Report on
Medicare Compliance

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Hospital Settles EMTALA Case Over Kidney Patient; OIG: Transfers Are Misunderstood

Palestine Regional Medical Center in Texas agreed to pay $45,000 to settle allegations it violated the Emergency Medical Treatment and Labor Act (EMTALA) when it discharged an unstable dialysis patient and failed to provide oxygen or transportation, according to the HHS Office of Inspector General. The 48-year-old woman died the same day.

When the patient, who had a kidney transplant and received dialysis, showed up at the outpatient dialysis center on Dec. 3, 2012, she was very short of breath, the settlement states. An ambulance came and took her to 142-bed Palestine Regional Medical Center, where she was diagnosed with acute pulmonary edema in the emergency department (ED). The hospital wasn't equipped to perform dialysis, which was necessary to stabilize the patient, and the patient declined to be transferred to a hospital that could provide dialysis, Sandra Sands, a senior counsel with OIG, tells *RMC*. Instead, the patient opted to return to the outpatient dialysis center. So the hospital discharged her, which is considered a transfer for EMTALA purposes. But the patient allegedly wasn't stable for discharge, according to the physician who reviewed the case for OIG.

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FCA Case Settles Over 60-Day Rule; Working Overpayments Is a Group Effort

In a landmark case, three New York City hospitals and Continuum Health Partners agreed to pay $2.95 million to settle false claims allegations that they overcharged Medicaid and then dragged their feet in returning $800,000 worth of overpayments in violation of the 60-day overpayment refund rule, the U.S. Attorney's Office for the Southern District of New York, the New York state attorney general and the New York state comptroller said Aug. 24.

Mount Sinai Beth Israel, Mount Sinai St. Luke's, Mount Sinai Roosevelt and Continuum admitted in the settlement that they took almost two years to repay Medicaid as a secondary payer payments they received by mistake in violation of the 60-day Medicare-Medicaid overpayment refund rule. Created by Sec. 6402(a) of the Affordable Care Act, the 60-day rule requires providers to refund overpayments within 60 days of identifying and quantifying them. In its February 2016 final regulation interpreting the law, CMS said the 60-day countdown starts when providers, through due diligence, determine they have received an overpayment and quantified it, but also gave them six months to investigate "credible information" about a potential overpayment before the 60-day clock starts *(RMC 2/15/16, p. 1)*.

There was high drama with the case against Continuum because its attempt to get the complaint thrown out resulted in a federal court decision that instead gave the government a leg up, setting the tone for other reverse false claims cases based on the 60-day rule *(RMC 8/10/15, p. 1)*. One year later comes the settlement, reinforcing

the obligation of providers to return overpayments on a deadline. But it takes a village to make this happen, says Atlanta attorney Sara Kay Wheeler, with King & Spalding. Several departments and stakeholders are often involved in nailing down the cause and amount of overpayments, including legal, revenue cycle and compliance. "I don't know that it's been easy on compliance officers to get the collaboration and buy-in that's needed so this case is really important for that," she says.

The hospitals, which became part of Mount Sinai Health System when Continuum merged with it, were sued by the U.S. attorney's office, which intervened in a whistleblower lawsuit filed by Robert Kane, who was Continuum's technical director of revenue cycle operations, hospital systems and operations, from Nov. 4, 2004, to Feb. 8, 2011.

At the heart of the false claims allegations are Medicaid managed care payments to the hospitals for enrollees in Healthfirst, New York state's prepaid health services plan, according to the U.S. attorney's complaint-in-intervention *(RMC 7/21/14, p. 1)*. HealthFirst makes monthly all-inclusive payments to hospitals for all covered services required by Medicaid enrollees, which means hospitals can't seek secondary payments. Healthfirst routinely sent hospitals electronic remittances with the codes for the services provided and their payments, which conveyed that providers couldn't seek payment elsewhere. But in 2009, a software glitch caused HealthFirst to send participating providers remittances with codes that mistakenly said they could pursue additional payments from secondary payers. "As a result, the electronic billing programs of numerous providers automatically generated bills to secondary payers, in particular Medicaid," the complaint alleged. Medicaid paid the hospital bills until the state comptroller caught on.

Kane Was Fired After Informing Managers

According to the settlement, in September 2010, the state comptroller "brought to Continuum's attention a small number of claims submitted by Continuum on behalf of the Hospitals that had been wrongly billed to Medicaid as a secondary payor." Over the next few months, Kane and other staffers got together to figure out whether other claims were affected. In February 2011, Kane emailed Continuum managers a spreadsheet of 444 claims that had been improperly billed to Medicaid.

He was fired the same month.

Continuum paid back Medicaid for five of the claims, but never shared Kane's findings. Over the next 11 months, the comptroller continued to point out to Continuum overpayments, at which time they would be repaid. Eventually Continuum paid all the money back, in stages, but it took two years, according to the settlement.

Hospitals are starting to come around to their obligations under the 60-day rule, but there are stumbling blocks, Wheeler says. Some hospitals are stuck in the credit-balance mindset, where they conflate the 60-day rule with the longstanding Medicare requirement to file quarterly credit balance reports (CMS-838). The 60-day rule, however, requires something more than credit balance reconciliation. There is "a clear duty to undertake proactive activities to determine if they have received an overpayment or risk potential liability for retaining such overpayment," as the final rule states. That's potentially a lot of risk areas, with "credible information" coming in from external and internal audits and hotline calls.

Wheeler encourages hospitals to develop processes that focus on non-routine potential overpayments. "Certain triggers should be analyzed by the right group of subject matter experts," she advises. Examples include billing, cost reports and grants. There are two steps: when the information comes in, do you have enough to determine whether it's credible? If the answer is "yes," the clock starts ticking on six months for an investigation plus 60 days to quantify and report. That may seem like

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plenty of time, and in isolation, it probably is, Wheeler says. But compliance officers may be juggling dozens or hundreds of potential overpayment analyses.

In the Continuum case, hospitals shouldn't be distracted by the fact the whistleblower was fired or that the overpayment was caused by a computer glitch, says former federal prosecutor Robert Trusiak. The bottom line is, the hospital was repeatedly told by a state agency of overpayments and put off returning the money. And software glitches won't shield them from the 60-day rule. "As a prosecutor, I always treated them in the same way as if an actual person made an error," says Trusiak, a principal at Health Care Compliance Solutions in Buffalo, N.Y. "We are not talking about artificial intelligence here. We are talking about systems that people program and systems people chose not to police. There is human action and inaction in any billing error. This is Medicaid as a secondary payer and Medicare and Medicaid as secondary payers are areas that hospitals should be policing through their compliance programs."

He wonders where the board was in all this. "Cases like this underscore the need for the board to play an active role when it comes to compliance consistent with the 2015 guidance" from the HHS Office of Inspector General on compliance oversight for health care board members *(RMC 4/27/15, p. 1)*, Trusiak says. When there is a dismissal of a compliance officer or a finance manager, the board should ask questions to make sure there is a good faith reason.

A lawyer for Continuum did not respond to *RMC*'s requests for comment.

Contact Wheeler at skwheeler@kslaw.com and Trusiak at robert@trusiaklaw.com. ✧

For EMTALA Reviews, Look Through Eyes of Surveyors; Logs Are Tricky

When patients arrive at the emergency department (ED), volunteers or security guards and other employees may mention how crowded it is inside and how long the wait will be and suggest they go to another hospital. That innocent comment could turn into a violation of the Emergency Medical Treatment and Labor Act (EMTALA) if patients perceive they are being turned away from the hospital.

"It's done with good intentions, but warning patients about long wait times or saying they may get faster service at other hospitals is beside the point," says Rob Brown, former assistant director of compliance at University of Washington Medicine in Seattle and now director of compliance at the UW School of Dentistry. "You don't ever want to discourage someone's care. Once the patient arrives at the hospital, there's an obligation to provide them a medical screening exam and, if necessary, stabilizing treatment. Even if it's well intentioned, comments that might cause a patient to seek care elsewhere can implicate EMTALA when dealing with emergency situations."

Without EMTALA audits and education that sweep in everyone connected to emergency rooms, provider-based urgent care centers and labor and delivery departments, hospitals are vulnerable to EMTALA violations. They can result in civil monetary penalties (see story, p. 1) or, in extreme cases, Medicare termination. State surveyors who evaluate EMTALA compliance on behalf of CMS may show up at hospitals because of a specific complaint, but once they're there, surveyors "audit for every piece" of EMTALA, using Appendix V of the CMS State Operations Manual, says Shannon Kennedy, chief compliance and privacy officer at Legacy Health in Portland, Ore.

"When was the last time you took a hard look at your compliance with EMTALA?" she says. "The industry can get complacent, and it isn't until a surveyor comes and people are kind of shaken up" that they realize that EMTALA policies are outdated, their patient logs are outdated and they haven't looked at transfer denials. "It's a call to duty for compliance professionals to put it in their work plans to make sure we are always in an EMTALA readiness state," Kennedy says.

EMTALA requires hospitals to provide a medical screening exam (MSE) and to provide stabilizing treatment if there is an emergency medical condition, without regard to the patient's ability to pay. Transfers to other hospitals are permitted only if the hospital lacks the capacity to treat the emergency conditions. It gets a lot more demanding, as spelled out in Appendix V, which is a good tool for internal reviews, says Kennedy, who also uses a compliance checklist (see box, pp. 4-5).

"With EMTALA, you want to make sure your house is in order and you can bounce a quarter off the bed," Brown says. "No one wants to have an EMTALA violation."

When he conducted EMTALA audits, Brown would walk through the ED and pull employees aside to ask

this question: If you saw what seemed like an EMTALA violation, what would you do? He wanted to know whether the answer would be consistent with hospital policy, which often directs employees to inform the ED manager. "People are funny. They say things like, 'I would call the Department of Health,' which isn't consistent with the policy," Brown says. "It's important for them to know what to do if they think there's an EMTALA violation because there's a time clock on reporting some EMTALA violations." If hospitals believe they have received an inappropriate transfer, the receiving hospital is required to report the other hospital for a possible EMTALA violation. According to Appendix V, the receiving hospital must report the transferring hospital's transgression to CMS or a state surveyor within 72 hours — or the receiving hospital could face fines or Medicare termination.

But Brown cautions hospitals not to rush to judgment. Sometimes what happened to patients doesn't rise to the level of an inappropriate transfer and pointing the finger will strain relationships with your fellow hospital. "Patients might say, 'I went to this hospital and they turned me away.' If they explain, it can be more complicated. They were probably screened and stabilized, but

Checklist for an EMTALA Compliance Review

Legacy Health in Portland, Ore., uses this checklist in its internal review of compliance with the Emergency Medical Treatment and Labor Act (EMTALA), says Chief Compliance and Privacy Officer Shannon Kennedy. She modified a checklist that was developed by Robert Brown, director of compliance at the University of Washington School of Dentistry in Seattle. Contact Kennedy at SAKENNED@lhs.org and Brown at rsbrown@uw.edu.

EMTALA Compliance Checklist	
Entrances and Signage	
	1. Identify and review all entrances to the Emergency Department that can be utilized by persons presenting for treatment.
	2. Are signs posted that give information about the person's right to a Medical Screening Examination (MSE) regardless of ability to pay?
	3. Are signs posted in the entrances, waiting areas, registration, triage and treatment areas?
	4. Are signs clearly visible from a distance of 20 feet or the expected vantage point of the patron?
	5. Are signs in the languages of the population(s) most frequently served by the facility?
	6. Is the waiting area visible to triage staff so that patients can be monitored?
Triage	
	1. Where is triage performed and how are patients directed there?
	2. When is triage performed? [Best practice is prior to registration]
	3. What happens if someone leaves before or after triage?
	4. Are patients informed to notify staff if condition worsens or if they choose to leave (so that Informed Refusal of Care can be documented)?
	5. Confirm that Informed Refusal of Care forms are located in close proximity to waiting area?
Registration	
	1. What information is obtained?
	2. Where is it documented?
	3. When is the central log initiated?
	4. Confirm that MSE and treatment not being delayed for registration; however, if patient triaged non-emergent, reasonable registration process can begin.
	5. Do registration staff have scripts to address patients who insist on discussing insurance coverage prior to MSE?
	6. Confirm that preauthorization of services with insurers is not occurring until after MSE.
Medical Screening Examination	
	1. Do physicians or Qualified Medical Personnel (QMPs) document when MSE has been completed?
	2. Are ancillary services used as needed to evaluate the presenting complaint and determine if an Emergency Medical Condition (EMC) exists?
Stabilizing Treatment	
	1. Is it performed within the capability of the facility and staff?
	2. Confirm that all physicians are presenting to the facility when called and in compliance with timeframe set forth in facility policy.
	3. Is there a communication process between the clinical staff and registration staff so that any required prior authorization can be sought once stabilization has been initiated?

told they had to get follow-up care elsewhere," Brown explains. "The material facts are so important in EMTALA investigations."

The central log is another area that requires oversight, and it's the first thing surveyors ask for, Kennedy says. Appendix V states that the ED must maintain a log of all people who seek treatment and if they "refused treatment, were denied treatment or were treated, admitted, stabilized, and/or transferred or were discharged."

It's no easy feat to centralize a log from electronic health records (EHRs), Kennedy says. "This can be a logistical nightmare if you don't have a procedure in place to generate a central log," she says. Not only is the ED subject to maintaining a central log, but the same goes for urgent care centers that are provider-based as well as labor and delivery departments. "They may work in different platforms," she says. "We have EPIC but it's not the same for every service. It's customized for the ED, labor and delivery and outpatient clinics." She suggests generating a log once in a while "to make sure the log still works. It becomes an IT maintenance project."

continued

Checklist for an EMTALA Compliance Review (continued)

Transfers Out			
	1. Audit transfer paperwork to confirm that all transfers of individuals with unstabilized EMCs are initiated either by (a) a written request for transfer or (b) a physician certification regarding the medical necessity for the transfer.		
	2. Documentation for the foregoing must be included in the medical record and a copy sent to the receiving hospital.		
		(a) If the transfer is requested, do forms allow clear documentation of the request and that the risks and benefits of transfer were discussed with the patient? [Form used to document requested transfers should include a brief statement of the hospital's obligations under EMTALA. Reason for request by patient must be documented as well.]	
		(b) How does the physician certify that the benefits of transfer outweigh the risks? Focus should be on the patient's complaints, symptoms and diagnosis.	
	3. Do facility policies and procedures define documentation standards and the facility person(s) responsible for		
		(a) Identifying a receiving physician at the receiving hospital;	
		(b) Obtaining acceptance of the patient by the receiving hospital; and	
		(c) Sending pertinent medical records with the patient.	
	4. Do available forms provide a place for the physician to write an order for the transfer and describe transportation staffing and equipment requirements?		
	5. If a transfer occurs due to an on-call physician's failure to appear, are the name and address of the physician included in the records sent to the receiving hospital?		
Transfers In			
	1. Has the facility established a transfer request log to capture the following information regarding requested transfers into the facility:		
		(a) date and time of request;	
		(b) facility requesting transfer;	
		(c) services requested/reason for transfer;	
		(d) service availability at receiving hospital;	
		(e) whether transfer accepted or denied; and	
		(f) if applicable, reason for denial?	
Documentation Review			
	1. Audit central log for disposition and compliance with additional state law requirements (e.g.,documentation of chief complaint, time of arrival and time of disposition).		
	2. Review Bylaws (or Rules and Regulations) to confirm indication of who may perform an MSE. If a non-physician is authorized to perform an MSE, confirm that the required credentials, competencies and practices standards/protocols identified.		
	3. Review physician on-call list to verify that it reflects coverage of services available to inpatients. Physicians must be listed by name rather than practice group.		
	4. Review triage and reassessment policy.		
	5. Confirm that EMTALA policy has been updated to reflect regulatory changes and interpretive guidance changes, for example:		
		(a) Definition of "comes to the emergency department";	
		(b) Definition of "dedicated emergency department" (DED);	
		(c) Concept of "prudent layperson observer";	
		(d) Changes in obligations for non-DED off-campus departments;	
		(e) Cessation of EMTALA obligations upon inpatient admission; and	
		(f) Requirement that back-up arrangements for on-call coverage be documented in policies	

During his reviews, Brown looked at patient experiences and work flow. How many people left the ED without being seen (LWBS)? Or left against medical advice (LAMA)? Maybe they were triaged and had a medical screening exam, and then disappeared, or were even in the middle of being stabilized and snuck out, which is known as left before final discharge (LBFD). "It's possible they might have been discouraged from getting care by the hospital staff if too early in the process they were asked how they intended to pay or asked for a copay," Brown says.

He suggests looking for trends in these areas. "If LWBS, LAMA or LBFD are trending upward, that might indicate staff needs more training and scripting," he says.

Scripts Keep Focus on Care

Giving scripts to employees can help them respond appropriately to patients' questions about money and assure them "their care takes precedence over the collection of financial information," Brown says. For example, patients who come to the ED may ask how much the encounter will cost them. "One reply might be, 'right now we just need to get you checked in and seen by the triage nurse and the examining physician. They'll take great care of you. Later on, another staff member will stop by to answer all your questions about financial matters.'"

EMTALA policies also should be revisited every two or three years, Brown says. "Don't have anything in your policy that you are not doing." For example, EMTALA requires hospitals to identify in their bylaws the "qualified medical personnel" who can perform MSEs. What can happen, Brown says, is hospitals name physicians as the qualified medical personnel but later employ nurse practitioners and physician assistants in the EDs without updating the bylaws.

Signs are another sign of EMTALA compliance or lack of it. Appendix V states that hospitals must "post signs in the dedicated ED specifying the rights of individuals with emergency medical conditions and women in labor who come to the dedicated ED for health care services, and indicate on the signs whether the hospital participates in the Medicaid program." One is not good enough. "Surveyors expect to see signs everywhere" — in English, Spanish or other languages reflecting the patient base — and be viewable from 20 feet, she says.

A sleeper EMTALA risk is hospitals' marketing their short ED wait times, Brown says. "It's vogue for hospitals to publish ED wait times," he says. "They do it on billboards and websites and patients mistakenly equate a shorter average wait time with getting quicker treatment." But after they are assessed by the triage nurse, patients are seen based on the acuity of their illness or injury, so patients with chest pain or overdose, for example, will be seen much sooner than a patient with a simple fracture. "The ED wait time thing could backfire without clearly explaining the relative importance of acuity," Brown says. "Make sure your hospital's average wait time information is clear and doesn't inadvertently discourage patients from coming to the ED (yours or anyone else's)."

Contact Kennedy at SAKENNED@lhs.org and Brown at rsbrown@uw.edu. ✧

JW Modifier for Drug Waste Is Almost Here; CMS Puts Out FAQs

In four months, all hospitals will have to use the JW modifier on claims that include wasted drugs and put them on a separate line from the dose that was administered to patients, CMS says, again, in new guidance.

"Effective January 1, 2017, the modifier must be used in order to obtain payment for a discarded amount of drug in single dose or single use packaging under the Medicare discarded drug policy," according to answers to frequently asked questions posted on the CMS website Aug. 26. CMS notes that the modifier "is not required if no discarded drug is being billed to any payer" — something some hospitals are taking to heart because the revenue from wasted drugs may not be worth the operational hassle and consequences for noncompliance (e.g., lack of documentation), one expert says.

"A lot of hospitals are evaluating the time it would take their pharmacist to do it vs. the money they get for waste and are electing to only bill the dose used because compliance is way more expensive than the payment they would achieve," says Valerie Rinkle, president of Valorize Consulting. However, some hospitals won't forego the drug-waste reimbursement since it adds up.

Some Medicare administrative contractors (MACs) already require use of the modifier, but CMS decided to go national with it. That mandate came down in early May, when CMS ordered all hospitals to start using the JW modifier in July if they weren't already *(RMC 5/9/16, p. 1)*. But CMS delayed it to Jan. 1, 2017, according to *MLN Matters* MM9603 Revised, which was released on June 9.

Medicare Part B pays for wasted drugs, which refer to the medication left over in a single-use vial after the prescribed amount is administered. It's a reimbursement opportunity because patients often get less than the amount in a single-use drug vial, and the rest should be thrown out according to guidance from the Centers for Disease Control and Prevention. But drug waste is also a compliance risk if there isn't documentation to explain a discrepancy between the dose administered and the dose

billed. Many expensive cancer drugs, for example, come in single-use vials.

According to the FAQs, "the JW modifier requirement applies to all separately payable drugs assigned status indicators G (Pass-Through Drugs and Biologicals) or K (Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals) under the OPPS for which there is an unused or discarded amount." Hospitals must separate the dose administered from the wasted amount. "The drug discarded should be billed on a separate line with the JW modifier," according to the FAQs. For example, if the patient needs 7 mg of a medication but it comes in 5 mg vials, the nurse would have to open two vials to administer the dose ordered by the physician. Seven mg would be administered and 3 mg would be wasted, and the nurse would document both the amount administered and the amount wasted. All 10 mg can be charged to Medicare, but the 3 mg is a separate line item with the JW modifier.

One challenge for hospitals with reimbursement for drug waste is making sure they document it. CMS said it's acceptable to use automatic calculations from software as documentation of discarded drugs and that it doesn't dictate how doses are calculated, Rinkle says.

Another challenge is sorting out when to append the modifier and charge for drug waste because only 335 drugs in Addendum B of the OPPS rule are eligible for recoupment for wasted drugs, Rinkle says.

Billing for discarded drugs "probably makes the most sense for hospitals with oncology and infusion clinics that are using expensive chemotherapy drugs where wastage amounts could result in potentially significant payment and it's possible pharmacists responsible for those drugs are very specialized and may be able to achieve that," Rinkle says.

Contact Rinkle at valerie.rinkle@valorizeconsulting.com. View the FAQs at http://tinyurl.com/j5m73tm. ✧

CMS Transmittals and *Federal Register* Regulations
Aug. 19 – Sept. 1

Live links to the following documents are included on *RMC's* subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- October 2016 Update of the Hospital Outpatient Prospective Payment System, Trans. 3602CP, CR 9768 (Aug. 26; eff. Oct. 1; impl. Oct. 3, 2016)
- October 2016 Update of the Ambulatory Surgical Center Payment System, Trans. 3601CP, CR 9773 (Aug. 26; eff. Oct. 1; impl. Oct. 3, 2016)
- October Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule, Trans. 3598CP, CR 9756 (Aug. 26; eff. Oct. 1; impl. Oct. 3, 2016)
- Healthcare Provider Taxonomy Codes October 2016 Code Set Update, Trans. 3597CP, CR 9659 (Aug. 26; eff. Oct. 1; impl. Oct. 3, 2016/Jan. 1, 2017)
- 2017 Annual Update of Healthcare Common Procedure Coding System Codes for Skilled Nursing Facility Consolidated Billing Update, Trans. 3603CP, CR 9735 (Aug. 26; eff. Jan. 1; impl. Jan. 3, 2017)
- Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes and Claim Adjustment Group Code Rule - Update from Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange, Trans. 3600CP, CR 9766 (Aug. 26; eff. Jan. 1; impl. Jan. 3, 2017)
- Common Edits and Enhancements Modules Code Set Update, Trans. 3604CP, CR 9657 (Aug. 26; eff. Jan. 1; impl. Jan. 3, 2017)
- Claim Status Category and Claim Status Codes Update, Trans. 3599CP, CR 9680 (Aug. 26; eff. Jan. 1; impl. Jan. 3, 2017)
- Annual Clotting Factor Furnishing Fee Update 2017, Trans. 3607CP, CR 9759 (Aug. 26; eff. Jan. 1; impl. Jan. 3, 2017)
- Quarterly Update to the Medicare Physician Fee Schedule Database - October CY 2016 Update (R), Trans. 3595CP, CR 9749 (Aug. 24; eff. Jan. 1; eff. Oct. 1; impl. Oct. 3, 2016)
- Additional Instructions for the Implementation of Round 2 Recompete of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program and National Mail Order Recompete, Trans. 3593CP, CR 9579 (Aug. 17; eff. Oct. 1; impl. Oct. 3, 2016)

Pub. 100-08, Medicare Program Integrity Manual

- Documentation for Durable Medical Equipment Prosthetics, Orthotics and Supplies Claims for Replacement of Essential Accessories for Beneficiary-Owned Continuous Positive Airway Pressure Devices and Respiratory Assist Devices, Trans. 672PI, CR 9741 (Aug. 19; eff. July 1; Nov. 2, 2016)

Pub. 100-20, One-Time Notification

- Coding Revisions to National Coverage Determinations, Trans. 17080TN, CR 9751 (Aug. 19; eff. Jan. 1; impl. Jan. 3, 2017)
- Adding a Foreign Language Tagline Sheet to Medicare Summary Notices, Trans. 17100TN, CR 9617 (Aug. 26; eff./impl. Oct. 28, 2016)
- The Provider Reimbursement Manual - Part 2
- Provider Cost Reporting Forms and Instructions, Chapter 41, Form CMS-2540-10, Trans. 79R241 (Aug. 19; eff. for cost reporting periods on or after Oct. 15, 2016)

Federal Register Regulations

Final Rules

- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates, 81 Fed. Reg. 56761 (Aug. 22, 2016)
- Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017, Correction: 81 Fed. Reg.59901 (Aug. 31, 2016)

Hospital Settles EMTALA Case

continued from p. 1

"[The hospital] felt she was stable for purposes of getting to the outpatient dialysis clinic, but that was an error in medical judgment," Sands says. EMTALA also requires stabilizing treatment to minimize the risk of a transfer, but the patient wasn't given oxygen at discharge or transported in an ambulance, she says. The patient called someone for a ride.

When the patient arrived at the dialysis clinic, her oxygen saturation was 46% to 59%, the settlement states. The clinic began dialysis, but the patient's condition "deteriorated" and she was brought back to Palestine's ED, where she was pronounced dead. "The fundamental mistake was that the doctor who was treating her made an inappropriate judgment as to whether she was stable to get to the outpatient facility," Sands says.

The hospital did not admit liability. Its attorney did not respond to *RMC*'s requests for comment.

EMTALA, which requires hospitals to provide a medical screening exam and to provide stabilizing treatment if there is an emergency medical condition without regard to the patient's ability to pay (see story, p. 3), was enacted 30 years ago and "hospitals are much more aware of what their responsibilities are," Sands says. But "we still have a lot of very serious cases."

Over the years, OIG has found that patients were turned away for financial reasons less often than expected. EMTALA violations stem more often from misconceptions by hospital staff and physicians about their responsibilities under the law and "communication breakdowns," she says. "There's a significant lack of understanding that EMTALA requires hospitals with specialized capability to accept a transfer from another hospital," Sands says. Hospitals that receive a request to accept a patient are expected to graciously accept, assuming they have the appropriate staff and equipment to provide the treatment.

Also, she says, some on-call physicians seem to think they aren't required to come in if the patient's being transferred to the hospital. "There's a lack of understanding by on-call specialists. They have an obligation to treat patients if they are not in the ED," Sands notes.

Contact Sands through OIG spokeswoman Katherine Harris at Katherine.Harris@oig.hhs.gov. ✧

NEWS BRIEFS

◆ **The overpayment amounts identified in Medicare compliance reviews keep climbing, reaching a new high of $15.48 million.** The HHS Office of Inspector General contends that Home Health VNA in Lawrence, Mass., made errors on 105 of the 497 home health claims audited. "On the basis of our sample results, we estimated that the Agency received overpayments of at least $15,483,448 for the audit period," OIG said. The second largest overpayment finding in a Medicare compliance review — $14.2 million at New York-Presbyterian Hospital — came down about a week earlier *(RMC 8/15/16, p. 1)*. In a written response, Home Health VNA said it "disagrees with the majority of the findings in the Report" and emphasized that compliance is a high priority. Visit http://go.usa.gov/xDB44.

◆ **In new guidance, the HHS Office of Inspector General set forth "principles" that should be used to evaluate the "independence and objectivity" of independent review organizations (IROs),** which are typically required in corporate integrity agreements when providers settle false claims lawsuits. OIG described services that a company could perform that probably would not impair its "objectivity and independence" if it doubled as an IRO for providers, including compliance training, exclusion screening and evaluation of compliance-program effectiveness. OIG also described the services that probably would impair the IRO's objectivity and independence. They include providers using the IRO's billing or coding software; involving the IRO in decisions related to the provider's confidential disclosure program, "such as determining which allegations warrant further investigation or the appropriate corrective action to take in response to compliance allegations"; or outsourcing the provider's internal audit to the IRO. An IRO's independence came up recently at Broward Health, which hired an IRO as part of its 2015 false claims settlement for alleged Stark violations *(RMC 9/21/15, p. 1)*. Visit http://tinyurl.com/j6l5pp6.

◆ **Hospitals probably have until Jan. 1 to implement the revised Medicare outpatient observation notice (MOON).** CMS said it expects the new draft *(RMC 8/8/16, p. 1)* to be approved by the Office of Management and Budget around Oct. 1, after which hospitals have 90 days to implement it. "We expect final [Paperwork Reduction Act] approval of the MOON around the time the implementing regulations are effective," CMS said on its website. Visit http://tinyurl.com/zeyxgk6.

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