COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

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EMTALA bulletin carries new risks for hospitals

Even a long wait in the emergency department can trigger violation

With the release of a final special advisory bulletin last week, the Health and Human Services (HHS) Office of Inspector General (OIG) has dramatically escalated its crackdown on violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), the federal law that prohibits patient dumping.

Mary Lou King, a partner with McDermott, Will & Emory in Washington, DC, says the bulletin released Nov. 9 includes several new components that could threaten hospitals. One particular trouble spot is the practice of dual-staffing, which refers to when a managed care plan places its own hospitalist in the emergency room to ensure that plan members who enter the emergency room are treated in accordance with the plan's utilization guidelines.

"The bulletin raises so many risks regarding those kinds of arrangements that it is difficult for me to see how many hospitals are going to be able to reconcile them," says King. She adds that it would be too difficult for hospitals to conduct two equal tracks in the same emergency room. "That is really what EMTALA has become," adds King. "It is really the Equality in Patient Treatment in the Emergency Room Act."

Additionally, another new component says hospitals could violate the patient anti-dumping statute if they routinely keep patients waiting so long that they leave the hospital without being seen. "It raises a very large question," King

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Congress sets sights on Medicaid fraud for 2000

Congress is likely to step up its efforts to reign in fraud and abuse in the Medicaid program when it returns next year. "In the Medicaid program alone, the cost of fraud and abuse may exceed $17 billion every year," House Commerce Committee Chairman Rep. **Tom Bliley** (R-VA) asserted at a Subcommittee on Investigations and Oversight hearing Nov. 9.

The General Accounting Office's (GAO) **Leslie Aronovitz** told the subcommittee that the Medicaid program's size and structure make it

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HCCA unveils compliance certification program

At its recent annual meeting in Chicago, the Philadelphia-based Health Care Compliance Association (HCCA) unveiled the health care compliance industry's most significant certification program to date, to be administered by the newly formed Health Care Certification Board (HCCB).

"Compliance is most effective when everybody in the organization that can help ensure that the organization stays compliant is actively involved, and we want to give those people the opportunity to become certified," explains HCCB President **Roy Snell**. "An organization that has several people certified in health care compliance sends a strong message that it has outside expertise and a commitment to compliance."

Mac Thornton, general counsel for the Health and Human Services Office of Inspector General (OIG) acknowledges that having HCCB-certified staff could weigh in an organization's favor. "I

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asserts, "for hospitals about the waiting time in their emergency rooms, but does not provide 'bright line guidance' about what is acceptable waiting time."

King says the inclusion of this item is "very ominous" for hospitals that are routinely overburdened in their emergency rooms. "These are the [situations] that EMTALA was enacted to prevent in 1986," she adds. "What they are saying now is we potentially will enforce EMTALA in hospital emergency rooms with long waiting times."

A third area of concern has to do with the collection of financial information from patients in the emergency room. "The bottom line is, they say don't collect financial information until after the medical screening examination," King says.

According to King, a patient's condition must be stabilized before financial information can be collected or authorization can be requested from the payer.

But she adds that the process can begin after stabilizing treatment has been commenced but not necessarily completed. "It is fairly explicit now that, once stabilizing treatment has commenced, financial information can be sought and prior approval can be sought."

The OIG's draft bulletin on EMTALA, issued last year, was supposed to clarify the obligation of hospitals to medically screen all patients seeking emergency services and provide stabilizing treatment as necessary. According to the OIG, the major issues raised in the 150 sets of comments it received in response to the draft concerned dual staffing, prior authorization, financial responsibility forms and advanced beneficiary notifications, and patient inquiries regarding the obligation to pay for emergency services.

EMTALA violations can result in termination from the Medicare program, as well as monetary penalties imposed by the OIG.

In recent years, the OIG has dramatically increased its anti-dumping enforcement activities — from a total of 66 settlements and judgements worth $1.45 million between 1986 and 1996 — to 67 settlements and judgements worth $2.31 million in 1997 and 1998 alone. Nine months into FY '99, the OIG had already racked up 49 settlements worth a total of $1.42 million. ■

How you can comply with EMTALA's new demands

Hospitals should view the Health and Human Services' Office of Inspector General's (OIG) Special Advisory Bulletin on the Emergency Medical Treatment and Active Labor Act (EMTALA) as an opportunity to clarify their rights and responsibilities, says **John Steiner**, chief compliance officer at the Cleveland Clinic Foundation.

"These kinds of investigations can get pretty volatile," warns Steiner, who was instrumental in the negotiation of the EMTALA statute as a former counsel at the Chicago-based American Medical Association. Complaints can be easy to trigger, and the Health Care Financing Administration's (HCFA) regional offices have a duty to follow up every call that appears credible, he notes. "Pretty soon, you're into it, and it chews up a lot of time and effort if people are not at least generally aware how to respond."

Steiner says that, from a pure, due-diligence standpoint, hospitals should use the document to perform a side-by-side comparison with HCFA's *State Operations Manual.* A hospital

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EMTALA's demands

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committee or workgroup can accomplish that, then decide if they want to change anything in their policies and procedures, he says.

At the Philadelphia-based Health Care Compliance Association's recent conference in Chicago, Steiner highlighted several areas in the HCFA manual that hospitals should closely scruntinize. Because it took two years of negotiation with HCFA to reach consensus on these recommendations, the language is very important, he says.

"This is the bible to take to your personnel in your emergency department and make sure they understand these procedural steps," Steiner emphasizes. Here are the critical areas in the *State Operations Manual:*

♦ **Review of Investigation.** "One thing to bear in mind is that the statute is very broad, so that a complaint investigation often escalates very quickly," warns Steiner. Moreover, given the way the system is set up, a single incident is often likely to trigger additional incidents.

Hospitals that have the ability to identify and address problems will be in a much stronger position with surveyors, says Steiner. He notes that the manual uses a six-month time frame to determine whether the hospital has satisfied federal regulations. "That is an important time clock."

He says HCFA surveyors will look at a large body of data, including central logs and medical records going back six to 12 months. "They start to get a snapshot of your facility, even though they are there only to investigate one complaint," he adds. "That's why your ability to scrub it yourself and have consistent and current policies is vitally important."

♦ **Procedures for Termination.** Hospitals should become educated on the distinction between situations that pose an immediate and serious threat to a patient's health or safety and those that don't, says Steiner. "Bear in mind that before this was written, they could come in and just take the position that your failure to comply because of a complaint meant you pose an imminent threat," he adds. "It was a very strong presumption to overcome, and this gives more procedural due process and protection."

According to Steiner, hospitals that have not been through the EMTALA process must also understand how rapidly it unfolds. The fast track is a 23-day process, but he says hospitals should seek the 90-day process, which allows more time.

Steiner notes that the manual includes new language that says hospitals may avoid termination action and notice to the public either by providing credible evidence of correction or by successfully showing that the deficiencies did not exist.

"That language was not there before, which made it a poker game about how you were doing in the eyes of HCFA," he says. "This gives you more opportunity to present where you are going and how you are going to get there, and it is codified and more stringent on the part of reviewing agencies."

The problem with EMTALA is that you never really close the door, warns Steiner. "If you are going to work through this on a fast-track basis, you are kind of in a Chinese fire drill," he says.

Hospitals often rush to put a corrective action plan in place to stop the government from publishing a notice that a hospital will be pulled out of the Medicare program for violating EMTALA.

"What happens is that you rush to get it done and everybody moves away from the issue," warns Steiner. HCFA's initial investigation is only the first bite at the apple, he explains. "They work hand-in-glove with the Office of Inspector General, so you may consider something closed and later receive a letter from the OIG." ■

Compliance certification

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have not seen the requirements," says Thornton. "But it could help demonstrate a commitment to compliance."

HCCB certification will require at least one year experience in the health care compliance field, as well as 20 continuing education (CE) credits per year, which can be obtained by attending compliance conferences or reading certain periodicals. HCCB believes setting a high threshold will give the program more immediate credibility.

The exam required for certification will be a

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100-question, multiple-choice, computer-based test available at 90 sites throughout the country. It will be available five days a week during regular business hours throughout the year. HCCB has selected Lexena, KS-based Applied Management Professionals, a certification and licensure testing company, to help develop the examination. The first examination is scheduled for July 2000.

HCCB's certification program is only loosely linked to HCCA, and was deliberately designed to function independently from the association, according to Snell, who was instrumental in developing the new program.

"The certification program is for certifying people in health care compliance, not for certifying members of a health care compliance association," he emphasizes.

According to Snell, HCCB hopes to incorporate not only compliance officers, but those health care employees involved in areas where compliance plays a role but is not a predominant factor.

That includes supervisors and managers in the areas of medical records, coding, human resources, legal services, risk management, and physician administration.

"These are all people that may want to be certified because they work in compliance as an ancillary part of their job but are not members of HCCA, and are not full-time in the area of compliance," Snell explains.

The test will be the same for all candidates regardless of position held, he adds. "The key thing to understand is that we do not test billing acumen any more than we test legal acumen or human resources acumen," he adds. "It basically revolves around the seven key elements of a compliance program."

Snell says candidates will not be required to purchase any book or attend any prescribed training. Also, unlike some certification programs, candidates will not be required to attend the sponsoring organization's annual meeting, he adds.

Instead, HCCB will develop a bibliography of periodicals and conferences that will help candidates prepare for the examination.

HCCB also plans to establish a higher level of certification that will impose additional requirements such as a more advanced academic degree and additional experience in the field of compliance. "To attain the higher level of certification, you will have had to dedicate a significant portion of your career," says Snell. "But it will mean you are qualified for a number of compliance-related positions."

Also serving on the HCCB are attorney Greg Miller of Alfano & Raspanti, RuthAnn Russo director of HP3 Research Institute, Al Josephs, corporate compliance officer at Hillcrest Baptist Medical Center, and Faith Marie Hope, director of physician compliance at Crozer Keystone Health Systems. ■

Medicare fraud

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inherently vulnerable to exploitation. "Fraud schemes often cross state lines and enforcement jurisdictions, entailing a number of federal, state, and local agencies that may have different or competing priorities in their efforts to investigate, prosecute, and enforce compliance."

"The magnitude of fraud and abuse in the Medicaid program has not been quantified. Fee-for-service providers do not have a monopoly on fraudulent and abusive health care practices," Aronovitz told the subcommittee. Under managed care, providers intending to exploit the program have adapted to new financial incentives, she added.

While promoting the Health Care Financing Administration's (HCFA) overall effort at curbing Medicaid fraud, **Penny Thompson**, director of HCFA's Program Integrity Group, told the subcommittee that HCFA is now working with states to develop systems to measure their progress.

She said HCFA has developed clear guidance to review state agency program integrity efforts, both in fee-for-service and managed care. She added HCFA also plans to send a national review team to conduct a targeted evaluation of anti-fraud efforts in eight states selected to represent a cross section of state Medicaid programs in January 2000. ■