

Fraud and Abuse: Home Health Care and Durable Medical Equipment

2000

A 1997 Report from the Office of Inspector General (OIG) examined whether Medicare payments to home health agencies (HHAs) met Medicare reimbursement requirements, particularly the requirement that physicians certify the need for the service. The OIG determined that physicians did not always review or actively participate in developing the plans of care they signed for home health services and durable medical equipment (DME).

Although the OIG determined that actual fraud is infrequent, it concluded that physician laxity in reviewing and completing required certifications of medical necessity is a problem that can contribute to fraudulent and abusive practices by unscrupulous suppliers and HHAs. In response to these concerns, the OIG issued a Fraud Alert for Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services. Certification is required for each.

While physicians are not personally liable for erroneous claims caused by mistakes or simple negligence, knowingly signing false or misleading certificates, or signing them with reckless disregard for the truth can lead to criminal, civil, and administrative penalties including fines of up to \$10,000 per claim. Therefore, *it is the position of the Academy*, that physicians should be actively involved in the supervision of home health care and DME to ensure the quality of care and to counter the potential for abuse.

Importance of Physician Certification

Medicare pays for medically necessary home health services and DME. Since the Health Care Financing Administration (HCFA) relies on the professional judgment of physicians in certifying the medical need for the service, physicians play a key role in determining both the medical need for and utilization of health care services including those furnished by other providers.

Payment for these services is conditioned on certification signed by a physician attesting that the item or service is medically necessary. Certificates of medical necessity (CMNs) substantiate that the physician has reviewed the patient's condition and has determined that services or supplies are medically necessary.

Medicare Requirements

- be confined to their home ("home" is defined as a place of residence but may not be an institution);
- be under the care of a physician; and
- require skilled nursing services on an intermittent basis or physical or speech therapy.

Homebound

A beneficiary does not have to be bedridden to be homebound. A patient will be considered to be homebound if the patient has a condition due to an illness or injury that restricts the patient's ability to leave his or her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, or the assistance of another person or if leaving home is medically contraindicated. The condition of these patients should be such that there



American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life®

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
phone 877/AAPMR 99
info@aapmr.org www.aapmr.org

exists a normal inability to leave the home and, consequently, leaving home would require a considerable and taxing effort.

Absences from the home should be for purposes of receiving medical treatment. Occasional nonmedical absences are considered acceptable, however, and HCFA specifies these to include "an occasional trip to the barber, a walk around the block, or a drive."

Physician Plan of Care

A patient must be under the care of a physician who is qualified to sign the physician certification and the plan of care. Although HCFA "expects" the patient to be under the care of the physician who signs the plan of care and the physician certification, any qualified physician could, in fact, do so. Similarly, the physician who signs the plan of care is "expected" to see the patient, although it is not a requirement of coverage. The certifying physician must be an MD or DO; a podiatrist also may establish the care plan if such is consistent with the HHA's policy and such care is authorized under state law.

As a condition of payment, Medicare requires a patient's treating physician to certify initially and recertify at least every 62 days (2 months) that:

- the patient is confined to the home;
- the individual needs or needed:
 - intermittent skilled nursing care;
 - speech or physical therapy or speech-language pathology services; or
 - occupational therapy or a continued need for occupational therapy;
- a plan of care has been established and periodically reviewed by the physician; and
- the services are (were) furnished while the patient is (was) under the care of a physician.

The plan of care must contain all pertinent diagnoses, including the patient's mental status, the types of services, supplies, and equipment required, the frequency of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, and all medications and treatments.

Medicare considers a plan of care to have expired if the patient receives no covered skilled nursing or therapy visits within a 62-day period unless the physician documents that a longer time period is required. Orders for services to be furnished "as needed" must indicate the patient's medical symptoms that would justify the services and specify a limit on the number of visits to be made under the order. A physician's oral orders are permitted if written documentation is made by the authorized nurse who received the orders and the oral orders are later countersigned by the physician before the agency bills Medicare.

Services

Qualified beneficiaries may receive the following services so long as they are reasonable and necessary to treat the patient's illness or injury:

- part-time or intermittent skilled nursing care provided by or under the supervision of a registered professional nurse;
- part-time or intermittent services of a home health aide when provided as an adjunct to skilled nursing or therapy care;

- physical, occupational, or speech therapy;
- medical social services, if related to the patient's health problems;
- medical supplies and DME; and
- any of the above services and supplies that are 1) provided on an outpatient basis under arrangements made by the HHA at a hospital or skilled nursing facility, or at a rehabilitation center; and 2) involve the use of equipment that cannot readily be made available to the patient in his or her home.

To qualify as skilled nursing services, the services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent. Where a service can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled service even if a skilled nurse actually provides the service.

"Intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.)

DME Requirements

Medicare will pay for DME and supplies ordered or prescribed by a physician if the order includes:

- the beneficiary's name and address;
- the physician's signature;
- the date;
- a description of the item needed;
- the start date for the order;
- the diagnosis (if required) and a realistic estimate of the total length of time the equipment will be needed (in months or years).

Certain items or supplies may require additional information. Certain kinds of DME must be accompanied by a CMN signed by the treating physician (unless the equipment is part of a plan of care for home health services). Sections B (medical necessity justification) and D (treating physician's attestation and signature) MUST be completed by the physician (or non-physician clinician involved in the care of the patient, or an employee of the physician).

Fraud and Abuse Concerns

The OIG report determined that physicians sometimes failed to discharge responsibility to assess their patients' conditions and the need for home health care or DME and that they did not always review or actively participate in developing the plans of care they signed.

While a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be facilitating the perpetration of fraud on Medicare by suppliers or providers. However, knowingly signing a false or misleading certification or signing with reckless



American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life®

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
phone 877/AAPMR 99
info@aapmr.org www.aapmr.org

disregard for the truth can lead to serious criminal, civil, and administrative penalties including;

- criminal prosecution;
- fines as high as \$10,000 per false claim plus treble damages; or
- administrative sanctions including;
 - exclusion from participation in Federal health care programs
 - withholding or recovery of payments, and
 - loss of license or disciplinary action by state regulatory agencies.

Academy Position and Recommendations

In light of this report and the Fraud Alert from the OIG, oversight of physician responsibility for Medicare patients receiving home health services and DME has increased significantly. *It is the position of the Academy*, that physicians should be actively involved in the supervision of home health care and DME to ensure access to and quality of care, and to counter the potential for abuse. The following guidelines are recommended to assist physicians in this role:

- DME and home health services should be ordered by a physician with appropriate documentation of medical necessity before such services are offered to the patient or family;
- the physician responsible for the patient's care should order such services;
- the physician who signs the plan of care should see the patient on a regular, periodic basis;
- the physician should receive from the supplier/provider the charge for all DME and home health services prior to the time the physician signs the order;
- the physician should carefully review all initial and renewal orders for DME and home health services and should authorize such services only for patients with whom the physician is professionally involved in providing care;
- the physician should not sign a certification as a Courtesy@ to a patient, service provider, or DME supplier. A physician must make a determination of medical necessity for such service;
- the physician should not knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted to a Federal health care program;
- the physician should not receive any financial benefit for signing the certification (including free or reduced rent, patient referrals, supplies, equipments, or free labor); and
- the physician should be cautious of business arrangements established between those in a position to refer business and those providing items or services for which a Federal health care program pays. The Stark physician referral law prohibits referrals derived from such arrangements unless one of the Stark exceptions has been met.

Approved 2000
Approved BOG 8/2012