# The RAP Sheet

Spring 2002 Volume 5 Issue 1

**A Publication of the American Health Lawyers Association Regulation, Accreditation, and Payment Substantive Law Committee**

## Table of Contents



**Leading Health Law to Excellence through Education, Information, and Dialogue**



## The New Provider Exemption to Routine Cost Limits: What is a Provider Anyway?[1]

Christopher L. Keough, Esquire
*Powers Pyles Sutter & Verville*
*Washington, DC*

Medicare reasonable cost principles provide for the establishment of prospective limits on the costs deemed reasonable and necessary in the efficient delivery of needed healthcare services. These limits include the routine cost limits (RCL) for skilled nursing facilities' (SNF) fiscal years beginning before July 1, 1998.

The RCL regulation, 42 C.F.R. § 413.30, provides for an exemption for a new SNF. For purposes of this exemption, a new SNF "is a provider of inpatient services that has operated a SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." *Id*, § 413.30(d) (formerly designated as § 413.30(e)).[2]

Within the last year, three federal courts have addressed the RCL new provider exemption, which is similar to the new provider exemptions under other Medicare reimbursement rules.[3] In each of these cases, the Centers for Medicare and Medicaid Services (CMS) denied new provider status to SNFs that acquired a certificate of need (CON), or other rights to operate beds, from other institutions that operated in the same area during the three-year look-back period. The first two decisions, from the Seventh Circuit and a district court in Maryland, upheld CMS' interpretation of the RCL regulation. The most recent decision, from a district court in Massachusetts, distinguished the Seventh Circuit's decision and reversed the denial of the new provider status.

The first part of this article provides a general overview of the new provider exemption under the RCL regulation. The second part discusses the three recent court decisions addressing that exemption. The remainder of this article considers possible distinctions from these earlier decisions and suggests further arguments that may be litigated in other cases involving the new provider exemptions under the RCL regulation or other similar rules.

### I. RCL New Provider Exemption

Medicare reasonable cost reimbursement principles generally define "reasonable cost" as "the cost actually incurred, excluding . . . cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). The Medicare statute also grants the Secretary the authority to establish prospective cost limits based on estimates of reasonable costs necessary in the efficient delivery of care. *Id*.

Pursuant to this authority, the Secretary promulgated a 1979 regulation, now codified at 42 C.F.R. § 413.30, setting forth a methodology for establishing these cost limits. As noted above, these limits are subject to an exemption for new providers. 42 C.F.R. § 413.30(d). A new SNF is defined as "a provider of inpatient services that has operated a SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." *Id.*

Prior to 1997, program guidelines in section 2604.1 of the Provider Reimbursement Manual (PRM) defined a "new provider," consistent with the regulation, as "an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years." *See* Medicare & Medicaid Guide (CCH) ¶ 7578.01. The Manual also stated that, while "a complete change in the operation of the institution" will affect whether an institution is considered a new provider, changes in ownership or location, without more, "shall not be considered in the determination" of new provider status. *Id*.

In 1997, CMS (then HCFA) issued a transmittal removing section 2604.1 from the PRM and adding a new section 2533. PRM Trans. No. 400 (Sep. 1997), *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 45,575. According to the transmittal, ¶ 2533 "clarifies, revises and replaces

*Continued on page 2*

*Continued from page 1*

§ 2604.1 as it relates to [SNFs]." *Id*. Also, according to the transmittal, section 2533 "integrates existing policy" as to "what constitutes a change in ownership (CHOW)" and "the effects of a CHOW . . . on a determination for new provider status." *Id*.

Section 2533 provides, among other things, that new provider status generally will not be recognized when an institution is established "through the purchase, reallocation or leasing of the right to operate (i.e. a certificate of need) long term care beds (operating or non-operating) from an existing institution or institutional complex (existing or closed). *See* PRM § 2533.1.B.3. In this instance, the "institution" is deemed to have "undergone a change in location" and will not be granted a new provider exemption unless it can demonstrate that "a substantially different inpatient population is being served." *Id*.

## II. Recent Court Decisions

In the past year, federal courts have addressed the denial of new provider status in three cases involving the acquisition of bed rights from another institution that operated in the same service area within the three-year look-back period. In each of these cases, new provider status was denied prior to the 1997 revisions to the PRM, when the guidelines in PRM § 2604.1 were still in place.

The first of these cases is the Seventh Circuit's decision in *Paragon Health Network, Inc. v. Thompson*, 251 F.3d 1141 (2001), *see* HLD, v. 29, n. 8, at p. 56. In *Paragon*, the Seventh Circuit affirmed the denial of a new provider exemption for a SNF that acquired a CON from a related facility operating in the same metropolitan area.

The provider in this case began operations in 1995, after acquiring CON rights to thirty-five beds from another SNF that was operated by the provider's parent company. The CON rights were the only assets transferred to the new facility, and the original facility continued to operate other beds after the transfer with staff and equipment.

The new facility applied for, and was denied, a new provider exemption in 1995.

On appeal, the Provider Reimbursement Review Board (PRRB or Board) affirmed, concluding that the new facility essentially is a relocated portion of the related SNF that transferred the CON rights and, therefore, did not qualify as a new provider. The Administrator declined to review the Board's decision, and the Seventh Circuit eventually affirmed for three principal reasons.

First, the Seventh Circuit concluded that the government's interpretation of the RCL regulation is entitled to the usual deference afforded an agency's interpretation of its own rules. *See Thomas Jefferson Univ. Hosp. v. Shalala*, 512 U.S. 504, 512 (1994). Absent evidence of any inconsistent interpretation of the RCL regulation prior to the 1995 denial at issue in this case, the Seventh Circuit ruled that CMS' delay in exercising its power to clarify the 1979 regulation did not diminish the level of deference owed to the agency's 1995 interpretation.

Second, the court ruled that the RCL regulation is ambiguous as to what bundle of attributes constitutes a "provider." Thus, the court concluded, the agency's interpretation is entitled to controlling weight unless it is plainly erroneous or inconsistent with the regulation.

Finally, applying this deferential standard of review, the court ruled that the Secretary's interpretation of the regulation is reasonable. The court acknowledged a "degree of merit" in the provider's argument that the new provider determination should focus on the institution as a whole and not just a single factor, such as the transfer of CON rights. Nevertheless, noting the agency's expertise in this highly complex and technical program, the court reasoned that the transfer of CON rights did not result in the provision of any new services.

Moreover, the court found that the transfer of services to a new, related facility in the same service area resulted in high start-up costs but did not benefit the overall delivery of health services in the area. Thus, the Secretary reasonably could rely on the State's moratorium on new CON rights to support the conclusion that additional SNF beds are unnecessary in the efficient delivery of necessary health services in that state.

The U.S. District Court for the District of Maryland was next to weigh in on this issue. *Maryland General Hospital, Inc. v. Thompson*, 155 F. Supp. 2d 459 (2001). In *Maryland General*, the district court affirmed the denial of a new provider exemption for a SNF that acquired Maryland "waiver bed" rights from three other facilities in the area.

Maryland law generally requires a CON to create or expand a healthcare facility. An existing facility may add up to ten "waiver" beds, however, without obtaining a CON. In this case, a new SNF purchased waiver bed rights from three other, unrelated facilities. The provider then applied for, and was denied, a new provider exemption. On appeal, the CMS Administrator upheld the denial on the ground that the SNF was created by the purchase and relocation of existing beds that had been used to provide equivalent services for more than three years.

Following the Seventh Circuit's decision in *Paragon*, the district court concluded that the transfer of bed rights is a sufficient basis, without more, for the denial of a new provider exemption. The court noted that the same conclusion applies whether the SNF acquired rights to operational beds or waiver rights to put additional beds in service. The court further observed that while the transfer of waiver bed rights may result in fewer unnecessary costs than the transfer of operational bed rights, it is clearly more costly than the activation of the beds as part of the existing operational facility. Finally, the court concluded that the RCL regulation looks not to whether the assets were operated during the three-year look-back period but to whether the "provider" operated during the three-year period.

On January 3, 2002, the U.S. District Court for the District of Massachusetts broke ranks in an opinion distinguishing *Paragon* and reversing the denial of a

new provider exemption for a SNF that acquired bed rights from a defunct facility. South Shore Hosp. v. Thompson, Medicare & Medicaid Guide (CCH) 300,934. In South Shore Hospital, a SNF acquired a determination of need permitting the operation of beds from a closed facility that had operated in the same service area two years earlier. No other tangible or intangible assets were acquired from the defunct facility and no patients were transferred to the new facility. CMS denied the provider's request for an exemption in 1995, and the PRRB later affirmed, concluding that the purchase of intangible bed rights constituted a "change of ownership" and disqualified the new SNF from the exemption.

The district court reversed the Board's decision, finding that the purchase of the license to operate beds did not constitute a change of ownership. Distinguishing the Seventh Circuit's opinion in Paragon, the court noted that the two facilities involved in this case had nothing to do with one another except for the purchase of the intangible bed license. Moreover, the district court concluded that the Seventh Circuit's public policy rationale is inapposite where, as in this case, bed rights are purchased from a defunct facility. In this case, the court reasoned, the transfer of bed rights benefited the healthcare delivery system as a whole because additional beds were put into service in the area.

### III. The Aftermath

Following these three decisions, a number of interesting issues remain to be litigated in other cases involving the "new provider" exemptions under the RCL regulation and other similar rules.

First, despite the Seventh Circuit's ruling to the contrary, there may be substantial merit to the argument that the denial of new provider status, based solely on the acquisition of bed rights, is inconsistent with the long-established definition and usage of the term "provider." The Medicare statute and agency precedents have traditionally defined a provider as the institution that is certified to provide patient care.[4] Thus, to say that the transfer of bed rights constitutes a "relocation" of the "provider" seems somewhat incredulous, particularly where no other assets, staff, or patients are transferred, the new institution operates under entirely separate management and control, and it participates in the program under a separate and distinct provider agreement.

Second, even assuming that the transfer of bed rights may defeat a new provider exemption when the transferor is an ongoing concern, the same results should not necessarily follow when bed rights are acquired from a defunct facility. As the district court observed in South Shore, the idea that a transfer of bed rights results in unnecessary costs holds less water when the bed rights are acquired from an already closed institution.

Third, some courts may find that the agency's interpretation of the RCL regulation does not deserve the high level of deference afforded to the Secretary's interpretation in Paragon and Maryland General. Although an agency's interpretation of its own regulations generally is entitled to substantial deference, some courts recently have declined to apply the same level of deference to informal agency interpretations, following the Supreme Court's decisions in Christensen v. Harris County, 529 U.S. 576 (2000), and United States v. Mead Corp., 121 S. Ct. 2164 (2001). See, e.g., U.S. *Freightways Corp. v. Commissioner* of Internal Revenue, 270 F.3d 1137 (7th Cir. 2001).

Indeed, the Seventh Circuit's opinion in Paragon expressly notes that the court might have reached a different decision if the evidence had shown that the Secretary's *decision in that case was inconsistent with prior interpretations of the RCL regulation. Paragon*, 251 F.3d at 1147-48 n.4. In a similar vein, a federal district court in Iowa recently reversed CMS' interpretation of another aspect of the RCL regulation, concluding that the standard established in the PRM is entitled to "little" deference. *St. Luke's Methodist Hosp. v. Thompson*, [2001-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 300,832 (N.D. Iowa 2001), see HLD, v. 29, n. 12, at p. 65. In that case, the court reasoned that the PRM provision was not entitled to substantial deference because (1) it was not adopted in accordance with the notice and comment rulemaking requirements prescribed by the Administrative Procedure Act, (2) it was not adopted contemporaneously with the regulation, (3) it constituted an abrupt departure from the agency's long-standing interpretation of the regulation, and (4) the agency did not provide a

*Continued on page 4*

*Continued from page 3*

"thorough and reasoned" explanation for its change in policy.

Finally, even if the Secretary's interpretation of the RCL regulation is otherwise entitled to deference, it may be argued that new provider status should not be denied an institution that acquired bed rights from another facility prior to the 1997 amendments to the PRM. It could be said that prior to that time, the RCL regulation and the relating instructions in PRM § 2604.1 did not fairly inform prospective new providers of the agency's perspective. See GranCare, Inc. v. Shalala, 93 F. Supp. 2d 24, 31 (D.D.C. 2000) (reversing the application of the "prudent buyer" guidelines in the PRM to disallow costs not shown to be substantially out of line under 42 C.F.R. § 413.9(c)(2)). Due process "prevents . . . deference from validating the application of a regulation that fails to give fair warning of the conduct it prohibits or requires." General Elec. Co. v. United States Environmental Protection Agency, 53 F.3d 1324, 1327 (D.C. Cir. 1995).

## IV. Conclusion

The recent decisions on denials of new provider status raise a host of interesting issues, some of which surely will be litigated further in other venues. Left unspoken in those cases, however, is perhaps the most perplexing question. More than thirty-five years after the enactment of the Medicare program, one of the central issues is the very question one might expect to have been resolved many years ago: What is a provider?

*Endnotes*

1 Christopher L. Keough is a shareholder in the law firm of Powers, Pyles, Sutter & Verville, P.C., in Washington, D.C. His e-mail address is chris.keough@ppsv.com.

2 The new provider exemption was redesignated as § 413.30(d) and amended by substituting "SNF" for "provider" in 1999. 64 Fed. Reg. 42612 (Aug. 5, 1999).

3 See, e.g., 42 C.F.R. § 413.40(f) (providing for an exception to the target amount limitation on the rate of increase in operating costs of inpatient hospital services); 42 C.F.R. § 412.300(b) (defining a "new hospital" for purposes of the prospective payment system for capital-related costs of inpatient hospital services).

4 See, e.g., 42 U.S.C. §§ 1395i-3(a), 1395x(e) and 1395x(j) (defining the terms "provider of services," "hospital," and "skilled nursing facility"); Cleveland Clinic Foundation v. Blue Cross and Blue Shield Ass'n/Community Mutual Ins. Co., [1994-2 Transfer Binder] Medicare & Medicaid Guide (CCH) 42,746 at 42,188 (HCFA Adm'r Dec. 1994) (holding that the Cleveland Clinic Hospital is a "provider" for Medicare reimbursement purposes and the owner of the institution, the Cleveland Clinic Foundation, is a "related party" of the provider).

**Register Now!**

# INSTITUTE ON MEDICARE & MEDICAID PAYMENT ISSUES

April 3 - 5, 2002


The **2002 Institute on Medicare and Medicaid Payment Issues** will feature a keynote address by CMS Administrator Tom Scully. The program will include sessions on more than 60 different topics including: Medical Necessity Denials, Overpayments and False Claims; EMTALA; Provider Based vs. Freestanding Entity; When, Whether & How to Make Repayments and Disclosures; Billing and Documentation Issues for Physicians; Practical Tips for Dealing with Carriers/Fiscal Intermediaries on Claims Overpaymetns; One-Day Stays; Medicare Payment and Compliance for Research/Clinical Trial; Coding for Health Lawyers and Medicare Payment for Pharmaceuticals.
This program sells out every year -- *please register early to ensure your spot.*

**Hotel Information:** **Please note the location of the program has changed.*
Baltimore Marriott Waterfront Hotel
700 Aliceanna Street
Baltimore, MD 21202
Toll Free Reservations: 800/228-9290 Phone: 410/385-3000 Guest Fax: 410/895-1900
Hotel Rates: $195 single or double occupancy
*Room block expires Wednesday, March 13, 2002.*

The following Substantive Law Committees will hold mid-year networking luncheons and presentations:

- **Wednesday, April 3 - Physician Organizations**
  There will be an interactive discussion amongst attendees of "Hot Topics" - those issues you may be dealing with in your practice on a day-to-day basis, any trends you see emerging, or other topics that may be of general interest to our members.

- **Thursday, April 4 - Regulation, Accreditation and Payment**
  **Patrick Morrisey, Esq**., *Deputy Chief of Staff to the House Energy and Commerce Committee (majority staff)* and **Elizabeth Fowler, JD, PhD**, *Chief Health Counsel to the Senate Finance Committee (majority staff)*
  Patrick Morrisey is responsible for directing all healthcare policy at the House Energy and Commerce Committee. Prior to working on the Hill, he worked for Arent Fox Elizabeth Fowler oversees health policy matters within the Senate Finance Committee's jurisdiction. Prior to working on the Hill, she was with Hogan and Hartson.

- **Friday, April 5 - Antitrust**
  **Arthur N. Lerner, Esq.,** *Crowell & Moring LLP, Washington, DC*
  "Clinically Integrated Physician Networks: The MedSouth FTC Advisory Opinion."

## CMS Manual Revisions Seen as Loosening Requirements for Purchased Diagnostic Tests

Robert N. Rabecs, Esquire
*Hogan & Hartson LLP*
*Washington, DC*

The Centers for Medicare & Medicaid Services (CMS) is revising current Medicare program manual provisions to loosen restrictions on the ability of physicians to bill Medicare for diagnostic tests performed using outside suppliers. Specifically, CMS has indicated that forthcoming revisions to the Medicare Carriers Manual (MCM) will allow physicians to bill diagnostic tests furnished using equipment, space, and personnel provided by test suppliers without violating the Medicare reassignment rule and the Medicare "anti-markup" rule. Such revisions may make it somewhat easier for physicians to profit from diagnostic test services furnished through independent suppliers.

Under the Medicare reassignment rule, subject to certain exceptions, Medicare Part B payments can only be made directly to the beneficiary or the physician who furnished the service.[1] An exception to the reassignment prohibition applies to diagnostic tests purchased by a physician from an outside supplier. This exception permits Medicare payment to be made to a physician for purchased diagnostic tests where the following requirements are met: (1) the purchasing physician does not "mark-up" the supplier's charge to the physician for the test; (2) the physician accepts from Medicare the lowest of the physician's actual charge, the supplier's net charge to the physician, or the Medicare fee schedule amount that would be paid to the supplier if the supplier billed Medicare directly for the test; and (3) the purchaser must perform the interpretation.[2] Thus, a physician purchasing a diagnostic test from a supplier may not charge Medicare for the purchased test in excess of the supplier's charge to the physician. A physician may find this type of arrangement unappealing because it prohibits the physician from "marking-up" the supplier's charge for the test, requires the physician to pay the supplier upfront for services, and means that the physician assumes nonpayment risk on submitted claims.

The anti-markup prohibition does not apply, however, where the test is personally performed by the physician, or performed by nonphysician personnel under the physician's "supervision." In such cases, the physician may bill Medicare for the test under the standard Medicare physician fee schedule rules (*i.e.,* Medicare payment is equal to the lower of the Medicare fee schedule amount or the physician's actual charge for the test). According to current manual provisions, services furnished under a physician's "supervision" has the same meaning as is required for services to be considered "incident to" a physician's service.[3]

Although the Medicare "incident to" rule permits physician supervision of nonemployed auxiliary personnel effective January 1, 2002, CMS still has in place a manual provision that states that a physician's use of supplier personnel to furnish technical component services in order to avoid the anti-markup prohibition may nevertheless be problematic."[4] For example, under one scenario that may implicate this provision, the physician may lease space, equipment, and technicians from the supplier and then bill both the technical and professional components without regard to the Medicare "anti-markup" rule. In other words, the physician would not necessarily restrict their charges to Medicare to the charges of the supplier for the technical component service.

In assessing such an arrangement, the CMS manual provision currently states that:

> *Some of these arrangements may involve cardiac scanning services . . . leasing their equipment to physicians for the day the equipment is used and hiring out their staff to the physicians to meet the supervision requirement. The bonafides of these arrangements are extremely suspect. [HHS] views this arrangement as a transparent attempt to circumvent the prohibition against mark-up on purchased diagnostic tests.* The mere issuance of a W-2 from the physician does not automatically make the leasing company's technician the physician's employee . . . . Rather, the determination as to a valid employer-employee relationship is dependent upon factors such as who has the right to hire and fire, who trains the employee, who is paying health and retirement benefits, who schedules work, who approves sick and vacation time, and so forth.[5]

Thus, this manual provision suggests that leased employee arrangements risk being viewed by enforcement officials as questionable business arrangements designed to circumvent the prohibition against the markup on purchased diagnostic tests. Nevertheless, recent informal communications from CMS staff suggest that forthcoming revisions to these manual provisions may now expressly permit such arrangements. In other words, the revisions will make clear that employment of the technician is no longer a factor in assessing how diagnostic tests should be billed. Rather, the physician must now simply provide the appropriate level of supervision of the auxiliary personnel performing the tests. However, the Medicare carrier may still inquire as to whether such arrangements were established to circumvent the anti-markup rule on purchased diagnostic tests. In order to reduce the risk that such arrangements might be viewed as a circumvention of the rule, CMS officials recommend that, at a minimum, the parties to such an arrangement should: (1) structure the arrangement so that it is not a "per-test" or "per-day" lease agreement, but rather a twelve month agreement that specifies a set time schedule and fee for the lease of the equipment, space, and technicians; (2) ensure that the physician provides the appropriate level of supervision of the auxiliary personnel furnishing the tests (consistent with Medicare rules for the supervision of diagnostic tests); and (3) seek assurances

*Continued on page 6*

*Continued from page 5*

from the Medicare carrier that the arrangement is permissible.[6] Ensuring that technical services agreements are carried out consistent with these guidelines may reduce the likelihood of future Medicare payment challenges and denials.

*Endnotes*

[1] MCM, at § 3060.

[2] 42 C.F.R. § 414.50; MCM, § 3060.4. Private payers may have similar prohibitions that would prevent the physician from marking-up the supplier's charges for services furnished to enrollees of these payers. For example, in some cases it is possible that a commercial insurer would reimburse a physician a global fee or a fee schedule amount for both the professional and technical components and require the physician to specify the technical component supplier or charge in claim forms submitted to the insurer.

[3] MCM, at § 15048.B. Prior to January 1, 2002, the Medicare "incident to" rule required that the direct supervision had to be of the physician's "employees." In order to be considered an "employee" the nonphysician performing the service could be a part-time, full-time, or "leased employee." A "leased employee" is defined as a nonphysician working under a written employee leasing agreement that provides for the following: (1) the nonphysician, although employed by the leasing company, provides services as the leased employee of the physician or entity, and (2) the physician or other entity exercises control over all actions taken by the leased employee with regard to the rendering of medical services to the same extent as the physician would exercise if the leased employee were directly employed by the physician. 42 C.F.R. § 410.26; MCM, at § 2050. Effective January 1, 2002, the Medicare "incident to" rule no longer requires that the nonphysician be an "employee" of the physician. Rather, the rule allows "incident to" services to be furnished by nonemployed "auxiliary personnel" who are directly supervised by the physician. 42 C.F.R. § 410.26; 66 Fed. Reg. 55,246, 55,267 (Nov. 1, 2001); MCM, at § 2050.

[4] MCM, at § 15048.B.

[5] MCM, at § 15048.D (emphasis added).

[6] E-mail correspondence from Paul Kim, Centers for Medicare & Medicaid Services, Center for Medicare Management, Purchasing Policy Group, Division of Practitioner & Ambulatory Care, to Robert N. Rabecs (Dec. 12, 2001). Such arrangements could still pose some risk under federal and state Anti-Kickback Statutes since it would allow the physicians to profit from the performance of the technical component services. In other words, by permitting the physicians to mark-up the supplier's charges, the physicians would share in the revenues from the performance of the technical component services even though they arguably played no role in furnishing those services. In order to reduce such risk, the payment amounts for the leased space, equipment, and technicians should reflect no less than fair market value and should not be based upon the volume or value of usage/referrals by the physician.

**The RAP Sheet Editor**
***2001-02***

**Andrew D. Ruskin,**
**Vice Chair and Editor**
Vinson & Elkins LLP
1455 Pennsylvania Ave. NW
Washington, D.C. 20004
Phone: (202) 639-6525
E-mail: aruskin@velaw.com

## Upcoming Health Lawyers Teleconferences

**Physician Payment Issues** - *April 17, 2002*
***Sponsored by:*** Physician Organizations and Regulation, Accreditation, and Payment Substantive Law Committees
This teleconference will include a discussion of the following legal issues:

1. Billing Non-Physician Practitioners, Including Nurse Practitioners, Physician Assistants, and Physical Therapists
2. Advance Beneficiary Notices
3. Reassignment of Medicare Benefits
4. Incident To Services
5. Consultations v. office visits
6. New Procedures
7. Inconsistency of facility/physician billing
8. Treating physician order rules and ICD-9 coding changes
9. Self-Disclosure

**Basic Legal Issues in Long Term Care** - *April 22, 2002*
***Sponsored by:*** Long Term Care Substantive Law Committee
This teleconference will be a primer in Long Term Care and geared for those new to the field as well as those who do not deal with LTC issues on a regular basis but want to be well informed in the substantive areas of LTC. It will address the following topics:

- Medicare and Medicaid reimbursement.
- OBRA and the survey, certification and enforcement process,
  including IDR.
- Unique characteristics of nursing home personal injury litigation

**Current Issues in Peer Review: Confidentiality, Immunity, Waiver of Due Process, and Conflict of Interest Issues Involving Employed Physicians** - *April 26, 2002*
***Sponsored by:*** Credentialling and Peer Reveiw and Labor and Employment Substantive Law Committees
The teleconference will address the following issues

- Discussion of recent case to set stage
- Confidentiality and privilege from discovery under state peer review laws
- Immunity from liability for peer review actions
- Reporting peer review actions involving employed physicians
- Potential conflicts of interest when employed physicians participate in peer review of non-employed physicians Investigations
- Waiver of due process rights in employment contracts
- Peer review actions within physician groups

To learn more about these and other teleconferences or to register, go to: www.healthlawyers.org/teleconferences.cfm

## Documentation Requirements Under New Clinical Laboratory Test Rules: A Status Quo

Bernard K. Ham, Esquire
*Alston & Bird LLP*
*Atlanta, Georgia*

Clinical laboratories do not typically see or have any direct contact with the patient. However, clinical laboratories are charged with the responsibility of ensuring the services ordered by physicians are medically reasonable and necessary under Medicare rules. Section 1862(a)(1)(A) of the Social Security Act provides that payment may not be made for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, and providers that submit claims to Medicare are subject to liability if they are not able to produce documentation supporting the medical necessity of services for which reimbursement is sought. These Medicare rules necessarily create a tension between physicians and clinical laboratories, as laboratories must rely on physicians' proper documentation for reimbursement from the Medicare program. The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS), in a recent final rule on Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services (the Final Rule), addressed this inherent tension between physicians and laboratories, and established administrative rules that define the expectations of parties in the Medicare clinical laboratory reimbursement scheme.

In the Final Rule on clinical laboratory tests, CMS established national coverage and administrative policies for clinical laboratory services paid under Medicare Part B.[1] The Final Rule was developed through a negotiated rulemaking process as mandated by the Balanced Budget Act of 1997 and involved a committee comprised of CMS representatives and industry interests affected by the Final Rule. Designed to promote program integrity and national uniformity and to simplify administrative requirements, the Final Rule affects physician office laboratories, hospital laboratories, independent laboratories, and other healthcare facilities, and covers all laboratory services billed to Medicare Part B regardless of the type of entity furnishing the service or of the type of Medicare contractor processing the claims. Significantly, the Final Rule established documentation and record-keeping requirements, and delineated responsibilities of physicians and clinical laboratories with respect to assuring the medical necessity of claims submitted to Medicare. In addition to a number of other administrative rules, the Final Rule replaced existing local medical review policies for laboratory services with a national coverage policy. The Final Rule established national coverage for twenty-three clinical lab tests that make up nearly 60% of the laboratory services billed to Medicare Part B. The lab codes for those tests are listed in the Final Rule and carry with them a presumption of medical necessity. The Final Rule also lists those tests that are not covered by Medicare.

Under the Final Rule, a physician or a qualified non-physician practitioner who orders a lab service is required to maintain documentation of medical necessity in the beneficiary's medical record.[2] The clinical laboratory submitting the claim to Medicare for the service it performs pursuant to that physician's order must maintain the following: (1) documentation it receives from the ordering physician; and (2) documentation that the information it submitted with the claim accurately reflects the information it received from the ordering physician.[3] If the laboratory is not satisfied that it has the documentation necessary to support the medical necessity of a claim, the laboratory may request additional diagnostic and other information from the ordering physician.[4] Any request for additional documentation must be limited to materials relevant to the medical necessity of the specific test, taking into consideration current laws on patient confidentiality. This process may be burdensome on physicians if they need to spend time and effort to provide additional diagnostic and other information sufficient to demonstrate the reasonableness and necessity of services billed by the laboratory.[5]

Nonetheless, CMS will look to the laboratory when it reviews claims. Upon request from CMS, the laboratory is required to provide the following: (1) documentation of the physician's order for the service billed, including information about the physician who ordered the service to enable CMS to contact the physician; (2) documentation showing accurate processing of the order and submission of the claim; and (3) any diagnostic or other medical information received from the physician, including any ICD-9-CM code or narrative description.[6] If the claim is determined not to be reasonable and necessary, CMS will contact the ordering physician to inform him or her about the claim being reviewed and request from that physician those parts of a beneficiary's medical record relevant to the specific claim being reviewed.[7] If the physician does not respond to CMS's request for further documentation, CMS will then inform the laboratory that the necessary documentation has not been produced by the ordering physician and proceed to deny the claim.[8]

The Final Rule's documentation and record-keeping requirements reaffirm the government's existing position that clinical laboratories have the ultimate responsibility of assuring medical necessity of claims they submit for reimbursement. In its Compliance Program Guidance for Clinical Laboratories, the DHHS Office of Inspector General (OIG) emphasized that laboratories should "ensure that the lab can support tests billed to Medicare with documentation obtained from the physician ordering the test."[9] Similarly, in the event the necessary documentation has not been provided by the ordering physician, the OIG places the responsibility for obtaining the necessary documentation on the billing laboratory by requiring the laboratory to "contact the ordering

*Continued on page 8*

*Continued from page 7*

physician" to obtain the information.[10] The OIG statements are consistent with the requirements in the Final Rule.

The Final Rule clarifies the expectations of physicians and laboratories with respect to demonstrating the necessity and reasonableness of lab tests billed to Medicare. Laboratories continue to have the burden of proving the medical necessity of claims submitted. Under the Final Rule, physicians are expressly required to maintain the documentation supporting the medical necessity of lab tests ordered. While physician cooperation is essential to the proper functioning of the clinical laboratory reimbursement process, the Final Rule does not sanction physicians who refuse to cooperate with laboratories seeking further documentation. Herein lies the importance of educating physicians on their significant responsibility of not only maintaining, but also supplying to laboratories, documentation of medical necessity for the services ordered.

*Endnotes*

1 66 Fed. Reg. 58,787 (Nov. 23, 2001).

2 42 C.F.R. § 410.32(d)(2)(i).

3 42 C.F.R. § 410.32(d)(2)(ii).

4 42 C.F.R. § 410.32(d)(2)(iii); Medicare Program Memorandum, Transmittal AB-02-030 (March 5, 2002).

5 66 Fed. Reg. 58,787, 58,807 (Nov. 23, 2001).

6 42 C.F.R. § 410.32(d)(3)(i).

7 42 C.F.R. § 410.32(d)(3)(ii).

8 42 C.F.R. § 410.32(d)(3)(ii).

9 *Compliance Program Guidance for Clinical Laboratories*, 63 Fed. Reg. 45,076, 45,080 (Aug. 24, 1998).

10 *Id.*

**RAP Liaison *2001-02***

**Jennifer A. Stiller, Esquire**
*Law Offices of Jennifer A. Stiller*
*625 Haydock Ln*
*Haverford, PA 19041-1207*
Phone: (610) 642-3366 Fax: (610) 642-7581
E-Mail: stiller@health-regs.com

## Health Lawyers' Publications

### CRIMINAL BACKGROUND REPORTS: A SURVEY OF THE FIFTY STATES

*by James S. Schultz*
© 2002, stapled, Topical Insight Series
Item TIS02-0001
Members $55 / Non-members $65

### THE APPLICATION OF NONPROFIT CORPORATION LAW TO HEALTHCARE ORGANIZATIONS

*by Michael W. Peregrine, Esq., and James R. Schwartz, Esq.*
© 2001, Monograph
Item WM200103
Members $65 / Non-Members $ 75

### PHYSICIAN COMPLIANCE PLANNING

*by Charles I. Artz*
(Note: This paper is included in the 2001 Fraud and Compliance Forum program binder.)
©2001, stapled, Topical Insights series
Item TIS01-0011
Member $30 / Non-member $40

### MANAGED CARE CONTRACTING HANDBOOK: A GUIDE FOR PAYORS AND PROVIDERS, 4TH EDITION

*by the Managed Care Contracting Handbook Task Force of the Hospitals and Health Systems and HMOs and Health Plans Substantive Law Committees*
*Cynthia F. Reaves, Esquire, Editor*
*Robert M. Keenan III, Esquire, Co-Editor*
© 2001, - 260 pages, softbound, Practice Guide
(includes CD-ROM)
Item WAA200101
Members $95 / Non-Members $110

### HEALTHCARE COMPLIANCE LEGAL ISSUES MANUAL, 2ND EDITION

(previously titled "Healthcare Model Compliance Manual")
*by the Corporate Compliance Task Force of the In-House Counsel Special Interest Committee of the American Health Lawyers Association. Task Force Chairs: Robert W. Biddle, Esq., Ankur J. Goel, Esq., and Karen Duke Schuller, Esq.*
© 2001 3-ring binder, Practice Guide
Item WAA200102
Members $135 / Non-Members $160

To Order these or any other publications:
1. Go to www.healthlawyers.org/ecommerce
2. Call Member Service Center at (202) 833-0766

## Successor Liability: Deerbrook Pavilion Ends the Debate*

Harvey M. Tettlebaum, Esquire
*Husch & Eppenberger LLC*
*Jefferson City, Missouri*

On October 29, 2001, the U.S. Supreme Court denied the Petition for Writ of Certiorari filed in the case of *Deerbrook Pavilion v. Shalala* decided December 26, 2000, by the Eighth Circuit. This action by the Supreme Court brought to an end four years of litigation to determine whether a successor operator of a nursing facility (and presumably a hospital) was liable for civil money penalties (CMPs) incurred by a predecessor. While ultimately not determinative of the outcome, the facts as taken by the U.S. District Court for the Western District of Missouri and all succeeding courts showed that the successor in this case had no knowledge of the predecessor's CMP and was not able to participate in the initial proceedings appealing those CMPs that were subsequently dismissed by the facility originally incurring them.

The original CMPs totaling $419,700.00 were assessed against a nursing facility in Kansas City for violations that occurred between March 22, 1996 and September 5, 1996. On January 10, 1997, Deerbrook Pavilion began operating the facility. It was the second operator after the operator who was originally assessed the CMPs. The operator originally assessed the CMPs had appealed the assessment but later abandoned that appeal. The Health Care Financing Administration (HCFA) waited until the period for reinstatement of the appeal had expired to notify Deerbrook Pavilion that it was seeking to collect the $419,700.00 in CMPs. When the operator originally assessed the CMPs had gone out of business, its successor had assumed its Medicare provider agreement and Deerbrook Pavilion assumed the provider agreement as next in line. HCFA took the position that the actions of assuming the provider agreements made Deerbrook Pavilion liable for the CMPs under the Fifth Circuit's decision in *United States v. Vernon Home Health, Inc.*, 21 F.3d 693 (1994).

Deerbrook Pavilion filed suit in district court to challenge in a declaratory judgment action HCFA's authority to impose the successor liability in its collection of the CMPs against Deerbrook. It claimed violation of its due process rights, andasserted that there was no statutory or regulatory authority authorizing the imposition of the CMPs and that the provider agreement did not supply that authority. HCFA responded that the provider agreement did give it that authority and that the federal regulations placed Deerbrook Pavilion on notice that HCFA could collect CMPs from a successor. HCFA incorporated these arguments in a motion to dismiss, which was sustained by the U.S. District Court for the Western District of Missouri.

The case was appealed to the Eighth Circuit. On December 26, 2000, a panel of the Eighth Circuit in a 2-1 decision sustained the actions of the district court. Moreover,, it also held, as a threshold matter, that the district court had jurisdiction under 28 U.S.C. § 1331 and that Deerbrook Pavilion did not have to exhaust administrative remedies under *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000). HCFA had argued that Deerbrook Pavilion should have intervened in the original appeal of the CMP. The Eighth Circuit held that it was "questionable whether Deerbrook even had the standing . . . to intervene in contesting the imposition of CMPs on its predecessor."

The Eighth Circuit then turned to the substantive arguments made by Deerbrook Pavilion. In that regard, the court held that, under 42 U.S.C. § 1395i-3(h)(2)(B)(iii), the DHHS Secretary had the authority to "specify criteria, as to when and how each of such remedies [including CMPs] is to be applied, the amounts of any fines, and the severity of each of the remedies." It went on to hold that under 42 C.F.R. § 489.18 the "new owner assumes the [provider] agreement subject to its prior terms and conditions." Although the regulation does not specifically mention CMPs, the court held that the language that: "An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to . . . (1) Any existing plan of correction. (2) Compliance with applicable health and safety standards," gave the agency that authority. Finally, the court relied upon language from the preamble to the regulation found at 59 Fed.Reg. 56174 (1994) to the effect that the "new owner acquires the compliance history, good or bad, as well as the assets."

The appeals court also relied on the *Vernon* case. It viewed the difference between the overpayment in *Vernon* and a CMP as a distinction without a difference. It held that in both cases a "monetary liability" was involved for the new operator.

Finally, the court rejected the argument by Deerbrook Pavilion that successor liability for CMPs is bad public policy and frustrates the statutory intent to hold providers accountable for their conduct. Rather, it held that the goals of the federal statute "would be frustrated if nursing home operators were able to avoid CMPs by engaging in sham transfers." It should be noted that there was nothing in the record before the district court or the appeals court to indicate that the transaction by which Deerbrook Pavilion took over the facility was a "sham transaction." The court specifically noted that the existence of CMPs could be accounted for in the purchase price for the facility. The appeals court ignored the fact that, in this case, there was merely a lease, but no purchase.. The lessor was not the facility originally assessed the CMPs nor the predecessor of Deerbrook Pavilion.

If there were any questions before, it is now settled law that any provider is liable for any overpayments or CMPs of a predecessor unless the successor chose to reject the Medicare and Medicaid provider agreements at the time it purchased or succeeded to the interests of the predecessor against whom the overpayments or penalties had been assessed. The remainder of the article will discuss the implications of that situation.

*Continued on page 10*

*Continued from page 9*

It should be understood that the decision of the Eighth Circuit makes no distinction between types of successors. That means that if anyone begins to operate a nursing facility that was previously operated by someone who had a CMP and the successor took assignment of the provider agreement, the government can and most likely will hold them liable. It should also be noted that in some states the same provider number is automatically assigned to successors whether they want to assume the provider agreement or not. While the constitutionality of that policy or regulation can be challenged, the fact remains that this situation exists in many states and must be noted by successors in interest. Therefore, it behooves persons purchasing, leasing, or succeeding in any way to the interests of a nursing facility to take steps to protect themselves if they are going to take assignment of the provider agreement of their predecessor or, in the case of Medicaid, they are going to succeed to the operation of a facility previously participating in the Medicaid program if there is automatic assignment of the provider number in that state.

A successor that chooses not to take assignment of the Medicare provider agreement will experience delays sometimes of as much as six to nine months before they can obtain a new provider agreement. While the Centers for Medicare & Medicaid Services (CMS) has indicated that it will expedite the processing of applications in those situations, it will still probably take at least sixty days for those applications to be processed and it could take as much as four months. That encourages many successors to contract around the possibility of CMPs or overpayments. This places a premium on terms in a lease or an asset purchase agreement that clearly places liability for those items. While it is possible for successors to obtain "no action" letters from some states with respect to Medicaid liability, that is quite difficult for Medicare liability. Some have suggested that a letter could be obtained from the U.S. Department of Justice on behalf of the federal Medicare program to indicate the amounts that would satisfy any prior existing penalties for that particular facility. Again, this is a time consuming process. If the predecessor, whether seller or lessor, is solvent, irrevocable letters of credit can be obtained to secure unknown liabilities in the form of overpayments or CMPs for some reasonable period of time. In addition, where it is a sale, a certain sum could be put into a basket to be held for at least a year while negotiations occur with the government on prior existing CMPs or overpayments.

For successors who are leasing facilities, it may be easier to include provisions in the lease that permit an offset of future lease payments against overpayment or CMP claims assessed by the government on the successor lessee. Other provisions that might be included are arbitration or mediation provisions to resolve these disputes.It should also be noted that in situations where CMPs are subsequently assessed after the successor takes over for conduct that occurred prior to the date the successor assumed control, CMS takes the position that both the predecessor and the successor cannot appeal. That position by CMS is not uniformly recognized by Administrative Law Judges. A joint appeal is preferred and recommended to prevent later claims by the government of lack of standing or the abandonment of appeal rights.

While it is obvious that someone purchasing or leasing a facility as part of its due diligence should determine the compliance history of the facility, that is sometimes easier said than done. The practice of state survey agencies in looking back at closed files to determine the compliance history of a facility can sometimes frustrate the due diligence process. Further compounding the situation is the fact that, as lenders and other financing sources become aware of the implications of the *Deerbrook Pavilion* decision, purchasers may find it more difficult to finance transactions without being able to provide concrete assurances to the lender that either there are no prior existing overpayments or CMPs or that proper security has been obtained to account for either should they arise in the future.

Those health lawyers whose practice is concentrated in long term care are well advised to acquaint their colleagues in their firms doing transactional work of this situation.

* This article orginally appeared in the *LTC Advisor*, Winter 2002, Volume 5, Issue 1, a publication of the American Health Lawyers Association Long Term Care Substantive Law Committee.

American Health Lawyer Association SISLCs Staff

1025 Connecticut Ave NW
Suite 600
Washington, DC
20036-5405
Phone: 202-833-1100
Fax: 202-833-1105
www.healthlawyers.org

**WAYNE MILLER,** CAE
Deputy Executive Vice President/COO
(202) 833-0775
wmiller@healthlawyers.org

**EILEEN M. BANTEL**
Manager of Special Interest and Substantive Law Committees
(202) 833-0778
ebantel@healthlawyers.org

**LAURIE M. GARVEY**
Special Interest and Substantive Law Committees Coordinator
(202) 833-0783
lgarvey@healthlawyers.org

## Myth of Consistent Evaluation and Management Coding in Emergency Department Billing

Michael T. Crowley, CPA
Glenville, New York

When hospitals and physicians provide services, someone (usually an insurance company and the patient) gets billed for these services. In most cases, two bills are submitted—one for the hospital's services, and one for the physician's services. Complications arise when considering these two bills. For example, payers distinguish between the technical (facility) and professional (physician) components of these two bills and make adjustments in reimbursements accordingly. Simplistically, one might argue that almost all services rendered in a hospital have these two components (technical and professional).

The technical component is intended to reimburse the hospital for its share of overhead and labor costs. Many of these costs (I prefer to call them "rates") are now predetermined, capped, or negotiated. In the past, and under certain circumstances currently, these "rates" were a function of each individual hospital's incurred costs. Hospitals were paid a pro rata portion of these costs, regardless of how efficient or inefficient they operated. Hence, cost reporting became a critical function in the finance area of most hospitals. How does this affect billing in the emergency department?

The codes used for reporting these technical procedures usually help to simplify some of the complications. The three major codes used are as follows:

1. CPT Physicians' Current Procedural Terminology,
2. HCPCS (pronounced "hix pix")—Health Care Finance Common Procedural Coding System; and,
3. ICD-9-CM (mostly used for diagnoses, there are some procedure codes as well).

In most cases, these codes are unique. For example, the HCPCS codes have modifiers that distinguish the upper left eyelid from the lower left eyelid from the lower right eyelid, etc. Codes for specific procedures usually provide enough definition to adequately describe the level of service, and, therefore, compensate the hospital and the physician appropriately.

The Evaluation and Management (E & M) codes, however, present some unique challenges. Because the codes used by both the hospital and the physicians are the same (99281 – 99285), there is a general perception that the level of these codes should match in order to avoid the appearance of impropriety or fraud. Therefore, many hospitals strive to insure that both technical and professional component bills have the same level code for E & M services (e.g. both 99283). However, there is also a tendency for hospitals to under-code these claims because their reimbursement formulas are often different from the physicians. If the hospital codes a 99282 instead of a 99284, the ultimate reimbursement may not be appreciably different. However, the same is not true for the physician.

Hence, when Medicare, Medicaid, or other payers look at these claims, a certain level of consistency may be expected. One Medicaid audit I am aware of singled out emergency department physicians because their claims were coded consistently higher than the hospital claims. This caused Medicaid to question the coding on the physician claims, but not on the hospital claims. The same medical record is used to code both claims (hospital and physician); therefore, shouldn't both claims indicate the same level code?

Not necessarily. If the physicians can prove their case (e.g. that the record supports the level code billed), then they should not worry about what the hospital codes. Leave it to the hospital to explain why they under code. Many physician practices, however, would rather avoid the hassle of an audit, and tend to under code their claims as well.

Because the reimbursement impact can be significant, it is good policy to insure that physician E & M codes in the emergency department "stand on their own." It is probably a mistake for physicians to concern themselves with how the hospital codes the claims.

An ideal situation would be to have the hospital medical records coders code both claims. This is how it works with most hospitals that employ the emergency department doctors. However, with the advent of practice management companies and hospital outsourcing, many emergency departments are staffed by specialist groups that do their own billing. This phenomenon will insure that auditors will remain employed over the next several years.

## Call for Authors

The RAP SISLC is presently soliciting proposals for articles for its upcoming issue of the RAP Sheet. Articles are generally about 5 to 8 pages, double spaced. For inclusion in the next issue, which is due out in early June, final drafts of articles are due on May 10. Topics must be submitted as early as possible to allow the editorial staff to make timely determinations regarding acceptance for publication.

Please contact Andy Ruskin, the editor of this year's RAP Sheet, via e-mail at aruskin@velaw.com with any proposed topics you may have. If you are interested in writing an article but do not have a topic in mind, please contact Andy Ruskin for suggestions.

# Year in Review

## Case Law Summary

Eric P. Zimmerman, Esquire
*McDermott Will & Emery*
*Washington, DC*

Plaintiff, a Medicare participating home health agency, brought an action seeking a preliminary injunction to enjoin the defendant and his fiscal intermediary from collecting alleged Medicare overpayments until plaintiff could fully exhaust its administrative remedies within the Department of Health and Human Services (DHHS). The court denied plaintiff's motion for lack of jurisdiction, finding 42 U.S.C. § 405(g) bars judicial review of claims arising under the Medicare Act until the plaintiff has presented its claims to the DHHS Secretary (Secretary) and exhausted all administrative remedies. The court rebuffed plaintiff's claim that *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667 (1986), allows judicial review where plaintiff is made to wait indefinitely for review, and instead found that *Shalala v. Illinois Council of Long Term Care*, 529 U.S. 1 (2000) requires total preclusion of review, and mere postponement of review will not suffice. *Great Rivers Home Care, Inc. v. Thompson,* 170 F. Supp. 2d 900 (E.D.Mo. 2001).

A coalition of eleven national medical societies filed suit challenging Medicare rules for phasing in the practice expense component of the Medicare physician fee schedule and asking the court to declare the practice expense transition formula unlawful and invalid. Plaintiff alleged that the transition formula for phasing in resource-based practice expense relative value units conflicted with the transition formula required by the plain language of the Balanced Budget Act of 1997. In April 2000, the district court granted the government's motion to dismiss on jurisdictional grounds and denied plaintiff's motion for expedited declaratory judgment. On the jurisdictional issue, the court concluded that because the transition formula is part of the formula for calculating practice expense relative value units, the challenge is to the relative value determinations themselves and therefore is precluded by the statutory provision that bars judicial review of such determinations. With regard to the statutory construction argument, the court found that the Secretary's regulation is a reasonable interpretation of an unclear statute and therefore was not inconsistent with the statute or arbitrary and capricious. On January 28, 2002, the Seventh Circuit affirmed the district court's decision on jurisdictional grounds, finding that the statutory bar on judicial review of relative value determinations applied to the transition formula. The appeals court did not directly address the merits, but did state that it would have found the Secretary's regulation to be a reasonable interpretation of an ambiguous statute. *American Society of Cataract and Refractive Surgery v. Thompson*, No. 00-2518, 2002 WL 104510 (7th Cir. Jan. 28, 2002).

Plaintiff, a home healthcare provider, challenged a Medicare fiscal intermediary's refusal to pay per visit amounts that exceeded the average per visit rate charged by comparable companies. The Provider Reimbursement Review Board found for plaintiff and awarded full reimbursement of the amount charged. The Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) reversed the Board and reinstated the intermediary's denial. The plaintiff appealed to the federal district court, which affirmed the Secretary's denial. On November 15, 2001, the Sixth Circuit reversed, finding that the Secretary had "informally imposed on Medicare providers a competitive bidding requirement not previously made a part of Medicare regulation." The appeals court found that, to institute such a requirement, the Secretary would have to comply with administrative rulemaking procedures. *Maximum Home Health Care Inc. v. Shalala,* 272 F.3d 318 (6th Cir. 2001).

Plaintiff, a Medicare participating hospital, challenged a Medicare fiscal intermediary's disallowance of interest expenses paid on notes held by a related Foundation. The Provider Reimbursement Review Board concluded that the interest expense was not an allowable cost under Medicare regulations, because the transaction was a related-party transaction, noting that the Foundation had the power to influence the Hospital at the time of the transaction. The Secretary adopted the Board's finding. Plaintiff appealed to the federal district court, which upheld the Secretary's decision denying reimbursement. On December 12, 2001, the Fifth Circuit affirmed, holding that the Secretary's interpretation of regulations defining related parties and control were reasonable. *Sid Peterson Mem'l Hosp.l v. Thompson*, No. 00-51138 2001 WL 1504688 (5th Cir. Dec. 12, 2001).

## Reimbursement/Payment Regulatory Summary

Lester J. Perling, Esquire
*Broad & Cassel*
*Fort Lauderdale, Florida*

### CMS Publishes Final Rule Regarding Clinical Diagnostic Laboratory Services

On November 23, 2001, the Centers for Medicare &and Medicaid Services (CMS) published a final rule (Rule) that establishes national coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B. The Rule's stated purpose is "to promote Medicare program integrity and national uniformity, and simplify administrative requirements for clinical diagnostic laboratory services." The Rule's effective date is November 25, 2002, with some minor exceptions. The Rule does not require that diagnostic information be submitted with every claim. CMS stated its belief that such a requirement would present significant burdens on some physicians, although it did state that it would continue to study this issue. CMS encouraged physicians to voluntarily provide diagnostic information (either the reason for the office visit or the reason for the test) with each order. CMS also encouraged laboratories to submit information that they receive with the claim. Diagnostic information is required for claims payment if there is a published national or local policy. The Rule contains detailed clinical indications for Medicare coverage of certain diagnostic laboratory tests. 66 F.R. 58788, (Nov. 23, 2001).

### CMS Delays 2002 Outpatient Prospective Payment System Update

On December 10, 2001, CMS announced the delay of the implementation of the 2002 Outpatient Prospective Payment System (OPPS) payment update until approximately April 1, 2002, although it kept the effective date applicable for services delivered on or after January 1, 2002, with regard to inclusion in OPPS. CMS has published several program memoranda addressing this issue since it first announced the delays, the most recent being on December 28, 2001. It requires fiscal intermediaries to publish a notice to providers regarding the delay. The December 28, 2001, Program Memorandum states that hospitals and community mental health centers will be paid for outpatient services they provide to Medicare beneficiaries during this delay at the 2001 rates, up until the time 2002 rates are made effective. CMS states that these claims will not be reprocessed using the new rates, once they are established. Program Memorandum Transmittal No. A-01-150, (Dec. 28, 2001). CMS has now finalized its changes to the system, which will go into effect on April 1, as scheduled. 67 Fed. Reg. 9556 (Mar. 1, 2002).

### Office of Inspector General Recommends Recovery of Prospective Payment System Transfer Overpayments

On November 13, 2001, the Department of Health and Human Services Office of Inspector General (OIG) released an audit report that examined 153,000 claims for incorrectly coded reported prospective payment system (PPS) transfers that occurred between 1992 and mid-2000. The OIG reported that 79,000 of those claims resulted in potential overpayments totaling nearly $164 million that were suitable for recovery. The OIG recommended that CMS issue instructions to intermediaries and hospitals to initiate collection of these overpayments, clarify transfer rules, and have intermediaries and hospitals review internal claim submission and payment procedures. CMS concurred with these recommendations, but stated that new processes would have to be implemented before undertaking large-scale recovery efforts. Under the PPS transfer payment system, a transfer occurs whenever a patient is admitted to a PPS hospital on the same day that the patient is discharged to another PPS hospital. When this occurs, payment is made on a per diem basis to the initial hospital and the full diagnosis related group (DRG) is paid to the receiving hospital. When a hospital incorrectly reports the transfer as a discharge, it receives the full DRG payment, which is often greater than the per diem. "Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported As Discharges," (A-06-00-00041, Nov. 13, 2001).

### CMS Issues Billing Instructions for Global Medical Equipment, Prosthetics, Orthotics, and Related Supplies (DMEPOS) Suppliers

On December 12, 2001, CMS issued instructions, effective April 1, 2002, that requires DMEPOS suppliers to submit claims on a monthly basis. The Carrier's Manual Transmittal stated that "suppliers should bill no more or less frequently than monthly, for a month's worth of DMEPOS, unless another policy that allows billing in a different frequency applies." Suppliers must submit their claims in sequence if there are continuous periods of service. Carrier's Manual Part 3, Transmittal No. 1730, (Dec. 12, 2001).

### Court Holds Shareholders Liable for Overpayment to Home Health Agency

In a decision issued December 4, 2001, the U.S. District Court for the District of Massachusetts found that two shareholders of a home health agency were personally liable for overpayments made to the home health agency under a theory of piercing of the corporate veil. The court held that the shareholders were liable because they failed to reimburse the government for a Medicare overpayment from funds received as a result of a sale of the agency's assets. The owners were receiving payroll and other checks from the entity after the sale, including one check that was used to pay for work on a residence belonging to one of the owners. The entity then dissolved. The court held that, because the owner's funneled corporate proceeds to themselves rather than paying off the debt to the federal government, they should be held personally liable for that debt. *United States v. Bridle Path Enterprises., Inc.,* No. Civ. A. 99-11051-GAO, 2001 WIL 1688911 (D. Mass. Dec. 4, 2001).

### CMS Issues New Instructions Regarding Coverage Appeals

In a Program Memorandum dated December 13, 2001, the Centers for Medicare and Medicaid Services (CMS) re-issued a program memorandum that it had originally issued one year earlier, addressing requests for reconsiderations and Part B reviews. In this Program Memorandum, CMS instructs carriers and intermediaries not to accept inadequate requests for appeal. If the relevant form to request reconsiderations or reviews is not used, then the appeal request must contain the following information: the beneficiary's name, the beneficiary's Medicare health insurance claim number, the name and address of the provider or supplier, the date of the initial determination under appeal, the date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with Medicare claims filing instructions; and which item(s) and/or service(s) are issue in the appeal). Program Memorandum Transmittal No. AB-01-183, (Dec. 13, 2001).

### CMS Announces Tthat Coding Information for Skilled Nursing Facility Consolidated Billing Available on Iits Website

In a Program Memorandum dated January 11, 2002, the Centers for Medicare and Medicaid Services (CMS) announced that, as of January 1, 2002, coding information for a skilled nursing facility (SNF) consolidated billing is located on its website at www.hcfa.gov/medlearn/refsnf.htm. The information found there may be used to determine by procedure code whether services rendered to beneficiaries in Part A-covered SNF stays or non-Ppart A-covered SNF stays are included or excluded from consolidated

*Continued on page 14*

*Continued from page 13*

billing. Only those services that are excluded from consolidated billing are reimbursed separately. All other services are included in the SNF's payment and, therefore, the suppliers of those services must bill the SNF. Program Memorandum Transmittal No. B-02-002, (Jan. 11, 2002).

### CMS Issues Proposed Rule Governing Reporting and Repayment of Overpayment

On January 25, 2002, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the *Federal Register* governing reporting and repayment of overpayments. UnderAccording to the proposed rule, providers, suppliers, individuals, and managed care organizations would be required to report and return overpayments to CMS. The rule would require that Medicare participants that have identified that they have been overpaid by Medicare, must report the an overpayment and return it within sixty60 days of its identification to the appropriate intermediary or carrier. 67 Fed. Reg..R. 3662, (Jan. 25, 2002).

## 2001-02

## American Health Lawyers Educational Programs and Special Interest and Substantive Law Committees Luncheons

April 3–5, 2002
***Institute on Medicare and Medicaid Payment Issues***
Baltimore Marriott Waterfront Hotel, Baltimore, MD
**Substantive Law Committee Luncheons:*
*Physician Organizations–April 3*
*Regulation, Accreditation & Payment–April 4*
*Antitrust–April 5*

May 16–17, 2002
***ADR Mediation Essentials Training: Practical and Theoretical Approaches to Effective Mediation of Healthcare Disputes***
The Carnegie Endowment for
International Peace, Washington, DC

May 7-8, 2002
***Managed Care Law Institute***
(co-sponsored with the American Association of Health Plans)
Broadmoor Hotel, Colorado Springs, CO
**Substantive Law Committee Breakfast:*
*HMOs and Health Plans*

June 30, 2002
***In-House Counsel Program***
San Francisco Marriott Hotel, San Francisco, CA
**Special Interest Committee Luncheon:*
*In-House Counsel (included in program registration fee)*

July 1–3, 2002
***Annual Meeting***
San Francisco Marriott Hotel, San Francisco, CA
**Special Interest and Substantive Law Committees Luncheons*
*Monday, July 1, 2002*
- *Antitrust*
- *Fraud and Abuse, Self-Referrals, and False Claims*
- *Teaching Hospitals and Academic Medical Centers*
- *Healthcare Liability and Litigation*
- *Tax and Finance*

*Tuesday, July 2, 2002*
- *Health Information and Technology*
- *Long Term Care*
- *HMOs and Health Plans*
- *Physician Organizations*

*Wednesday, July 3, 2002*
- *Credentialling and Peer Review*
- *Labor and Employment*
- *Hospitals and Health Systems*
- *Regulation, Accreditation, and Payment*

**Registration fees paid by May 30, 2002:
Member–$895; Group Member–$820;
Non-Member–$1,045; Celebration Sale–$820

For more Program and SISLC Luncheon information, go to: www.healthlawyers.org or call our Member Services Center (202)833-0766

AMERICAN HEALTH LAWYERS ASSOCIATION

## Program Registration Form

### Institute on Medicare and Medicaid Payment Issues
April 3-5, 2002
Baltimore Marriott Waterfront Hotel - Baltimore, MD

**Cancellations/Substitutions:**
Cancellations must be received in writing no later than March 27, 2002. Registration fees, less a $100 administrative fee will be refunded following the program. If you wish to send a substitute, please call the Health Lawyers Member Service Center at 202/833-0766. Please note that registration fees are based on the membership status of the individual who actually attends the program.

**Hotel: (PLEASE NOTE NEW LOCATION)**
Hotel accommodations are not included in the registration fee. Call the Baltimore Marriott Waterfront Hotel at 410/385-3000. Indicate that you are attending the Health Lawyers program to be eligible for the special group rates. The room block expires March 6, 2002. (Rooms at the group rate are limited and may sell out prior to the cut-off date).

To register: Remit payment and completed registration form
by mail to the American Health Lawyers Association, PO Box 79340, Baltimore, MD 21279-0340
by fax with credit card information to (202) 833-1105 by phone to AHLA Member Service Center at 202/833-0766

*To avoid duplicate charges, please do not mail this form if you have already faxed it to us.*

Name:_____ AHLA Member ID #: _____
First Name for Badge (if different than above): _____
Title:_____
Organization: _____
Address: _____
City: _____ State:_____ Zip: _____
E-mail: _____
Telephone: (_____) _____ Fax: (_____)_____

☐ This is a new address; please update my file.

### REGISTRATION FEES *(fees increase by $75 after March 6, 2002):*

AHLA ***Members***:
☐ $780
☐ $705 group rate for each additional member registering from the same organization/firm at the same time

***Non-Members:***
☐ $930

### Special Interest and Substantive Law Committee Luncheons and Presentations

***(all registrants are welcome to register for these luncheon presentations and networking opportunities)***

| | | |
|---|---|---|
| Physician Organizations | (Wednesday, April 3, 2002) | ☐ $37 |
| Regulation Accreditation & Payment | (Thursday, April 4, 2002) | ☐ $37 |
| Antitrust | (Friday, April 5, 2002) | ☐ $37 |

### PAYMENT INFORMATION

Total Enclosed: $_____

***(Sorry! Registrations cannot be processed unless accompanied by payment.)***

Check enclosed (U.S. funds; make payable to American Health Lawyers Association)
Bill my credit card: ☐ VISA ☐ MasterCard ☐ American Express
Card Number: _____ Exp. Date: _____
Name of Cardholder: _____
Signature of Cardholder: _____
ZIP Code of Cardholder's Billing Address: _____ - _____
Please note: AHLA will charge your credit card for the correct amount if your total is incorrect.

501(C)(3) FED ID No. 23-7333380 SN

AMERICAN HEALTH LAWYERS ASSOCIATION

1025 Connecticut Ave, NW, Suite 600
Washington, DC 20036-5405
Phone: (202) 833-1100
Fax: (202) 833-1105
www.healthlawyers.org

Plan to Attend

Regulation, Accreditation, and Payment SISLC Annual Meeting Luncheon - ***Wednesday, July 3, 2002***

*Co-sponsored with Credentialling and Peer Review SISLC*

*"Current and Future NPDB Reporting Issues"*

**Cynthia Grubbs**, *Acting Deputy Director/Associate Director for Policy, US Department of Health & Human Services Division of Practitioner Databanks*

**In-House Counsel Program *(June 30th)* and Annual Meeting *(July 3, 2002)***

San Francisco Marriott Hotel ▪ San Francisco, California

For more information and to register, go to www.healthlawyers.org/programs/prog_02annual.cfm

# The RAP Sheet

Spring 2002 Volume 5 Issue 1