Report on
Medicare Compliance

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

Contents

Appealing Medicare Advantage Denials For Patients Gives Hospitals More Leverage

Fed up with claim denials for inpatient admissions by Medicare Advantage (MA) plans months after they were approved, Self Regional Healthcare in Greenwood, S.C., complained to the CMS regional office in Atlanta.

"We started sending information to CMS saying that if the Medicare Advantage plans do concurrent review and authorize inpatient care, we have every right to expect payment," said Roy Baker, M.D., medical director of case management. Otherwise, the hospital should have the right to hold the beneficiary liable for the hospital stay. That had an impact. "CMS cares about beneficiaries. They took that to heart and [went to] the Medicare Advantage plan," Baker said at a March 8 webinar sponsored by Intersect Healthcare and AppealMasters. "In 24 hours, a group of denials was overturned in one fell swoop. It made my CFO happy."

CMS intervention is one way the hospital fights MA payment denials, Baker said. It has found success in new ways, along with other hospitals that have used assorted strategies to protect their revenue from the increasing number of claim denials they say they are experiencing. Some are appealing claim denials on behalf of patients because they have far greater rights, said Brian McGraw, president of Intersect Healthcare and AppealMasters.

"If you fight and win on the patient's behalf, you get paid, even if your own [appeal] rights are exhausted," he noted.

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With Growth in DEDs, 'Extrapolation' and New Rule, EMTALA Compliance Gets Trickier

A Texas hospital did a double take when it was informed by state surveyors that one person and a driver must accompany transfers of unstable psychiatric patients and that CMS was on board with that position. It was a setback because the hospital had just signed a contract with a transportation group that provides trained drivers and special vehicles to transfer psychiatric patients to inpatient psychiatric facilities, and now, after an Emergency Medical Treatment and Labor Act (EMTALA) survey, the state and CMS told the hospital that wasn't good enough.

"It's a big deal," says Austin, Tex., attorney Kathy Poppitt, with King & Spalding. Although she said the CMS regional office in Dallas told the hospital that safely transporting a patient requires the presence of qualified personnel and only having the driver for transfers of psych patients isn't adequate because their condition could worsen, "that's an extrapolation," Poppitt says. Two attendants are required by the conditions of participation, according to CMS, "but they really aren't." Because the hospital's survey results have not been released, the hospital may not have to challenge CMS's position, but Poppitt is concerned about the implications of a *de facto*

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HCCA
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expansion of EMTALA. "They couldn't require you to have two people in that situation if the patient is stable," she says.

That's just one example of the recent twists and turns EMTALA has been taking. Confusion about EMTALA compliance has been sown by hospital consolidations and the growth of off-campus dedicated emergency departments (DEDs), attorneys say. There has also been a number of civil monetary penalty (CMP) settlements recently for alleged EMTALA violations involving psych patients (see News Briefs, p. 8). And in December 2016, OIG finalized a regulation that increased CMP penalties for various violations, including EMTALA, and modified other aspects of EMTALA CMPs.

"We are seeing our clients grappling with this on a regular basis," Poppitt says.

Hospitals are subject to EMTALA if they bill federal health care programs and have a DED, says Atlanta attorney Caitlin Pardue, with King & Spalding. There's a three-part test for being considered a DED, whether it's on or off the main campus of the hospital: (1) they're licensed by the state as an emergency department; (2) they're held out to the public as a place where emergency care is provided; and (3) at least one-third of the outpatient visits are for emergency medical services, Pardue says. Some hospital-owned off-campus urgent care centers that are provider-based may count as DEDs for purposes of EMTALA, Poppitt said. That was the case in Rhode Island, where a federal court ruled that an urgent care center was subject to EMTALA because it held itself out as a DED through signage (*RMC 11/21/16, p. 8*).

New DEDs Can Still Be Provider-Based

Now DEDs are showing up in increasing numbers away from hospital grounds, in the form of provider-based departments and freestanding entities that are not affiliated with hospitals but present themselves to the public as providing emergency care. "We are seeing a rise in the number of EDs that are off the hospital's main campus," says Washington, D.C., attorney Christopher Kenny, with King & Spalding. "It's a growing trend and shows no sign of abating." Partly this reflects the continued shift of services "outside the four walls of the hospital and into communities," he says. "There have always been a number of payment incentives to do that." Primarily, there are the reimbursement benefits of being a provider-based department of a hospital, which means billing under the outpatient prospective payment system (OPPS) for technical payments as well as the Medicare physician fee schedule for physician payments. Although Sec. 603 of the 2015 Bipartisan Budget Act put an end to OPPS billing by off-campus provider-based entities established after Nov. 2, 2015 (*RMC 11/2/15, p. 1; 11/7/16, p. 1*), DEDs are exempt. That means hospitals can continue to build DEDs and enjoy the fruits of their labor, although they are obligated to comply with the provider-based and EMTALA regulations, Kenny says. "It's one of the few [types of] facilities you can continue to acquire or establish that will be excepted from Sec. 603's payment changes," he notes.

There's a difference between provider-based DEDs and freestanding emergency rooms that are separate and apart from the hospital, Kenny says. Government payers and many commercial insurers won't enroll freestanding EDs, he says. They rely on self-paying patients and the occasional insurer that will pay for their services, Kenny says. "It can be burdensome to patients," he says. "They show up at something that looks like an ED at a hospital only to discover they don't take their insurance," he says. Patients complain to the state, and that's where there might be additional regulations.

EMTALA Applies to Off-Campus DEDs

Provider-based DEDs are like any other hospital department even when they're off-campus. Because they're subject to EMTALA, DEDs must offer or otherwise make available the full range of services offered at their host hospital, Kenny says. "If someone presents

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needing inpatient care, the DED can stabilize them and transport them to the main hospital," he says. Like any provider-based space, the DED has to be within 35 miles of the hospital and inpatient services have to be "immediately available," but there's no objective definition for that, he says. "Some people use 20 minutes as a rule of thumb, but the rules are deliberately vague because every geographic area will be different," he says. "What's considered close and proximate in Montana may not be the same in Washington, D.C."

Hospitals also have to keep state restrictions in mind. Some states don't allow freestanding EDs, some states restrict them and others are mum on the subject, Kenny says. Texas, for example, lightly regulates them. "Texas is a very large state, with lots of big empty spaces and potentially underserved communities, so these types of facilities are being built and sometimes they're not affiliated with hospitals," he says. Some are held out as emergency rooms, but patients can't get the same range of services they have access to at a real hospital, and the quasi-EDs may not be open 24/7. Hospitals tempted to compete with them have to be careful to fulfill provider-based and EMTALA requirements.

For example, there are management companies that specialize in managing DEDs, but the provider-based regulation requires the hospital to keep its eye on things and make sure the DED remains fully integrated with the hospital (42 CFR 413.65(h)), Kenny says. "You can't just have a turnkey operation where the hospital puts its name on the door and there's no oversight," he says.

EMTALA Obligations Get Complicated

Health systems also have been challenged by EMTALA compliance amid the merger and acquisition mania. "There seem to be a lot of EMTALA issues going on with large hospital systems as they expand the footprints of their campuses," Poppitt says. "The application of EMTALA becomes less clear." EMTALA applies to the main hospital and buildings within 250 yards of it. Sometimes following that bright-line rule is easier said than done as health systems evolve. For example, a health system recently built a cancer treatment center on the edge of its campus. It's more than 250 yards away from the main hospital, but the hospital has asked CMS to treat the cancer center as provider-based, Poppitt says. If the answer is yes, that raises questions about its EMTALA obligations. The cancer center is closer to another hospital on the campus than it is to the main hospital, so if patients need to be transferred for emergency care to the hospital, what is the EMTALA obligation?

"If it's determined they have an emergency medical condition, then it's a hospital's obligation to stabilize them, admit them as an inpatient or make an appropriate transfer before your EMTALA obligation ends, but sending them to another hospital instead of back to the main hospital can be seen as shirking your EMTALA obligation," Poppitt says. Her advice: always include what's best for the patient "in that mix."

Complicating matters, when patients receive outpatient treatment at the cancer center, EMTALA doesn't apply, she says. But the cancer center has similar responsibilities under Medicare's conditions of participation. The same goes for hospitals after inpatient admission, because EMTALA obligations end there. "The hospital has to respond to the emergency appropriately, but not according to EMTALA. It's according to the CoPs that would apply in those circumstances," she says.

The stakes for EMTALA compliance have always been high in terms of the potential to harm the hospital's reputation and the risk to patient safety. Noncompliance also became more expensive in a Dec. 7, 2016, OIG regulation that was proposed in September (*RMC 9/12/16, p. 3*). All CMPs were increased—some substantially—to account for inflation. For example, hospitals with more than 100 beds face an increase from $50,000 to $103,139 for each EMTALA violation. The OIG can assess these fines against the violating hospital as well

CMS Transmittals and *Federal Register* Regulations
March 3 - 9

Live links to the following documents are included on *RMC*'s subscriber-only webpage at www.hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing

- April 2017 Update of the Ambulatory Surgical Center (ASC) Payment System, Trans. 3726 (March 3, 2017)
- April Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, Trans. 3729 (March 3, 2017)
- April 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 3728 (March 3, 2017)
- Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, Trans. 3730 (March 3, 2017)

Pub. 100-03, Medicare National Coverage Determinations

- Gender Dysphoria and Gender Reassignment Surgery, Trans 103 (March 3, 2017)

Federal Register

Final Regulation

- Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Corrections 82 Fed. Reg. 12509 (March 6, 2017)

as the responsible physician. The regulation also clarified the liability guidelines for EMTALA CMPs, Poppitt says. OIG expanded the definition of "responsible physician" to include physicians who are on call at hospitals with specialized capabilities. "Usually EMTALA only applies to hospitals with EDs, but EMTALA also applies to hospitals with specialized capabilities or facilities even if they don't have an ED," such as psychiatric hospitals, Poppitt says.

Also, the regulation states that the negligence standard now subjects hospitals to EMTALA CMP penalties based on negligence, not necessarily willful conduct, Poppitt says. OIG modified the mitigating and aggravating factors it considers when pursuing a CMP case. For mitigating factors, OIG removed the patient's intent to leave because it's possible the departure is a function of the hospital's failure to appropriately screen the patient. But "corrective action" was added as a new mitigating factor, she says. Patient harm or the risk of harm has always been an aggravating factor, but now OIG doesn't have to show actual patient harm.

Contact Poppitt at kpoppitt@kslaw.com, Kenny at ckenny@kslaw.com and Pardue at cpardue@kslaw.com.✧

CMS Guidance: MOON Must State Clinical Reason For Observation

In March 8 guidance, CMS says hospitals must put a specific clinical reason why patients are receiving observation services on the Medicare Outpatient Observation Notice (MOON). That's a somewhat more formal version of statements that CMS officials made at a Feb. 28 open door forum (*RMC 3/6/17, p. 4*) on the MOON, which informs patients they are outpatients receiving observation services, not inpatients.

Hospitals are required to give patients who receive 24 hours or more of observation services the MOON within 36 hours after physicians have written the observation order (*RMC 12/12/16, p. 1; 2/13/17, p. 3; 7/4/16, p. 1*). The MOON, which was developed by CMS and took effect March 8, tells patients that "You're a hospital outpatient receiving observation services. You are not an inpatient because:" followed by a blank space where physicians or other hospital personnel explain why.

In answers to frequently asked questions about the MOON posted March 8 on its website, CMS said hospitals are responsible for populating the free-text field of the MOON "with a clinical rationale specific to each beneficiary's circumstances, based on the treating physician's clinical judgment."

FAQs Are Not Rules

That gives hospitals something more to go on than the voices of CMS officials over a telephone line. "This adds more authority than something verbally communicated on an open-door forum," says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. "It reinforces that hospitals that planned not to do this should reevaluate their decision." However, FAQs are not regulations or manual instructions, and some hospitals may choose not to put a specific clinical reason on the MOON, Hirsch notes. "They may say an FAQ has no regulatory weight," he says. It's disappointing that CMS didn't give an example of the kind of clinical details it's after, Hirsch says.

The FAQs didn't shed any light on whether the MOON can be modified when it's translated into other languages besides Spanish. Because the form was approved by the Office of Management and Budget, hospitals can't tinker with it. But CMS's Spanish-language version is slightly different, and that begs the question of whether hospitals can alter theirs when translating it into other languages, Hirsch said. "I'm going to assume because they rearranged the text, anyone can rearrange the text" for this purpose, he says.

Hospitals are still unsure what to do if they neglect to give patients the MOON before they are discharged from observation, Hirsch says. "My advice is you do the same thing you would do if you don't give patients the Important Message from Medicare" (IMM), which informs inpatients of their hospital discharge appeal rights. "The IMM is the big sister of the MOON, and you don't want to treat your sisters any different even if one is your favorite," he says. If the hospital's policy is to let it go, then let it go. If your policy is to do a root cause analysis to determine why the form fell through the cracks, follow it, he suggests.

In the FAQs, CMS reiterates that hospitals and critical access hospitals (CAHs) must issue MOONs to both traditional Medicare and Medicare Advantage patients. Also, "hospitals and CAHs may develop and use pre-populated check boxes with common clinical explanations so long as a free-text field is retained for circumstances that do not fit within the pre-populated check boxes," CMS states.

Contact Hirsch at rhirsch@r1rcm.com. View the FAQs at www.cms.gov/bni. ✧

Sample Agreement for Workforce Use of Mobile Devices

Here's an example of a mobile device use agreement that employees and other workforce members could sign if they're allowed to use personally-owned mobile devices for work purposes. The agreement puts employees on notice they will not put protected health information—and their employer—at risk through the use of smart phones, laptops and other mobile devices. It was developed by Chris Apgar, president of Apgar & Associates in Portland, Ore. He sees problems with covered entities and business associates in this area because they lack policies on "bring your own devices" (BYOD) to work. For example, mobile devices should be run through the IT department and subject to a procedure for reporting losses or thefts to the security officer, who should be able to remotely wipe them using a mobile device management vendor tool, Apgar says. Mobile devices also may not be encrypted. This is a high-risk area for covered entities and business associates. For example, Oregon Health & Science University paid $2.7 million to settle potential HIPAA violations with the HHS Office for Civil Rights in July 2016 after it submitted multiple breach reports that stemmed partly from two unencrypted laptops and a stolen unencrypted thumb drive, and it also agreed to a three-year corrective action plan. Contact Apgar at capgar@apgarandassoc.com.

The use of mobile devices represents a significant risk to [Entity]. Mobile devices are prohibited from being used at any [Entity] facility to capture and then transport electronic information outside of [Entity] facilities unless the use of such devices are approved by senior management, the device is secure, and accountability procedures are adhered to.

By signing this agreement you agree to:

1. Maintain the confidentiality of [Entity] owned information and provide all reasonable protections to prevent unauthorized disclosure, loss, or use of such information.
2. You are required to keep confidential all information of patients, including that which is disclosed to you, or otherwise comes within your control, and provide all reasonable protections to prevent unauthorized disclosure or use of such information. A breach of this duty may subject you to disciplinary action including, but not limited to, revocation of your access privileges and corrective action may be taken against you.
3. You are responsible to ensure [Entity] and/or patient information is not accessed by anyone whose current professional duties do not require such access.
4. You must not disclose to anyone any access identification information provided you or permit such information to be viewed by any unauthorized persons.
5. [You will not store ePHI on your mobile device] or [You will limit storage of ePHI on your mobile device].
6. You are authorized to store and/or transport [Entity] owned information on a mobile device only in connection with your assigned duties. No other [Entity] and/or patient information may be transported by you.
7. The use of a digital camera to capture pictures of patients and/or proprietary equipment or documentation is strictly forbidden unless the use of this type of device is required to perform your day-to-day activities or is pre-approved by senior management.
8. You are required to safeguard Information stored on your mobile device at all times. The use of strong user authentication, file compression, and/or automatic data encryption to access the data contained on the device is required. You shall not tamper in any way with the configuration established by the Information Systems Department.
9. You will not modify or delete configuration and security software installed by [Entity]
10. You will not leave your mobile device unattended or unsecured.
11. In the event you lose your device and cannot find it after reasonable attempts to do so, you are required to report the loss to the [Entity] Information Security Officer within one business day.
12. In the event that your device is stolen, you are required to immediately report the loss to the [Entity] Information Security Officer.
13. You agree to the remote wipe or destruction of all [Entity] applications, data and related security configuration.
14. You understand your device will be monitored when connected to [Entity] network.
15. You understand that [Entity] reserves the right to inspect the contents stored on electronic portable devices and delete contents as it deems necessary. In addition such devices may be seized at any time if necessary as related to a security investigation and/or legal hold.
16. You will hold [Entity] harmless if the mobile device is damaged or your personal data viewed.
17. You will make your mobile device available in the event of an information security investigation or in the event of a legal hold.

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OIG: Mayo Clinic Florida Was Overpaid for DRG Coding, Surgeries

In a new Medicare compliance review, the HHS Office of Inspector General says that Mayo Clinic Florida in Jacksonville received $103,000 in overpayments for inpatient services that were billed from January 2013 through September 2014.

From a universe of 1,145 claims that were potentially at risk for billing errors, OIG picked a stratified random sample of 199 paid claims. It audited 170 inpatient and 29 outpatient claims, and concluded that 14 claims had errors. That resulted in overpayments of $71,396 for the audit period, which OIG attributed to inadequate controls to prevent certain billing errors. "On the basis of our sample results, we estimated that the Hospital received overpayments of at least $103,091 for the audit period," OIG stated.

All the errors occurred on inpatient claims. Mostly OIG said 304-bed Mayo Clinic Florida made mistakes on DRG coding. "For example, the Hospital submitted a claim with the secondary diagnosis code 202.80 (Other Malignant Lymphomas). The medical record indicated that the patient's Non-Hodgkin's Lymphoma was a previous condition contained in the patient's medical history, not a current problem," OIG stated. "Therefore, the hospital should have assigned code Vl0.79 (personal history of other lymphatic and hematopoietic neoplasms) rather than code 202.80."

Also, the hospital submitted Medicare claims for patients whose surgeries were cancelled. "The Hospital stated that these errors occurred because the surgical changes may not have been communicated to the case manager by the operating room staff when the case manager was out of the office," according to the Medicare compliance review.

In a written response to the Medicare compliance review, Mayo Clinic's Chief Compliance Officer Kimberly Otte emphasized its "steadfast" commitment to compliance, as shown in its "very low error rate," which indicates that Mayo has good controls. The hospital disagreed with one of OIG's finding, but not the rest. However, it noted there is no pattern of error. Notwithstanding the lack of pattern, Otte said Mayo carried out a plan of correction, including educating coders on coding guidelines and increasing coding quality reviews. However, she noted that Mayo voluntarily refunded to the Medicare administrative contractor some overpayments it identified for patients whose surgeries were cancelled, so "further extrapolation is not appropriate." Otte also disagreed that OIG used a stratified random sample of 199 claims. Two of the strata, she contends, were judgmental samples.

Visit https://go.usa.gov/xXayg. ✧

Hospitals Appeal Denials for Patients

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MA plans are denying claims after clinical validation audits and readmissions within 30 days, said Denise Wilson, vice president of clinical audit and appeal services at AppealMasters. They also often refuse to authorize inpatient admissions, instead approving longer stays in observation. Most don't follow Medicare's two-midnight rule, Wilson noted. "UnitedHealthcare jumped on it right away and, after a year, they said they are not doing it anymore," she said.

There also are some quirks in MA policy manuals, which are referenced in contracts, Baker said. Although MA plans must follow Medicare local and national coverage determinations and other regulations, hospital contracts govern many aspects of the relationships between MA plans and hospitals. For example, UnitedHealthcare's policy manual has a statement that hospitals must provide a home visit to ensure safe discharges, Baker said. "I don't know how many hospitals can afford

Sample Agreement for Workforce Use of Mobile Device (Continued)

18. If you are a non-exempt employee, you will not use your mobile device for company business outside of your normal working hours.
19. You will retain a copy of the description of the mobile device assigned to you, to include make, model and serial number, so that when necessary a timely report can be made to law enforcement.
20. You understand and acknowledge that [Entity] policies and procedures apply to mobile device use.

Print Assignee's Name	Assignee's Signature	Date
Print Assignor's Name	Assignor's Signature	Date

to do a home visit for every discharge, and I haven't seen them enforce it for denials yet," he said. "But be careful."

Self Regional doesn't participate in any MA plans, although obviously the hospital treats patients enrolled in MA plans and accepts their payments. "There is no advantage to [participation]," Baker said. Hospitals lose most of their appeal rights, and "you have to go by what they say rather than what CMS says."

Baker has made a lot of headway with MA plans by escalating problems to CMS (see box below). For example, when MA plans disagree with a diagnosis, they downgrade MS-DRGs by removing a complication and comorbidity (CC) or major CC. In response, Baker asked CMS whether the MA plans reported the diagnosis changes so their own risk scores could be adjusted. After Baker raised the risk adjustment issue to CMS, "we got a group of claims overturned," he said. "Risk scoring is way off." CMS has been conducting risk adjustment data validation audits of MA plans, and the Department of Justice in February joined a False Claims Act lawsuit against UnitedHealthcare that alleges the MA company exaggerated patients' risk factors to increase reimbursement.

One caveat about complaining to CMS: it only intervenes when hospitals don't have a contract with an MA plan. Otherwise, CMS defers to contract terms, McGraw said.

Appealing for Patients Requires Authorization

Meanwhile, Baker also has seen improvement by going directly to the source—the MA plan—with help from the American College of Physician Advisers and South Carolina Hospital Association. "We now have friends at Humana. I never thought I would say this," Baker remarked, noting the MA plan has a new regional medical director who "has been extremely helpful." Humana also has a corporate compliance department that addresses CMS complaints.

His hospital also appeals claims on behalf of patients. This is a powerful strategy that's underappreciated by hospitals, McGraw says. Unless they negotiate better terms in their MA contracts, hospitals typically have one level of appeal. But patients in MA plans have an internal grievance process and then the same five levels of appeal that hospitals and beneficiaries enjoy under traditional Medicare, McGraw says. "If you're a provider, it's internal review only," he says. "But patients have the five steps of the Medicare process in Medicare Advantage plans."

'Soft Approach' Is Recommended

The catch: Hospitals need patients' authorization to appeal payment denials on their behalf. This isn't a big deal, however. McGraw said they just have to ask patients to sign authorized representative forms, which can be added to existing registration or discharge forms. Self Regional Healthcare asks patients for authorization on admission paperwork and hasn't gotten pushback from anyone, Baker said.

Asking patients to authorize the hospital to appeal claim denials on their behalf usually requires a soft approach, McGraw said. When hospitals don't get authorization upfront, they may ask for it in a post-discharge letter. "We talk about the hospital service to the community, and inform the patient that the insurance company

National Contacts at CMS for Complaints

The following CMS officials are assigned to address complaints about Medicare Advantage plans, says Phillip Baker, M.D., physician adviser at Self Regional Healthcare in South Carolina. Contact him at roy.baker@selfregional.org.

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Coventry Health/Aetna
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BCBS Anthem
Anne McMillan
Health Insurance Specialist
Chicago Regional Office
Phone: 312-353-1668

Source: Phillip Baker, M.D., Self Regional Healthcare

in its infinite wisdom has deemed the stay medically unnecessary or changed the diagnosis that the doctor selected, which we disagree with, and that we would like to appeal on the member's behalf," he said. "Often your language is about your caring for your patient, and hopefully the patient had a good experience at the hospital. But not everyone does, so you might want to check out whether they were a satisfied patient before you send it out." Include a stamped, self-addressed envelope and keep the letter to one page, McGraw advised.

Whether hospitals do it upfront at registration or after the fact, this is pretty easy. "I don't understand why hospitals aren't doing it," McGraw said. Even when they have the form in place, they don't tend to pursue appeals on behalf of patients.

They think it's too burdensome, but it's the same appeal they file on their own behalf, plus an address change.

Each MA plan may have its own authorization form, so hospitals must make sure they use the correct one, McGraw said. The forms are different from consent to treat and assignment of benefits forms.

Appealing on patients' behalf should be part of hospitals' payer dispute management approach, an organized method for protecting their MA payments that begins with the contract terms and takes them straight through the appeals process, McGraw said. The contract should set forth the levels of internal appeal, the time frame for submitting medical records and receiving a response, the name of the medical director and all the other details required for the hospital to manage its denials and appeal rights. "You will get denials whether or not they repeal Obamacare," he said.

Contact Baker at roy.baker@selfregional.org, McGraw at bmcgraw@intersecthealthcare.com and Wilson at dwilson@intersecthealthcare.com. ✧

NEWS BRIEFS

◆ **A plan by a hospital to provide free or reduced-cost lodging and meals to some financially strapped patients got a green light from the HHS Office of Inspector General.** In an advisory opinion (17-01) posted March 10, OIG said although the free housing and meals could generate illegal remuneration under the anti-kickback law, it won't pursue sanctions. The hospital provides specialized services, including organ transplants and advanced outpatient cancer treatment. The hotel is modest and the meals are provided at the hospital cafeteria. To qualify, patients must live 90 or more miles from the hospital in a medically underserved area of the state and meet other criteria. Although the plan implicates the civil monetary penalty (CMP) law barring beneficiary inducements, OIG said it satisfies the promotes-access-to-care exception. The plan also implicates the anti-kickback law, but because there's a low risk of harm to Medicare or patients, and for the same reasons it satisfies the CMP law exception, OIG gave it a pass. "It's a common problem when patients are referred to university hospitals from a long distance and the physician is reluctant to discharge the patient and ask them to drive several hundred miles back in two days for a follow-up appointment or to have a needed surgery," says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. "Those hospital days are not medically necessary and will not be reimbursed. This guidance gives hospitals a viable option for these patients at a much lower cost than a night in a hospital bed." Visit https://go.usa.gov/xXCyg.

◆ **Covenant Medical Center in Waterloo, Iowa, agreed to pay $100,000 to settle a civil money penalty case over alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA) with respect to three psychiatric patients,** the HHS Office of Inspector General said. The hospital allegedly didn't provide a psychiatric screening exam or stabilizing treatment to these patients in the emergency department (ED) in February 2015 although an on-call psychiatrist was available, according to OIG. "A woman presented to the ED complaining of depression and suicidal thoughts, but was later discharged with instructions to follow-up with her primary care physician. A child presented to the ED following violent outbursts, but was later discharged with instructions to follow-up with his primary care physician. A man presented to the ED stating his mind was 'disturbed,' but later eloped from the ED into single degree weather wearing paper scrubs while his discharge was processed. His body was found about 300 feet from Covenant with the cause of death attributed to hypothermia," OIG alleged. Covenant did not admit liability in the settlement and did not respond to *RMC*'s request for comment by press time. There have been other psych EMTALA settlements recently (*RMC 3/28/16, p. 1*).