

“HOT LEGAL ISSUES FOR 2008”

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There is always something new for home care providers to master! Never a dull moment! The coming year will undoubtedly bring new challenges including the following:

- Increased enforcement by state Medicaid Fraud Control Units (MFCU's).
- Increased regulation of referrals by state governments.
- The Centers for Medicare and Medicaid Services will move closer to the application of Pay for Performance (P4P) to home care providers.

Below is more information about what providers can expect during the coming year and what they should do to prepare.

Increased Enforcement by State Medicaid Fraud Control Units

Many states spend large amounts of money on their Medicaid Programs. In fact, according to the most recent Annual Report from the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services on MFCU'S, Medicaid has been the largest payor source since 2002, when expenditures exceeded those of the Medicare Program. Both state governments and the federal administration are determined to reduce expenditures using a variety of mechanisms. One method for reduction of expenditures will undoubtedly involve more rigorous enforcement of fraud and abuse prohibitions by MFCU's.

The Omnibus Budget Reconciliation Act of 1993, Section 13625, Section 1902(a)(61), requires all states to operate a MFCU. The activities of these Units are overseen by the OIG's Medicaid Fraud Unit Oversight Division (MFUOD), Office of Evaluation and Inspections.

The efforts of MFCU's to save money for strapped Medicaid Programs are already substantial. In 2005, for example, MFCU's reported to the OIG total recoveries of more than \$709 million. During the same period, MFCU's obtained 1,123 convictions of providers. In addition, MFCU's pursued 633 civil actions that had successful results. The activities of MFCU's in 2005 also resulted in the exclusion of 737 individuals from participation in the Medicare and Medicaid Programs.

Below are some examples of successful enforcement actions by MFCU's:

Home Health Services

In Maryland, the owner and operator of a health care franchise specializing in providing nursing and other health care services to Medicaid recipients pled guilty to one count of felony theft for fraud. Before the defendant pled guilty, the parent company of the franchise settled with the State by paying approximately \$1.3 million in overpayments, penalties, and costs related to the defendant's claims submissions from which the parent company benefited. The defendant failed to disclose to the Medicare Program that he owned a medical supply company from which his home care franchise business purchased its supplies. An investigation revealed that the defendant illegally marked up his supply costs by 40 percent when sending cost reports to the parent company. The defendant also included other fraudulent items on his cost reports. He was sentenced to 8 years in prison, with 27 months to be served and the rest suspended, and five years of probation. He was ordered to pay \$1 million in restitution and penalties.

Home Medical Equipment

In Florida, an HME company agreed to pay more than \$1.3 million to settle allegations that it fraudulently billed the Medicare and Medicaid Programs by double billing and submitting false claims for medical equipment sales. An investigation conducted by the Florida MFCU and the U.S. Attorney's Office revealed that the company improperly billed both programs for certain HME items, such as wheelchairs and nebulizer supplies. When the company was sold in 1999, the new owners discovered the improper billings and properly disclosed them.

Private Duty Home Care Services

In Washington, an in-home personal care aide pled guilty to two (2) counts of making a false statement to the Medicaid Program. The defendant was sentenced to serve 30 days in jail on each count, which was subsequently converted to 240 hours of community service and 12 months of probation. The defendant was also ordered to pay \$24,730 in restitution to the State's Medicaid Program. The defendant contracted with Medicaid to provide in-home personal care services to patients under a Medicaid Individual Personal Care Program. Under this Program, the defendant was required to telephone in the hours worked in the preceding month in order to receive payment. Over a 13-month period, the defendant telephoned in hours to the Medicaid Program for work that was never performed.

The cases above are just the tip of the proverbial iceberg. MFCU's are in the process of increasing their efforts to recover monies for state Medicaid Programs through fraud enforcement efforts. Providers must respond with more vigilance in order to help ensure compliance. Specifically, providers must be certain that they have Medicare/Medicaid

Fraud and Abuse Compliance Plans that meet applicable requirements and are fully implemented.

Increased Regulation of Referrals by State Governments

Federal regulators have been active for many years in oversight and monitoring of referral arrangements. The bases for these activities include the federal anti-kickback statute and the so-called Stark laws. Many states have also enacted statutes and implemented regulations governing referrals.

Based upon a recent court decision of the Supreme Court in South Carolina, it appears that states may become more aggressive about regulating referral arrangements.

In Sloan v. South Carolina Board of Physical Therapy Examiners, No. 26209 (S.C. Sept. 25, 2006) the Supreme Court concluded that a state statute prohibits physical therapists from being employed by physicians who refer patients to them for therapy services. The Court also specifically recognized the right of the state's Board of Physical Therapy Examiners to enforce the statute against therapists who violate it.

South Carolina Code §40-45-110(A)(1), enacted in 1998, states that the Board of Physical Therapy Examiners may restrict, refuse to renew, suspend, or revoke licenses of physical therapists when the Board decides that therapists "request, receive, participate, or engage directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services or profits by means of a credit or other valuable consideration, including...wages...with a person who referred a patient..."

Prior to 2004 the Board did not take any action to enforce the statute, but in 2004 the Attorney General in South Carolina issued an opinion addressing the statute. Specifically, the Attorney General said that physical therapists cannot work for physician-employers who make referrals to them.

After the Attorney General's opinion was issued, the Board voted to endorse it. Then the Board announced at an open meeting that it was going to begin to enforce the statute. The Board also announced, however, that no enforcement action would occur for ninety (90) days so that physicians and therapists would have a chance to modify referral relationships that violated the statute.

Individual practitioners and state trade associations then joined forces to sue the Board to prevent the Board from enforcing the statute. The trial court decided in favor of the Board. This decision was appealed to the South Carolina Supreme Court. The Supreme Court upheld the Board's position despite a number of arguments raised against it. The Court generally expressed concern about overutilization. "It is no great stretch to conclude that [§40-45-110(A)(1)] was passed for the same reasons which prompted enactment of the state Provider Self Referral Act...to protect consumers as well as...Medicare and Medicaid...from actual and potential conflicts of interest which are

likely to lead to overuse of medical services by physicians who, for their own financial gain..., refer patients to entities in which the physicians hold a financial interest.”

Arguments made by the initiators of the lawsuit also included the following:

- 1) The Board’s formal endorsement of the Attorney General’s opinion amounted to a new regulation that should have been developed consistent with the requirements of the state’s Administrative Procedure Act (APA).
- 2) The Board’s decision improperly infringed upon physicians’ right to practice medicine.
- 3) The Board’s decision to start enforcing the statute violated therapists’ rights to equal protection and due process.

All of these arguments were rejected by the Court and the decision of the Board was upheld.

As a result of this decision, providers should:

- 1) Review statutory and regulatory requirements, if any, in the state(s) in which they do business to make sure that they are in compliance with these requirements.
- 2) Closely monitor new developments in the state(s) in which they do business so that they are up to date on recent developments and can account for them as they structure referral arrangements.

The South Carolina Supreme Court’s recent decision signals that the states will become more active in monitoring and overseeing referral relationships.

Pay for Performance

Until recently, implementation of pay for performance (P4P) for providers who are reimbursed for services by the Medicare/Medicaid Programs has been limited to so-called “pay for reporting.” Specifically, the Centers for Medicare and Medicaid Services (CMS) has withheld 2% of annual payments from providers who did not comply with certain reporting requirements. CMS is now prepared to move from “pay for reporting” to implementation of reimbursement measures that are directly related to the quality of care rendered.

CMS announced on August 19, 2007, for example, that it will no longer pay for treatment of preventable errors, injuries, and infections that patients contract while in hospitals. In addition, hospitals cannot pass the costs of such treatment on to patients. Specifically, Medicare will stop paying hospitals for treating “reasonably preventable” conditions

acquired in hospitals. Examples of “reasonably preventable” conditions identified by CMS include:

- Patient falls
- Pressure ulcers
- Urinary-tract infections
- Vascular-catheter-associated infections
- Mediastinitis (an infection that may develop after heart surgery)

While this recent development currently applies only to hospitals; not to home health agencies, hospices, or home medical equipment (HME) companies; it is certainly possible that CMS may develop similar criteria for these types of providers in the future.

The application of similar criteria to providers who render services in patients’ homes is, of course, inherently problematic. Unlike hospitals, providers who render services in patients’ homes do not have control over patients and primary caregivers who are responsible for care between visits from professional staff. They also lack control over patients’ environments.

In addition, this recent development and its possible application to home health, hospice, and HME companies in the future underscores yet again the crucial importance of achieving compliance with plans of care by both patients and/or their primary caregivers. Non-compliance likely interferes with the ability of providers to control reasonably preventable conditions. The consequences include enhanced risk, compromised quality of care, and the possibility of reduction or loss of reimbursement.

At a minimum, therefore, providers should take the following steps with regard to non-compliant patients and primary caregivers:

- 1) Staff must document every instance of non-compliance by both patients and/or their primary caregivers, regardless of the risk associated with the non-compliant behavior.
- 2) Documentation must be very specific. It is insufficient to document as follows: “Patient (or primary caregiver) non-compliant.” Practitioners, for example, may document the failure to change the diaper of a bed-bound patient who is incontinent of both bowel and bladder as follows: “RN found patient with urine and feces in diaper. RN removed diaper, cleaned patient, and placed clean diaper on patient. RN marked the right tab of the clean diaper with a red X. When the RN visited the following day, the patient was again lying in urine and feces. When the RN removed the diaper, she observed a red X on the right tab of the diaper that the patient was wearing when she arrived.”
- 3) Providers must then counsel with patients and/or primary caregivers regarding each instance of non-compliance and document that they have done so.

- 4) Providers must also provide additional education, if there appears to be a need for it, and document that they have done so.
- 5) Successful return demonstrations, if appropriate, must be obtained and documented.

The number of times practitioners are willing to repeat this “protocol” depends on the risk of injury/damage to patients associated with the non-compliance and/or the likelihood that non-compliance will adversely affect quality of care. If patients are likely to be injured or damaged, or quality of care may suffer, providers should not tolerate additional instances of non-compliance after taking appropriate action. Achieving compliance is an important issue for providers. It should be moved to the top of their lists in preparation for P4P.

Conclusion

Home care providers have been highly successful in their efforts to understand and comply with complex legal requirements. The coming year will present new challenges but providers will master them as they have in the past.

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