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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

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HRSA Plans Several Audits of Provider Relief Fund; Reporting Requirements Raise Alarm

Providers should brace themselves for several different types of audits by the HHS Health Resources and Services Administration (HRSA), which administers the COVID-19 Provider Relief Fund. It has a "strong and robust program integrity component," according to Joe Roach, the leader of the Program Integrity Team in the Office of Provider Relief at HRSA.

HRSA's program integrity strategy has four prongs (see box, p. 7).[1] "They're our way of establishing clear strategies used to monitor mission results" and address potential problems, Roach said Oct. 1 at the Fraud and Compliance Forum sponsored by the American Health Law Association (AHLA). His team is using automation and data analytics to "eliminate manual, repetitive tasks in the program integrity area."

The Provider Relief Fund, which was created by the Coronavirus Aid, Relief, and Economic Security Act, made $175 billion available to hospitals and other providers for diagnosing and treating patients and replacing revenue lost because of the pandemic.[2] Providers must submit an attestation that they will comply with the terms and conditions attached to the money, and in the latest development, HHS on Sept. 19 posted a post-payment notice of reporting requirements.[3] They apply to providers that received $10,000 or more in aggregate Provider Relief Fund dollars.

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Compliance Audit Manual Helps Keep Auditors on Same Page; Pre-Audit Surveys Are Useful

To give compliance auditors tools to go about their business uniformly, WellSpan Health in York, Pennsylvania, developed a comprehensive manual of its audit process, which was converted to an electronic version when employees headed home to work because of COVID-19. The audit manual doesn't leave a lot to chance, with step-by-step guidance on researching risk areas, determining sample size, surveying departments before and after audits and presenting results to executives, among other things.

"We found that a lot of coders who came to compliance knew coding, but they didn't know auditing," said Compliance Audit Coordinator Frank Mesaros, who did the electronic conversion. "This helped them through the process so we are all on the same page."

There are a lot of elements in the audit manual, which is structured around an audit checklist (see box, p. 4-5).[1] Auditors are instructed to research the areas they will audit, and an example of an HHS Office of Inspector General provider compliance audit is included, as well as documentation checklists from Targeted Probe and Educate that were created by Medicare administrative contractors. With sample reports and spreadsheets, auditors don't always have to create something from scratch, said Wendy Trout, WellSpan's director of corporate compliance.

There's also a pre-audit survey for auditors to send the department affected by the area being audited to ensure efficiency and give the department a heads-up

continued

that an audit is coming. The departments are asked 30 questions, including:

- Are there any areas you feel should be emphasized in this audit?
- Is your staff aware of the financial integrity and compliance reporting line and/or how to contact the compliance officer?
- Do you have a poster of the financial integrity and compliance reporting line anonymous reporting mechanisms clearly visible for staff?
- Who does the diagnosis coding for this department/facility?
- Whom does your staff contact for coding questions outside the department or office?
- Do you have an internal outpatient and inpatient coding quality monitoring process in place?
- Is there an effective claims denial feedback process in place?
- Is each employee who leaves asked if they are aware of any instances of fraudulent activity or noncompliance?
- Do you have an effective process in place for medical device credits?

In a post-audit survey, the department is asked "how the auditor did," Mesaros said. "We take that feedback to improve our processes." Both surveys are consistent with the overarching goal of having departments monitor themselves in collaboration with compliance. "Because of staffing limitations, we have to prioritize what audits we can do," he explained. If departments shoulder more of the monitoring, "that frees us up so we can audit a wider area."

The audit manual also explains how to prepare reports on audit findings. There are different guidelines for preparing reports, depending on the substance of the findings. For example, the cover memo should be a stand-alone document with a brief description of the audit performed and a list of significant findings. The report itself will have details of the audit process, findings, recommendations and management response. Completed audit reports are uploaded to a portal for review by the directors of corporate compliance.

For the C-suite, Mesaros said the compliance team keeps reports short and sweet. "We felt the front page gives a short synopsis of what executives want to see. They don't need to read through the whole report to get an idea of the audit substance," he said. To that end, the cover page also has a "gauge" of how the department performed on the audit. It's a graphic depiction of the audit results, using red, green and yellow to convey the findings based on precise numbers. Green is favorable, red is unfavorable and yellow means the findings are borderline. "Unless the gauge is yellow or red, they won't take the time to look at it." For example, if the auditor found three errors in a sample of 25 claims, the department's score would be 88%, which is green.

Contact Mesaros at fmesaros@wellspan.org and Trout at wtrout@wellspan.org. ✧

Endnotes

1. Nina Youngstrom, "Corporate Compliance Audit Process Checklist," *Report on Medicare Compliance* 29, no. 36 (October 12, 2020).

M.D. Review of Dietician Notes May Help Prevent Malnutrition Denials

Hospitals will continue to see Medicare denials for severe protein-calorie malnutrition when reviewers aren't convinced the code is accurate or the clinical evidence supports it, experts say. There's a Catch-22 because registered dieticians evaluate patients for malnutrition, but malnutrition can't be coded unless physicians diagnose it, and they may not review the notes of the registered dieticians. Hospitals are trying to bridge that gap with smart phrases and other strategies.

Hospitals are already in a malnutrition billing pressure cooker. It was the focus of a July report[1] from the HHS Office of Inspector General (OIG), which

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estimated that hospitals overcharged Medicare $1 billion by incorrectly assigning two malnutrition diagnosis codes—nutritional marasmus (E41) or unspecified severe protein-calorie malnutrition (E43) as the sole major comorbid condition or complication—on inpatient claims. OIG recommended that CMS and hospitals split the job of repaying Medicare, with CMS recouping money from the reopening period and instructing providers to follow suit under Medicare's 60-day refund rule.

Malnutrition is usually a secondary diagnosis, which means it may serve as a complication and comorbidity (CC) or major CC (MCC) that will increase the reimbursement of the MS-DRG it's attached to, rather than as the principal diagnosis that occasioned the admission.

Secondary diagnoses are defined as "other diagnoses" in the Uniform Hospital Discharge Data Set (UHDDS). For reporting purposes, "the definition of 'other diagnoses' is additional conditions that affect patient care in terms of requiring clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring."

Compliance experts have raised the question of whether Medicare denials are really more clinical denials than coding denials. If the documentation supports one of the five criteria in the UHDDS and the provider documents the diagnosis, malnutrition can be coded. The question then becomes whether a clinical evaluation of the physician's documentation and clinical indicators support the diagnostic statement, said Leslie Slater, specialist leader at Deloitte Advisory in New York City. A coder cannot make that determination, she noted. "This has been a longstanding documentation issue, because physicians typically rely on the registered dieticians for their clinical expertise of the patient's nutritional status and dietary requirements," Slater explained.

Smart Phrases Prompt Physician Review

At UCHealth in Denver, Colorado, the goal is to have an "airtight" malnutrition diagnosis, with support from registered dieticians, said Debra Anoff, M.D., senior medical director of clinical documentation integrity. They use American Society for Parenteral and Enteral Nutrition (ASPEN) guidelines. To further that goal, UCHealth has added smart phrases to its electronic medical records.

"The purpose is not to try to get malnutrition documented on everyone, but to find those patients with moderate or severe malnutrition and make sure we are telling their story," Anoff said. The smart phrase—"Upon nutritional assessment by the registered dietician, the patient meets the criteria for malnutrition type ___"—prompts physicians to review the dietician's assessment and document whether they agree with the assessment. Only when physicians agree with the dietician would malnutrition be a reportable secondary diagnosis.

The smart phrase helps compensate for the risk that physicians skip over nutritional evaluations. "There is so much white noise in charts and so much to see," she said. "They may assume registered dieticians are able to carry out their recommendations without a physician order."

Also, if the patient doesn't meet any of the five UHDDS criteria for a secondary diagnosis, "we wouldn't create a query for the doctor," Anoff said. But if one or more of the criteria are met, they could query the physician, unless the dietician's note is on the day before discharge or the day of discharge, because "there's not even time for further evaluation or treatment."

Slater warns of the risk of malnutrition downcoding when the notes in the chart contradict. The doctor may have copied and pasted an old note that described the patient as a well-nourished 90-year-old, while the registered dietician has documented a malnourished patient.

Some hospitals allow physicians to sign the dietician's note to indicate they've read it and agree with the patient's nutritional status and how it affects their recovery, Slater said. The documentation should also spell out what the physician found in the exam, such as muscle wasting, weight loss and cachexia.

Contact Slater at leslater@deloitte.com and Anoff at debra.anoff@ucdenver.edu. ✧

Endnotes

1. Nina Youngstrom, "OIG: Hospitals Overbilled $1B for Malnutrition, CMS Will Recoup; Other Audits to Resume," *Report on Medicare Compliance* 29, no. 26 (July 20, 2020), https://bit.ly/33IYlHo.

CMS Transmittals and *Federal Register* Regulations, Oct. 2-Oct. 8

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3, Trans. 10382 (Oct. 2, 2020)
- New Waived Tests, Trans. 10381 (Oct. 2, 2020)
- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 90.4.2 for Liver Transplants, Trans. 10376 (Oct. 2, 2020)

Pub. 100-08, Medicare Program Integrity Manual

- Updates to Chapters 1, 2, 3, 4, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08, Trans. 10365 (Oct. 2, 2020)

Corporate Compliance Audit Process Checklist

To ensure consistency and efficiency in the audits at WellSpan Health in York, Pennsylvania, Compliance Audit Coordinator Frank Mesaros documented its audit process in a manual and then put it in an electronic form when everyone scattered because of COVID-19 (see story, p. 1).[1] Here's one of the documents from the audit manual. Contact Mesaros at fmesaros@wellspan.org.

STEP 1: RESEARCH AUDIT TOPIC	DATE COMPLETED	COMMENTS/ WORK PLAN REFERENCE
◆ Identify risks from previous internal/external audits or other risk analyses (such as bell curve analysis).		
◆ Review source of risk documents.		
◆ Identify department contacts.		

STEP 2: NOTIFY MANAGEMENT OF THE AUDIT IN PERSON OR VIA CALL	DATE COMPLETED	COMMENTS/WP REF
◆ Send pre-audit survey to manager.		
◆ Discuss any issues/concerns with manager.		
◆ Schedule date to begin field work.		
◆ Address any deficiencies noted in the pre-audit survey (such as lack of a hotline poster).		

STEP 3: PERFORM AN OVERVIEW OF DEPARTMENT FUNCTIONS, IF APPLICABLE	DATE COMPLETED	COMMENTS/WP REF
◆ Request relevant policies and procedures.		

STEP 4: PREPARE PAPER/ELECTRONIC AUDIT FOLDER, INCLUDING WORKPAPER INDEX	DATE COMPLETED	COMMENTS/WP REF

STEP 5: DETERMINE SCOPE AND SAMPLE SIZE TO REVIEW	DATE COMPLETED	COMMENTS/WP REF
◆ Obtain population of claims for sample selection.		
◆ Select sample (describe population and document how sample was selected).		

STEP 6: DETERMINE AUDIT CRITERIA (ATTRIBUTES TO BE TESTED) AND DEVELOP AUDIT PROGRAM/SPREADSHEET	DATE COMPLETED	COMMENTS/WP REF

STEP 7: REQUEST AND VIEW RECORDS, BILLING, AND CLAIMS	DATE COMPLETED	COMMENTS/WP REF
◆ Record findings in spreadsheet.		
◆ Review findings for trends; group findings into categories.		
◆ Document last date of field work (this will be the report date).		

STEP 8: HOLD AN EXIT CONFERENCE TO NOTIFY DEPARTMENT MANAGER OF PRELIMINARY FINDINGS	DATE COMPLETED	COMMENTS/WP REF
◆ Allow for department to provide additional supporting documentation, if available.		
◆ Revise spreadsheet, if applicable.		

STEP 9: WRITE DRAFT REPORT (REFERENCE AUDIT REPORT POLICY)	DATE COMPLETED	COMMENTS/WP REF
◆ Include audit number from work plan in report title.		
◆ Send draft report to audit coordinator for review.		
◆ After coordinator approves, send draft to director for review and approval.		

STEP 10: SEND DRAFT REPORT AND "GUIDANCE FOR MANAGEMENT COMMENTS" TO DEPARTMENT MANAGER	DATE COMPLETED	COMMENTS/WP REF
◆ Allow two weeks for management to respond (diary your calendar).		
◆ Review management response for sufficiency.		
◆ If responses are sufficient, continue to next step. Else, work with manager to address insufficient or incomplete responses.		

STEP 11: WRITE FINAL REPORT	DATE COMPLETED	COMMENTS/WP REF
◆ Include "Compliance Response to Management" comments, if appropriate.		
◆ Send report to coordinator for review and approval.		
◆ Send report to director for review and approval.		
◆ Enter link to final approved report.		LINK:

STEP 12: RELEASE FINAL REPORT, ONCE APPROVED	DATE COMPLETED	COMMENTS/WP REF
◆ Send paper copies to designated managers, VP, president of entity, counsel, etc.		a. Ensures reports are not easily forwarded on to anyone outside WellSpan b. Makes sure the reports do not get lost in email of our senior leaders
◆ Ensure a copy of final report is included in audit work papers.		
◆ Send a copy to coordinator for inclusion in the audit binder.		
◆ Upload to portal.		
◆ Send an email copy of the completed report to compliance department team members that conduct hospital or defense audits.		
◆ Prepare audit slides and save to report folder.		

STEP 13: SEND POST-AUDIT SURVEY TO MANAGER WITH INSTRUCTIONS TO RETURN TO DIRECTOR	DATE COMPLETED	COMMENTS/WP REF

STEP 14: DETERMINE POST-AUDIT CORRECTIVE ACTIONS TO MONITOR (AUDIT COMMENT FOLLOW-UP)	DATE COMPLETED	COMMENTS/WP REF
◆ Perform testing to ensure corrective actions have been put into place (60 days from report date).		
◆ Diary your calendar for this follow-up.		

STEP 15: DETERMINE IF/WHEN RE-AUDIT IS REQUIRED. DISCUSS WITH AUDIT COORDINATOR	DATE COMPLETED	COMMENTS/WP REF
◆ Diary your calendar for the follow-up audit.		

STEP 16: INCLUDE A COPY OF THIS CHECKLIST IN THE AUDIT WORK PAPERS	DATE COMPLETED	COMMENTS/WP REF

STEP 17	DATE COMPLETED	COMMENTS/WP REF
◆ On a scale of 1-5, with 5 being the best, rate the department on how knowledgeable you feel the staff is on compliance.		1 2 3 4 5

Endnotes

1. Nina Youngstrom, "Compliance Audit Manual Helps Keep Auditors on Same Page; Pre-Audit Surveys Are Helpful," *Report on Medicare Compliance* 29, no. 36 (October 12, 2020).

CMS: Hospitals Face Termination for Failure to Report COVID-19 Data

In an Oct. 6 memo,[1] CMS said hospitals could be kicked out of Medicare if they don't report COVID-19 data every day to HHS, as required by the Sept. 2 interim final rule. But they will be given several chances to make things right, according to the memo, issued by the Quality, Safety & Oversight Group in the Division of Continuing and Acute Care Providers.

If hospitals or critical access hospitals fail to consistently report test results throughout the COVID-19 public health emergency (PHE), CMS will conclude they are noncompliant with the Medicare conditions of participation, the memo said. It sets forth the steps CMS will take toward terminating hospitals from Medicare under these circumstances.

The COVID-19 data reporting requirements were established by CMS's interim final rule—Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.[2] Every day, hospitals must report a lot of information to a data platform called HHS Protect, or to their state health departments or information technology vendors. The data include inpatient bed

occupancy, intensive care unit bed occupancy, number of mechanical ventilators in use, total hospitalized adult and pediatric suspected or confirmed positive COVID-19 patients, and supply of personal protective equipment, among other data. Optional reporting on the flu begins Oct. 19, with the intention to make it mandatory soon after, CMS said. Psychiatric and rehabilitation hospitals only have to report the data weekly.

If hospitals drop the ball, they are subject to CMS's multi-step approach to enforcement, according to the memo. They will be warned repeatedly of their "failure to meet the reporting requirements" and have a chance to get back in compliance. Ultimately, however, hospitals that don't comply with the reporting requirements within a week of receiving the second enforcement notification letter will get a termination notice that will take effect in 30 days unless they come into compliance.

"There is that threat of termination, but they are giving plenty of opportunities to get back into compliance," said Mary Ellen Palowitch, former EMTALA technical lead in the CMS Quality, Safety & Oversight Group. "It's not like if you don't report for a day or two you will be terminated." She said the threat of termination is the same for not reporting COVID-19 data as it is with any other conditions of participation.

The data gathering is labor intensive, added Palowitch, with Dentons US LLP in Washington, D.C. "It will probably be someone's job every day to gather this information. It gives [CMS] a better idea how to provide care, and when flu season picks up, it will impact hospitalizations."

But the American Hospital Association (AHA) objected to the threat of Medicare termination, calling it "heavy-handed." In a statement, AHA said, "The impact of barring hospitals from Medicare and Medicaid has the potential to harm more than those program's enrollees, and threatens more than just the life-saving care hospitals are providing to COVID-19 patients."

In Another Memo, CMS Explains Training Exemption

In another new memo[3] from the Quality, Safety & Oversight Group, CMS explained how hospitals get a break from some training requirements in the emergency preparedness regulation.

"It's important information," Palowitch said. "You don't want to be thinking you need to do a drill this year" if you initiated emergency plans for COVID-19.

As the Sept. 28 memo explained, a Sept. 30, 2019, CMS regulation[4] on reducing provider burden created an exemption from the testing requirements during or after an actual emergency. "In light of the PHE, CMS is clarifying the testing exercise requirements to ensure that surveyors, as well as providers and suppliers, are aware of the exemption available based on activation of their emergency plans."

Contact Palowitch at maryellen.palowitch@dentons.com. ✧

Endnotes

1. CMS, "Interim Final Rule (IFC), CMS-3401-IFC; Requirements and Enforcement Process for Reporting of COVID-19 Data Elements for Hospitals and Critical Access Hospitals," memorandum, October 6, 2020, https://go.cms.gov/34I0bHQ.
2. Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 54,820 (September 2, 2020), https://bit.ly/2FaI0BB
3. CMS, "Guidance related to the Emergency Preparedness Testing Exercise Requirements- Coronavirus Disease 2019 (COVID-19)," memorandum, September 28, 2020, https://go.cms.gov/2GNtQXL.
4. Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, 84 Fed. Reg. 51,732 (September 30, 2019), http://bit.ly/2NMWEQZ

HRSA Plans Provider Relief Fund Audits

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The Provider Relief Fund's program integrity team is responsible for ensuring the accuracy of provider payments and that they are given to eligible recipients, "not duplicative and free of waste and abuse," Roach said. HRSA will pull data that comes in through the new reporting requirements and blend them with information HRSA receives from attestations and financial information. "It gives us broader information about how providers are using the funds, which will drive audit selection," he explained.

HRSA Will Use 'Multi-Layered Audit Approach'

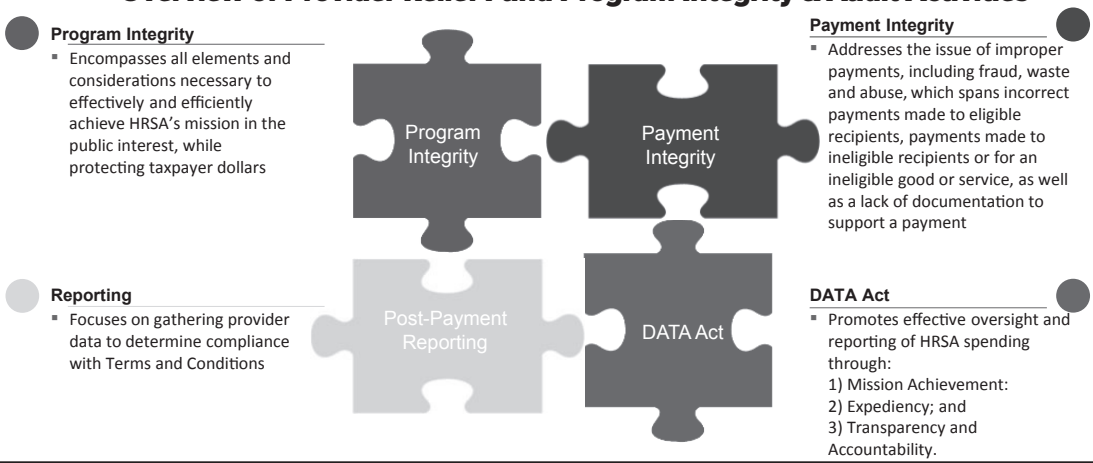
There's a "multi-layered audit approach" in the works, Roach said. Financial audits will be performed in accordance with Generally Accepted Government Auditing Standards (GAGAS), with an expected start date of fiscal year 2021. In addition, providers who received more than $750,000 in Provider Relief Fund money are subject to "single audits" under the Single Audit Act. He said a small percentage of providers that received funds to date—maybe 3%—will fall in that category. The provider relief/payment integrity team also will review entities to determine whether they're compliant with the terms and conditions of the Provider Relief Fund. "Think of these as desk reviews or non-GAGAS-type reviews," he said. "But they're equally important for us to gain insights about the use of these funds."

Separately, Provider Relief Fund money is being audited by the HHS Office of Inspector General.

HRSA's Oversight Strategy for Provider Relief Fund Money

Joe Roach, the lead of the Program Integrity Team in the Office of Provider Relief at the HHS Health Resources and Services Administration (HRSA), explained its oversight strategy for the Provider Relief Fund Oct. 1 at the Fraud and Compliance Forum sponsored by the American Health Law Association (see story, p. 1).[1]

Overview of Provider Relief Fund Program Integrity & Audit Activities



Endnotes

1. Nina Youngstrom, "HRSA Plans Several Audits of Provider Relief Fund; Reporting Requirements Raise Alarm," *Report on Medicare Compliance* 29, no. 36 (October 12, 2020).

As for audit analytics, Roach said HRSA has "an expansive financial data warehouse. This data warehouse will be a feeder for all future potential audits." The data will be used to support the audit selection process, post-payment analysis and recoupment, with future audits based on a broad array of risk factors that will be updated in real time. Among other things, analytics will be used to:

- Identify anomalies in the use of Provider Relief Fund money within peer groups.
- Validate changes of ownership against attestations.
- "Detect outliers using expense or revenue loss correlation relative to self-reported COVID-19 caseload for high-impact distributions," he said.

Reporting Requirements Set Teeth on Edge

As of the end of September, HHS had distributed $108 billion in Provider Relief Fund money to Medicare providers, said Martie Ross, a health care consultant with PYA, at an Oct. 5 webinar sponsored by the firm. The first distribution (Phase I) was $50 billion and the payments were made to every fee-for-service Medicare provider with a taxpayer identification number, based on 2% of the provider's patient revenue in 2019.

The second distribution (Phase II) was $18 billion and focused on Medicaid, State Children's Health Insurance Program and dental providers, based on about 2% of their annual revenue from patient care. HHS also did a targeted distribution for providers most affected by COVID-19. Finally, Ross said, HHS used Provider Relief Fund dollars for other purposes, such as nursing home infection control incentive payments.

On Oct. 1, HHS announced a Phase III $20 billion general distribution. It's available to providers that haven't yet received payments equal to 2% of their patient revenue, providers that went through a change in ownership and others. HHS may then distribute leftover funds to providers that already hit the 2% mark.

Timing is critical for the reporting of funds, according to the Sept. 19 provider reporting requirements, Ross said. "The crucial date is Feb. 15, 2021, when you will report on funds expended through the end of this year," she explained. Then on July 31, providers report on funds expended through June 30. "HHS clarified that your use of Provider Relief Funds must be completed by June 30, 2021. Any finds not attributed to expenses or lost revenue would be returned to HHS," Ross said. So far, though, there's no guidance on the refund process.

Some of the reporting requirements are driving providers a little crazy because they're different from what HHS said in June 19 answers to frequently asked questions (FAQs).[4] For example, the lost revenue calculation is solely focused on lost patient care income. "Most folks thought they would look at the overall year at the macro level," said attorney Richard Church, with

K&L Gates in Research Triangle Park, North Carolina. But HHS now is asking for a specific calculation that can't be pulled off the cost report or out of the budget.

Further, the lost revenue in the current guidance is capped by the provider's 2019 patient income, Church said. "If you lost money in 2019, then you can't take any money at all beyond what you are able to retain for [COVID-19-related] expenses," he explained. This is the subject of intense lobbying by the American Hospital Association, which asked HHS in a Sept. 25 letter to reinstate the COVID-19 reporting requirements in the June FAQs.

Compliance Depends on Terms and Conditions, Reporting

Compliance ultimately will turn largely on whether providers complied with the terms and conditions and reporting requirements of the Provider Relief Fund and can "justify the amount of funds received," Church said. Among the terms and conditions:

- Providers must certify that funds "will only be used to prevent, prepare for, and respond to coronavirus." Brenna Jenny, HHS deputy general counsel and CMS chief legal officer, said at the AHLA conference that the definition of preventing and preparing for the coronavirus is "incredibly broad." For example, if a hospital built a surge facility in April with the expectation of an influx of admissions, even if they never materialized "that would be a permissible" use of Provider Relief Fund money.
- Provider Relief Fund money can't be spent to pay more than $197,300 of an executive's salary.
- The funds can't be used to reimburse expenses or losses that are already covered by other sources, such as insurance payments. "We expect others to pay first," Jenny noted.
- Providers can't charge COVID-19 patients more if they are out of network.

A lot of nonprofit hospitals are already familiar with audits under the Single Audit Act because they receive grant money, but for physician practices and for-profit hospitals, "this is a whole new ball game," said Catherine Bunch, an audit partner at PYA, during the webinar. "If a health care organization gets $2 million and has a June 30 year end date, and expended $1 million before June 30 and the rest after, it will have two fiscal years subject to single audit requirements," she noted.

Church suggested that compliance officers get engaged now in Provider Relief Fund oversight and "build that documentation" to support how the organization has complied with the terms and conditions. He also recommends establishing a working group with finance and legal people in the hospital who are prepared to assess how to support reporting related to the funds that were received.

Contact Ross at mross@pyapc.com, Church at richard.church@klgates.com and Bunch at cbunch@pyapc.com. ✧

Endnotes

1. Joe Roach, "Overview of Provider Relief Fund Program Integrity & Audit Activities," Report on Medicare Compliance 29, no. 36 (October 12, 2020).
2. Nina Youngstrom, "With Its Vague Terms, Relief Fund Has Compliance Risks; 'Look from Several Angles,'" Report on Medicare Compliance 29, no. 16 (April 27, 2020), https://bit.ly/3esvZUd
3. HHS, "General and Targeted Distribution: Post-Payment Notice of Reporting Requirements," September 19, 2020, https://bit.ly/3d9vzCE.
4. HHS, "CARES Act Provider Relief Fund: Frequently Asked Questions," August 10, 2020, https://bit.ly/3eoCRSi.

NEWS BRIEFS

◆ **St. Joseph's Hospital and Medical Center in Phoenix, Arizona, has agreed to pay $160,000 and adopt corrective measures to settle a potential violation of the HIPAA Privacy Rule's right of access provision, the HHS Office for Civil Rights (OCR) said Oct. 7.**[1] A mother complained to OCR in April 2018 that starting in January of that year, she made multiple requests to St. Joseph's for a copy of her son's medical records. The hospital produced some but not all of them, despite follow-up requests from the mother, who is her son's personal representative, OCR said. "As a result of OCR's investigation, [the hospital] sent all of the requested medical records to the mother on December 19, 2019, more than 22 months after her initial request," OCR said. In the resolution agreement with OCR, St. Joseph's did not admit liability.

◆ **CMS said**[2] **Oct. 8 it has amended repayment terms for providers under the Accelerated and Advance Payment Program.** Although providers were required to start returning the money, which was available to ease the cash crunch early in the COVID-19 pandemic, in August, CMS is delaying repayment until one year after the payment was made. After that, Medicare will recoup 25% of the provider's Medicare payments for 11 months and 50% of Medicare payments for another six months. After that, "CMS will issue letters requiring repayment of any outstanding balance," with 4% interest.

◆ **Advanced Pain Management in Wisconsin agreed to pay $1 million to settle false claims allegations** they performed medically unnecessary lab tests and paid kickbacks, the U.S. Attorney's Office for the Eastern District of Wisconsin said[3] Oct. 2.

Endnotes

1. HHS, "St. Joseph's Hospital and Medical Center Resolution Agreement and Corrective Action Plan," September 25, 2020, https://bit.ly/34zzAwd.
2. CMS, "CMS Announces New Repayment Terms for Medicare Loans made to Providers during COVID-19," news release, October 8, 2020, https://go.cms.gov/3jXZ25n.
3. Department of Justice, U.S. Attorney's Office for the Eastern District of Wisconsin, "Pain Management Companies Agree to Pay $1 Million to Resolve Allegations They Violated the False Claims Act and Anti-Kickback Statute," news release, October 2, 2020, https://bit.ly/2GzVEiC.