior to the amendments, a CLIA laboratory could only disclose laboratory test results to three categories of individuals or entities: (1) an "authorized person," (2) the person responsible for using the test results in the treatment context, and (3) the laboratory that initially requested the test. In states that did not allow individuals to access their own test results, patients were required to receive their test results through their health care providers. The rule amends the CLIA regulations and gives patients the right to access their test reports directly from laboratories.

HIPAA and its implementing regulations apply to "covered entities." A laboratory, as a health care provider, is only a covered entity if it conducts one or more covered transactions electronically. The rule does not alter the requirements for what makes a laboratory a HIPAA-covered entity; therefore, if a laboratory does not conduct any HIPAA standard transactions electronically, then the laboratory is not subject to the HIPAA Privacy Rule. Under the rule, HIPAA-covered laboratories will be required to provide an individual (or the individual's personal representative) with access, upon request, to the individual's completed test reports in accordance with the Privacy Rule.

10 Things to Know

The rule amends the CLIA regulations and the Privacy Rule in various ways. Listed below are 10 things HIPAA-covered laboratories should fully understand prior to the rule's compliance date.

1. The Rule Preempts State Laws Prohibiting Release of Test Reports

The rule, and the CLIA and HIPAA amendments it finalizes, preempt a number of state laws that prohibit laboratories from releasing test reports directly to individuals or individuals without their ordering provider's approval. Now, under the HIPAA Privacy Rule, all HIPAA-covered laboratories are required to provide test results upon patient requests and may provide the results directly to the requesting patients.

2. Who May Access Laboratory Results

The rule gives an individual, or the individual's personal representative, the right to request access to their protected health information (PHI) directly from HIPAA-covered laboratories; these laboratories may not require these individuals to make such requests through their providers. Under the HIPAA Privacy Rule, an individual generally has a broad right of access to any or all of his or her health information maintained in a designated record set. The rule extends that broad right to the laboratory setting. However, patient access to laboratory results is not unqualified. For example, patient direct access to "sensitive" test results, such as genetic, cancer, pregnancy, sexually transmitted disease, and mental health tests may be limited if a licensed health professional determines, in the exercise of professional judgment, that the access is reasonably likely to endanger the "life or physical safety" of the individual or another person. Patients who are denied access to "sensitive" test results may challenge the denial by having the decision reviewed by an unaffiliated health care professional.

The rule, and the CLIA and HIPAA amendments it finalizes, preempt a number of state laws that prohibit laboratories from releasing test reports directly to individuals or individuals without their ordering provider's approval.

3. What Records May Be Requested

Pursuant to HIPAA, individuals have a right to access PHI about themselves in a designated record set. With respect to laboratory tests, results are not considered part of the designated record set until they are "complete." To maintain consistency with CLIA, a test report under the rule is considered complete when all results associated with an ordered test are finalized and ready for release. Additionally, the rule requires the clinical laboratory to provide access to all maintained records in the designated record set for as long as the laboratory maintains the information (even in those cases where the information is maintained beyond CLIA's applicable record-retention requirements). The requirement to provide access to all records in the designated record set applies to records that precede the effective date of the rule.

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4. Patient Authentication Requirements

The identity of patients requesting information from laboratories and their authority to request such information must be verified by the laboratory prior to releasing any information. Depending on the circumstances, a HIPAA-covered laboratory could verify a person's authority by asking for documentation of a health care power of attorney, general power of attorney, durable power of attorney that in-

cludes the power to make health care decisions, proof of legal guardianship, or, in the case of a parent, information that establishes the relationship of the person to the minor individual. Although the amendments do not specifically address the verification process, other than to point to the HIPAA Privacy Rule's requirements for verification, laboratories may not attempt to avoid the reporting obligation by imposing unreasonable verification measures on an individual. Nevertheless, no reporting obligation exists when the laboratory receives insufficient information to permit verification of the requestor with the patient for whom the analysis is being undertaken.

In addition, HIPAA-covered laboratories may include digital signatures on electronic copies of test reports given to individuals, provided the electronic copy is still in a format that has either been requested by the individual or is an alternative that has been agreed to by the individual and the laboratory.

5. Transmitting PHI to Another Entity

Under the rule, HIPAA-covered laboratories will be required to abide by an individual's request to have the laboratory transmit the copy of the individual's PHI to another person or entity designated by the individual. The Privacy Rule requires that such requests must be made in writing, signed by the individual, clearly identify the designated person or entity, and provide information regarding where to send the copy of the protected health information. In addition, HIPAA-covered laboratories may include digital signatures on electronic copies of test reports given to individuals, provided the electronic copy is still in a format that has either been requested by the individual or is an alternative that has been agreed to by the individual and the laboratory.

6. Deadline for Responding to Information Requests

Generally, laboratories will be required to provide individuals with access to their laboratory test reports within 30 days of the request. In instances when retrieving records may take longer than 30 days, laboratories may request one 30-day extension, as long as the laboratory provides the reason for the delay in writing to the requesting individual. Additionally, in instances when the report is unlikely to be "complete" within 30 days, laboratories may suggest an individual withdraw and resubmit a request at a time when the requested results will be "complete" within the 30-day response time frame.

The rule does not require laboratories to interpret test results for patients. Patients merely have the right to inspect and receive a copy of their completed test reports and other individually identifiable health information maintained in a designated record set by a HIPAA-covered laboratory.

7. Interpreting Lab Reports

The rule does not require laboratories to interpret test results for patients. Patients merely have the right to inspect and receive a copy of their completed test reports and other individually identifiable health information maintained in a designated record set by a HIPAA-covered laboratory. Laboratories may continue to refer patients with questions about the test results back to their ordering or treating providers. Therefore, the rule does not alter the role of the ordering or treating provider in reporting and explaining test results to patients. Patients should continue to obtain test results and advice about the meaning of the test results through their ordering or treating providers.

8. Employment-Related Testing

As for employment-related testing, the CLIA regulations do not apply to an employer or entity that performs substance abuse testing strictly for the purpose of employment screening where test results are merely used to determine compliance with conditions of employment, as opposed to counseling or some other form of treatment. However, substance abuse testing is covered by CLIA if it is part of a treatment program. Even if CLIA does not apply to the conduct of certain types of laboratory tests, HIPAA may still apply and require access to certain test reports to the extent the laboratory is a HIPAA-covered entity that has access to PHI. Individuals have a right to access test reports in designated record sets held by or for HIPAA-covered laboratories that constitute PHI under the Privacy Rule, including reports that relate to the past, present, or future physical or mental health or condition of an individual, or the provision of health care to an individual, and identify the individual even if the information includes testing for the presence of alcohol or drugs.

9. Charges for Producing PHI

A HIPAA-covered laboratory may charge an individual a reasonable, cost-based fee that includes only the cost of (1) labor for copying the requested PHI, (2) supplies for creating the paper copy or electronic media, (3) postage, when the individual has requested the copy be mailed, and (4) preparation of an explanation or summary of the PHI, if agreed to by the individual. HIPAA-covered laboratories may not charge fees to reflect the costs they incur in searching for and retrieving the information that is the subject of the individual's request. Fees that are expressly permitted under state law for copying and postage are deemed reasonable as long as they do not include amounts associated with fees not provided for under the HIPAA Privacy Rule—such as the fees for the cost of search and retrieval or other costs.

By the compliance date of the rule, Oct. 6, 2014, HIPAA-covered laboratories must revise their privacy practices to inform individuals of their right to access their own test results directly from the laboratory and must include a brief description of how the patient can exercise this right.

10. Revising Notices of Privacy Practices

The rule provides individuals with a right to access their PHI directly from HIPAA-covered laboratories. A change in an individual's access rights constitutes a material change to the privacy practices of HIPAA-covered laboratories. Whenever there is a material change to any of its privacy practices, including those pertaining to individuals' rights to access their protected health information, a covered entity is required to promptly revise its HIPAA notices of privacy practices. Therefore, by the compliance date of the rule, Oct. 6, 2014, HIPAA-covered laboratories must revise their privacy practices to inform individuals of their right to access their own test results directly from the laboratory and must include a brief description of how the patient can exercise this right.

Conclusion

The newly enacted rule gives patients greater access to their laboratory records so that these patients may begin taking more active roles in managing their health care. Although the rule allows patients greater access to their PHI, it imposes additional regulatory obligations upon HIPAA-covered laboratories. These HIPAA-covered laboratories should begin taking affirmative steps to ensure that they are in compliance with the amended CLIA regulations and Privacy Rules before Oct. 6, 2014, the compliance date of the rule.

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Compliance Perspective of the Doc Fix, *from page 1*

H.R. 4302, which passed both the House and Senate and was signed into law April 1 (P.L. 113-93), requires applicable laboratories to report test volumes and private market payment rates to the Centers for Medicare and Medicaid Services (CMS) beginning Jan. 1, 2016, and every three years thereafter. The data reported in this collection will be used to calculate new payment rates for virtually all tests on the CLFS and some on the Physician Fee Schedule.

The lab industry has been seeking a modernization or updating of the CLFS since before the 2000 Institute of Medicine study titled *Medicare Laboratory Payment Policy: Now and in the Future* concerning how labs are reimbursed for their services. However it has failed to produce a solution of its own, partly because the industry consists of laboratories in a variety of settings and sizes, and often there are conflicts within the industry that paralyze any effort to make a concerted effort on controversial topics like fee setting.

"Applicable laboratories" includes any laboratory that operates as a dedicated independent laboratory billing for laboratory services, small or large. It will likely include the nonpatients of hospital outreach laboratories, who are considered to be acting as independent labs when testing nonpatient samples. It may also include very large physician-owned labs, but that is not absolutely clear in the law. Section 216 provides that the secretary of Health and Human Services may exclude certain low-volume laboratories from the definition of an applicable laboratory.

The law also contains provisions for the introduction of new tests and new advanced laboratory tests like molecular and genetic tests. Among the provisions is a process that should help labs bring tests to market faster than ever before. The new law would create an "expert outside advisory panel" by July 1, 2015, to help with this process. This would be in addition to the existing annual public meeting to decide how to price new tests created by the American Medical Association's Current Procedural Terminology Pathology Coding Caucus group.

Ensuring Accuracy and Completeness

H.R. 4302 uses a variety of definitions, certifications, and civil monetary penalties (CMPs) to ensure laboratories do not inflate or leave out data in order to manipulate the outcome during the data collection periods.

The government and CMS have stated previously that they believe that Medicare pays more for clinical laboratory services than other payers, including those described in H.R. 4302. Government officials may expect that the data reporting requirements of this legislation will prove they are correct. On the other hand, labs have repeatedly refuted this idea, saying on many occasions that Medicare is not the highest payer. In fact, a study conducted by Avalere Health for the American Clinical Laboratory Association found that commercial health plans often pay more for lab services than Medicare.

The payment rates resulting from the new data reporting processes included in the new law will begin in 2017. The law describes "applicable information" as the payment rate paid by each private payer during a data collection period and the volume for each payer during the same collection period. A significant exception to the payment rate is any arrangement where payment is made on a capitated or similar basis, with the similar basis left undefined. Discounted payment rates will be included in the calculations. According to the text of the law, "The payment rate

reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1847A(c)(3)." Section 1847A(c)(3) says "such price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates." Several of these terms raise questions that labs will need to get answers to before the first reporting period in 2016.

The law provides mechanisms that try to ensure accurate and complete reporting of data, such as addressing what the reporting lab should do in the case of differing rates for the same test or different rates for different payers. In this case, labs would be required to report both rates. The law also requires certification by an officer of the laboratory that the data provided are complete and accurate. Finally, it also defines *private payer* as any health insurer or group health plan, a Medicare Advantage plan, or a Medicaid managed care organization. CMS hopes that by using what it considers a specific definition of what a private payer is, it will collect all of the data it is seeking.

Finally, H.R. 4302 provides for a CMP of up to $10,000 for each day an applicable lab has failed to report, provided inaccurate data, or omitted data under the law. It is possible that these determinations may not be made until sometime after the new rates take effect. With such a significant amount of money at stake, laboratories will have to carefully review the data collected and submitted or they may face problems in the future.

For laboratories that may be concerned about confidentiality of the data they report, the law provides that reported data "shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payer or laboratory, or prices charged or payments made to any such laboratory." There are exceptions to the prohibition on disclosure if the secretary deems disclosure is necessary to carry out the provisions of the law.

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These reporting requirements can be a problem for those labs reporting data for the establishment of the new fees since CMS has data from Medicare Advantage plans and Medicaid plans. Any discrepancies in reported data could raise red flags. Presumably, reporting labs will not be sharing the data they report, so there are many potential hazards for labs related to the reporting of prices, particularly when considering the penalties involved.

Potential Compliance Issues

The legislation presents the laboratory community with an unprecedented opportunity to participate in the process of setting the fees government payers reimburse for laboratory services. There are several areas where some providers may be tempted to inflate market rates or to try to influence the members of the new expert panel that will be created under the law. The process for establishing rates for new molecular and genetic tests is an area where laboratories could attempt to get higher reimbursements for a new test but, according to the law, CMS will assess the new rates, and any that prove to be more than 130 percent of what eventually becomes the market rate will have to be refunded to the program.

The reporting requirements are the more hazardous parts of this legislation from a compliance point of view. Laboratories could simply misinterpret or misunderstand a term, like a discount based on volume, and report erroneous information or omit data that CMS considers relevant. It would be prudent for labs to carefully

consider the details of this new legislation and construct appropriate comments, ask relevant questions, and seek clarification wherever the legislation is unclear or ambiguous.

Takeaway: The Protecting Access to Medicare Act is about more than reimbursement and includes many compliance-related provisions that laboratory compliance officers and administrators must address to ensure labs report accurately and completely.

Late Filing Costs Hospital $570,000

An acute-care hospital that missed a reporting deadline under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program lost its final appeal seeking refund of $570,000 it says it was underpaid in 2009.

According to an April 8 ruling by the Ninth Circuit in its ruling on the appeal filed by PAMC Ltd. d/b/a Pacific Alliance Medical Center (PAMC), the Centers for Medicare and Medicaid Services (CMS) acted reasonably when it reduced the hospital's market basket update payments under the RHQDAPU program by 2 percent. PAMC filed for a reconsideration with CMS, which was denied. PAMC then appealed to the Provider Reimbursement Review Board (PRRB), which upheld CMS's decision in denying the reconsideration decision. PAMC then appealed to the Ninth Circuit, which upheld the PRRB decision.

PAMC missed the deadline for submitting quality data for the second quarter for fiscal year 2007. PAMC argued in its reconsideration request that CMS acted arbitrarily and capriciously in its refusal to excuse PAMC's late filing and that it had a right to equitable relief or the benefit of contract doctrine of substantial performance. The hospital argued that the late filing was not its fault because it had used a third-party vendor, Thompson Reuters, which was responsible for submitting the data in a timely manner. Thompson Reuters took responsibility for the missed deadline. The hospital also argued that the filing was not very late, approximately 12 hours.

In the ruling, the court pointed out that PAMC did have sufficient time to file the required data in a timely manner like the vast majority of hospitals did successfully. It also pointed out that the vendor PAMC used had reported timely data for about 400 other hospitals. PAMC admitted to missing the deadline and CMS holds hospitals ultimately responsible for ensuing that their vendors submit timely data and comply with all requirements of the RHQDAPU program. Ultimately, the court upheld the PRRB decision.

Takeaway: A hospital, or any other health care provider, is responsible for the actions of it vendors and agents and any errors they may make.

Compliance Corner

Can a lab add diagnosis codes to a claim in addition to those provided by the ordering physician, based on the results of the test?

The answer to this depends on the tests involved and who is providing the new diagnosis information. First, for routine lab services such as routine chemistry, routine urine analysis, and routine hematology tests, the laboratory may not add diagnosis codes simply based on the results of its tests. Any diagnosis codes included on claims for these kinds of tests must come from the ordering physician. For tests that are reviewed or read under a microscope by a pathologist who then renders an interpretation or a diagnosis based on that review and issues a written report that includes an additional diagnosis beyond those provided by the ordering physician, the lab may add that diagnosis in addition to those provided by the ordering physician.

News-At-A-Glance

NLRB INVALIDATES EMPLOYEE STANDARDS OF BEHAVIOR: The National Labor Relations Board (NLRB) in an April 1 ruling found that Hills and Dales General Hospital (Cass City, Mich.) violated the National Labor Relations Act because of certain policies in its employee handbook. The case concerned an employee, Danielle Corliss, who was disciplined for a Facebook posting that disparaged the hospital, violating some of the policies in the handbook. The NLRB held that policies that prohibited employees from making negative comments about fellow team members and prohibited employees from engaging in or listening to negativity or gossip were invalid. Also, a policy that required employees to present the hospital positively in the community was also illegal because employees could reasonably construe the policies to prohibit engaging in protected activities, said the NLRB. As part of the ruling, the hospital was required to post a notice that announced the deletion of the standards and behavior policies the NLRB found to be a problem.

TUOMEY HEALTHCARE SYSTEM FILES STAY: Tuomey Healthcare System (Sumter, S.C.) has filed a motion for stay of a $70 million payment in order to prevent bankruptcy, according to an April 9 order in U.S. District Court for the District of South Carolina court documents. Tuomey was found in violation of physician self-referrals laws (Stark) and the False Claims Act on Sept. 30, 2013, and ordered to pay $237 million. Tuomey told the court it could not pay that fine and still continue operations. Tuomey appealed, but while waiting for the appeal, the government filed additional responses and motions that effectively required Tuomey to pay $70 million. The court ruled that the motion for stay is granted but Tuomey must obtain a supersedeas bond or equivalent in the amount of $30 million within 10 days of the ruling. Tuomey and the government will also enter into an escrow agreement in the amount of $40 million. It is possible that Tuomey may not survive its Stark violation case and it may yet be forced into bankruptcy.

CHANGES FOR MEDICARE SECONDARY PAYER CONTRACTOR: Medicare's Coordination of Benefits Contractor is now known as the Benefits Coordination and Recovery Center (BCRC), according to a recent *MLN Matters* (*MM*) article (SE 1416). The *MM* article provides new contact, address, and Internet address information for the BCRC. SE 1416 updates a previous article that describes initiatives used to make sure that the Medicare Secondary Payer (MSP) information is up-to-date and accurate. The *MM* instructs providers to make sure appropriate staff are aware of options for updating a beneficiary's MSP information and the new contact information and name of the new contractor. The Centers for Medicare and Medicaid Services (CMS) has implemented a process to obtain up-to-date information from private insurers for the BCRC about coverage. The BCRC initiatives provide information for providers trying to update a beneficiary's records. In order to resolve errors and conflicts in the MSP files, after April 4 files will not be updated based on a telephone call. Providers must give proof of information by fax or mail on the employer's company letterhead. Alternatively, the beneficiary or the insurer will need to contact the BCRC. CMS and the BCRC believe that this policy will reduce the number of errors in the MSP files because of the requirement for proof of information.

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