Published on *The National Law Review* https://natlawreview.com

OIG Issues Stark Warning to Skilled Nursing Facilities: Potential Abuse or Neglect of Residents Receiving Emergency Room Services is Being Underreported to Law Enforcement

Article By:

Tax Practice at Cadwalader

Introduction

On August 24, 2017, the Office of Inspector General ("OIG") of the Department of Health and Human Services ("HHS") issued an "Early Alert" that disclosed the preliminary results of its ongoing review of abuse of Medicare beneficiaries in skilled nursing facilities. Specifically, OIG determined: (i) that a significant number of incidents of potential abuse or neglect of nursing facility residents receiving emergency care has not been reported to law enforcement as required under the Elder Justice Act; and (ii) that the Centers for Medicare & Medicaid Services ("CMS") lacked adequate procedures to ensure proper reporting. The Early Alert, which includes a list of suggestions for immediate remedial action to be taken by CMS, highlights the increased scrutiny that nursing facilities will face for failing to comply with the Elder Justice Act's reporting obligations, and points to proactive measures nursing facilities can take, now, to mitigate risk of any enforcement action.

Requirements to Report Abuse or Neglect of Residents of Skilled Nursing Facilities

The "Elder Justice Act," adopted with the passage of the Affordable Care Act ("ACA") effective March 23, 2011 (see 42 U.S.C. § 1320b-25), requires "covered individuals" -- including an owner, operator, employee or agent, of a long term care facility -- to [A] report to HHS (or the State Survey Agency) and one or more law enforcement entities any reasonable suspicion of a "crime" against any individual who is a resident of the facility; and [B] make such report within two hours after forming the suspicion that the resident suffered serious bodily injury, or within 24 hours if there is no serious bodily injury.

Failure to make the required reports could result in civil monetary penalties of up to $300,000 and exclusion from participation in the Medicare and Medicaid programs. Id. Although the law went into effect in 2011, the corresponding regulations requiring skilled nursing facilities to develop and implement conforming policies and procedures do not go into effect until November 28, 2017. See 42 C.F.R. § 483.12(b).

Separately, skilled nursing facilities must also report resident abuse, neglect, mistreatment, injuries of

unknown origin, and misappropriation of resident property to the administrator of the facility and the State Survey Agency. See 42 C.F.R. § 483.12(c); see also N.Y. Public Health Law § 2803-d and 10 N.Y.C.R.R. § 81.1 et seq.

OIG's Audit

Although its review of skilled nursing facility abuse reporting is not yet complete, OIG issued its preliminary audit results through the Early Alert because of the "importance of detecting and combating elder abuse."

Audit Methodology and Findings: To conduct this audit, OIG reviewed hospital emergency room records of 134 residents of skilled nursing facilities transferred to the hospital, in which the emergency room staff assigned one of 12 primary diagnoses codes utilized for Medicare reimbursement claims that indicate potential abuse or neglect (e.g., adult sexual abuse, adult physical abuse, adult maltreatment). OIG also reviewed the State Survey Agency records for each of the relevant skilled nursing facilities. Based on these records, OIG found that, for 28% of these cases, there was no evidence that the underlying incident had been reported to law enforcement. Notably, OIG assumed that every emergency room visit associated with one of the 12 "abuse" diagnostic codes was an incident reportable under the Elder Justice Act. OIG, however, did not independently verify whether there was actual abuse or neglect of these individuals.

Based on its findings, OIG concluded that CMS lacks procedures to enforce the Elder Justice Act, and specifically to ensure that incidents of abuse or neglect of nursing facility residents are being properly reported to law enforcement. In particular, OIG noted that CMS does not "match" hospital Medicare claims for emergency room services with claims for nursing home reimbursement, to identify instances of potential abuse or neglect.

CMS acknowledged that it has not identified any instances in which a covered individual failed to make a report to law enforcement. In its defense, CMS informed OIG that it has not taken any enforcement action yet because HHS has not yet delegated enforcement authority to CMS. Furthermore, CMS stated that it has recently updated the State Operations Manual, used by the State Survey Agencies, to reference the applicable Elder Justice Act regulations, with an effective date of November 28, 2017.

OIG's Recommendations to CMS

In the Early Alert, OIG provided the following "suggestions" for CMS to take immediately:

- Implement procedures to compare hospital Medicare claims for emergency room treatment with nursing home claims to identify incidents of potential abuse or neglect and to periodically provide the details of this analysis to the State Survey Agencies for further investigation of compliance with Elder Justice Act reporting obligations;

- Continue to work with HHS to secure the authority to impose the civil monetary penalties and exclusion of providers pursuant to the Elder Justice Act;

- Promulgate additional regulations, if necessary, to impose penalties for non-compliance with the reporting requirements;

- Impose penalties when appropriate; and

- Direct State Survey Agencies to refer suspected violations of the reporting obligations to CMS for appropriate action.

Lessons for Skilled Nursing Facilities

- With the issuance of the Early Alert, the mandate to report to law enforcement, suspected crimes against residents, including abuse and neglect, will continue to be a compliance focus of OIG and will likely be an enforcement priority for CMS going forward. Nursing facilities need to revisit and, to the extent they have not done so already, update their policies and procedures to comply with the reporting obligations contained in the Elder Justice Act -- before the applicable regulations go into effect on November 28, 2017.

- OIG focused its attention on skilled nursing facility residents receiving emergency room services. Skilled nursing facilities should likewise be particularly focused on resident transfers for emergency care for potential incident reporting pursuant to the Elder Justice Act.

- OIG equated any emergency room visit associated with one of the 12 “abuse” diagnosis codes to be reportable under the Elder Justice Act. However, at the time of an emergency room transfer, nursing facilities in some cases may not have identified evidence of potential abuse of a criminal nature, and would not have the benefit of the emergency room physicians’ evaluation when the resident arrives at the hospital. As a matter of course, skilled nursing facilities should consider requesting records of the emergency room diagnoses and, whenever one of the 12 codes has been assigned, presume that the incident should be reported to law enforcement if it has not been already, unless the evidence clearly indicates the coding is mistaken and no abuse took place.

Bottom Line: Nursing facilities -- and “covered individuals” -- that fail to heed OIG’s alarm may be putting themselves in regulatory jeopardy.

National Law Review, Volumess VII, Number 249