1997 MEDICARE UPDATE:

DEVELOPMENTS FOR HOME HEALTH
AND DME PROVIDERS

ADDRESS TO THE ALAMO AREA HOME CARE COUNCIL
SAN ANTONIO, TEXAS

JANUARY 22, 1997

EDGAR C. MORRISON, JR.
Jackson & Walker, L.L.P.
112 E. Pecan Street, Suite 2100
San Antonio, Texas 78205
(210) 978-7700
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I. PAYMENT ISSUES

Adjustments to Cost Limits

In November 1996, HCFA published a notice revising upward home health agency limits on per visit costs. HCFA commented that the notice corrected a technical error found in its original cost limits announcement. The new correction involves a higher budget neutrality adjustment factor which should be 1.078. Intermediaries were requested to make adjustments based on the new figure immediately. Home health agencies should bring this notice to their intermediaries’ attention if they have reason to believe that the intermediary has failed to make the appropriate adjustment.

Co-Payments for Home Health Services

In 1996, the Prospective Payment Assessment Commission (“PROPAC”) recommended to Congress that it require HCFA to institute a co-payment by beneficiaries for home health services. The co-payment was designed to cause the beneficiaries to limit their use of home health services. The original proposal suggested a 10% co-pay limited to total out-of-pocket expenditures of $700.00. Industry representatives expressed strong opposition to the proposal.

At a December 11 meeting, PROPAC members declined to again recommend the co-payments to Congress. The commissioners now believe that such a policy would do little to curve home health spending growth, and, with respect to dually eligible Medicare and Medicaid patients, would simply shift Medicare costs to the Medicaid program.

PROPAC is already on record as approving and recommending a prospective payment system for home health, but while that proposal is under study, the Commission intends to discuss at its January meeting, imposing an interim home health payment system that might include monthly limits on per visit payments. Providers should expect to see some form of additional home health cost limitations in 1997.

II. DURABLE MEDICAL EQUIPMENT

Two recent developments in HCFA’s regulation of the DME industry should be of interest to DME suppliers everywhere.

Surety Bonds

In May of 1996, the Florida medicaid agency began requiring new applicants for a DME supplier number to post a $50,000 surety bond. The bond was designed to ensure that if a provider went bankrupt or was accused of billing fraud, that HCFA would recoup at least a minimum amount of any potential losses. The surety bond also was designed to “weed out” undercapitalized or less scrupulous suppliers in hopes of preventing losses to the program before they occurred. HCFA has endorsed the Florida medicaid agency’s policy, and administrator Bruce Vladeck has noted that HCFA in a few months will propose regulations to require all DME suppliers to obtain a surety bond if they want to participate in Medicare.
HCFA is also looking at the possibility of requiring all DME suppliers to re-enroll in the program, under stricter guidelines, in order to continue participation. HCFA recently required all 8,000 Florida DME suppliers to re-enroll. Those suppliers will be subject to closer screening and possibly an on-site review prior to certification.

Orthotics

HCFA recently published a notice “clarifying” the definition of orthotics to specify that the orthotics benefit is limited to braces used independently of other medical or non-medical equipment. The orthotics issue became prominent because of the increased use of thoracic lumbar sacral orthoses (TLSO’s) in nursing homes. All TLSO’s are supposed to be fitted to a patient’s body and provide support for the back. Some are attached to wheel chairs, and, according to HCFA, are little more than sophisticated seating restraints. Under HCFA’s clarification, although Medicare will continue to pay for TLSO’s, the payment could be substantially less than the current price range which varies from $155.00 to almost $1,700.00. The HCFA ruling requires that DME is only payable as an “orthotics” benefit if the device can be used independently of other medical or non-medical equipment.

III. REGULATORY ISSUES

CSM Home Health

In July, 1996, the HCFA Region IX office in California notified CSM Home Health of Los Angeles that it was terminating its provider agreement because it failed four conditions of participation. CSM immediately filed suit in federal district court in California seeking a temporary restraining order to prevent HCFA from implementing its termination notice. Although the district court denied the temporary restraining order request, CSM was able to obtain an expedited hearing before an administrative law judge (“ALJ”), at which hearing, the ALJ concluded that HCFA had improperly terminated the agreement, failing to prove that the provider had not satisfied its conditions of participation.

The government appealed the ALJ ruling, but agreed to reinstitute CSM’s payments while the appeal was pending. During the time period between the original notice of termination and the results of the hearing, however, CSM was forced to enter into an agreement with another home health agency to transfer its patients while they were awaiting the results of the hearing. During the pendency of the appeal, HCFA notified CSM that because CSM had voluntarily ceased providing services during that interim period, it had voluntarily relinquished its provider agreement.

The case is still under appeal, and CSM has been forced to transfer all of its patients to other area home health agencies while it tries to obtain funding to continue operations. The CSM case is an example of a provider that chose to fight its termination notice, and was successful; however, even under those “best of circumstances” it appears likely that CSM will go out of business because of its inability to have enough cash to survive during the pendency of the appeal.
HCFA has become more aggressive about denying initial applications for home health certification, and terminating existing provider agreements for alleged violations that do not threaten the health and safety of patients.

Revisions to Conditions of Participation

HCFA has announced a pilot program to test the feasibility of revising Medicare conditions of participation for home health agencies to focus more on patient outcomes than procedural correctness. Current conditions of participation focus on processes of care such as staffing levels, committees and other systems in place. HCFA would like to amend those conditions to include outcomes measurements.

No date is set for any proposed rule making, but providers should be aware of this potential change in HCFA’s focus. It highlights the agency’s continued efforts to reduce the growth of home health costs by recouping overpayments to existing providers, sanctioning providers for failure to meet appropriate standards, or preventing new providers from entering the program to begin with. When a notice of proposed rule making is published, providers should be prepared, along with their industry representatives, to submit comments to the agency on those regulations. Outcomes based conditions, while superficially appealing, should only be used -- if at all -- as a payment adjustment mechanism. Enabling HCFA or the OIG to terminate a provider based upon a subjective “outcomes” analysis simply gives the agency a club which could be used inappropriately and arbitrarily (see the CSM Home Health discussion above).

IV. FRAUD AND ABUSE

RECENT OIG AUDITS

One way HCFA has attempted to slow down the exponential growth in the home health program is through closer scrutiny of HHA cost reports, and statistical sampling of individual claims under audits conducted by the Office of Inspector General (OIG). The recent OIG audits indicate areas of scrutiny for home health providers, and also perhaps give a glimpse into HCFA’s future audit plans for the industry.

Home Health Care, Inc.

On September 30, 1996, the OIG released a report containing its audit results of Home Health Care Services, Inc. (HHC) of Hialea, Florida. Upon the request of the Atlanta HCFA regional office, the OIG sampled 100 claims submitted by HHC during fiscal year 1993 and determined that 44% of the sample did not meet Medicare guidelines. The report concluded that the claims were deficient as follows:

- 25% of the claims were not reasonable or medically necessary;
- 14% of the claims were for beneficiaries who were not “homebound”;
- 10% of the claims were for patients who were not “homebound”.

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5% of the claims were for services which physicians did not authorize or for services which were not actually provided.

The OIG determined, based on that statistical sampling, that HHC had been overpaid between $1.2 and 2 million, and recommended that HCFA recover all overpayments from the provider and refer all cases of possible fraud (the 5%) to the OIG.

First American Health Care, Inc.

On the heels of the HHC audit, in November, 1996 the OIG issued a second report of an audit of First American Health Care, Inc. (FAP), a subsidiary of First American Health Care (f/k/a ABC Home Health Services). The OIG also performed a sampling of 100 of FAP’s claims and concluded that 28% of those claims contained 1 or more items that were ineligible for Medicare reimbursement. The OIG determined that 19% of the total services rendered were improperly paid by Medicare.

The parent of FAP, formerly known as ABC Home Health, had previously entered into a Settlement Agreement with the United States due to other fraud and abuse claims against the agency by the OIG. The civil settlement provided for payments of approximately $232,000,000 to HCFA over the next several years, including the alleged overpayments to FAP.

Summary of OIG Audits

In conducting its audits, the OIG focuses on five areas of allegedly improper home health claims. Those areas include:

- beneficiaries were not homebound;
- beneficiaries did not require skilled nursing care or physical or speech therapy;
- services provided were medically unnecessary or excessive;
- insufficient documentation in medical records;
- services claimed not actually provided.

Large home care providers who are part of a for-profit chain with greater than 2,000 visits per year are the most likely targets for an OIG audit. OIG, and sometimes FBI investigators may interview the beneficiary, the family, close family friends, the patient’s personal physician, and the physician certifying the plan of care. Frequently the tone of those investigations and the types of questions asked by the OIG cause the person being interviewed to respond in a fashion that did not substantiate that the home health services were necessary or rendered as claimed.

Long term patients, those requiring services in excess of the initial three month certification period, are the most likely patients to be investigated by the OIG. Agencies should
be careful to thoroughly document the need for extended care, and should be able to document their efforts to teach the patients or family members to care for themselves.

Agencies may wish to include the Medicare definition of “homebound” on the Certificate of Medical Necessity signed by the physician, and send a “confirmation copy” of the CMN and the referral form to the physician.

V. REVIEW OF FRAUD AND ABUSE STATUTES

Illegal Remuneration or Anti-Kickback (42 U.S.C. § 1320a-7b(b))

The statute makes it unlawful for anyone to knowingly solicit or receive, offer or pay any remuneration directly or indirectly, in cash or in kind, for referring an individual to a person for the furnishing or arranging for the furnishing of any service or for purchasing, leasing, or ordering any good or service for which payment may be made under Medicare or Medicaid.

Violations are felonies, punishable up to five years in prison and a fine of not more than $25,000. Violators also will be excluded from participation in Medicare and Medicaid.

Various Safe Harbors have been promulgated by the Department of Health and Human Services allowing providers to have examples of conduct that will not be prosecuted. A few areas addressed by the Safe Harbors include investment interests, equipment and space rental, personal services contracts, referral services and managed care. See 56 Fed. 35952.\(^1\)

\(^1\) Texas has a similar statute. It provides that a person commits an offense if he or she intentionally or knowingly offers to pay or agrees to accept any remuneration directly or indirectly, in cash or in kind, for obtaining or soliciting patients or patronage for or from a licensed health care provider. The statute continues that, if a practice is permitted under the federal illegal remuneration statute, it is permitted under Texas law, as well. Tex. Health and Safety Code §161.091.
Stark (42 U.S.C. § 1395nn)

If a physician or immediate family member has a financial relationship with an entity, the physician may not refer patients to that entity for the furnishing of designated health services if payment for the services may be made under the Medicare or Medicaid programs. A financial relationship may be either through ownership/investment or through a compensation arrangement. Designated health services subject to the ban include:

(a) clinical laboratory services
(b) physical therapy services
(c) occupational therapy services
(d) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services
(e) radiation therapy services and supplies
(f) durable medical equipment and supplies
(g) parenteral and enteral nutrients, equipment and supplies
(h) prosthetics, orthotics, and prosthetic devices and supplies
(i) home health services
(j) outpatient prescription drugs
(k) inpatient and outpatient hospital services

Several exceptions to the statute exist, including exceptions for designated health services provided by a doctor or employee within a group practice, exceptions for an ownership interest in a hospital, exceptions for ownership interests in an entity in a rural area, and ownership interests in a large publicly traded health care corporation. Compensation arrangements that will be permitted include certain space and equipment rental arrangements, personal services contracts meeting statutory guidelines, and isolated financial transactions, such as the one-time sale of a medical practice.

Sanctions for referrals made in violation of the statute include a) the entity may not bill for the service rendered pursuant to a prohibited referral, b) any billings already done must be refunded, and c) a monetary penalty of not more than $15,000 per service may be assessed. Finally, any attempt to circumvent the statute, such as a through a cross referral arrangement, is subject to a penalty of not more than $100,000.

The primary difference between Stark and the anti-kickback statute is that Stark is an absolute prohibition against referrals if no exception applies, and is essentially self enforcing through the built in reporting requirements. The anti-kickback statute is intent based, however. The government must prove the purpose of the relationship was to induce referrals. It is subject to prosecutorial discretion as to enforcement.
Hypothetical No. 1

Dr. Jones refers patients to Lone Star Home Health Agency. Dr. Jones’ wife has a consulting contract with Lone Star as its marketing director. She is paid a salary of $1,500 per month which is commensurate with the value of the services rendered. May Dr. Jones continue to make referrals to Lone Star?

Notes:

Hypothetical No. 2

Same facts as above, except that Mrs. Jones receives bonuses each year, in addition to her salary, equivalent to 1% of the increased business of Lone Star over the prior year. May Dr. Jones continue to make referrals to Lone Star?

Notes:

Hypothetical No. 3

Same facts as above, except that in lieu of the 1% bonus, Lone Star increased Mrs. Jones’ compensation to $2,500.00 per month. May Dr. Jones continue to make referrals to Lone Star?

Notes:
Hypothetical No. 4

Dr. Jackson and Dr. Walker each own 1,000 shares of Acme Home Health Care Corporation, a healthcare business with assets of $500 million, which is publicly traded on the New York Stock Exchange. Dr. Jackson acquired his shares as partial payment for the purchase of his medical practice by Acme. Dr. Walker acquired his shares by taking the cash proceeds from the sale of his practice to Acme and purchasing Acme stock from his broker. Both Dr. Jackson and Dr. Walker continue to refer patients to Acme. May each continue to do so?

Notes:

Hypothetical No. 5

Dr. Garza owns a 15% interest in a home health agency located in San Juan, Puerto Rico. Dr. Garza vacations for three months during the winter in Puerto Rico, and provides services at the local hospital under a part time arrangement with a local physician. Dr. Garza refers Medicare and Medicaid patients to the home health agency and treats them during his three months in Puerto Rico each year. May Dr. Garza continue his ownership interest in the home health agency while making referrals to the home health agency?

Notes:

Hypothetical No. 6

Dr. Andrews leases office space to Central Home Health Agency. As his rental fee, Andrews receives one percent of Central’s monthly gross revenue, which is consistent with fair market value. Is the lease arrangement acceptable?

(a) If Andrews refers patients to Central

(b) If Andrews does not refer patients to Central

Notes:

Hypothetical No. 7
Wheelchairs-R-Us is a DME supplier owned jointly by Dr. White and his brother-in-law. The Company is located in a rural area in West Texas where Dr. White is one of only three physicians in the community. He refers all of his patients requiring DME to the Company, and last year he received $50,000.00 in profit distribution from the Company’s operations. His brother-in-law is President of the Company, drawing an annual salary of $70,000.00.

(a) May Dr. White continue to refer patients to Wheelchairs-R-Us?

(b) May his brother-in-law continue to act as President of Wheelchairs-R-Us?

Notes:

Hypothetical No. 8

Home Solutions is an intravenous therapy company owned by a small group of health care lawyers. Home Solutions employs Dr. Clark as its Medical Director. Dr. Clark receives a salary of $2,500.00 a month, which is commensurate with the value of the services he provides. He also refers approximately 10% of Home Solutions business to the Company. His contract is in writing, for a term of one year, and it specifies exactly the services Dr. Clark is expected to provide. Home Solutions can demonstrate that it requires his services as Medical Director. May Dr. Clark continue to refer patients to Home Solutions?

Notes: