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◆ **Doctors Hospital of Augusta in Georgia agreed to pay $180,000 in a civil monetary penalty settlement over alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA).[1]** The HHS Office of Inspector General alleged the hospital violated EMTALA in two instances on Dec. 13, 2015. In one instance, the hospital didn't provide an adequate medical screening exam (MSE) and stabilizing treatment to a 25-year-old woman who showed up at the emergency room complaining of ingestion of an unknown substance and loss of consciousness. The woman "was reportedly tearful and anxious, and complained of a headache, neck pain, face pain, and left shoulder pain," the settlement states. She was triaged by a nurse and given an Emergency Severity Index score of three, which was considered urgent under the hospital's triage policy. A physician medically screened the patient, but didn't include lab work related to her presenting symptoms, and then entered the patient into the hospital's MSE process for nonemergent patients. She was asked for money to continue evaluation, and because she couldn't pay, the patient was discharged, OIG said. She immediately sought and received treatment at another hospital. In the other instance, the hospital wouldn't accept an appropriate transfer of an 84-year-old woman with pneumonia and severe hypernatremia and hyperglycemia who needed intensive care unit (ICU)-level care, OIG said. The transferring hospital lacked an ICU. A physician at Doctors Hospital of Augusta declined to accept the transfer, "stating that the referring facility could manage the patient," according to the settlement. The hospital didn't admit liability.

◆ **CMS on Oct. 21 put out a request for information (RFI) on the "Future of Program Integrity" as Medicare moves to value-based care models and incorporates advanced data analytics and artificial intelligence in fraud prevention and detection.** The RFI mentions provider enrollment, claim review, Medicare Advantage, value-based payment systems and education. "CMS must elevate program integrity, unleash the power of modern private sector innovation, prevent rather than chase fraud, waste and abuse through smart, pro-active measures, and unburden our provider/supplier partners so they can do what they do best – put patients first," the RFI said. **https://go.cms.gov/33TZmt5**.

◆ **The HHS Office of Inspector General has updated its Work Plan, its road map of audits and evaluations.** The Work Plan has new items on Medicare Part B payments for speech language pathology and urine drug testing services, among other things. Visithttps://go.usa.gov/xVJf3.

◆ **The Fraud Risk Indicator has been updated on the HHS Office of Inspector General's website.** The Fraud Risk Indicator has five categories of risk, from low to highest, that describe the degree of danger that organizations are thought to pose to federal health care programs. They mirror OIG's 2016 risk spectrum for applying its permissive exclusion authority. Visit **https://go.usa.gov/xVJfq**.

1 42 U.S.C. § 1395dd .

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