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

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HCCA

Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

QIO Lets Hospital Off the Hook on Pre-Oct. 1 Orders; PA: Change Is About Co-Signing

There's an unburdening now that Medicare auditors aren't denying inpatient hospital claims when there's no physician admission order, even as some hospitals try to improve their compliance with the order requirement by using technology and hospitalists. Meanwhile, short-stay audits may go better than anticipated, if one hospital's experience with denials stemming from admission orders before the regulation changed is predictive.

The 2019 inpatient prospective payment system regulation, which took effect Oct. 1, 2018, was a watershed moment for admission orders. CMS said physician orders won't make or break claims for medically necessary inpatient admissions anymore (*RMC 8/6/18, p. 1*). Auditors will no longer insist on a written admission order for Medicare Part A payment, "although hospitals and physicians are still required to document relevant orders in the medical record to substantiate medical necessity requirements." CMS said it made this change because it was disturbed that Medicare auditors denied admissions solely because of missing or deficient orders.

So Brian Kozik, chief compliance officer at Lawrence General Hospital in Massachusetts, was concerned when Livanta, one of two quality improvement organizations (QIOs)

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Some EMTALA Surveys of MSEs Go Too Far, Experts Say; CMS: MSEs Are Also About Quality

Emergency Medical Treatment & Labor Act (EMTALA) reviews at some hospitals have reportedly gone a little too far with respect to medical screening exams (MSEs), as state surveyors question patient care instead of simply checking whether they were performed appropriately, experts say. Although patient safety is paramount, EMTALA has a specific goal—to ensure patients receive emergency care until they're stabilized or admitted to the hospital regardless of their ability to pay—and other laws and agencies address quality of care.

"EMTALA was written to make sure we didn't turn people away for payment reasons. It wasn't about the quality of care necessarily," according to the compliance officer at one health system. "To me, there has been a drift away." Hospitals in her health system have had EMTALA reviews where state surveyors, in her opinion, pushed the MSE envelope.

The scope of the MSE under EMTALA as described in regulations and CMS instructions to state surveyors, who review compliance on behalf of CMS, is straightforward. The regulation requires hospitals to perform an appropriate MSE to determine whether an emergency medical condition exists "within the capability of the hospital's emergency department." Hospitals also have to decide which clinicians are qualified to perform MSEs, with formal approval from the governing body.

And yet, the compliance officer says, it seems like surveyors are "Monday morning quarterbacking." For example, if patients wind up diagnosed with pneumonia, the surveyors question why the physician didn't order X-rays and EKGs after the MSE. "You

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are telling physicians how to practice medicine," says the compliance officer, who prefers not to be identified.

'It's Edging Toward a Trend'

This doesn't seem to be a random occurrence. "I have heard this complaint—that surveyors are looking more at outcomes as opposed to just whether you met the MSE standards," says attorney Kathy Poppitt, with King & Spalding in Austin, Texas. "I won't say this is an alarming trend, but I have seen it enough to say it is a substantiated trend. It's in more than one [CMS] region. It's edging toward a trend." EMTALA is supposed to be "process driven," she noted, "as opposed to, 'Did you come to the right ultimate outcome for this patient?'"

This development seems to fly in the face of CMS guidance to state surveyors, Poppitt says. According to the *State Operations Manual* (Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases), "Regardless of a positive or negative individual outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements under 42 CFR 489.24. The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable." Although there is a small caveat from CMS—"The outcome may be a 'red flag' indicating that a more thorough investigation is needed"—the agency tells surveyors not to "make decisions based on clinical information that was not available at the time of stabilizing or transfer. If an individual was misdiagnosed, but the hospital utilized all of its resources, a violation of the screening requirement did not occur."

But a CMS spokesperson tells *RMC* something that sounds somewhat different. "The medical screening examination must be appropriate for each individual who presents at an emergency room for evaluation. The appropriateness of an examination is determined based on the quality of care provided, not just that an examination was performed," she said. "Additionally, the EMTALA regulations and statute require a review of the quality of medical (or surgical, obstetric, psychiatric, etc.) care provided in emergency rooms. These reviews are conducted by quality improvement organization expert physician reviewers as part of both CMS and HHS Office of Inspector General enforcement actions. The QIO reviews are conducted to determine the appropriateness of the medical screening examination as well as any stabilizing treatment provided based on nationally accepted standards, rather than simply that an examination was performed."

Poppitt says CMS's statement expresses "a different standard than what the CMS inpatient conditions of participation or state medical malpractice laws might require. EMTALA does not establish a national standard of care or specify what is medically adequate and sufficient treatment." Although EMTALA isn't an insubstantial requirement by any means, "it only requires hospitals to develop and provide appropriate uniform screening procedures to detect emergency medical conditions, regardless of the patient's ability to pay. The screening must be done according to the hospital's protocols and policies," Poppitt says.

There Is Risk of 'Immediate Jeopardy'

The implications of MSE (or other EMTALA) noncompliance are serious. If surveyors cite hospitals for deficiencies, they could be terminated from Medicare and referred to OIG for an investigation and potential civil monetary penalties for an EMTALA violation. "EMTALA has a very different enforcement mechanism than the typical quality reviews you get from the state or Joint Commission," the compliance officer explains. Most EMTALA violations result in "immediate jeopardy," which means there's potential for patient harm. CMS gives hospitals a deadline for implementing a corrective action plan, but there's no room to contest the supposed MSE violation because too much is at stake: potential Medicare termination. When the hospital is back in good standing with CMS, the hospital has more options to resolve its concerns about MSEs, but that can be frustrating, she says.

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However, Poppitt sees an earlier chance to challenge MSE and other deficiencies based more on quality than technical compliance. "You have the opportunity to submit, along with the plan of correction, a separate rebuttal statement," she says. "Some hospitals are reluctant to do rebuttal letters, but if you think surveyors have gone too far, that is where you have the opportunity," she notes. "Also, if surveyors are still in the building for the investigation, that is the best place to talk to them and register any disputes."

MSEs can get complicated in other ways. For example, questions can come up about whether the appropriate clinician performed the MSE. "I see this with women who may be in labor. Should it have been the obstetrician or nurse? What tests have to be done and who has to read them? There are ways these things become murky," Poppitt says. But there's still a crucial distinction between performing the MSE and evaluating the quality of care, she says. Surveyors should determine whether the appropriate clinician screened the patient, sent her home without stabilizing her emergency medical condition or transferred her inappropriately, not whether their medical care was up to snuff. It's not that there aren't ways to hold a hospital accountable for providing poor care in the absence of an EMTALA violation. The Medicare conditions of participation for hospitals still apply after a patient is admitted, and people from the state Department of Health and The Joint Commission, for example, and internal committees, including quality assurance and medical staff executive committees, "also have oversight and review of care practices beyond the initial determination of whether an emergency exists and the MSE," Poppitt notes.

Contact Poppitt at kpoppitt@kslaw.com. ✧

Even When Payers Use Sepsis-3, Appeals May Succeed With Sepsis-2

Most payers are using Sepsis-3 guidelines in their audits without acknowledging it, leaving the door open for hospitals to appeal claim denials using the signs and symptoms of systemic inflammatory response syndrome (SIRS) plus infection, which is Sepsis-2.

"Think outside the box a little," said Denise Wilson, vice president of Intersect Healthcare + AppealMasters in Towson, Maryland, at a Jan. 23 webinar sponsored by the company. "Most payers are looking for Sepsis-3 criteria in their audits/denials, but that doesn't mean the provider can't or shouldn't argue that the use of Sepsis-2 criteria constitutes a valid sepsis diagnosis."

Hospitals should do whatever they can that's appropriate to support the diagnosis because it's very common and vulnerable to claim denials. For example, last year at a 22-hospital system, 43% of clinical validation denials she was aware of were for sepsis.

Sepsis is the talk of the town partly because physicians, payers and hospitals don't always agree how best to

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Making the Case for a Sepsis Diagnosis Using Sepsis-3 Guidelines

Denise Wilson, vice president of Intersect Healthcare + AppealMasters, recommends pointing auditors to the exact spot in the medical records where they will find clinical support for a sepsis diagnosis (see story, p. 3). "Providing a road map makes it easier for the auditor to find the supporting documentation in the record that will lead to a decision in the provider's favor," she says. Contact her at dwilson@intersecthealthcare.com.

Vital Signs/Measurements	Date(s)	Results	Reference Range of Values That Are Representative of Sepsis	Page(s)
Systolic Blood Pressure			<100 mmHg	
Respiratory Rate			>22/minute	
Sepsis: Mean Arterial Pressure (MAP)			<70 mmHg	
Glasgow Coma Scale (GCS)			<14	
Septic Shock: Mean Arterial Pressure (MAP)			Vasopressors needed to keep MAP ≥65	
Urine Output			< 500 mL/d	

Test	Date(s)	Results	Reference Range of Values That Are Representative of Sepsis	Page(s)
PaO2/FiO2			<400mmHg	
Platelets			<150	
Bilirubin			>1.2 mg/dL	
Creatinine			>1.2 mg/dL	
Lactate			> 2mmol/L (<18mg/dL)	