Referral and Encounter Requirements for Home Health Providers and Durable Medical Equipment Suppliers

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Healthcare Reform Law contains new referral and encounter requirements for home health providers and durable medical equipment suppliers. New enrollment rules could impact all Medicare suppliers and providers.

The Patient Protection and Affordable Care Act added new referral requirements for home health providers and DME suppliers and new compliance mandates for all providers participating in Medicare and Medicaid. The Act also contains significant important changes to the Medicare and Medicaid enrollment process for providers and suppliers. This advisory will describe some of the new standards and challenges created by the Act.

Additional Documentation and Encounter Requirements for Home Health and Durable Medical Equipment Referrals

Physicians who order durable medical equipment or home health services for Medicare beneficiaries must be enrolled with the Medicare program. Further, the Secretary of Health and Human Services is authorized to extend this recruitment to other items or services under Medicare, including Part D covered drugs.

This requirement will become effective July 1, 2010.

While apparently a simple requirement, this new rule is likely to force home health providers and equipment suppliers to verify the Medicare enrollment of physicians who order services, which could become a significant administrative burden. Failure to observe their requirement could lead to false claims liability or other sanctions. Until now, it was only necessary to take reasonable steps to verify that physicians ordering services were not excluded from Medicare at the time of the referral. This rule will also put additional burdens on physicians who “opt out” of Medicare, as they will no longer be able to order home health services and durable medical equipment for their Medicare patients.

Enhanced Documentation of Referrals for Certain Items or Services, and Encounter Requirements

Physicians, suppliers and providers are required to maintain documentation relating to written orders or requests for payment for durable medical equipment or home health services. Significantly, the Act empowers the Secretary to expand this requirement to other kinds of services covered by Medicare. The Secretary is also empowered to revoke the Medicare enrollment of suppliers and physicians who do not provide access to such documentation on request. This documentation requirement will become part of Medicare provider agreements for all Medicare provider types. The Act expands the Office of the Inspector General’s permissive exclusion authority to exclude entities that fail to provide information relating to the “ordering, referring for furnishing, or certifying the need for” items or services covered by the Medicare and Medicaid programs.

This requirement applies to orders, certifications, and referrals made on or after January 1, 2010.

Congress appears to be concerned that home care orders are not being properly documented and that some portion of the home health services and items currently being paid for by Medicare are not medically necessary.

The Act also requires a face-to-face encounter between a patient and a physician before the physician may certify the need for home health services, and the Secretary may define the permitted timeframe for such encounters. The face-to-face encounter may be through telehealth technology.

Similarly, the Act requires a face-to-face encounter between a patient and one of a physician, physician assistant, nurse practitioner, or clinical nurse specialist before an order is made for durable medical equipment. This section also permits encounters made through telehealth technology. The Act’s requirements apply to both Medicare and Medicaid. Significantly, the Act allows the Secretary to expand the scope of this face-to-face encounter requirement to other items and services covered by Medicare, based upon a finding that such a requirement could reduce the risk of waste, fraud, and abuse.

These requirements have an effective date of January 1, 2010.

Some, but not all, existing Medicare coverage policies require an encounter between the ordering physician and the patient before a referral can be made. Adding this requirement to two major categories of Medicare benefits is a

significant administrative change for the home care industry. As suppliers and providers do not maintain the documentation proving whether and when a face-to-face encounter occurred, this requirement will place more stress on the relationship between home care providers and referring physicians.

Enhanced Provider Disclosures and New Enrollment Standards for Providers and Suppliers

The Act mandates increased disclosure of ownership and governance information for all skilled nursing facilities and long term care facilities, including officers, directors, managers, and trustees. The Act also mandates disclosure of information regarding the organizational structure of the provider for each affiliated entity. This includes all entities that provide management services, financial services, clinical services, or accounting services to the facility. Organizational disclosures include all detailed information on management, governance and ownership of each disclosing entity. All such information reported shall be made publicly available by the Secretary.

These requirements evidence a concern about related party transactions within provider organizations, and are part of a broader transparency initiative within the Medicare program.

The Act requires the Secretary to promulgate regulations implementing these reporting requirements, which regulations are to be effective 90 days after publication.

Provider Pre-Enrollment Screening and Other Enrollment Requirements

The Act directs the Secretary to develop enrollment screening procedures that will apply to all persons seeking to enroll as new providers or suppliers in the Medicare, Medicaid and CHIP programs. Screening procedures may include licensure checks, criminal background checks, fingerprinting, pre-enrollment site visits, database checks, and such other screening procedures as the Secretary may deem appropriate.

The Act also allows the Secretary to establish enrollment fees for providers and suppliers in these programs. The screening processes will apply to new providers and suppliers, and eventually will apply to existing providers and suppliers upon re-enrollment. The Secretary is also directed to establish processes for enhanced oversight of new providers, to last at least 30 days and up to one year. Such oversight can include prepayment reviews or payment caps, as determined by the Secretary.

The Act also changes the enrollment process by requiring new and re-enrolling providers and suppliers to disclose current or previous affiliations with a provider or supplier that has uncollected debt, has been subject to payment suspensions, or has been excluded from Medicare, Medicaid or CHIP. The Secretary may deny enrollment if he deems the new provider or supplier to pose a risk of program abuse.

The Act directs the Secretary to implement the new screening requirements 180 days after the date of enactment.

Supplier and providers who are contemplating transactions that will involve the enrollment of new entities should anticipate delays in enrollment due to the new screening criteria. It seems likely that other routine transactions, such as re-enrollment, will become more complex and time-consuming, as well.

The Act also gives the Secretary the authority to impose a temporary moratorium on enrollment of new providers and suppliers, whenever the Secretary determines that a moratorium in necessary to prevent or combat fraud, waste or abuse. There is no judicial review available of the Secretary's decision to implement a temporary moratorium. This provision appears to be effective immediately. A moratorium could work a significant hardship on new providers and suppliers, and it is troubling that the Act provides no standards for the imposition of a moratorium and no route for judicial review.

The Act requires state Medicaid programs to abide by provider screening processes imposed by the Secretary, and to abide by any enrollment moratorium imposed by the Secretary. Making a false statement or material representation during the enrollment process is now grounds for exclusion.

The Act gives the Secretary of Health and Human Services the authority to increase surety bond requirements for DME and home health care providers based on the billing volume of the company. Further, it gives the Secretary that latitude to require surety bonds for any other kind of provider or supplier (which could include physicians, IDTFs and hospitals, among others) with a minimum surety bond requirement of $50,000.

The Act does not specify an effective date for the new surety bond requirements, but it appears that implementation will follow rulemaking by the Secretary.

Healthcare organizations have treated enrollment in the Medicare program almost as an entitlement. Unlike managed care organizations, which have often created limited networks for specialized services, Medicare enrollment is open to

any organization that can meet enrollment criteria. The Secretary's new ability to impose a moratorium on enrollment, combined with the mandate to impose new screening criteria, is a move toward restricting enrollment of new healthcare organizations in Medicare.