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Long-Term Care Newsletter

Making Sure Arbitration Agreements Are Enforceable

By Rod Confer

Long term care facilities have recently begun offering residents the option of agreeing to arbitrate disputes that arise during residency. An arbitration agreement may benefit both facilities and residents as an alternative to litigation, by reducing the expense, delay and emotional stress associated with court trials. These agreements are usually enforceable under the Federal Arbitration Act.

Arbitration agreements typically are signed upon admission to the facility, along with other agreements covering residency and care. Often they are signed by family members or others who accompany the resident. This may occur because of physical infirmity, mental incapacity or other reasons.

The Nebraska Supreme Court recently held an arbitration agreement invalid that was signed by a

nursing home resident's son in *Koricic v. Beverly Enterprises*. The son wasn't the resident's appointed conservator or guardian and had no power of attorney. Even so, the trial court had found the resident had given her son permission to sign papers for her admission to the nursing home.

On appeal the Nebraska high court reversed, concluding the mother's statements authorizing her son to sign papers didn't include the arbitration agreement, because it wasn't required as a condition for her admission. Since the son wasn't legally authorized to sign the arbitration agreement it was not binding on his mother's estate.

Koricic demonstrates that nursing home admissions personnel have to insure that anyone signing an arbitration agreement has legal capacity to enter into a binding commitment for the resident.

Unless the resident is incompetent, the best practice generally calls for the resident to personally sign the arbitration agreement and other admissions documents.

If someone other than a resident must sign admissions documents, they must have legal authority to sign for the resident. That generally means the one signing must be a court-appointed conservator or guardian, or else possess a power of attorney, signed when the resident was competent, authorizing the signer to execute the document on the resident's behalf.

Knudsen Law Firm can provide long term care facilities with properly drafted arbitration agreements. Just as important, we can advise on training admissions staff to insure a legally authorized person signs the agreement, to make it enforceable and effective.

Long-Term Care Insurance Provisions in the Pension Protection Act Take Effect January 1, 2010

By Laura Troshynski

The Pension Protection Act of 2006 (PPA) was signed into law on August 17, 2006. Included among the many provisions in the PPA is Section 844 which, in part, encourages individuals to purchase insurance for future long-term care needs. This Section takes effect January 1, 2010 and is effective for contracts issued after December 31, 1996.

Section 844 of the PPA addresses the treatment of long-term care insurance riders that are added to annuity contracts or life insurance policies. In the past, the

Tax Code has prohibited combinations of long-term care insurance policies with annuity contracts because payouts from these policies were taxed differently under the Code. However, beginning January 1, 2010, the PPA permits long-term care insurance riders to be attached to annuity contracts. Once these riders are attached, they will be treated as separate contracts which are independent from the original annuity contracts. Accordingly, when a rider attached to an annuity contract is a tax-qualified long-term care rider,

benefits paid out under the rider for long-term care will generally be paid as tax-free long-term care insurance benefits, if certain triggering events occur.

These new "combination" policies are expected to be desirable to individuals previously concerned with the "use-it-or-lose-it" feature which is found in most stand alone long-term care insurance policies because the annuities included in the policies can be utilized, even if no long-term care services are ever needed by the policyholders.



Preparing the
Way Forward

**November is
National Long-
Term Care
Awareness
Month**

HIPAA Breach Notification Rule: Safe Harbor & Current Obligations

By Kevin R. McManaman

Interim HIPAA breach notification regulations from the U.S. Department of Health and Human Services, ("HHS") became effective September 23, 2009, requiring entities to give notice to affected individuals of any breach of unsecured, protected health information. These rules originate with the Stimulus Bill and are part of the administration's promotion of "electronic health records."

Safe Harbor

The new rules contain a safe-harbor. Entities that use HHS-approved technologies and methodologies that result in the encryption and destruction of certain health records need not comply with the notification rules (although notification is still considered a best practice).

Key to the safe-harbor is the fact that the rules apply only to breaches of "unsecured" Protected Health Information ("PHI"). The term "unsecured" refers to PHI that has not been secured through the use of technology or methodology approved by HHS. HHS Guidance (called the "HITECH Breach Notification Guidance") describes those approved technologies and methodologies, making PHI "unusable, unreadable, or indecipherable to unauthorized individuals". Electronic PHI is secured when it has been ade-

quately encrypted. Hard copies of PHI can only be secured when shredded or destroyed such that they cannot be read or reconstructed.

Current Obligations

A covered entity and a business associate must be able to identify, record, investigate and report to an affected individual and HHS any breach occurring after September 23, 2009. A covered entity's work force must be trained on the new breach notification regulations. Additionally, a covered entity must include sanctions for violating the new breach of notification rules, and the sanction must be included in the covered entity's policies. Therefore, covered entities should examine their handbooks or other provisions regarding sanctions to insure that they are broad enough to include sanctions relating to the breach of notification rules. If not, they need to be updated.

Definition of Breach

If there is a saving grace in all of this, it is that the definition of a "breach" has been modified as well. The regulations now provide that a "breach" exists if there is an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rules and such action "compromises" the security or the privacy of the PHI. The definition of "compromise"

now includes a helpful risk analysis, and under that analysis the PHI is compromised only if the event poses "a significant risk of financial, reputational, or other harm to the individual." In other words, many minor or insignificant breaches may not pose a significant risk of such harm, and need not be reported to the affected individual or to HHS. A breach of unsecured PHI is also not considered to have occurred under certain exceptions:

1. If an unauthorized person to whom the unsecured PHI is disclosed would not reasonably have been able to retain the PHI;
2. An unintentional acquisition, access, or use of unsecured PHI occurs by an employee or individual acting under the authority of a HIPAA covered entity or business associate, but only if (a) the acquisition, access or use is made in good faith and within the course and scope of employment or other professional relationship with the covered entity or business associate and (b) such unsecured PHI is not further acquired, accessed, used, disclosed by anyone; or
3. Where the inadvertent disclosure occurs from an individual who is otherwise authorized access to unsecured PHI at a facility operated by a HIPAA covered entity or business associate, to another similarly situated individual at the same facility, but only if the unsecured PHI is not further accessed, acquired, used or disclosed without authorization.

HIPAA covered entities and business associates should each identify their business associates, agents and sub-contractors and review their agreements to include compliance with the new regulations. Handbooks and training need to be updated as well.

CMS Rule Affects MDS Assessments

By Tammy Schroeder

A controversial new CMS rule will change Medicare case mixes under the Resource Utilization Group (RUG) system. This new rule eliminates a section of the MDS and changes the RUG classification for short stay residents.

Effective October 1, 2010 the new regulation will eliminate section T of the MDS which is what helps to determine RUG placement. Section T is used to estimate how much therapy a resident will receive during his or her first 14 days in a skilled nursing facility. It is CMS' belief that projections have been inaccurate and a large number of residents aren't receiv-

ing the amount of therapy forecasted for them.

The plan set out by CMS is to implement an option start-of-therapy Other Medicare Required Assessment (OMRA) with an Assessment Reference Date (ARD) to be carried out five to seven days after therapy begins. It is the belief of CMS that this new rule will reduce payments to nursing homes by about \$1.05 billion in the fiscal year 2010.



*We would like to
wish everyone a
Happy and Safe
Holiday Season*



Congressional Committee Wants Review of 5 Star Rating System

By Tammy Schroeder

The House of Representatives Committee on Energy and Commerce has asked for a review and study of the CMS' Five Star Quality Nursing System. And that makes the American Health Care Association (AHCA) very happy.

The Committee asked in a letter to the Government Accountability Office that it do a comprehensive evaluation of the Five Star system, focusing on the process used by CMS to develop it, the steps CMS takes to ensure the reliability of the data, the weighting of the calculated ratings, and steps taken by CMS to ensure reliability of the data used to calculate ratings, including actions

to provide more dependable staffing data.

President and CEO of the AHCA, Bruce Yarwood, has commended the committee for demanding a review of the addition of a consumer satisfaction component. Mr. Yarwood stated that the current system doesn't specifically measure quality, rather it only measures compliance with state and federal regulations. Yarwood further has emphasized that the survey system is not unimportant; instead how a resident and the family perceives the actual care given is a much superior indicator of the quality of care and quality of life a resident receives.



Pressure from Pressure Ulcers

By Michael Khalili

Centers for Medicare and Medicaid Services (CMS) have finally taken the first swing at the problem of undiagnosed pressure ulcers. Undiagnosed pressure ulcers are extremely costly, both in terms of patient suffering and use of healthcare resources.

Beginning last fall, CMS has made it a pain in the wallet for healthcare providers if they do not follow CMS's new reimbursement rules. These rules were designed as a preventative measure to catch pressure ulcers before they become hospital-acquired pressure ulcers, which are considered by CMS to be avoidable complications.

Under these new rules, a patient's pressure ulcer must be identified and documented within two days of admission in order for the facility to be reimbursed for the cost of treating the ulcer. This timeframe is meant to encourage facilities to recognize risks early and take steps to avoid them.

Next, it is vital for CMS reimbursement to correctly and thoroughly document the pressure ulcer to establish the true condition of the patient's skin at the

time of admission. The documentation must be done by a physician or other person legally responsible for establishing patient diagnosis. This documentation will be used to determine if a pressure ulcer was present or not at the time of inpatient admission, unknown because of document insufficiency, or clinically undetermined.

Documentation of the skin and risk assessment should be conducted daily, especially with patients who have identifiable trends of skin breakdown or pressure ulcers. This daily diligence should identify the improvement or worsening of the skin. The correct classification system should be used as well as distinguishable documents clarifying the type of ulcer, in order to correctly communicate the problem to others.

These few methods of recognizing, describing, documenting, and communicating the skin condition of every patient who enters the facility will allow for CMS reimbursement when required and may improve diagnosis and prevent avoidable complications for patients.



**Reminder:
Enforcement of the
Red Flags Rule is
scheduled to begin
November 1, 2009.
The effective date of
this rule has been
delayed twice; how-
ever, another delay
is unlikely.**



CDC Recommends Pneumonia Vaccine and Flu Vaccine

By Jeanelle R. Lust

Many of the people in the U.S. who have died from the H1N1 strain of influenza had a bacterial co-infection, often caused by streptococcus pneumonia. While those age 65 and older are not considered high risk for contracting H1N1, the CDC is concerned about co-morbid diseases. Therefore, the CDC recommends that seniors aged 65 and older should get vaccinated against pneumonia as well as the seasonal influenza strain.

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