CCH Healthcare Compliance LETTER

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The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

Defendants charged in $8 million Medicare fraud scheme

by Sharon Sofinski, Coordinating Editor

Fourteen people have been charged with participating in a scheme designed to defraud Medicare of more than $8 million, according to a press release from the U.S. Attorney for the Southern District of Florida.

The indictment alleges that three therapy companies paid kickbacks to assisted living facilities and to patient recruiters in exchange for access to patients. The companies then billed Medicare for medically unnecessary and non-qualifying therapy. In addition, several physicians have been charged with accepting kickbacks for ordering medically unnecessary or questionable therapy for the patients provided by the assisted living facilities and patient recruiters.

The fraud scheme also allegedly included:

- the forging of physician orders and treatment notes;
- charges to Medicare for treatments that were not performed;
- the destruction of medical records to avoid an audit of a related therapy company;
- the alteration and fabrication of medical records after the government initiated a civil fraud case against the companies;
- the attempt by three of the defendants to conceal the proceeds of the fraud scheme by transferring money to off-shore accounts, to accounts in other names, or through shell companies; and
- extravagant purchases by three of the defendants with the proceeds of the fraud scheme.

Among the fourteen indicted are several physicians, the owners of the three therapy companies, and the patient recruiters. If convicted, the defendants will face maximum prison sentences ranging from 5 to 20 years, and fines of up to $16 million.

The Department of Health and Human Services Office of Inspector General, the Internal Revenue Service, and the United States Postal Inspection Service participated in the investigation. To read the U.S. Attorney's press release, go to http://www.usdoj.gov/usao/fls/latest_district_news.html. ■

CCH Chicago Bureau, August 16, 2004

OIG issues two Advisory Opinions

by Sharon Sofinski, Coordinating Editor

The Office of Inspector General (OIG) of the Department of Health and Human Services recently issued Advisory Opinion 04-09, approving a geriatric group practice's proposal to hire primary care physicians to act as consultants in con-

nection with the group's nursing home patients; and Advisory Opinion 04-10, in response to a county's proposal for an exclusive arrangement for emergency ambulance services.

Advisory Opinion 04-09. In response to problems it encountered obtaining complete and accurate patient histories and other information for its nursing home patients, a geriatric group practice proposed to hire the primary care physicians who treated each nursing home patient before the patient was admitted to the nursing home, to help the practice physicians treat the patient. Under the employment agreement, the primary care physician (the "consulting physician") would be on call 24/7 to respond to the group practice's requests for consultation. The counsulting physician would be paid $50 per hour for a maximum number of hours per month based on the number of patients the consulting physician agreed to consult. The maximum monthly compensation would be $750 for 15 hours of service for 20 or more patients. None of the consulting physician costs would be billed to Medicare or Medicaid, or to any patient or third-party payor.

Under Section 1128B(b)(3)(b) of the antikickback statute, any amount paid by an employer to an employee (who has a *bona fide* employment relationship with such employer) for employment in the provision of covered items or services is excepted. The geriatric group practice included in its request for an Advisory Opinion, a copy of a private IRS letter ruling that indicated that the consulting physicians would qualify as *bona fide* employees of the group practice. The OIG concluded that based on the facts and the IRS determination letter, the proposed arrangement would not constitute prohibited remuneration under the antikickback statute.

Advisory Opinion 04-10. In this advisory opinion, the OIG responded to a county's proposal for an exclusive arrangement for emergency ambulance services. The county operates a fire and emergency response system that includes "first responder" services for fire, rescue and medical emergencies, and "second responder" services for ambulance transportation. The county made a policy decision to reorganize its emergency response system to concentrate on first responder services and minimize resources spent on secondary responder services. Under CMS payment regulations, as well as the state's Medicaid program, payment for ambulance services are made to the entity that furnishes those services; there is no separate payment for first responder services.

The county issued an invitation to bid for an ambulance company to provide second responder services. It plans to award an exclusive two-year contract to the ambulance company, with the option to renew for an additional two years. Under the proposal, the second responder is expected to respond to dispatches for ambulance transportation services and pay the county per response for first responder services. The second responder will be able to bill the appropriate payors, including Medicare and Medicaid, for services it provides.

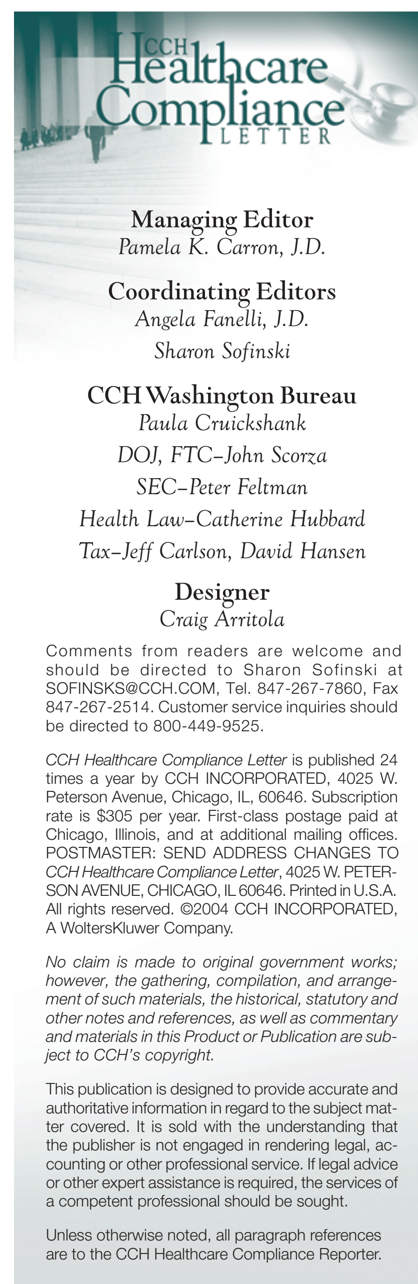
According to the OIG, the county is soliciting payment for first responder services in exchange for an exclusive contract to provide nearly all emergency secondary responder ambulance transportation services in the county. Thus, the proposal implicates the antikickback statute. However, the OIG would not impose sanctions on the proposed arrangement because:

(1) The per-response fees are only one part of the county's comprehensive regulatory scheme to manage the delivery of emergency medical services, including first responder and second responder services.
(2) The per-response fee would only be partial compensation for the costs of its first responder services.
(3) The per-response fee would not pose an increased risk of overutilization or increased costs to federal health care programs.
(4) The exclusivity of the contract would not have an adverse impact on competition, because the county is using an open, competitive bidding process.
(5) The public would receive the financial benefit of the county's receipt of the per-response fees by getting the best possible reimbursement for county expenditures.

The OIG warned, however, that if the facts presented were changed—for example, if the county did not currently provide first responder services and decided to provide them because an ambulance company offered to pay for such services—it would have reached a different conclusion.

The full text of the Advisory Opinions is available on the OIG website at http://www.oig.hhs.gov/. ■

CCH Chicago Bureau, August 17, 2004



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Unless otherwise noted, all paragraph references are to the CCH Healthcare Compliance Reporter.

Schering-Plough agrees to settle in Claritin pricing investigation

by Sharon Sofinski, Coordinating Editor

Schering Sales Corp., the sales and marketing subsidiary of Schering-Plough Corporation, will plead guilty to criminal charges and pay a $52.5 million fine, and Schering Plough Corporation will pay more than $290 million, to settle charges stemmimg from its fraudulent pricing of its allergy drug Claritin, Deputy Attorney General James B. Comey and U.S. Attorney Patrick L. Meehan have announced.

Under the settlement:

- Schering Sales Corp. will plead guilty and pay $5.25 million for violating the Antikickback Statute by paying a kickback to an HMO in exchange for inducing the HMO to keep Claritin on its fomulary;
- For its failure to report its true best price for Claritin, Schering-Plough Corporation will settle its False Claims Act liability by paying the United States, 50 state Medicaid programs, and certain Public Health Services entities more than $290 million;
- Schering-Plough Corporation will enter into a five-year corporate integrity agreement with the Department of Health and Human Services Office of Inspector General.

According to the charges, the HMO, one of Schering Sales Corp.'s best customers, asked Schering Sales Corp. to drop the price of Claritin because it cost the HMO millions of additional dollars per year to purchase Claritin rather than Allegra, a less expensive competitor. Schering Sales Corp refused. After the HMO decided to remove Claritin from its formulary, Schering Sales Corp. offered to make up the difference in price between Claritin and Allegra by giving the HMO a $10 million "value added" package to influence the HMO to keep Claritin on its formulary. Under the "value added" package, Schering Sales Corp. offered to pay the HMO two percent of the annual gross sales of Schering drugs—what it called a "data fee." By using that terminology, Schering Sales Corp. gave the appearance that the fee was a fair market value transaction rather than a hidden inducement to keep Claritin on the HMO's formulary.

Also in response to threats by two managed care customers to remove Claritin from their formularies, Schering-Plough funded significant price concessions to the customers through various payments and services, including:

- $3 million of deeply discounted Claritin reditabs;
- health managment services at far below fair market value;
- an interest-free loan in the form of prepaid rebates;
- a risk-share arrangement where Schering covered a portion of the managed care customer's respiratory drug costs; and
- deep discounts on other Schering products.

Under the Medicaid Rebate Program, Schering was required to report its best price for and to pay rebates on Claritin. Also, under the Public Health Service (PHS) drug pricing program, Schering was required to charge PHS entities a discounted price based in part on the Medicaid price. Since Schering failed to account for the discounts listed above in its reported best price for Claritin, the Medicaid program and PHS entities paid more for Claritin than the managed care customers.

According to Mark B. McClellan, Administrator for the Centers for Medicare and Medicaid Services (CMS), "Drug companies should take notice that they need to be vigilant in verifying the prices they report for drugs." He added, "We will be watching closely to assure the accuracy of the information reported on drug prices and to assure that all business practices are in compliance with federal rules and regulations."

Calling this case "significant," Deputy Attorney General James Comey remarked that it "sends the message that secret payments fraudulently made to disguise the price of drugs will be subjected to criminal and civil enforcement."

In a press release, Brent Saunders, Schering-Plough Corporation's senior vice president, Global Compliance and Business Practices, remarked, "This agreement is another important step in the transformation of Schering-Plough. We are making progress with our corporate strategy to build a new company where quality, compliance and business integrity are at the center of our work."

To read the Department of Justice press release on the settlement, go to http://www.usdoj.gov/opa/pr/2004/July/. ■

CCH Chicago Bureau, August 12, 2004

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On The Front Lines

IRS initiative targets executive compensation

by Cynthia F. Reaves, Esq.

On August 10, 2004, the Internal Revenue Service (the "IRS") published Announcement 2004-106,[1] which described a new enforcement effort designed to identify and put an end to abuses by tax-exempt organizations that pay excessive compensation and benefits to their officers and other insiders. While the IRS interest in executive compensation arrangements is nothing new, the enforcement program, which the IRS had initially announced several months ago, represents a broader scope of review than had been previously announced. Exempt organizations would do well to review their compensation programs and assess whether they comply with existing IRS guidance.

Exempt organizations should take notice of this IRS compensation review program. In particular, the program is more expansive than the original initiatives which had been first announced several months ago. Currently, the IRS proposes to contact nearly 2,000 charities and foundations to seek more information about their compensation practices and procedures. Originally, the IRS had informally indicated that it would be targeting only those executives with compensation in excess of one million dollars. Indeed, IRS officials have stated that they are "concerned that some charities and private foundations are abusing their tax-exempt status by paying exorbitant compensation to their officers and others..."[2] The number of contacts which the IRS anticipates making is a strong signal that the agency has considerably broadened its scope of review beyond its original initiative, which would have been likely to produce far fewer candidates for review.

Additionally, the IRS stated that the purpose of the review project was to: (1) address the compensation of specific individuals or instances of questionable compensation practices; (2) increase awareness of tax issues as organizations set compensation in the future; and (3) learn more about the practices exempt organizations are following as they set compensation and report it to the IRS and the public on their annual Form 990 returns. While the stated purpose of the project is to gather information, and contact by the IRS does not imply or otherwise suggest improper activity by an organization, exempt organizations should nonetheless approach the audit review with care as they assemble and prepare responses to IRS inquiries and interviews.

How compensation amounts are calculated, and the timing of the inclusion of certain compensation benefit amounts are likely to be the subject of the IRS reviews. Further, the rebuttable presumption guidelines set forth in the intermediate sanctions rules as discussed below will provide a basis upon which to identify issues with respect to the development of compensation arrangements for senior executives. Indeed, the IRS is clearly focused on how compensation is reported on the Form 990. Announcement 2004-1006 states that the IRS will inquire about not only compensation amounts but various kinds of insider transactions, such as loans and the sale, exchange or leasing of property to officers and others. The Announcement also states that the IRS will focus on how exempt organizations answered question 89(b) on their Form 990 which requests the preparer to report information on excess benefit transactions and other compensation information.

"Exempt organizations must invest the resources to develop documentation which supports the reasonableness of their transactions."

The IRS compensation review program will not present substantial surprises for the well-advised exempt entity. For years, exempt organization practitioners have advised and counseled their clients to develop internal audit and other review programs designed to document the reasonableness of compensation amounts and other transactions involving exempt organizations and senior executives or other insiders. The intermediate sanctions rules provide helpful information which is designed to guide exempt organizations in developing documentation which will allow it to create a "rebuttable presumption" that a particular transaction or compensation arrangement is reasonable under the rules.

The IRS audit review programs arise during a period of extreme controversy for exempt organizations. This summer, the Senate Finance Committee issued reports containing proposals for reforms in exempt organization accounting practices. Among the suggested recommendations was a cap on fees paid to directors and trustees of private foundations. Further, the recent spate of class actions suits against nonprofit hospital systems have raised the issue of the amount of charity care

which the organizations provide to their communities. Such cases are likely to focus additional attention on the operations of exempt organizations and their transactions with insiders, including senior executives. In light of the scrutiny being placed upon exempt organizations, such entities should take steps to review their current arrangements in preparation for an IRS audit inquiry.

Excess Benefit Transactions

The IRS is focusing its review on excess compensation amounts flowing to executives and other insiders and whether those arrangements result in an "excess benefit transaction." An "excess benefit transaction" is a transaction in which an economic benefit is provided by a 501(c)(3) or 501(c)(4) tax-exempt organization, directly or indirectly, to or for the use of a disqualified person, and the value of the economic benefit provided by the organization exceeds the value of the consideration received by the organization. The IRS has stated that in order to determine if an excess benefit transaction occurred, *all* consideration and benefits exchanged between or among the disqualified person and the applicable tax-exempt organization and all entities it controls must be included. An excess benefit can occur in an exchange of compensation and other benefits in return for the services of a disqualified person in employment, or in an exchange of property or services between a disqualified person and the applicable tax-exempt organization.

Where an excess benefit transaction has been found, the IRS will assess a penalty upon the disqualified person in the amount of 25 percent of the excess benefit (which amount can increase to 200 percent of the excess benefit if the party fails to correct the transaction). In addition, a penalty tax is imposed upon any organization manager who approved the excess benefit transaction, knowing that it was such a transaction, in an amount equal to ten percent of the excess benefit.

An exempt organization may create a "rebuttable presumption" that a particular transaction or compensation arrangement is reasonable if it meets the following three conditions under Section 4958 of the Code. First, the compensation arrangement must be considered and approved solely by independent members of the governing board (or committee of the board) who are unrelated to and not subject to the control of the person(s) involved in the compensation arrangement. Second, the independent board or committee must obtain and rely on appropriate comparability data, such as compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions. Finally, the independent board or committee must adequately document the basis for its determination, and its meeting minutes must describe in detail the entire process by which it intended to qualify for the presumption. If these requirements are met, the burden shifts to the IRS to prove that the compensation arrangement is unreasonable.

If an exempt organization undertakes an internal review of its compensation arrangements and finds that there may be a potential excess benefit transaction, it may correct the excess benefit transaction by undoing the excess benefit to the extent possible and by taking any additional measures necessary to place the organization in a financial position not worse than that in which it would be if the disqualified person were dealing under the highest fiduciary standards. The organization is not required to rescind the underlying agreement; however, the parties may need to modify an ongoing contract with respect to future payments. The disqualified person corrects an excess benefit transaction by making a payment in cash or cash equivalents equal to the amount of the excess benefit to the applicable tax-exempt organization.

Potential Areas of Inquiry

Based upon the stated area of interest, and the guidance available to exempt organizations under the intermediate sanctions rules, it is likely that the IRS will request detailed information and supporting documents regarding the following aspects of an exempt organization's compensation and transaction activities:

- The exempt organization's compensation practices and procedures, including how the exempt organization charity establishes and reports compensation for its senior executives;
- Information which establishes the independence of the organization's governing body (e.g., the board of trustees or directors) that approves compensation and other transactions involving insiders;
- The process and procedures, including the documentation of such process and procedures, employed by the exempt organization in approving compensation and other insider transactions;
- The duties and responsibilities of the exempt organization's executives given their compensation amounts;
- The management of other transactions with executives and other insiders, such as sales of property, loans, and service or provider contracts; and
- Compliance with the excess benefit disclosure requirements of the IRS Form 990.

Clearly, documentation is key to surviving an IRS review program. Exempt organizations must invest the resources to develop documentation which supports the reasonableness of their transactions. Consequently, exempt organizations should review these arrangements immediately along with any supporting documentation and include appropriate reports and final determination documents in the records of the exempt

entity. In this regard, the intermediate sanctions rules provide a specific time frame within which such information should be gathered for documentation purposes.[3] Information supplied after the applicable time period may not be used to establish a rebuttable presumption under the Code. However, arguably, an exempt organization should include whatever documentation it can in its records irrespective of the timing of the receipt of such information if it can prove helpful during an audit review—even if the applicable time periods have expired—so long as the information is rationally related to the compensation arrangement in question and the exempt organization discloses that the information was added later in time.

For example, if the organization has accurate and correct survey information for the year that a particular compensation arrangement was approved, and such information supports the reasonableness of a particular compensation arrangement, the organization would be in a better position if it includes the information in its documentation and discloses the date of its inclusion than if it had no documentation whatsoever. While this information will not support a rebuttable presumption claim (since the governing board did not have such information to rely upon in approving the transaction), it may prove helpful nonetheless in establishing the reasonableness of the compensation amount in general.

Proactive Steps for Exempt Organizations

Exempt organizations should review existing compensation arrangements and assess the strength and appropriateness of their compensation approval process and their documentation protocols. Several IRS communications exist which provide a strong starting point in assisting exempt organizations in determining whether their existing programs comply with current guidelines. Commentators suggest that the primary source of problems for exempt organizations in establishing the reasonableness of executive compensation is a failure to document the arrangement in a manner consistent with IRS guidelines.

Consequently, exempt organizations should establish policies and programs which will enable them to adhere to the requirements of the intermediate sanctions rules. Adherence to these rules will allow them to establish a rebuttable presumption that their compensation arrangements are reasonable. In this regard, compensation data should be compiled in a timely manner, and the individuals who approve the arrangement must be determined to be independent and free of conflict in the particular arrangements which they approve. Other important activities include:

- Reviewing the corporation's conflict of interest policy in order to insure that those individuals who approve transactions are not in any way conflicted from participating in the compensation process.
- Reviewing and confirming that the organization has assembled appropriate comparability data for the compensation arrangements which it has with its senior executives.
- Reviewing the minutes of the board or committee meeting which approved the compensation arrangement to insure that it reflects that the board or committee obtained and relied upon appropriate data and that independent directors approved the transaction.
- Confirming that all forms of compensation paid at an executive are reflected in a written compensation arrangement.
- Reviewing the IRS 990 to determine whether the organization properly disclosed any excess benefit transaction.
- Reviewing the IRS 990 to identify those individuals who are likely to be the subject of an IRS review; included in this group should be those individuals who own companies which are top service providers to the exempt organization where those individuals also hold senior positions as trustees or officers of the exempt organization.

By taking these precautionary steps, an exempt organization will be well positioned to respond to an IRS inquiry regarding its executive compensation programs and other transactions involving insiders. ■

Cynthia F. Reaves is a partner with the law firm of Honigman Miller Schwartz and Cohn LLP in Detroit, Michigan. She is a member of the CCH Healthcare Compliance Portfolio Editorial Advisory Board, a frequent lecturer on exempt organization issues and the co-author of several articles and treatises on the topic of compensation arrangements for exempt organizations.

[1] (August 10, 2004).

[2] Statement of Mark W. Everson, Commissioner of the Internal Revenue Service, IRS Announcement 2004-106 (August 10, 2004).

[3] The documentation must be prepared before the later of the next meeting of the decision-making body, or 60 days after the final actions of the body. In addition, the decision-making body must approve the documentation within a reasonable time after.

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ASPEN PUBLISHERS

Effective records management can improve medical outcomes, prevent against lawsuits, experts say

by Catherine Hubbard, MA, Contributing Editor

Creating effective and compliant records management policies can help health care organizations improve medical outcomes while protecting the legal interests of both patients and the facility, according Sue Bowman, director of coding policy and compliance at the American Health Information Management Association.

Good medical record documentation enhances the quality of health care by providing a record that caregivers can use to evaluate, plan and monitor the patients' treatment, Bowman said. "When completed consistently, it also provides a running account of the patients' care that will eliminate oversights and ensure a more timely response to problems," she said during an August 10 audioconference sponsored by the Health Care Compliance Association.

In the event of a lawsuit, Bowman said, the provider will have to rely on the medical record documentation to support that it acted in a prudent manor in providing medical care. "Ensuring good medical record documentation can mitigate the effects of litigation," she emphasized.

Effective and compliant policies also lead to administrative convenience and cost savings, said Karen Lovitch, with Mintz, Levin, Cohn, Ferris, Glovsky & Popeo. For instance, she said, good documentation practices can save storage space by ensuring documents are routinely and lawfully destroyed, can save time and money by making it easier for providers to respond to subpoenas and discovery requests and can lead to increased efficiency in carrying out day-to-day duties.

"Effective and compliant records management policies are a must in the health care operating environment," Lovitch said. "Resources spent on developing and implementing policies will pay off in many ways," she added.

"By having strong, effective policies related to medical documentation practices, you're going to improve the quality of documentation," said Bowman.

Facilities also should make sure their documentation requirements are consistent and standardized, Bowman said, recommending providers establish multidisciplinary teams to develop, monitor and update policies. These teams should represent the management, the clinical departments and the physicians, she said. "Ensure that physicians are involved in a leadership capacity," she urged, suggesting facilities provide benefits and incentives for physicians who cooperate with the new policies. "Use negative reinforcement only as a last result," she said, adding that negative incentives, such as fines and removal of privileges, usually are not the most successful ways of earning cooperation.

"While information technology can be a huge boon to improving documentation practices, it has to be built correctly. Otherwise, it could add more errors and problems to the whole system."

In addition, physicians should be involved in developing appropriate measures and monitors to assess the quality of medical record documentation, Bowman said. For example, the physician should document the relationship between the patient's current hospital stay and any recent admissions, should document major changes in the patient's condition and should state the status of unresolved problems and discharge notes, she said. "These steps will ensure that the record reflects that the patient was stable for discharge, continuity of care was maintained and any readmission was appropriate," she added.

To create effective policies, facilities should establish a chain of command for reporting problems based on the severity and potential impact on the organization, Bowman said. "If you've identified a problem, what are you going to do?" she asked, stressing that a chain of command will establish who the problem should be referred to and who has the authority to take action.

Electronic health records. As the health care industry moves toward electronic health care records, organizations will increasingly rely on information technology. This will present the industry new challenges in ensuring the accuracy of the claims and of the information used to generate claims, said Bowman. "While information technology can be a huge boon to improving documentation practices, it has to be built correctly. Otherwise, it could add more errors and problems to the whole system," she warned.

It's often difficult for purchasers of computer systems and software to know exactly how that system operates and generates information. That's why health care organizations need to thoroughly assess all computer systems and software that impact coding, billing or the generation or transmission of information, Bowman said.

In addition, Bowman stressed the importance of effective coding policies, saying they will lead to:

- More accurate and complete coding policies.
- More accurate reimbursement fees from all payers.
- A more accurate case mix index.
- Improved quality outcomes.
- Improved documented support for length of stay and resource use.
- Improved performance profiles for facilities and physicians.
- A more reliable database for quality improvement, outcomes management, clinical pathway development, benchmarking and research.

Reducing physician queries. Bowman said policies and procedures should include a process for physician queries, which are questions coding professionals ask when a physician's

documentation contains incomplete, conflicting or ambiguous information. "Queries should be the exception, rather than the norm," she said, adding that if a physician is being queried often, the matter should be investigated.

A sound query process can help identify documentation problems, said Bowman. She said queries should be clearly and concisely written, should present relevant facts from the medical record and should include specific, open-ended—rather than "yes" or "no"—questions. Also, she said, "Every effort should be made to keep that query process to a minimum and to improve the documentation at the point of care, which is where it should happen."

"A sound query process can help identify documentation problems"

Query policies should be designed to promote timely, complete and accurate coding and documentation, should be specific to the unique situation and should determine whether a query should occur while the patient is still in-house or after he or she has been discharged, Bowman said.

Finally, Bowman said, any changes to the documentation program need to be communicated to clinicians through regular newsletters and meetings. "We need to help them keep on top of those changes that would impact the way they're documenting care," she said. ■

CCH Washington Bureau, August 16, 2004

EMTALA

CMS providing $1 billion for undocumented alien care

by CCH Editorial Staff

The Centers for Medicare & Medicaid Services (CMS) has announced a new program to provide $1 billion over four years to help hospitals and other providers recoup the costs of providing emergency medical care to uninsured patients regardless of their citizenship status. The Medicare Modernization Act of 2003 (MMA)(PubLNo 108-173) set aside $250 million per year for fiscal years 2005-2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens.

Two-thirds of the funds will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented alien apprehensions for such fiscal year. Payments will be made directly to hospitals, physicians, and ambulance providers.

EMTALA. The Emergency Medical Treatment and Labor Act (EMTALA) imposes specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions. EMTALA sets forth requirements for medical screening examinations of medical conditions, as well as necessary stabilizing treatment or appropriate transfer. It specifically prohibits a delay in providing required services in order to inquire about the individual's method of payment.

CMS is seeking public comment concerning the policies and process that it will use to make payments under this program. CMS' proposed approach provides information on the policies under consideration, and establishes the general framework for submitting an enrollment application and payment requests. ■

CCH Chicago Bureau, August 5, 2004

HIPAA Security Guide

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