Report on
MEDICARE COMPLIANCE

Volume 32, Number 20 • May 22, 2023

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

Contents

Publisher's Note
RMC will not be published next week. The next issue will be dated June 5, 2023.

HCCA

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Tampa General Hospital Settles CMP Case Over 14 Unlicensed Nurses; 'It's a Tricky Balance'

Tampa General Hospital in Florida has agreed to pay $136,065 in a settlement with the HHS Office of Inspector General (OIG) over 14 unlicensed nurses. The settlement stemmed from the hospital's self-disclosure to OIG.

According to the settlement, which was obtained through the Freedom of Information Act, OIG alleged that Tampa General billed Medicare, Medicaid and TRICARE for items or services it knew or should have known were fraudulent. "Specifically, the OIG contends that during the period April 30, 2022 through August 27, 2022, Respondent submitted claims that included services provided by 14 unlicensed nurses identified in Respondent's disclosure," the settlement stated. OIG alleged the conduct subjects the hospital to civil monetary penalties. The hospital was accepted into OIG's Self-Disclosure Protocol (SDP) Jan. 6, 2023. OIG noted that "single damages were calculated as the full salary and benefits paid to the nurses during the period they worked without a valid license."

The hospital didn't admit liability in the settlement. It didn't respond to *RMC*'s repeated requests for comment.

It's conceivable the alleged unlicensed nurses were related to Operation Nightingale, a Department of Justice-OIG enforcement action that exposed the sale of 7,600 fake nursing diplomas and transcripts from three now-defunct nursing schools.[1]

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EMTALA Violation Is 'Opportunity for Us to Do Better'; Self-Reporting May Be a Hard Call

A young patient who came to the emergency department (ED) at a UofL Health hospital in Kentucky was turned away by a registration staffer who mistakenly told the patient the hospital doesn't treat minors. After returning home, the patient called the ED to report the brush off, triggering an immediate response from the ED clinicians and the compliance department that was helpful when state surveyors came on the scene.

"ED was on it as quick as they could be," Shelly Denham, senior vice president of compliance, risk and audit at UofL, said April 24 at the Health Care Compliance Association's Compliance Institute.[1] The event led to discussions with registration staff, a review of educational materials and a corrective action plan. "We had a training script developed to make sure registration staff understood what the conversation is when patients present" (e.g., not asking for payment, not turning patients away), she said.

"When the surveyors showed up, we were able to provide evidence we were aware [of the issue] and responded as quickly as we could and were taking ownership of the issue," Denham said. "The quick response and corrective action plan were appreciated; however, it did not negate the deficiency as we did not meet the EMTALA requirement." But it's an "opportunity for us to do better," she said.

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to give medical screening exams (MSEs) to all patients who show up in the ED regardless of their ability to pay and to stabilize them if they have emergency medical conditions.

continued

When hospitals lack the capacity and capability to treat them, they may transfer patients. Receiving hospitals are required to accept transfers if they have the capacity and capability to treat the patients. If unstable patients were transferred, receiving hospitals are required to report the transferring hospital to CMS or the state survey agency, Mary Ellen Palowitch, a former CMS EMTALA technical lead, said at the conference. "The idea is if you get a patient and clearly you feel dumped on, you're required to report. I have seen hospitals get cited." There's a 72-hour deadline for reporting, but it's in guidance, not regulations, she noted.

Hospitals don't have an obligation to turn themselves in for any potential EMTALA violation, but there are payoffs for self-reporting, said Palowich, senior managing director at Dentons US LLP in Washington, D.C. There are also risks. "It's a delicate balancing act," she noted.

According to the CMS State Operations Manual (SOM), which guides the surveyors who assess compliance with EMTALA, if the CMS regional office substantiates an alleged EMTALA violation, but the hospital identified the violation itself, took correction action before the investigation and didn't have EMTALA violations for the previous six months, CMS won't initiate termination action.[2] The regional office will notify the hospital of a "past violation—no termination letter." Past violations also are referred to the HHS Office of Inspector General for possible civil monetary penalties.

Notwithstanding the upside to self-reporting, hospitals may decide against it, Palowitch said. "It's horrible when the state comes in. It sets off a fire alarm." Surveyors may find other areas of potential noncompliance. "But consider the patient is angry and may report it," she pointed out. These are all the things you have to be thinking about." Meanwhile, hospitals should address the issue and improve processes, Palowitch said.

'You Have to Address That With Security Staff'

In terms of potential EMTALA vulnerabilities, ancillary services, including security, housekeeping and dietary, "typically get you in trouble," Denham said. "If you have a patient who is disruptive and security makes the decision to escort that patient off unbeknownst to staff and you haven't had time to do the screening, that's a problem," Denham said. "You have to address that with security staff. In some cases, unfortunately, it's contract staff and it makes it that much more difficult."

But there are other situations that don't violate EMTALA despite what it may seem on the surface. Palowitch described a situation where a patient was treated in the ED and awaiting transfer to a psychiatric facility when police officers arrived. The police officers said they usually take this type of patient to a different facility. When surveyors came in, the hospital wasn't cited because the event was well-documented. "It's not a transfer. It's a discharge under police authority," Palowitch said. But she urges hospitals to document everything.

Strategies for Improving Compliance

Here are ways that UofL's compliance team helps ensure compliance with EMTALA:

- Verifying EMTALA signage is in the appropriate place at all its hospitals. She said compliance puts eyes on signage at UofL's different hospitals and asks staff to take pictures and send them.
- Providing quarterly EMTALA training to employees. "We burn them out with training from a compliance perspective, but we made the decision because we had an issue that we needed to provide training quarterly," Denham said.
- Compliance rounding in the ED to observe registration intake. They use a checklist to "look consistently at all hospitals," she said (see box, pages 3 and 4).
- Testing staff EMTALA awareness. "It's OK to ask questions," Denham said. "Make sure staff knows you're there to support them and answer questions. Once they have that comfort level, they will ask great questions and bring you good information. You may not realize what's happening in your ED" and finding out more allows you to intervene early before an incident.

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6462 City West Parkway, Eden Prairie, MN 55344. 888.580.8373, hcca-info.org.

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- Posting answers to frequently asked questions about EMTALA on the UofL's webpage. It also has educational videos and signs in breakrooms with a QR code that takes employees directly to the policy (see box, p. 5). "We try to think of every way to disseminate information," Denham explained.
- Reviewing medical staff bylaws because some bylaws differ among hospitals in terms of who is considered qualified medical personnel (QMP). A hospital board certifies QMPs to perform medical screening examinations and certify patient transfers in consultation with a physician.

Contact Denham at shelly.denham@uoflhealth.org and Palowitch at maryellen.palowitch@dentons.com. ✧

Endnotes

1. Shelly Denham and Mary Ellen Palowitch, "EMTALA: To Self-Report (or Not) and What to Do Next," Compliance Institute, Health Care Compliance Association, April 24, 2023.
2. Centers for Medicare & Medicaid Services, "Chapter 5 - Complaint Procedures," *State Operations Manual*, Pub. 100-07, revised February 10, 2023, https://go.cms.gov/458nqcd.

Checklist for Reviewing Compliance With EMTALA Requirements

This checklist was developed by the compliance department at UofL Health in Kentucky for use when they round at emergency departments in their hospitals (see story, p. 1), said Shelly Denham, senior vice president of compliance, risk and audit. Contact her at shelly.denham@uoflhealth.org.

EMTALA Compliance Checklist

Area of Focus	Checklist	Notes
Entrances and Signage	1. Identify and review all entrances to the emergency department (ED) that can be used 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? Note: CMS has specific language that must be used.	
	3. Are signs posted in the entrances, waiting areas, registration, triage and treatment areas?	
	4. Are entrance signs clearly legible from a distance of 20 feet or the expected vantage point of the individual?	
	5. Are signs in the languages of the population(s) most frequently served by the facility?	
Triage		
	1. Where is triage performed and how are patients directed there?	
	2. When is triage performed? [Best practice is prior to full 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? MSE.	
	3. When is the central log initiated?	
	4. Confirm that MSE and treatment not being delayed for registration; however, if patient triaged nonemergent, reasonable registration process can begin.	
	5. Do registration staff have scripts or training 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.	
	7. Scripting—are staff trained on appropriate standards for scripts? And do those scripts comport with EMTALA? Consistency of message for all patients.	
Medical Screening Examination	1. Do physicians or qualified medical personnel (QMPs) document when the 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 on-call physicians are presenting to the facility when called and in compliance with time frame 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 stabilizing treatment has begun?	

Transfers Out	1. Audit the 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 facility.	
	3. If the transfer is requested by the patient, do your forms allow clear documentation of the request and that the risks and benefits of transfer were discussed with the patient?	
	4. Forms used to document requested transfers should include a brief statement of the hospital's obligations under EMTALA, as well as the patient's reason for request.	
	5. How does the physician certify that the benefits of transfer outweigh the risks? Focus should be on the patient's complaints, symptoms and diagnosis.	
	6. Do facility policies and procedures define documentation standards and the facility person(s) responsible for: a. Identifying a receiving physician and that individual's title at the receiving hospital; b. Obtaining the receiving hospital's acceptance of the patient; and c. Sending pertinent medical records with the patient.	
	7. Do available forms provide a place for the physician to write an order for the transfer and describe transportation staffing and equipment requirements?	
	8. 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	Confirm that the facility established a transfer request log to capture the following information regarding requested transfers into the facility: 1. Date and time of request; 2. Name of facility requesting transfer; 3. Services requested/reason for transfer; 4. Service availability at receiving hospital; 5. Whether transfer is accepted or denied; and 6. If applicable, reason for denial?	
Documentation Review	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).	
	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 have been identified.	
	Review physician on-call list to verify that it reflects coverage of services available to inpatients. Physicians must be listed by name rather than solely by practice group.	
	Does on-call list include any updates for substitutions?	
	Review triage and reassessment policy.	
	Confirm that EMTALA policy has been updated to reflect regulatory changes and interpretive guidance changes, for example: 1. Definition of "comes to the ED;" 2. Definition of "dedicated emergency department;" (DED) 3. Concept of "prudent layperson observer;" 4. Changes in obligations for non-DED off-campus departments; 5. Cessation of EMTALA obligations upon inpatient admission; and 6. Requirement that back-up arrangements for on-call cover-age be documented in policies.	
Best Practices	Does the hospital avoid "ED wait time clocks" types of advertising?	
	Does ED log contain name, date, time and disposition? Does it answer the question, "Why are patients leaving without being seen?"	
	Does ED round regularly in ED waiting room/lobby?	
	Does hospital participate in a community call plan agreement with other hospitals? Is this agreement shared with CMS?	

CMS Extends Certain Waivers; 'Conversations Are Happening'

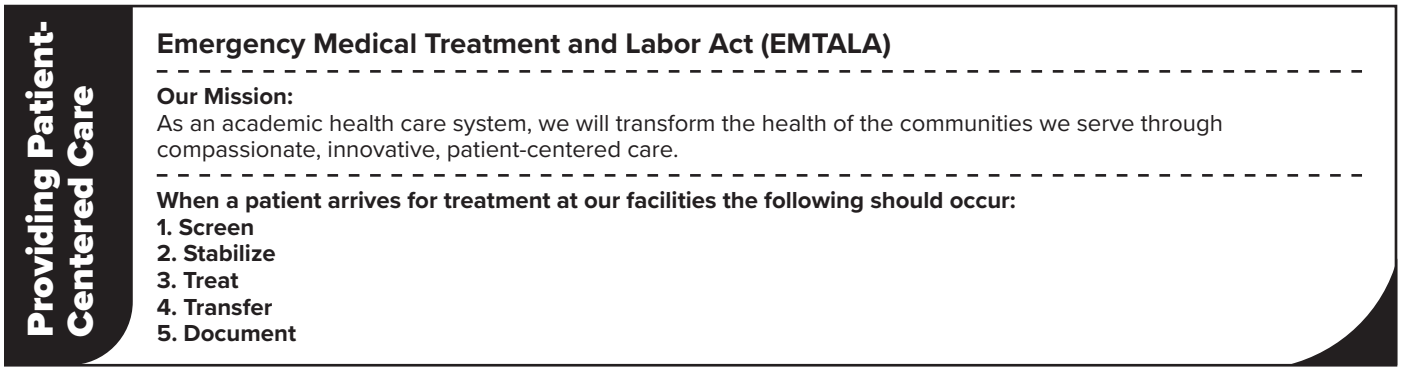
It almost sounds like a riddle, but CMS said May 15 that two waivers that expired with the end of the COVID-19 public health emergency (PHE) on May 11 won't expire yet. Or, more precisely, CMS will use its enforcement discretion through Dec. 31, 2023, according to updated answers to FAQs.[1] CMS is allowing teaching physicians to continue virtual supervision of residents and not reverting to pre-PHE frequency limits on telehealth visits for subsequent hospital and skilled nursing facility (SNF) visits until 2024. Not to look a gift horse in the mouth, however, some hospitals are weighing whether to pretend this isn't happening because otherwise it requires them to unflip a switch after already flipping it in anticipation of the PHE's end, an attorney said.

"Those conversations are happening," said Richelle Marting, an attorney and certified coder in Olathe, Kansas. The decision on whether or how to operationalize last-minute extensions will depend partly on what's in the 2024 proposed Medicare Physician Fee Schedule (MPFS) rule, she noted.

"We spent two months educating our providers" and "implementing workflows and changing operations" to incorporate the expired waivers, Marting said. Now some of the waivers are being reversed and while "it's ultimately a good thing for providers," it turns the communication about the rules on its head. Already

EMTALA Sign with QR Code for Policy

UofL Health hangs this sign in employee break rooms at its hospitals to keep the Emergency Medical Treatment and Labor Act (EMTALA) at the front of their minds. It has a QR code that takes employees to the EMTALA policy without having to go to the policy management system (see story, p. 1), said Shelly Denham, senior vice president of compliance, risk and audit. Contact her at shelly.denham@uoflhealth.org.



the variable dates during the PHE unwinding are an invitation for noncompliance, she noted.

In another significant move, the FAQs allow additional hospital-employed staff to continue to bill telehealth services provided to patients at home through the end of 2023. CMS had already said that provider-based departments will be able to bill Medicare for professional services delivered by telehealth to patients at home after the PHE ends without corresponding facility fees, as a CMS spokesperson explained to *RMC* April 20. In other words, provider-based departments won't jeopardize their status if they bill only professional fees.

"After the end of the COVID-19 PHE, when a practitioner located in a hospital-based clinic furnishes a Medicare telehealth service, the hospital will no longer be able to bill for either the hospital clinic visit (HCPCS code G0463) or the originating site facility fee (HCPCS code Q3014). However, the practitioner may bill separately for their professional services provided all other Medicare telehealth requirements are met," the spokesperson said.[2]

But CMS indicated on an April 25 national call that provider-based departments can only bill professional fees for services delivered by telehealth to patients at home after the PHE ends versus services delivered by hospital staff (e.g., diabetes self-management training). After getting feedback, however, CMS on May 12 reversed course and opened the door to physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), diabetes self-management training (DSMT) and medical nutrition therapy (MNT). "Through the end of CY 2023, PT, OT, SLP, DSMT, MNT providers should continue to bill for these services when furnished remotely in the same way they have been during the PHE," according to the FAQ.

Attorney Andrew Ruskin sees this as CMS "leveling the playing field" because both physicians and other hospital-based staff are allowed to bill for services furnished by telehealth. "There was a possibility the mere furnishing of these services meant that when patients came in the front door, you had to bill them as freestanding," said Ruskin, with K&L Gates in Washington, D.C. "Many people weren't focused on provider-based compliance." Now CMS has put that worry to rest.

But the physicians delivering telehealth services to patients at home from hospital outpatient departments, including provider-based space, won't be reimbursed at the Medicare fee-for-service facility rate, said Ronald Hirsch, M.D., vice president of R1 RCM. "They'll only receive the professional fee at the lower facility rate, but the facility can't bill for G0463 to cover the facility costs," he said. If physicians are employed by the hospital, they'll use modifier 95 (for telehealth), a CPT code (e.g., 99214) and place-of-service codes 19 (off-campus outpatient hospital) or 22 (on-campus outpatient hospital), he said. Without the facility fee, the total payment for the visit is less than the amount paid to an independent physician, Hirsch said. But Ruskin explained that protecting provider-based status trumps the loss of the higher physician payment.

'Do We Go Back and Re-Educate?'

In terms of the enforcement discretion granted after the waivers briefly expired, CMS said in the updated FAQ that it's allowing teaching physicians to meet the physical presence requirement virtually in all settings through Dec. 31, 2023, "as we anticipate considering our policy for services involving teaching physicians and residents further through our rulemaking process." Marting said teaching physicians have become accustomed to "this more relaxed way they can supervise residents" but "a tremendous amount of work has gone into planning for the reversal of these policies."

CMS also put a stop order on the end of the waiver of certain telehealth frequency limits. Before the PHE, providers were allowed to deliver hospital visits by telehealth once every three days and SNF visits once every 14 days, Marting said. Those frequency limits were waived during the PHE. Although that was set to

expire at the end of the PHE—which meant providers again faced frequency limits May 12—CMS changed its mind because "we have received a number of inquiries from interested parties regarding temporarily continuing our suspension of these frequency limitations beyond the end of the PHE," the FAQ stated. It refers to "our requirement that CPT codes 99231-99233 may only be furnished via Medicare telehealth once every 3 days, and our requirement that CPT codes 99307-99309 may only be furnished via Medicare telehealth once every 14 days. We are exercising enforcement discretion and will not consider these frequency limitations through December 31, 2023, as we anticipate considering our policy further through our rulemaking process."

But some hospitals and practices may be reluctant to tell physicians, "Never mind." Marting said it has taken months of discussions with providers to educate them about the importance of resuming in-person visits with patients and the renewed cap on them. "It has been a significant talking point for participants in the Acute Hospital at Home program," she noted. After already weighing down providers with the shift back to pre-PHE rules, hospitals may be treading carefully with the seven-month reprieve.

Save FAQs Because of Changing Dates

"Do we go back and re-educate providers on the enforcement discretion now or do we wait until July and see what's in the proposed [MPFS] rule to understand if CMS is signaling that these policies are here to stay? Or if CMS is signaling they will go away at the end of the year, perhaps re-education on CMS's enforcement discretion isn't worth the confusion and potential benefit only to revert again at the end of the year," Marting said.

Whatever the decision, it's critical to download FAQ updates in the event of audits down the road. "Because the effective date of CMS's enforcement discretion decision isn't there and CMS can edit and re-post the document later, it's a great idea to save the FAQ document with the date," Marting said. FAQs are dynamic and "because CMS did not cite the dates when it added several updates," providers should print or save it to ensure they can prove their billing and other practices are consistent with CMS's declarations at specific points in time.

On a different PHE topic, CMS said in a May 18 MLN Connects that it's time to say goodbye to the CR (catastrophe/disaster-related) modifier and DR (disaster-related) condition code now that the PHE is over.[3] There are two exceptions: (1) CMS said to continue to use the "CR modifier and COVID-19 narrative on claims for supplies and accessories associated with certain DMEPOS items provided during the PHE" and (2) "For benefit period and qualifying stay waivers, submit condition code DR for inpatient claims with admission dates before May 12, 2023."

Contact Marting at rmarting@richellemarting.com, Hirsch at rhirsch@r1rcm.com and Ruskin at andrew.ruskin@klgates.com. ✧

Endnotes

1. Center for Medicare & Medicaid Services, "Frequently Asked Questions: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency," FAQ, last accessed May 18, 2023, https://bit.ly/3MH8x9P.
2. Nina Youngstrom, "CMS OKs Provider-Based Billing for Telehealth Without Facility Fees After PHE Ends," *Report on Medicare Compliance* 32, no. 16 (April 24, 2023), https://bit.ly/3VbqD6l.
3. Center for Medicare & Medicaid Services, "COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency — Reminder," MLN Connects, May 18, 2023, https://bit.ly/3OjhBmt.

MACs Will Audit Five Claims at All SNFs; Reviews Identify Three Trends

CMS said May 15 it will audit five claims from all skilled nursing facilities (SNFs) in a national prepayment review, according to a new Medicare transmittal (12,037).[1] The catalyst for the review was a significant increase in the SNF improper payment rate, which has almost doubled since CMS remodeled the SNF prospective payment system in 2020.

Although the emphasis seems to be on improving SNFs' understanding of compliant billing practices, "claims will be adjusted/denied if an improper payment is identified," CMS said. And Medicare administrative contractors (MACs) will "prioritize" SNFs that fail the audit for Targeted Probe and Educate (TPE) if SNFs are already "in their medical review strategy."

The SNF probe-and-educate review is one of at least three new program integrity initiatives. The other two are a less-burdensome version of TPE for smaller providers and suppliers unveiled at CMS's Provider Compliance Focus Group May 9[2] and a review choice demonstration for inpatient rehabilitation facility services in one state—Alabama—announced May 15.[3]

Because of the small sample size, the review won't be very enlightening for SNFs, said Olga Gross-Balzano, a senior manager at BerryDunn in Portland, Maine. "Five claims can't identify the state of compliance," she noted. The idea that one error translates to a 20% error rate is misleading. At the same time, SNFs with no errors in the sample shouldn't come away with "a false sense of security," Gross-Balzano said.

CMS explained how the prepayment review will play out. MACs will do the SNF audits, with only one round of prepayment audits instead of the usual three with TPE. SNFs with one error have the option to receive one-on-one education, according to the transmittal. SNFs with two or more errors will hear from the MACs about scheduling one-on-one education.

Reviewers will apply COVID-19 public health emergency waivers and flexibilities that were in effect on the date of service of claims selected for review.

MACs will no longer offer SNFs deadline extensions for responding to documentation requests, but they'll cut

SNFs slack for other reasons. "The MAC should accept documentation received after 45-calendar days for good cause. 'Good cause' means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation," CMS explained. "The MAC shall use their easily curable error processes should reviewers identify an easily curable error, and have a mechanism for reaching a provider/supplier point of contact that may be able to provide the compliant documentation."

CMS noted that the Comprehensive Error Rate Testing program for SNFs expects the error rate to be 15.1% in 2022, up from 7.79% the previous year—the top driver of the Medicare fee-for-service improper payment rate, with missing documentation the main root cause. The timing coincides with Medicare's shift from a PPS driven by resource utilization groups IV to a patient-driven payment model (PDPM).

Consider Three Compliance Vulnerabilities

With CMS laser focused on SNFs, they may want to identify their compliance soft spots. Three trends have surfaced in reviews conducted by Gross-Balzano:

- SNFs may submit unsupportable claims because of hybrid medical records (a paper-electronic combination). "This hybrid model results in facilities not being able to extract all applicable or relevant information at the same time," she said. They either produce only the electronic part of the medical records or copy paper medical records, which may result in failing to provide a complete record, Gross-Balzano explained. "That drives a lot of missing medical records. SNFs with a hybrid model—and there are plenty—should have a checklist to ensure all critical elements are on the claim, with documentation to support them, she said.
- SNF claims may neglect to include some ancillary services, such as lab tests, drugs and radiology. Provider statistical and reimbursement reports may come back without those services, which seems to happen when the SNF converts its medical record software. "The concern is that the ancillary providers are billing Medicare directly, which is noncompliant," she said. "That's important because SNF stays are subject to consolidated billing."
- SNFs may have problems related to the PDPM. One factor that affects payment is non-therapy ancillaries (NTAs), and certain risk factors or diagnoses result in higher NTAs, Gross-Balzano said. Malnutrition is an example. Some providers code patients as "at risk for malnutrition" without proper supporting documentation, she explained. "They would do a screening and write an MDS assessment note stating the patient is at risk, but as you review the patient's chart, the risk is not addressed anywhere in the medical records or included in the patient care plan or ongoing assessments. Sometimes we can't find weight monitoring and other checks the provider would do to substantiate that. It results in higher payments and providers really need to be treating that as an indicator of patient wellbeing."

She recommends providers carefully review PDPM items that result in higher payment levels and make sure "you have all the support included with that claim when you provide medical records to CMS. They need to understand it's not just checking a box. It's taking care of a patient and showing how they take care of patients."

Contact Gross-Balzano at ogross-balzano@berrydunn.com. ✧

Endnotes

1. Center for Medicare & Medicaid Services, "Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review," Pub 100-20 One-Time Notification, Trans. 12,037, May 15, 2023, https://go.cms.gov/3pxlKsr.
2. Nina Youngstrom, "New Version of TPE for Smaller Providers Is Coming To Reduce Burden," *Report on Medicare Compliance* 32, no. 19 (May 15, 2023), https://bit.ly/3IqFHrx.
3. Center for Medicare & Medicaid Services, "Review Choice Demonstration for Inpatient Rehabilitation Facility Services," last modified May 18, 2023, https://go.cms.gov/42DzQax.

CMS Transmittals and *Federal Register* Regulations, May 12-18

Transmittals

Pub. 100-04, Medicare Claims Processing

- July 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 12,053 (May 18, 2023)
- July 2023 Quarterly Update to Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement, Trans. 12,052 (May 18, 2023)
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2023 Update, Trans. 12,048 (May 18, 2023)
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens and New Updates for 2023, Trans. 12,045 (May 16, 2023)

Pub. 100-20, One-Time Notification

- Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review, Trans. 12,037 (May 15, 2023)

Pub. 100-02, Medicare Benefit Policy

- Educational Instructions for the Implementation of the Medicare Payment Provisions for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule, Trans. 12,047 (May 18, 2023)

Pub. 100-01, Medicare General Information, Eligibility and Entitlement

- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-01, IOM Chapter 2 Hospital Insurance and Supplementary Medical Insurance, Trans. 12,046 (May 18, 2023)

Federal Register

Notice

- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances-January Through March 2023, 88 Fed. Reg. 30,752 (May 12, 2023)

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Hospital Settles Case Over Unlicensed Nurses

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More than a third of the people nationally who bought their degrees passed their licensing exams and were licensed as registered nurses (RNs) or licensed practical nurses (LPNs). Tampa General wouldn't respond to *RMC*'s question about whether the 14 unlicensed nurses had something to do with Operation Nightingale.

The U.S. Attorney's Office for the Southern District of Florida said 25 people were charged in January with wire fraud in connection with an alleged scheme to sell fraudulent nursing degrees and transcripts from three accredited Florida-based nursing schools to people in search of nursing licenses and jobs as RNs and LPNs/licensed vocational nurses (LVNs). More than 7,600 RN and LPN/LVN phony diplomas were issued by the now-defunct nursing schools: Siena College, the Palm Beach School of Nursing and Sacred Heart International Institute. It's now up to hospitals to weed them out, and they're getting information from state boards and the National Council of State Boards.

'Psychological Dissonance in my Brain'

Although it's unclear whether the Tampa General Hospital settlement is connected to Operation Nightingale, one of the takeaways is that if providers self-disclose to OIG, "they will charge you penalties exactly as they stated, even if you have a sympathetic tale to tell," said attorney Jeffrey Fitzgerald, with Polsinelli in Denver, Colorado. The nurses had licenses and even if they were based on fake degrees, hospitals across the country had verified the licenses. "It's hard to see a lot of fault on behalf of hospitals," he contended.

On the one hand, he said he's not sure this deserves penalties. "I have a certain amount of psychological dissonance in my brain," he noted. "If you are a victim, why do you have to self-disclose and pay a penalty?" What was the hospital supposed to do, when the alleged "lie and scheme was truly deceptive?" On the other hand, self-disclosure gives hospitals finality "and the dollars aren't that high," Fitzgerald said. "It's a tricky balance."

Meanwhile, the U.S. attorney's office said May 15 that five Operation Nightingale defendants pleaded guilty to wire fraud conspiracy.[2] They "admitted to soliciting and recruiting people who sought nursing credentials that would allow them to work as registered, licensed practical, or vocational nurses. They also admitted to working with Palm Beach School of Nursing to create and distribute fraudulent diplomas and transcripts representing that the aspiring nursing candidates had attended the school and completed the necessary courses and clinicals to obtain their nursing diplomas," the U.S. attorney's office said.

Obviously, phony degrees aren't the only challenges around licensure. Fitzgerald said exclusion screening should cover both federal health care programs and state exclusion and any program termination databases (e.g., Medicaid billing privileges). They're "core compliance blocking and tackling," he noted. Recently he has handled several cases where providers overlooked employee exclusions or hired applicants even though they came back on reports as excluded. "I've had a rash of those happening," Fitzgerald said. "It gives you a black eye if you get caught employing someone on the prohibited list."

He has a case where an employee had been excluded by Medicaid but not by OIG. When the employer screened for exclusions, the person's name didn't pop. "It's one of those anomalies," Fitzgerald said. In another situation, a nurse had her license suspended for not paying her dues, and when she realized this, the nurse quickly paid up and was reinstated. "While the law is clear you shouldn't do that, the law is less clear" what the employer should do, he noted. The SDP is not available for this kind of technical state licensure violation when a person briefly didn't pay dues or is overdue on continuing nurse education, he noted.

Contact Fitzgerald at jfitzgerald@polsinelli.com. ✧

Endnotes

1. Nina Youngstrom, "Fake Nurse Diplomas Lead Organizations to Check Licensure; New Process May Be Needed," *Report on Medicare Compliance* 32, no. 6 (February 13, 2023), https://bit.ly/436TThm.
2. U.S. Department of Justice, U.S. Attorney's Office for the Southern District of Florida, "Guilty Pleas in Fraudulent Nursing Diploma Scheme," news release, May 15, 2023, https://bit.ly/45hLCsI.

NEWS BRIEFS

◆ **The HHS Office of Inspector General has updated its work plan.**[1] New items include an evaluation of hospital identification of patient harm events and nursing home-initiated facility discharges.

◆ **MedEvolve Inc., a business associate that provides practice management, revenue cycle management, and practice analytics software services to covered entities, agreed to pay $350,000 to settle potential HIPAA violations,** the HHS Office for Civil Rights (OCR) said May 16.[2] "The settlement concludes OCR's investigation of a data breach, where a server containing the protected health information of 230,572 individuals was left unsecure and accessible on the internet," OCR stated. MedEvolve didn't admit liability in the settlement.

Endnotes

1. U.S. Department of Health & Human Services, Office of Inspector General, "Recently Added," last accessed May 19, 2023, https://bit.ly/2AxFtyP.
2. U.S. Department of Health & Human Services, "MedEvolve, Inc. Resolution Agreement and Corrective Action Plan," last reviewed May 16, 2023, https://bit.ly/3pTD77d.