

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DURABLE MEDICAL EQUIPMENT
PAYMENTS IN NURSING HOMES**



**JUNE GIBBS BROWN
Inspector General**

**MARCH 1996
OEI-06-92-00862**

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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

To identify Medicare Part B payments for Durable Medical Equipment (DME) services provided to residents in nursing homes.

BACKGROUND

DME is equipment which can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home. To be covered by Medicare Part B, the *DME must be furnished for use in the beneficiary's home*. Medicare defines a beneficiary's home as his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, a hospital or skilled nursing facility is specifically excluded as a resident's home. A skilled nursing facility is defined as a facility primarily engaged in providing skilled nursing care.

We obtained information about Part B expenditures from a 1992 nationally projectable sample of nursing home residents from 10 States and 150 nursing homes. This includes residents receiving Medicare extended care benefits in a skilled nursing facility (SNF), residents paying for their stay with private insurance or personal funds, residents on Medicaid, or a combination of the above.

This inspection was conducted as a part of Operation Restore Trust (ORT). The initiative, focused in five States, involves multi-disciplinary teams of State and Federal personnel seeking to reduce fraud, waste, and abuse in nursing homes and home health agencies, and by durable medical equipment suppliers.

FINDINGS

Medicare carriers allowed as much as \$35 million in 1992 for DME during nursing home stays. Of this, \$27 million was paid by Medicare. The remaining \$8 million was paid by beneficiaries.

No effective mechanism currently exists to ensure the appropriate payment of durable medical equipment under Medicare Part B for beneficiaries in nursing homes. To ensure correct payments, clarification is needed in the program policy utilized to determine which nursing homes are "primarily engaged" in providing skilled care.

RECOMMENDATIONS

In attempting to address this problem, we originally developed a series of options regarding coverage policy for durable medical equipment in nursing homes. One of those options, which we supported most strongly in our draft report, was to exclude payment for any piece of durable medical equipment provided to any resident in a nursing home. We originally believed that this option should be pursued primarily because of its administrative simplicity and because it reflected a policy which holds nursing homes responsible for routine items needed by their residents. After considering both the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) comments on the draft report expressing concerns about the impact of such a policy on beneficiaries and consistency with current legal authority, we have chosen to eliminate this recommendation in our final report.

Rather, we agree with both HCFA and ASPE that this issue should be considered within the confines of current law. And while we appreciate and thank ASPE for its point about the distinction between routine and nonroutine items, which we agree can be important, our reading of current law would prohibit any DME payment made on behalf of a resident of a nursing facility primarily engaged in providing skilled nursing care. Further, if such a distinction could be made, it would be easier to make based on beneficiaries' specific circumstances and the amount, duration and scope of need, than on categories of equipment. We believe that to make such a distinction based on categories might invite the routine billing of "non-routine" DME in order to qualify for payment under Part B, and potentially create an escalation in DME payments for residents in nursing homes.

Thus, we recommend that HCFA develop and implement a workable and fair definition of what constitutes a skilled nursing facility, for the purposes of payment of DME under Part B. It might be that such a definition could implement a policy such as that discussed in our draft report, in which Medicare certified facilities are designated as skilled nursing facilities (whether or not they are also certified by Medicaid). However, other definitions might be more appropriate.

In any event, such a definition should reflect the principle that (1) skilled nursing facilities are responsible for the provision of a basic range of services to the residents under their care, and (2) a skilled nursing facility cannot be considered a home for the purposes of DME coverage under Medicare Part B.

We have previously recommended that HCFA institute appropriate payment safeguards to ensure that payments for DME are not made for beneficiaries in a Medicare covered SNF stay. The HCFA agreed. We refer readers to our report, "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays," for more discussion of the options we presented and HCFA's response.

Cost Savings: The exact amount of savings that could be obtained by the Federal Government in implementing this recommendation depends on a number of factors, including the definition of skilled nursing facilities. To illustrate, assuming a scenario where 75 percent of the facilities are deemed to be skilled facilities, we estimate roughly \$23.5 million in savings (of which 80 percent is saved by the program and 20 percent by beneficiaries) would accrue from implementing both this recommendation and our prior recommendation regarding payment during Medicare covered SNF stays.

COMMENTS

The full text of the HCFA and the ASPE comments are provided in Appendix B. Since we revised the recommendation from the draft report, HCFA's proposed action to revise and improve the Medicare criteria for identifying a "skilled" facility would implement the action which we agree is appropriate.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	
INTRODUCTION	1
FINDINGS	3
DME payments in 1992	3
No effective mechanism	5
RECOMMENDATIONS	6
ENDNOTES	9
APPENDICES	
Part B Classification of DME Services	A-1
Agency Comments	B-1

INTRODUCTION

PURPOSE

To identify Medicare Part B payments for Durable Medical Equipment (DME) services provided to residents in nursing homes.¹

BACKGROUND

DME is equipment which can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home. DME includes such items as wheelchairs, hospital beds, canes, crutches, oxygen concentrators, and nebulizers. In addition, reimbursement may be made for necessary repairs and maintenance of the equipment under specified conditions.

DME is reimbursed using a fee schedule. Five categories of DME have been established, each with a different reimbursement methodology. These five principle DME payment categories include:

- 1) inexpensive or other routinely purchased DME, defined as equipment costing less than \$150 or which is purchased at least 75 percent of the time;
- 2) items requiring frequent and substantial servicing;
- 3) customized items, which are defined as equipment constructed or modified substantially to meet the needs of an individual patient, with fee schedule amounts determined by carriers without regard to average or reasonable charges;
- 4) other DME frequently referred to as "capped rental"; and
- 5) oxygen and oxygen equipment, requiring frequent and substantial servicing, with payment calculations based on the average Medicare *reasonable* charge.

Equipment may be covered under Medicare's Supplemental Insurance Program (Part B), if it is furnished for use in the beneficiary's home. Medicare defines a beneficiary's home as his or her dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, a hospital or skilled nursing facility is specifically excluded as a resident's home.

In the past, Medicaid nursing homes were classified as facilities providing skilled nursing care (SNF), providing intermediate care (ICF), or as providing both. The distinction was important, as some ICFs provided care at a level that could be considered a beneficiary's residence for DME payment purposes.² This determination was generally made by the State agency and communicated to the local carrier. However, with legislative changes to the certification process prescribed in the Omnibus Budget Reconciliation Act of 1987, the ICF/SNF certification distinction was removed. All nursing homes now meet the same certification standards of a Medicare-participating SNF.

This inspection was conducted as a part of Operation Restore Trust (ORT). The initiative, focused on five States, involves multi-disciplinary teams of State and Federal personnel seeking to reduce fraud, waste, and abuse in nursing homes and home health agencies and by durable medical equipment suppliers.

SCOPE

This report is one of two reports on DME for nursing home residents. The other report, *Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays*, was limited to DME billed for residents receiving extended care benefits in a Medicare nursing home providing skilled or rehabilitative care. Since such a nursing home is specifically excluded as a beneficiary's "home," all Part B payments for DME in that setting should have been denied. We identified approximately \$8.9 million in 1991 and \$10.8 million in 1992 of incorrect DME payments in nursing homes providing extended care benefits.

This report expands our review to include not only residents receiving extended care benefits in a Medicare-certified nursing home, but also any Medicare-eligible resident in any Medicare or Medicaid-certified nursing home.

METHODOLOGY

Data for this inspection was obtained from a nationally projectable two-stage random sample of 150 nursing homes from California, Delaware, Florida, Indiana, Kansas, Louisiana, Maine, Michigan, Montana, and Wyoming (10 per State). Stratification was based on facility size (large, medium, and small).

Each sample nursing home provided us with a list of all Medicare-eligible residents residing in the nursing home during 1992, along with each resident's corresponding date(s) of stay. After verification of the beneficiaries' health insurance claim numbers (HICN) with the Medicare enrollment database, all Medicare services provided during the nursing home stay were extracted from the Medicare National Claims History File for calendar year 1992. The Supplementary Medical Insurance (SMI) for the Aged and Disabled services (Part B Medicare), processed by both the carrier and the intermediary, were identified. Data from the sample were projected to the total nursing home population (residents in Medicare or Medicaid-certified nursing homes).

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Carriers Allowed \$35 Million in 1992 for DME During Nursing Home Stays.

An estimated \$35 million³ was allowed (\$27 million paid) for DME billed during a beneficiary's stay in a Medicare and/or Medicaid-certified nursing home. The remaining \$8 million was paid by or on behalf of beneficiaries. However, the exact amount of incorrect payment is dependent upon whether the nursing home qualified as the beneficiary's residence.

- Over 80 percent of the allowed charges were for wheelchairs, beds, oxygen equipment, and related supplies.

Most of the DME payments were for the rental or purchase of oxygen equipment, wheelchairs, beds, and related items. (See Figure 1.)

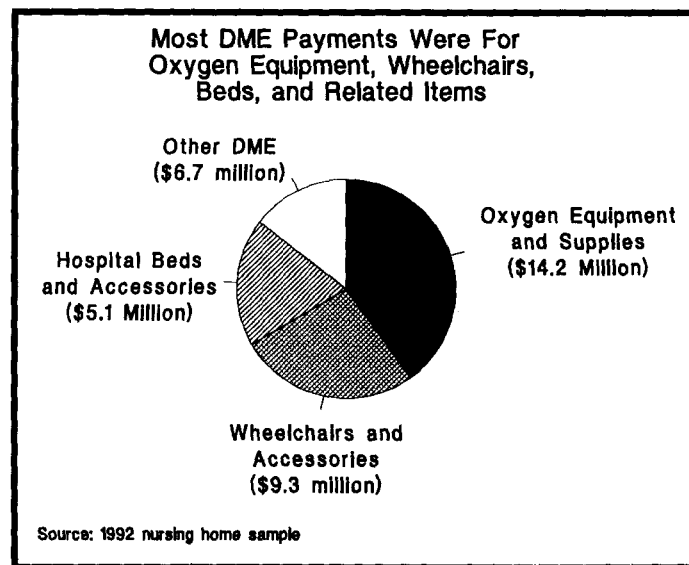


Figure 1

The most often rented or purchased oxygen equipment is the oxygen concentrator which delivers 4 liters per minute. The most expensive item in the wheelchair category is the standard wheelchair with fixed arms and detachable legs. For beds, the semi-electric bed is the largest expense.

The items for which payments were made reflect a typical array of medical equipment necessary for nursing homes to have in order to serve their residents. Further, with the exception of some oxygen equipment and perhaps some wheelchairs, these are not sophisticated, customized, or high technology items. In addition to hospital beds and basic wheelchairs, the payments were for walkers, canes and crutches, commodes, seat/patient lifts, and pressure pads.

- Overall, DME payments are attributable to less than 5 percent of all nursing home stays, with moderate differences between States and sizeable variations among nursing homes.

During 1992, 4.6 percent of all nursing home stays had DME allowed charges for Medicare residents in nursing homes. Among the 10 sample States, the percentage of stays with DME ranged from an estimated high of 7.7 percent in Maine to an estimated low of 1.4 percent in Kansas. However, among nursing homes, there are sizeable variations in the percent of stays with DME. While the average percent of stays with DME was 4.6 percent, some 38 percent of nursing homes exceeded this amount, and 10 percent exceeded 10 percent.

- As much as a third of these DME payments may have been made for beneficiaries in a Medicare covered SNF stay.

We previously estimated⁴ that approximately \$11 million in DME payments under Medicare Part B were made for beneficiaries in Medicare covered SNF stays during 1992. This more general estimate, using a different methodology, includes these payments (as well as payments for beneficiaries who have exhausted their Medicare benefits and/or whose stays are paid by Medicaid, private insurance, or out of pocket).

- The certification status of the nursing home appears to have little impact on DME billing.

We looked at the certification status of the nursing home and found little variation in the levels of DME billing. This was regardless of whether the nursing home was Medicare-certified, dually certified for both Medicare and Medicaid, or Medicaid-only certified.

- 19 percent of the DME payments were made within one week of discharge or death.

While DME should not be billed during a “skilled” nursing home stay, some of the billing may have been for DME intended for use at the beneficiary’s residence following his or her discharge from the nursing home. In reviewing payments occurring within a short time of discharge, we found \$6.8 million (or 19 percent) billed within seven days of leaving the nursing home. However, we were unable to determine if the person went home or to another inpatient facility. We do know that one-half million dollars can be attributed to residents that died. Figure 2 shows the allowed charges within 7 days of discharge.

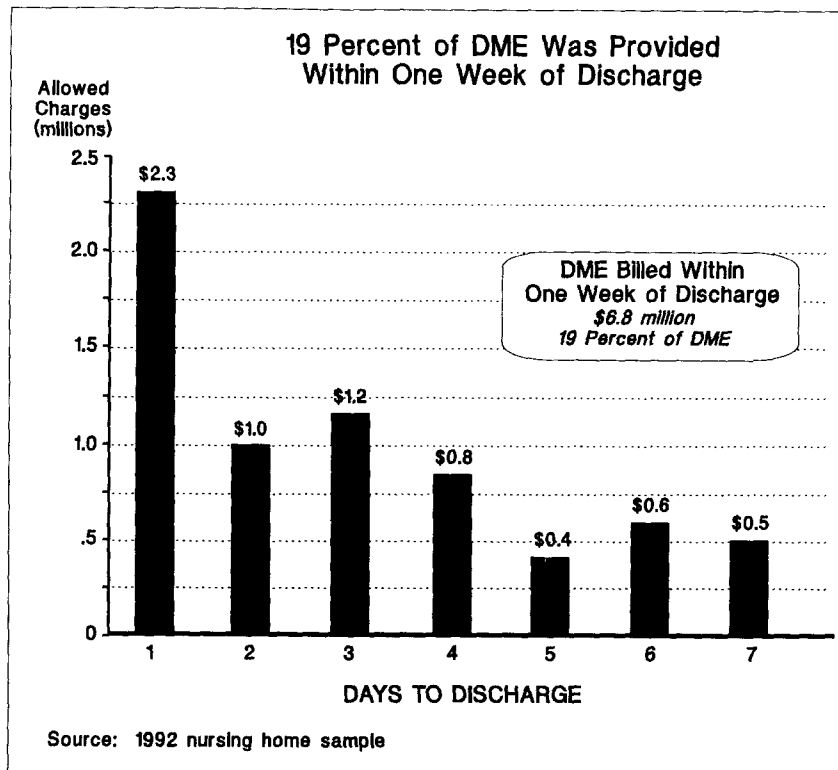


Figure 2

No effective mechanism currently exists to ensure the appropriate payment of durable medical equipment under Medicare Part B for beneficiaries in nursing homes.

As indicated earlier, a skilled nursing facility is specifically excluded from consideration as a beneficiary's residence, for the purposes of payment under Part B for durable medical equipment.

While policy is clear that a resident in a Medicare covered skilled nursing facility (SNF) stay would not be eligible for coverage of durable medical equipment under Part B (even though some such payments were still made, as discussed earlier), Medicare currently has no mechanism which otherwise determines when a beneficiary is residing in a skilled nursing facility.

As indicated earlier, prior to passage of OBRA 1987, Medicare used certification information to make the distinction between skilled nursing facilities and other facilities. The OBRA 1987 eliminated this distinction and the mechanism Medicare used to make payment decisions. No new mechanism has been developed to replace it.

Without a formal mechanism for defining whether, or under what conditions, DME is covered in a nursing home, carriers were forced to adopt their own policies. Resulting policies generally denied DME coverage if provided in a nursing home setting. Generally, this denial was based on the supplier's designation of the place of service as a "nursing home." This

policy is confirmed by our finding that virtually none (0.4%) of the payments in our sample were coded with place of service "nursing home."

In 99 percent of instances where DME payments were made, suppliers submitted claims with the place of service coded as "home" (91 percent) or "other unlisted facility" (nine percent). We cannot say whether suppliers coded the place of service in this way in order to avoid a denial of the claim, or represented the place of service as home because they in fact considered it a beneficiary's residence.

RECOMMENDATIONS

In attempting to address this problem, we originally developed a series of options regarding coverage policy for durable medical equipment in nursing homes. One of those options, which we supported most strongly in our draft report, was to exclude payment for any piece of durable medical equipment provided to any resident in a nursing home. We originally believed that this option should be pursued primarily because of its administrative simplicity and because it reflected a policy which holds nursing homes responsible for routine items needed by their residents. After considering both HCFA and ASPE comments on the draft report expressing concerns about the impact of such a policy on beneficiaries and consistency with current legal authority, we have chosen to eliminate this recommendation in our final report.

Rather, we agree with both HCFA and ASPE that this issue should be considered within the confines of current law. And while we appreciate and thank ASPE for its point about the distinction between routine and nonroutine items, which we agree can be important, our reading of current law would prohibit any DME payment made on behalf of a resident of a nursing facility primarily engaged in providing skilled nursing care. Further, if such a distinction could be made, it would be easier to make based on beneficiaries' specific circumstances and the amount, duration and scope of need, than on categories of equipment. We believe that to make such a distinction based on categories might invite the routine billing of "non-routine" DME in order to qualify for payment under Part B, and potentially create an escalation in DME payments for residents in nursing homes.

Thus, we recommend that HCFA develop and implement a workable and fair definition of what constitutes a skilled nursing facility, for the purposes of payment of DME under Part B. It might be that such a definition could implement a policy such as that discussed in our draft report, in which Medicare certified facilities are designated as skilled nursing facilities (whether or not they are also certified by Medicaid). However, other definitions might be more appropriate.

In any event, such a definition should reflect the principle that (1) skilled nursing facilities are responsible for the provision of a basic range of services to the residents under their care, and (2) a skilled nursing facility cannot be considered a home for the purposes of DME coverage under Medicare Part B.

We also suggest that HCFA consider a provision allowing for case-by-case, beneficiary based determinations of special circumstances; grandfathering in current beneficiaries receiving DME under Part B while in a nursing home, to avoid disruption in their services. We agree with ASPE that the policy should allow billing for DME provided in the last week of a resident's nursing home stay, regardless of payer, to facilitate discharge planning when the DME is intended for use in the resident's home.

We have previously recommended that HCFA institute appropriate payment safeguards to ensure that payments for DME are not made for beneficiaries in a Medicare covered SNF stay. The HCFA agreed. We refer readers to our report, "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays," for more discussion of the options we presented and HCFA's response.

Cost Savings: The exact amount of savings that could be obtained by the Federal Government in implementing this recommendation depends on a number of factors, including the definition of skilled nursing facilities, programmatic controls implemented to expressly allow or prevent cost shifting to other parts of the Medicare program, the Medicaid program, or beneficiaries. Additionally, controls must be adequate to detect incorrect place of service coding by suppliers.

A rough estimate of savings can be derived as follows. From the total \$35 million in allowed amounts, we subtract \$6.8 million for payments made in the last week of a nursing home stay. Of the remaining \$28 million, roughly a third is addressed by implementing our previous recommendation regarding nonpayment during Medicare covered SNF stays, for a savings of \$9.3 million. Assuming a new policy defining most nursing facilities as "skilled" (conceivable given marketplace conditions and law which have increased nursing facility capacity and staffing) would affect 75 percent of billings, savings for the remaining \$19 million would be \$14.2 million. (These savings are shared by beneficiaries in copayments.) Thus, a total of \$23.5 million savings (of which 80 percent is saved by the program and 20 percent by beneficiaries) accrues by implementing both this recommendation and the prior recommendation we made regarding payment during Medicare covered SNF stays in this scenario.

COMMENTS

The key points of HCFA and ASPE comments are discussed in the introduction to our revised recommendation. The full text of their comments are provided in Appendix B. Since we revised the recommendation, HCFA's proposed action to revise and improve the Medicare criteria for identifying a "skilled" facility would implement the action which we agree is appropriate.

ENDNOTES

1. While this report deals with DME services provided in nursing homes, a companion report, *Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays* (OEI-06-92-00860) discusses DME services solely in the Medicare SNF environment.
2. Until the nursing home reform of OBRA 1987, the Health Care Financing Administration administratively denied coverage of DME in nursing homes by the rules used to determine "primarily engaged in" (PEI). The PEI question was determined by a mathematical formula identifying the ratio of caregivers to nursing home beds or residents (e.g., if more than 1 caregiver to 15 residents, then the facility was deemed to be a PEI/ICF nursing home regardless of whether any skilled or rehabilitation patients were in the nursing home.) As a result, most Medicaid certified nursing homes providing (then) ICF level care could not qualify as a "home" under the administrative rules.

As a result of OBRA 1987, certification is no longer based on levels of care and specific staffing ratios. Instead, facilities providing skilled care and/or rehabilitative services are categorized along with facilities that formerly were categorized as ICFs. Any nursing home providing any of these three types of care is now considered a nursing facility under the Federal statute affecting the Medicaid program. However, we learned that not all States have reorganized their State programs along these lines. Specifically, several States continue to license nursing home beds as skilled, intermediate, sheltered living, and other categories.

3. At the 95 percent confidence level, we project Part B charges for DME between 27.4 million and 43.4 million were made in 1992 on behalf of residents during nursing home stays.
4. Estimate can be found in our report entitled, "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays" (OEI-06-92-00860).

APPENDIX A

PART B CLASSIFICATION OF DME SERVICES

Components of DME and Applicable HCPCS Codes

Hospital Beds and Accessories

Bed Codes: E0250, 0251, 0255, 0260, 0265, 0266, 0294, 0296

Bed Accessory Codes: E0272, 0277, 0310, 0325

Oxygen Equipment and Supplies

Codes: E0410, 430, 435, 457, 1400, 1401, 1402, 1403, 1404, Q0036,
0040, 0042, 0043, 0046

Misc Code: E1399

Oxygen Supply Codes: E0457

Wheelchairs and Accessories

Wheelchair Codes: E1031, 1060, 1083, 1084, 1085, 1086, 1087,
1088, 1089, 1090, 1092, 1093, 1100, 1130, 1140,
1150, 1160, 1170, 1180, 1213, 1220, 1221, 1222,
1223, 1224, 1240, 1250, 1260, 1270, 1280, 1285,
1290, 1295, 1296, 1297, 1298

Wheelchair Accessory Codes: E0950, 953, 959, 961, 963, 971, 978,
990, 991, 992, 993, 994, 996, 997,
1069

Walkers

Codes: E0130, 0135, 0141, 0143, 0147

Canes and Crutches

Codes: E0100, 0105, 0114

Commodes

Codes: E0163, 0164, 0165, 0166, 0167

Seat/Patient Lifts

Codes: E0627, 0630

Pressure Pad or Cushion or Mattress

Codes: E0176, 0178, 0180, 0181, 0182, 0184, 0185, 0186, 0191, 0192,
0193, 0196, 0199

APPENDIX B

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 16 1996

TO: Claudia Cooley
Executive Secretary

FROM: Acting Assistant Secretary for
Planning and Evaluation

SUBJECT: Formal Comments Regarding OIG Draft Reports On Medicare Payments for
Services Provided to Nursing Home Residents

In our earlier response to the three OIG reports on Medicare payments for nursing home residents, we expressed concern that the reports could inadvertently lead to the conclusion that Medicare Part B payments should not be made on behalf of nursing home residents and that we would discuss this concern and other issues during a meeting with OIG staff on December 12, 1995. As a result of this discussion between ASPE and OIG staff the following formal ASPE comments are offered regarding the three OIG reports entitled "Part B Services in Nursing Homes - An Overview," "Durable Medical Equipment Payments in Nursing Homes," and "Enteral Nutrients Payments in Nursing Homes".

Enteral Nutrients Payments in Nursing Homes

We agree with the OIG conclusion that food should be considered a basic nursing home service that is included in a nursing home payment rate. In addition, we agree that enteral nutrition is a way for certain persons to meet daily nutritional requirements. Further, we agree, to the extent that the costs of enteral nutrition are comparable to the costs of meals for the general nursing home population, that the costs of enteral nutrition should be included in the basic nursing home payment rate. Based on the preceding, we agree that Medicare Part B payments for enteral nutrition should not be made on behalf of persons residing in nursing homes.

However, we recommend the report note that the extent to which other payers (e.g., Medicaid) take into account the costs of enteral nutrition or meals for the general nursing home population is unknown, and, as a result, the impact on nursing home residents of a policy prohibiting Medicare Part B payments for enteral nutrition is unknown.

Durable Medical Equipment (DME) Payment in Nursing Homes

We are opposed to the OIG recommendation to expand the current prohibition on Part B DME payments on behalf of persons in a Part A covered SNF stay to also include persons in non-Part A covered stays. At this time, there is no agreement on the core services that should be included

in a nursing home payment rate. As a result, we are unable to identify which Medicare Part B DME payments are made for routine nursing home services (i.e., services that should be included in a nursing home payment rate) and which are not. Further, while we understand current law limits Part B DME to persons who are residing in their "home," it is not clear when a nursing home resident (i.e., in non-Part A covered stay) is permanently residing in such a facility, and, thus, is at home in the facility, versus a resident that is receiving short-term care and intends to return home. To ensure that beneficiaries are not inappropriately denied needed coverage, a policy prohibiting Part B DME payments to all nursing home residents would have to assume that Part B DME payments are for routine or core nursing home services and that there are no long-term, permanent nursing home residents for whom the nursing home has, in fact, become their home. We do not believe that these are accurate assumptions. Further, we are concerned that denying Medicare Part B DME payments to nursing home residents could have a negative effect on their quality of care. Therefore, we believe, at least in the interim, the Department should presume that nursing home residents in a non-Part A covered SNF stay are residing in their "home" and permit Part B DME payments on behalf of such residents in need of these supplies. We recommend the OIG study this issue and recommend a categorization of equipment routinely covered in nursing home payment rates and DME not routinely included in such rates. A review of State Medicaid nursing facility payment methods may provide some insight into this issue.

Finally, we recommend that the conclusion of this report clearly indicate that Part B DME payments made within a week of discharge for any nursing home resident (regardless of payer) who is eligible for Part B are appropriate to facilitate discharge planning.

Part B Services in Nursing Homes

We recommend including in the Background section a discussion of the circumstances under which Medicare Part B payments on behalf of nursing home residents are appropriate, the difficulties in identifying when such payments are inappropriate, and the variable impact that proposals to limit Medicare Part B payments will have on different nursing home residents (i.e., those in a Part A covered SNF stay, those who are not, and those who are also eligible for Medicaid) and on State and Federal governments.

We understand that the OIG intends to undertake a study of State Medicaid nursing facility payment rates and methods. We agree that such a study is needed in order to understand when duplicate payments have been made (i.e., Medicare and Medicaid both have paid) and when Medicaid cost sharing is inappropriate.


Peter Edelman

HEALTH CARE FINANCING ADMINISTRATION
COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE DEC 15 1985

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck *Bruce Vladeck*
Administrator

SUBJECT Office of Inspector General Draft Report: "Durable Medical Equipment
Payments in Nursing Homes," (OEI-06-92-00862)

We reviewed the above-referenced report which examines how suppliers ensure their durable medical equipment payments will be made by submitting claims that incorrectly code the place of service as "home" or "other" rather than "nursing home." Attached are our comments on the report recommendation.

Thank you for the opportunity to review and comment on this draft report.

Attachment

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Report "Durable Medical Equipment Payments in Nursing Homes," (OEI-06-92-00862)

OIG Recommendation

OIG recommends that HCFA never pay for durable medical equipment (DME) supplies or equipment for any patient residing in a Medicare or Medicaid-certified nursing home, regardless of level of care, by implementing the following actions:

- Clearly designate that no Medicaid- or Medicare-certified facility, regardless of the patient's level of care, is a patient's "home" for DME payment purposes.
- Consider developing an additional Common Working File edit to identify a possible nursing home stay (in addition to the Medicare extended care benefit stay alert already in plan) overlapping any DME claim.
- Require Medicaid agencies to deny Medicare crossover claims for DME (crossover refers to claims processed and paid by Medicare for dual eligibles, for whom Medicaid is required to pay the coinsurance and deductible for the beneficiary) unless the State has determined the facility qualifies as a residence according to the previously stated criteria. Further, require Medicaid agencies to report to HCFA all denials involving DME for dually eligible nursing home residents.
- Direct contractors to inform nursing homes of their status for DME payment purposes, and routinely communicate to suppliers that DME is not covered if provided to nursing home residents (clearly specifying that the DME can only be provided on or after the date of discharge to the beneficiary's home from the nursing home).

HCFA Response

The above recommendation would impose a blanket Part B exclusion of DME payment in all Medicare skilled nursing facilities (SNF) and all Medicaid nursing facilities (NF). However, as the law is currently written, we cannot do this for all Medicaid NFs (see attached).

We do hope to simplify this process considerably by introducing a set of rebuttable administrative presumptions under a proposed rule (BPD-834-P) that we are currently developing. The proposed rule would revise and improve the Medicare criteria for identifying a "skilled facility" (i.e., a nursing home meeting the basic definition of a SNF

**Medicare Part B Coverage Exclusion for Durable Medical Equipment
(DME) furnished in a Skilled Nursing Facility (SNF)**

- o The Medicare law (at section 1861(n) of the Social Security Act (the Act) provides for Part B coverage of DME when furnished for use in a patient's "home," except when that home is an institution that meets the requirements of the Act at sections 1861(e)(1) (for hospitals) *or* 1819(a)(1) (for SNFs).
- o Section 1819(a)(1) (formerly section 1851(j)(1)) of the Act, in turn, defines an "SNF" broadly as *any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.*
 - + This broad, inclusive SNF definition omits the specific, more restrictive requirements contained in the remainder of section 1819—requirements that an institution must meet in order to participate in the Medicare program as a certified SNF.
 - + Thus, in excluding Part B's DME coverage from "SNFs" as defined in section 1819(a)(1), Congress intended for this exclusion to apply not only to Medicare-participating SNFs, but also to institutions which, though not participating in Medicare, do provide the type of care described in that section of the law.
- o Medicaid nursing facilities (NFs) were created when the 1987 nursing home reform legislation combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category.
- o Like section 1819(a)(1) of the Act for Medicare SNFs, section 1919(a)(1) similarly defines Medicaid NFs in terms of the care that they are primarily engaged in furnishing. However, while this section contains a clause (A) (skilled nursing) and clause (B) (rehabilitation services) that are identical to their SNF counterparts in section 1819, it contains *an additional clause (C)* (health-related institutional care above the level of room and board) that is *not* found in section 1819, and is comparable to the type of care furnished by ICFs prior to the nursing home reform legislation.
- o Thus, it is possible for a NF to be primarily engaged in furnishing skilled care (sections 1919(a)(1)(A) or (B)), in which case it cannot be considered a "home" for purposes of DME coverage under Part B. However, it is also possible for a NF to be primarily engaged in furnishing essentially ICF-level care under section 1919(a)(1)(C), in which case it does *not* meet the basic SNF definition and *can* be considered a home for DME coverage purposes. Thus, since some NFs (as described in section 1919(a)) will meet the basic SNF definition while others will not, NFs cannot as a class automatically be regarded as either qualifying or not qualifying as a "home" for DME coverage purposes.

OPERATION RESTORE TRUST AND NURSING HOMES

On May 3, 1995, President Clinton announced a new anti-fraud initiative undertaken by the Department of Health and Human Services. Led by the Office of Inspector General in partnership with the Health Care Financing Administration and the Administration on Aging, this project utilizes the expertise of many Federal, State, and private sector personnel. They will direct their combined energies to crack down on Medicare and Medicaid fraud, waste, and abuse initially associated with home health agencies, nursing homes, hospices, and durable medical equipment suppliers. They will work closely with the Department of Justice and an intergovernmental team comprised of other Federal and State personnel.

In addition to identifying and penalizing those who defraud the government, the project is designed to alert the public and industry to the fraud schemes or vulnerable areas in policy. To aid in this endeavor, the Office of Evaluation and Inspections will work within the Office of the Inspector General to perform its primary mission of conducting evaluations that provide timely, useful, and reliable information and advice to the pertinent decision makers involved in the demonstration. To this end, the following reports on nursing homes have been completed:

Medicare Services Provided to Residents of Skilled Nursing Facilities (OEI-06-02-00863)

Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities (OEI-06-92-00864)

Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays (OEI-06-92-00860)

Part B Services in Nursing Homes - An Overview (OEI-06-92-00865)

Enteral Nutrient Payments in Nursing Homes (OEI-06-92-00861)

Durable Medical Equipment Payments in Nursing Homes (OEI-06-92-00862)

Ongoing evaluations are being conducted related to Medicare payments for residents of nursing homes for such services as mental health therapy, wound care, imaging, hospice, ambulance transportation, and nail debridement. Also under review are duplicate payments between Medicare and Medicaid for nursing home services.