Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR NON-PROFESSIONAL SERVICES IN SKILLED NURSING FACILITIES

JUNE GIBBS BROWN
Inspector General

JUNE 1995
OEI-06-92-00864

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EXECUTIVE SUMMARY

PURPOSE

To assess the Part B payment pattern and Medicare policy for the provision of non-professional services covered by the skilled nursing facility (SNF) benefit.

BACKGROUND

The Medicare program provides coverage under Part A for stays, of up to 100 days per benefit period, in SNFs. Section 1861h of the Social Security Act specifies the covered SNF services provided to an individual during a Part A skilled nursing stay. Among these are services which can be categorized as "non-professional institutional services" (e.g., room, board, supplies and equipment).

Many services and supplies billed directly to Part B are the same as non-professional institutional services covered under Part A. Thus, if provided by the SNF, these services and supplies would typically be included in the rate paid by Medicare for beneficiaries in a Part A covered SNF stay. However, if provided by a supplier directly to the beneficiary, billings could be made to Part B rather than Part A. In fact, a recent OIG report substantiates that billing Part B for these items does occur in Medicare covered SNF stays.

This report examines the extent of Part B billings for nonprofessional institutional services such as enteral nutrition services, incontinence care services, and surgical dressings provided to beneficiaries during Medicare covered SNF stays. We did not review situations where an individual in a SNF was not covered by Part A but receiving a SNF level of care.

To determine how many payments were made for Medicare beneficiaries during SNF stays, we first developed a one percent sample of Medicare beneficiaries. Within this sample, we selected beneficiaries with a Medicare covered SNF stay in 1991 and 1992, along with the dates of the stay. We then obtained Part B claims submitted and allowed on behalf of these beneficiaries with service dates coinciding with the dates the beneficiary was in a SNF stay being paid for by Medicare.

FINDINGS

Current Medicare Policies May Inappropriately Allow Billing Of Non-Professional Services To Part B During Medicare Covered SNF Stays.

Overall, non-professional institutional services provided during covered Part A SNF stays accounted for approximately $90 million in 1991 and $102 million in 1992 in allowed Part B payments. Section 1833(d) of the Medicare law states that no payment can be made by Part B for a service provided under Part A. However, there is no requirement that SNF

services must be paid by Part A. Thus, paying for non-professional services through Part B rather than part A is often legal. Nevertheless, allowing Part B payment for services covered in the SNF benefit seems incongruent with the intent of the benefit. This action removes responsibility from the SNF to provide for these services. Part B allowance also leads to greater beneficiary financial responsibility. The beneficiaries may not even be aware that the facility provides these services in such a way that their personal costs for care increase.

Over $70 Million Were Allowed By Part B For Three Specific Services Provided To SNF Residents In 1992.

- *$57 Million for Enteral Nutrition Services.*
- *$6 Million for Surgical Dressings.*
- *$10 Million for Incontinence Care Items.*

Enteral Nutrition

Since enteral nutrients provide all needed nutrition for some patients, it is obvious that they are food. Further, they are considered to be a food by the Food and Drug Administration. Given this acceptance, to not consider nutrients a basic benefit of a SNF and allowing billing outside of the per diem seems illogical. However, SNFs may either include these services in their routine costs and bill Part A of Medicare, or allow suppliers to provide the services and bill Part B. Further, SNFs can perform as the suppliers and thus, bill both the SNF per diem rate under Part A **and** the food (enteral nutrients) costs under Part B.

Incontinence Care

Prior to 1972, incontinence items were included in routine costs of a SNF and thus, were payable within the Part A payment. Although they have since been deleted from the routine cost listing, they are included under inpatient ancillary services, also a component of the SNF payment. Yet, while 92 percent of the nursing homes in 1992 provided services to patients with incontinence needs, Part B paid for some of these services.

Surgical Dressings

Surgical dressings have also been removed from the list of routine services provided in a SNF and are now included as an ancillary service payable by Part A. While dressings are considered items generally provided by SNFs, they are also listed in regulation as items covered by Part A **only** if the individual SNF generally provides the service. This further complicates the ability to determine the correct payment source during a SNF stay and may partially explain why Part B pays for some surgical dressings for SNF residents.

Paying For These Services And Supplies Under Part A Could Save Medicare Money And Reduce Improper Incentives For Providers.

Part B payment clouds responsibility for patient care, removes incentives for reasonable utilization and cost control, and makes it more difficult to compare costs and to set reasonable limits on per diem rates. If SNFs acted as prudent purchasers, by buying in bulk and taking advantage of negotiated rates, savings might result. This activity could lead to acquisition costs lower than the Part B reimbursement rates. Including non-professional services in the Part A payment would also reduce facility incentives to avoid the SNF cost limit by allowing suppliers to provide the services and bill Part B. Finally, including non-professional services in the SNF payment could prevent marketing abuses.

Paying For These Services Under Part A Would Also Save Beneficiaries Money.

By including enteral and incontinence services and surgical dressings in the Part A SNF payment, the beneficiary would not bear the burden of the deductible and 20 percent copayment involved in Part B. This would have resulted in beneficiary savings of approximately $17.6 million in 1991 and $18.5 million in 1992. While a significant portion of these savings might shift as costs to Medicare, Part A, these costs may be offset by the potential savings described in the previous finding.

Coding Problems Exist On Claims Submitted For These Services.

While all of the claims included in this report represent care provided during a covered SNF stay, many claims indicated a place of service other than a SNF. While coding practices improved between 1991 and 1992 for incontinence services and surgical dressings, problems increased for enteral nutrition service claims.

RECOMMENDATIONS

The current fragmented manner in which Medicare payment is made for SNF residents is a result of statutory provisions originally intended to ensure access to care. This report demonstrates that the ability of a SNF to make use of both Part A and Part B to underwrite care to its residents can result in increased program expenditures and waste and may dissipate the SNFs incentives to oversee the total package of care the resident receives.

In light of this, we recommend that:

- HCFA develop a legislative recommendation to prohibit entities other than the SNF from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings and limit Medicare coverage of these services to Part A.

- HCFA clarify 42 CFR 483.35 (Dietary Services) to specifically include parenteral and enteral nutrition.

COMMENTS

Comments were received from the HCFA, ASPE, and PHS on the draft report. The full text of the comments is included in Appendix C.

The HCFA and ASPE made suggestions about refocusing the recommendations to more clearly address the problems discussed in the report, which we adopted. Both HCFA and ASPE stated several concerns about language in the draft report raising questions about quality of care and about tying the problems discussed to residents' rights. We agree with HCFA and ASPE and have eliminated the language on these points.

Both HCFA and ASPE also raised questions about how savings might accrue to the Medicare program by implementation of the recommendations. We attempted to clarify our discussion of this point within the text of the report. It is true that merely shifting costs to Part A, without putting in place proper payment policies, accomplishes little. Medicare payment policies should both create incentives for prudent purchasing and reflect the economies achieved through prudent purchasing. As indicated in the report, the OIG plans more work on this subject, focusing first on payment for enteral nutrition.

Lastly, we adopted a number of suggested technical improvements made by the commenters.

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INTRODUCTION

PURPOSE

To assess the Part B payment pattern and Medicare policy for the provision of non-professional services covered by the skilled nursing facility (SNF) benefit.

BACKGROUND

The Medicare program provides coverage under Part A for stays, of up to 100 days per benefit period, in SNFs. A SNF stay is dependent on a specific set of conditions necessary for coverage (e.g., need for skilled services on a daily basis following a three-day qualifying hospital stay).

Section 1861h of the Social Security Act specifies the covered SNF services provided to an individual during a Part A skilled nursing stay. Among these are services which can be categorized as "non-professional institutional services." These services are listed in Table 1.

TABLE 1

Non-Professional Institutional Services Covered During Part A SNF Stays

- ***Bed and board in connection with the furnishing of nursing care.***
- ***Such drugs, biologicals, supplies, appliances and equipment, furnished for use in the SNF, as are ordinarily furnished by such facility for the care and treatment of inpatients.***
- ***Such other services necessary to the health of the patient as are generally provided by SNFs.***

Many services and supplies billed directly to Part B are the same as non-professional institutional services covered under Part A. Thus, if provided by the SNF, these services and supplies would typically be included in the rate paid by Medicare for beneficiaries in a Part A covered SNF stay. However, if provided by a supplier directly to the beneficiary, billings could be made to Part B rather than Part A. In fact, a recent OIG report substantiates that billing Part B for these items does occur in Medicare covered SNF stays.[1]

SCOPE

This report examines the extent of Part B billings for non-professional institutional services such as enteral nutrition services, incontinence care services, and surgical dressings provided to beneficiaries during Medicare covered SNF stays. We did not review situations where an individual in a SNF was not covered by Part A but receiving a SNF level of care.

Previous OIG reports have presented an overview of Medicare SNF services and payment for durable medical equipment (DME) billed during skilled stays.

METHODOLOGY

To determine how many payments were made for Medicare beneficiaries during SNF stays, we first developed a one percent sample of Medicare beneficiaries. Within this sample, we selected beneficiaries with a Medicare covered SNF stay in 1991 and 1992, along with the dates of the stay. We then obtained Part B claims submitted and allowed on behalf of these beneficiaries with service dates coinciding with the dates the beneficiary was in a SNF stay being paid for by Medicare.

In addition to claims review, we reviewed the law, as well as Medicare Carrier and Durable Medical Equipment Regional Carrier (DMERC) manuals, to identify established policy in the areas examined.

FINDINGS

Current Medicare Policies May Inappropriately Allow Billing Of Non-Professional Services To Part B During Medicare Covered SNF Stays.

Non-professional institutional services provided to patients and billed to Part B during covered Part A SNF stays accounted for $89.8 million in 1991 and $101.6 million in 1992. Included in this category of services are incontinence care services, surgical dressings, and dietary services, such as enteral nutrient services. Such services are billable to Part A if provided by the SNF during a Medicare covered SNF stay. However, as noted above, these items are also allowed as Part B services during Part A stays.

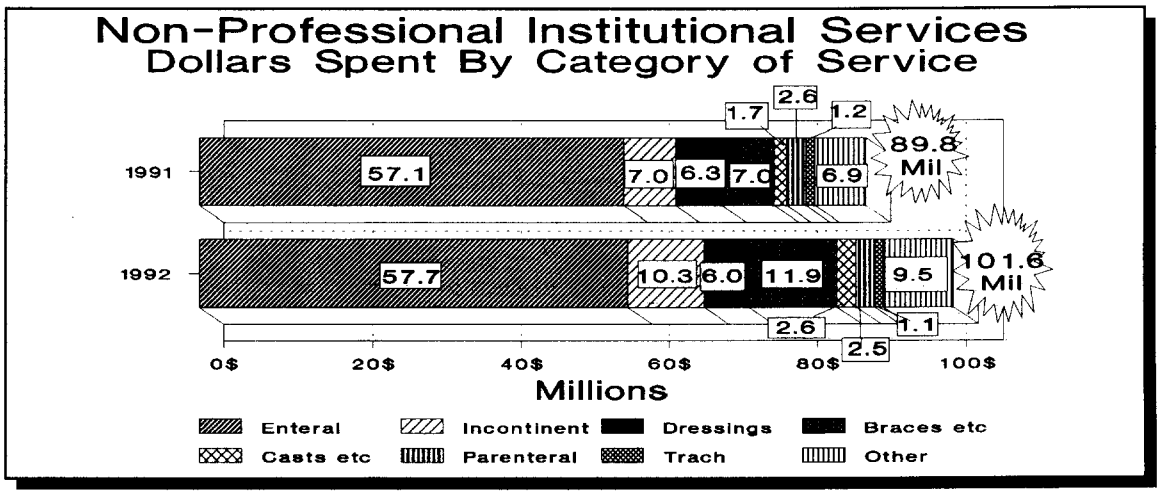


FIGURE 1

SOURCE: OIG Projections from a one-percent sample of Medicare beneficiaries.

Section 1833(d) of the Medicare law states that no payment can be made by Part B for a service provided under Part A. However, it does not indicate that covered institutional SNF services must be paid by Part A. Thus, while it is obvious that the law intends for these services to be provided during a Part A covered SNF stay, the law does not require that the services be provided by the SNF or paid by Part A. The ability of a SNF to provide services under arrangements does not remove responsibility from the SNF for the overall care provided to a beneficiary. However, it does permit the facility, to the extent allowed by law, to determine what costs will be subject to the SNF routine cost limit.

Allowing Part B payment for covered Part A services not only seems incongruent with the intent of the SNF benefit, it also leads to greater beneficiary financial responsibility. This occurs since the beneficiary is responsible for an annual deductible and 20 percent co-payment for Part B services. However, the beneficiary may not know that the facility does not provide these services, thus incurring unexpected personal costs for care. For

example, in 1991 and 1992, co-payment expenses represented $22 million and $25 million, respectively.

The impact of Part B payment for Part A covered services will be explored through three examples: enteral nutrition services, incontinence care services, and surgical dressings. These items accounted for over 70 percent of the Part B payments allowed in 1991 and 1992 for non-professional services provided during Medicare covered SNF stays.

ENTERAL NUTRITION POLICY

Definition of Enteral Nutrition: Enteral nutrition is a form of liquid nutrition that is provided to a patient who, due to a chronic illness or trauma, is unable to eat in the normal manner. This diet is generally required to sustain life and provides all of the patient's nutritional and caloric needs. Patients surviving on enteral nutrition require a tube to be placed either directly into the stomach or small intestine through the skin, or indirectly via the nasal passage. The receipt of enteral nutrition services often requires skilled care, although patients can receive this service at home.

Enteral nutrition is considered reasonable and necessary for a patient with a functioning gastrointestinal tract in certain circumstances. Individuals who are unable to ingest food, due to pathology or non-functioning of structures that permit food to reach the digestive tract, require enteral nutrition services. Examples of conditions that would qualify for coverage are head and neck cancer with reconstructive surgery, central nervous system disease affecting the ability to ingest food orally, and severe difficulty swallowing after a stroke.

Medicare Coverage Requirements for Enteral Therapy: As specified previously, enteral nutrition services may be covered by Part A or B during a covered SNF stay. Enteral nutrients are classified as a food by the Food and Drug Administration (FDA), and thus, are considered food for purposes of Part A coverage.[2] However, for Part B coverage, enteral nutrition services are considered a prosthetic device and must meet certain requirements. First, the beneficiary must have a permanently inoperative internal body organ, or an impairment lasting at least 90 days. A second requirement is patient dependence on enteral nutrients. To show a dependence on nutrients, the patient must require 20 to 35 calories of enteral nutrients, per kilogram of body weight per day. Although patients may only require supplements to their daily protein and caloric intake, this is not covered under Medicare Part B services. However, supplements are covered by Part A. Finally, if these Part B requirements for therapy are met, related supplies, equipment, and nutrients are also covered.

Part B Payment For Enteral Nutrition Provided To Beneficiaries In SNFs Seems Inconsistent With The Purpose Of The SNF Benefit.

A recent OIG review determined that Part B payments were made for enteral nutrition and related equipment and supplies in seven percent of Medicare covered SNF stays in 1991, and in six percent in 1992. The Health Care Financing Administration (HCFA) has a

longstanding practice of allowing Part B payment for enteral nutrition services provided to residents of SNFs. This practice continues under the DMERCs, which have issued instructions that enteral nutrition services may be covered under either Part A or under Part B for such beneficiaries, depending on who supplies the service. However, if the individual resides in a SNF under a Medicare covered stay, this policy may effectively relieve the facility of fundamental responsibilities inherent in the SNF benefit.

The FDA has stated that enteral nutrients may be considered as food or drugs, dependent on the stated purpose of the claims. Since most patients receiving enteral nutrition services in SNFs depend on them to sustain life, it would appear that these services should represent their food consumption and should be included in the SNF's dietary cost center.

Provision by a SNF

Despite the FDA classification of enteral nutrients as a food, the DMERC manual indicates that a SNF may either provide enteral nutrition services and supplies directly, or through an outside supplier. A SNF is considered to be providing enteral items when it purchases them directly from any source, and then provides them to a resident. If an individual is in a Part A SNF stay and the SNF furnishes the nutrients to the beneficiary, the DMERC manual notes that such services are to be billed to Part A. In this case, the manual states, "Enteral nutrients are classified as food and are included as a component of the SNF's routine costs."[3] Further, the DMERC suppliers' manuals state that no payment may be made by Part B for enteral nutrition services provided by the SNF during a Part A stay. In addition, the Social Security Act (Section 1833d) and the Medicare coverage policy indicate that any item covered under Part A cannot be billed to Part B.

Provision by a Supplier

As mentioned, the DMERC manual also indicates that nutrients may be furnished by an outside supplier to a beneficiary during the course of a covered Part A stay. In such a case, the services are covered by Part B since the SNF does not buy the items from the supplier.

It is unclear how a resident in a SNF could obtain enteral nutrition services other than by having the facility provide them, since this is generally his/her total nutritional intake. To have a resident responsible for providing his/her own food is contradictory to the SNF benefit to provide for dietary needs. If an outside supplier assumes the responsibility for a resident's nutritional needs, this also appears to abrogate the provider's responsibility to provide for dietary needs.

The provision of enteral nutrition services by a supplier can become even further complicated, since a SNF can perform as a supplier. If a SNF provides nutrients to a patient as a supplier rather than as a provider, the services may be billed to Part B. However, in <u>either</u> situation, the SNF is providing the services to the individual.

Dietary Services Requirement

Failing to include enteral nutrition services within the Medicare payment raises concerns about a facility's compliance with 42 CFR 483.35 which states that "the facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special needs of each resident."

INCONTINENCE CARE POLICY

Definition of Incontinence Care: Urological, Ostomy, and Colostomy: Some patients have an involuntary loss of urine, or permanent urinary incontinence, due to a permanently inoperative or malfunctioning urinary bladder and/or bladder outlet. The bladder problem may be due to a structural impairment of a body organ or result from a nerve dysfunction or obstruction. A urinary collection system is required for patients with urinary incontinence. Such a collection system may require an indwelling catheter or intermittent catheterization in addition to drainage bags or bottles and related supplies. Also, some patients may require a surgically created opening to divert urine or feces outside the body. These individuals require a collection system that attaches directly to the body and will require bags or pouches, as well as related supplies.

Medicare Coverage Requirements for Incontinence Items: Incontinence care supplies may be covered by Part A or B during a covered SNF stay and are considered a prosthetic device, since they replace all or part of a body organ. For the purposes of Part A coverage, incontinence services are included as inpatient ancillary services and included in the provider's allowable costs. These services are included as a Part A payment during a Medicare covered SNF stay. For coverage by Part B, the condition of urinary incontinence must meet a test of permanence. Permanency is present if the device is required for a long and indefinite period of time of at least three months.

Incontinence Care Services Can Also Be Paid By Part B During Covered SNF Stays.

As previously mentioned, incontinence services may be covered under Part A or B, depending upon who supplies the items. Although the coverage policy for incontinence care items is not as clear as that of coverage for enteral nutrition services, allowing Part B coverage may continue to relieve the SNF of responsibilities implied in the benefit.

Prior to 1972, the HCFA Providers Reimbursement manual specifically included incontinence appliances and supplies in the routine costs of a SNF, thus making them payable by Part A. After 1972, this clear listing was deleted from the manual. Incontinence items, provided by the SNF, are now included under inpatient ancillary services, which are included as part of the Part A payment.

The category of ancillary services allows certain services, not generally provided to all patients, to be considered allowable costs for Medicare payment. Thus, while food and nursing care are required by all patients, urological and ostomy items are not. Although these are individualized items, 1994 nursing home data indicate that 92 percent of all

nursing homes provide services to patients with indwelling catheters.[4] Incontinence items represent critical services for patients requiring them and, if not carefully provided, can lead to negative health consequences such as decubitus ulcers.

Further discussion in various manuals indicates that incontinence care items are generally considered services provided by a SNF; thus, they are extended care services.[5] However, convention has allowed coverage of these items to be determined at the individual SNF level. This determination resulted from the inclusion of incontinence items in the benefit category (referenced earlier) stating that such items are covered if they are "ordinarily furnished by such facility for the care and treatment of inpatients." Despite this categorization, none of the regulations or manuals specifically state that incontinence items should be covered in this manner. Once again, various references to urological and ostomy items state that when these services are provided by the SNF payment may only be made under Part B when Part A payment is not available.[6] Thus, if a facility does not choose to furnish incontinence items to its patients, it may allow a supplier to provide them and bill Part B of Medicare for the items.

SURGICAL DRESSINGS POLICY

Definition of Surgical Dressings: Patients who have undergone a surgical procedure requiring an incision or sharp debridement require surgical dressings in order to promote healing or to protect the wound from infection. Surgical dressings are therapeutic and protective coverings which are applied directly to wounds, either on the skin or opening to the skin. These dressings require regular changing and may be primary, applied to the wound, or secondary, used to secure the primary dressing (e.g. tape, elastic, gauze).[7]

Medicare Coverage Requirements for Surgical Dressings: Surgical dressings may be covered under Part A or Part B during a Medicare covered SNF stay. For purposes of covered Part A stays, these items are considered ancillary services. For Part B coverage, dressings must be required as a result of a surgical procedure. Further, they must be medically necessary to facilitate the healing of the wound or to protect it from infection.

Part B Coverage Of Surgical Dressings During SNF Stays Is Also Inconsistent From The Perspective Of The SNF Benefit.

Surgical dressings can also be covered by Part A or B during a covered SNF stay, depending upon who provides the service. However, this is a service that many would assume is included in a covered skilled stay, given the type of patients generally cared for in SNFs.

Surgical dressings, like incontinence items, were also included as routine supplies and costs of a SNF before 1972, but are now included as an inpatient ancillary service. Thus, they continue to be covered by Part A. In addition, dressings are included within the category of service, "other services necessary to the health of the patient as are generally provided by SNFs." As previously stated, these items are generally considered services provided by SNFs and would be considered as included within the Medicare SNF benefit.

However, the regulations applying to coverage of services in post-hospital SNF stays give sterile dressings as an example of a service categorized as "supplies, appliances, and equipment."[8] This category, as previously discussed, states that these are items included as a covered SNF benefit only if they are ordinarily furnished by the facility to inpatients. Thus, the decision to provide this item can be interpreted as being made at the individual SNF level. This further complicates the ability to decide what is the most appropriate payment source for surgical dressings during a covered SNF stay.

Over $70 Million Were Allowed By Part B For These Three Services In 1991 And 1992, When Much Of The Costs Could Have Been Borne By Part A.

The total allowed Part B payments for enteral nutrition services, incontinence care and surgical dressings were $70 million in 1991 and $74 million in 1992. While the amounts allowed for enteral nutrition services and surgical dressings remained relatively constant, allowed amounts for incontinence care increased substantially.

An additional concern which arises in the discussion of Medicare covered SNF care is whether these services are provided by the facility to some patients but by a supplier to other patients. The program requires that a facility use the same method for providing services to all of the patients requiring those services. This indicates that either the SNF would bill for all services, to Part A or B, or the supplier would bill for all services to Part B. We have no information on whether services provided to patients in the same facility vary. However, the potential to vary service delivery may also be an issue to examine.

Paying For These Services And Supplies Under Part A Could Save Medicare Money And Reduce Improper Incentives For Providers.

Payment for enteral nutrition services, incontinence items, and surgical dressings under the Part A program could result in savings to the Medicare program if the SNF acted as the purchaser and negotiated favorable pricing (lower than Medicare Part B allowed amounts).

To illustrate the implications for savings, we provide the following example. Currently, Medicare Part B reimburses enteral formulae (procedure code B4150) at the rate of approximately 61 cents per unit (100 calories). One large hospital buying group routinely obtains nutrients classified under procedure code B4150 for as little as 20 cents. Contacts with several nursing homes suggest that, in addition to hospitals, nursing homes may obtain nutrients at prices significantly below the 61 cent reimbursement level. Fee schedules used for Part B reimbursement may not represent an efficient delivery of service when compared to facility acquisition costs. If facility acquisition costs are indeed lower, and Medicare payment policy could reflect the lower costs, the program might save significant dollars. We are currently conducting an inspection to assess nutrient pricing for nursing homes.

Current policies allowing outside suppliers to provide supplies to nursing home residents through Part B can lead to excessive utilization. Previous work by the OIG examining the marketing of incontinence supplies found: 1) some suppliers engage in questionable marketing practices, 2) beneficiaries may be receiving unnecessary or non-covered supplies, 3) some suppliers present the nursing home with false or misleading information in order to get nursing home business.

Paying For These Services Under Part A Would Also Save Beneficiaries Money.

Part B billing for enteral and incontinence services and surgical dressings increases patients' financial liability for their care. Part B coverage includes annual deductibles and a co-payment of 20 percent. Unfortunately, the patient may not be aware that the provision of his/her enteral nutrition services may result in a greater financial responsibility in some SNFs but not others. The inclusion of these services would have resulted in beneficiary payment savings of $17.6 million in 1991 and $18.5 million in 1992.[9]

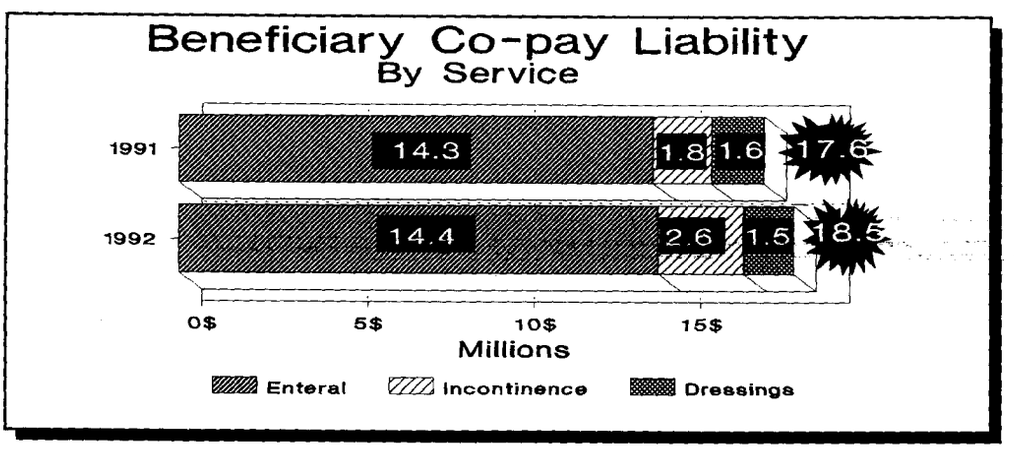


FIGURE 2

SOURCE: OIG Projections from a one-percent sample of Medicare beneficiaries.

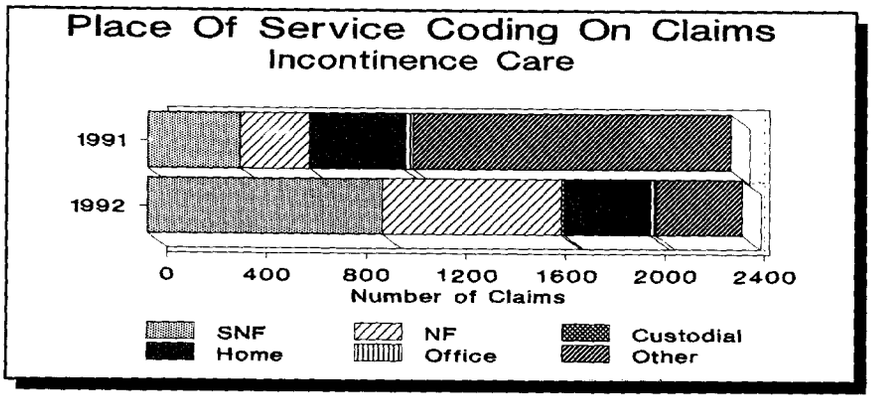
We recognize that a considerable portion of the co-payment savings discussed might shift to Medicare Part A, if Part B payment were prohibited. However, the potential savings described in the previous finding may offset these costs.

Coding Problems Exist On Claims Submitted For These Services.

Although the claims for enteral nutrition services, incontinence care, and surgical dressings reviewed for this report represented care billed during a Part A SNF stay, many of the claims represented the place of service as a location other than a SNF. While coding practices improved for both dressings and incontinence items, coding accuracy declined for claims for enteral nutrition services. However, the problem remained the greatest for incontinence claims.

Place of Service Coding Problems increased for Enteral Claims during SNF Stays.

Many of the enteral nutrition services provided to beneficiaries in a Part A SNF stay were indicated as being for individuals outside of the SNF setting. This may indicate continued billing by individuals who were previously in other locations, as was found to be occurring for other services billed during a SNF stay.[10] The use of a place of service code representing a place other than a SNF may also indicate that double billing is occurring for individuals who received services prior to SNF admission and continued receiving services, with both facilities billing. A further examination of place of service coding showed there were some patients with two billings, allowed for the same code and the same period, with the place of service coded SNF on one and NF on the other.



Although Place of Service coding for Incontinence Claims improved, the Majority of Allowed Claims indicated a Place of Service other than a SNF.

FIGURE 3

While Place of Service Coding has improved on Surgical Dressing claims, problems still exist.

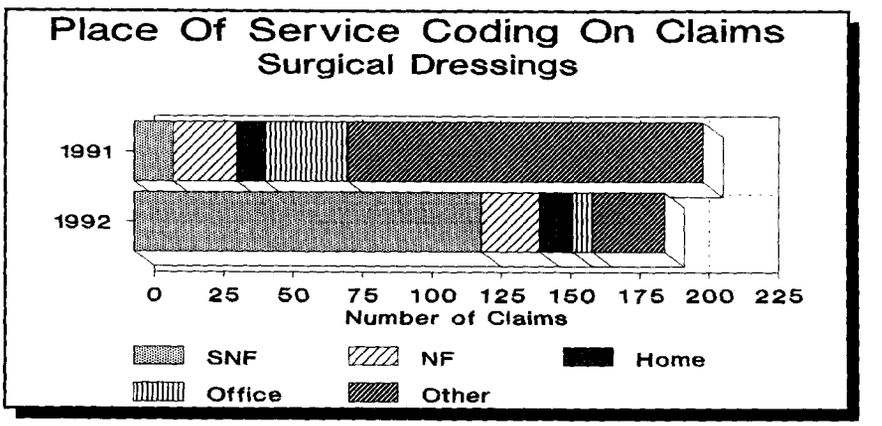


FIGURE 4

While correct coding on claims for surgical dressings have increased from seven percent in 1991 to 65 percent in 1992, problems still exist. Additionally, if the claims representing "office" as place of service are correct, this activity would indicate additional expenses involved for changing dressings. These expenses may represent transportation via ambulance for the beneficiary.

SOURCE: OIG Projections from a one-percent sample of Medicare beneficiaries.

RECOMMENDATIONS

The current fragmented manner in which Medicare payment is made for SNF residents is a result of statutory provisions originally intended to ensure access to care. This report demonstrates that the ability of a SNF to make use of both Part A and Part B to underwrite care to its residents can result in increased program expenditures and waste and may dissipate the SNFs' incentives to oversee the total package of care the resident receives.

In light of this, we recommend that:

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Comments were received from the HCFA, ASPE, and PHS on the draft report. The full text of the comments is included in Appendix C.

The HCFA and ASPE made suggestions about refocusing the recommendations to more clearly address the problems discussed in the report, which we adopted. Both HCFA and ASPE stated several concerns about language in the draft report raising questions about quality of care and about tying the problems discussed to residents' rights. We agree with HCFA and ASPE and have eliminated the language on these points.

Both HCFA and ASPE also raised questions about how savings might accrue to the Medicare program by implementation of the recommendations. We attempted to clarify our discussion of this point within the text of the report. It is true that merely shifting costs to Part A, without putting in place proper payment policies, accomplishes little. Medicare payment policies should both create incentives for prudent purchasing and reflect the economies achieved through prudent purchasing. As indicated in the report, the OIG plans more work on this subject, focusing first on payment for enteral nutrition.

Lastly, we adopted a number of suggested technical improvements made by the commenters.

ENDNOTES

1. The Office of Inspector General, Office of Evaluation and Inspections has produced a report entitled "Medicare Services Provided to Residents of Skilled Nursing Facilities, An Overview," OEI-06-92-00863. The report presents information on all Part B payments made in 1991 and 1992 for services provided to Medicare beneficiaries during Part A SNF stays.

2. The FDA classifies products that contain nutrients. Under current FDA policy, these products may be considered to be foods or drugs, or both, depending on their intended use as determined by the claims that are made for the product.

3. All four of the DMERC manuals have this and the following statements present. In addition, the Provider Reimbursement Manual, section 2203.1 E, provides the same information.

4. This figure comes from the Online Survey and Certification Annual Review (OSCAR) database. The percentage represents a combined total of all SNFs and all nursing facilities that have patients with indwelling catheters.

5. A rather disjointed discussion is provided on the extended care benefit and what is included in the benefit in both the law, regulations and manuals. While it appears that convention has included many items within the category drugs, biologicals, supplies, appliances, and equipment, this is not clearly indicated in either the regulations or manuals. Including incontinency items within this category allows for the items to not be covered, since this section indicates these items are only covered if the facility generally provides them to its inpatients.

The Intermediary Manual refers the reader to several additional sections, including the section referring to services covered under a Medicare Hospital stay and services covered by Part B if no payment by Part A is available. At the end of the discussion, it becomes clear that incontinency services, as prosthetic devices, are considered an extended care service under the section of the benefit "such other services necessary to the health of the patients." A further discussion within the Provider Reimbursement Manual, 2203.1 and 2203.2, discusses the routine and inpatient ancillary services included in the Part A SNF payment. Urological and ostomy care items are included within the ancillary services area.

The following provides more specifics on the references made to incontinence services in several places.

There are regulations addressing coverage of services in post-hospital SNF care at section 409.20. At 409.25 there is a reference to a category called medical supplies, appliances and equipment. Within this section there is a reference indicating that these generic items (medical supplies, appliances and equipment) are only covered by Part A if they are

ordinarily furnished by the facility to inpatients. However, no mention is made of prosthetic devices within this section. In fact, very few specific examples are provided in the entire section of items covered during a SNF stay. A clear interpretation of the Part A and B benefit is further complicated when wording is absent or is not consistent between the law, the regulations and manuals.

The discussion in the Medicare Intermediary manual, section 3133.9, indicates the SNF coverage area mentioned previously, "such other services necessary to the health of the patients," are covered if SNFs generally provide the service. This area is further defined as those "medical and other health services" that are listed in section 3110-3110.5. It is stated that the services listed in this section are generally provided by skilled nursing facilities and thus they are considered extended care services. Further discussion indicates that the SNF medical and other health services are basically the same as those included as inpatient hospital ancillary services. Within the listing of inpatient hospital services are prosthetic devices and more specifically, catheter, ostomy and colostomy equipment and supplies. The discussion also indicates that these items may be covered by Part B only if Part A coverage is not available. The reasons for Part A being unavailable are 1) benefits have been exhausted, 2) the 3-day prior stay requirement is not met, or 3) the patient is receiving a non-covered level of care. No mention is made that some of the items in this listing are not covered if the facility does not generally provide them to inpatients.

Within the discussion of the Part B coverage of incontinency care items contained within the secondary medical insurance regulations, section 410.10, these items are still referred to as "medical and other health services." However, when these items are covered by Part B, the regulation section 410.36(a)(2) indicates that incontinency items are included within an area called "medical supplies, appliances and devices," equipment is listed separately. However, there is no reference to such a category elsewhere.

6. Medicare Intermediary Manual A3 section 3137.

7. The information presented here and in the next section represents the most recent changes to the SNF manual.

8. Medicare Regulation 409.25.

9. For purposes of this calculation, a rate of 25 percent was used to account for deductibles and co-payments when assessing the burden to the Medicare beneficiary for Part B co-payments. This number is used as a conservative approximation of the deductible and co-payment portion of the allowed charges. A recent OIG report on Part B DME payments during SNF stays indicates that deductibles and co-payments accounted for 27 percent of the allowed charges.

10. The Office of Inspector General, Office of Evaluation and Inspections has produced a report entitled "Payment For Durable Medical Equipment Billed During Skilled Nursing Facility Stays" OEI-06-92-00860. One of the problems noted in this report was the

incorrect coding for the place of service. Often the place of service was coded incorrectly due to what appears to be the lack of knowledge of the patient's location.

APPENDIX A

CONFIDENCE INTERVALS

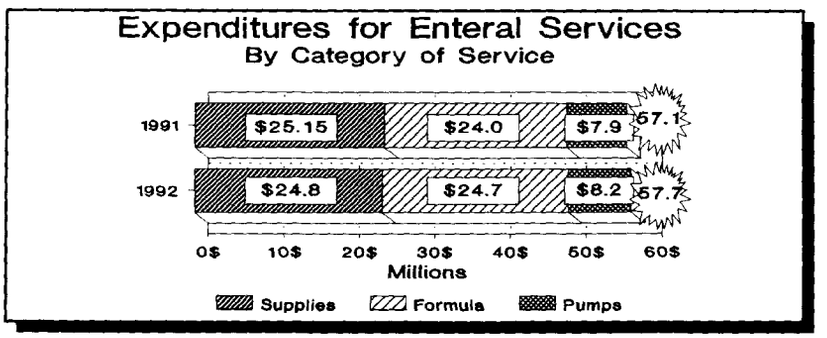
The following presents the 95 percent confidence intervals of the point estimates for the three services discussed in this report. We reported our findings by multiplying 100 by the point estimates in our samples. The point estimates represent the total Medicare allowance for each service as reported in Appendix B. The confidence intervals present the range of possible findings at the 95 percent level.

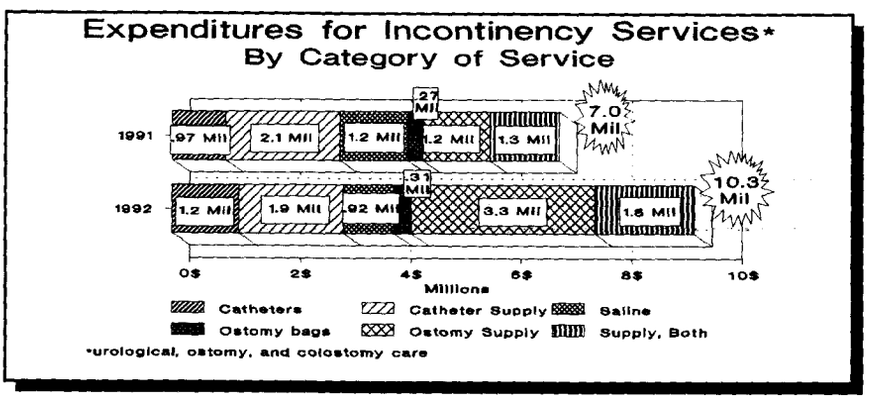
Year	Allowances	
	Projected Total	**95% Confidence Interval**
Enteral Nutrition Services: 1991 - 1992		
1991	$57,138,058	$55,769,606 - $ 58,506,510
1992	$57,724,751	$56,346,521 - $ 59,102,981
Incontinence Services: 1991 - 1992		
1991	$7,003,804	$6,529,793 - $7,477,811
1992	$10,357,533	$9,164,521 - $11,550,545
Surgical Dressing Services: 1991 - 1992		
1991	$6,275,711	$4,697,988 - $7,853,434
1992	$5,962,657	$4,636,487 - $7,288,827

APPENDIX B

MEDICARE EXPENDITURES BY CATEGORY OF SERVICE

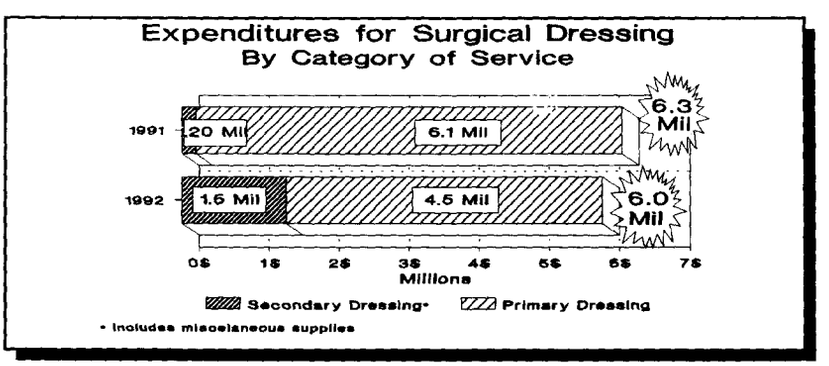
Medicare Allowed Approximately $57 Million in Part B Charges in 1991 and 1992 for Enteral Nutrition, Equipment, and Supplies.





Medicare Allowed $7 Million in 1991 and $10.3 in 1992 in Part B Payments for Urological, Ostomy, and Colostomy Services during Part A SNF Stays.

Surgical Dressings Accounted for $6.2 Million in 1991 and $6.0 Million in 1992 in Part B Payment for Beneficiaries in Medicare Covered Part A SNF Stays.



SOURCE: OIG Projections from a one-percent sample of Medicare beneficiaries.

APPENDIX C

TEXT OF AGENCY COMMENTS

COMMENTS OF THE PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date FEB 2 1995

From Director
Office of Resource Management, OM

Subject Office of Inspector General (OIG) Draft Report "Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities," OEI-06-92-00864

To Deputy Inspector General for Evaluations and Inspections, OS

The Public Health Service has reviewed the subject OIG draft report. We have no comments on the report's recommendations which are directed to the Health Care Financing Administration. However, we submit the attached technical comments for your consideration.

We appreciate the opportunity to review the draft report.

John C. West

Attachment

IG ✓
SAIG ✓
PDIG ✓
DIG-AS ✓
DIG-EI ✓
DIG-OI
AIG-CFAA
AIG-MP
OGC/IG ✓
EXSEC
DATE SENT 2/3

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE
OFFICE OF INSPECTOR GENERAL DRAFT REPORT
"MEDICARE PAYMENTS FOR NONPROFESSIONAL SERVICES
IN SKILLED NURSING FACILITIES,"
(OEI-06-92-00864)

The Public Health Service has reviewed the Office of Inspector General draft report and has the following comments.

TECHNICAL COMMENTS

1. The draft report indicates that the Food and Drug Administration (FDA) classifies products intended for use in enteral nutrition as food and not drugs in three places: page 4, third paragraph; page 4, fifth paragraph; and page 5, first paragraph. There are two significant points that we want to bring to your attention.

   - First, all three references to FDA policy use the terminology "enteral nutrients." In reality, FDA does not classify "nutrients," but classifies the products that contain the nutrients. It would be more accurate to use a phrase such as "Products that are intended for use in enteral feeding..."

   - Second, the statements that FDA classifies these products as foods are not completely accurate. Under current FDA policy, these products may be considered to be foods or drugs, or both, depending on their intended use as determined by the claims that are made for the product.

2. The draft report uses a variety of different words and phrases in its discussion on the provision of enteral nutrition services to patients. To improve the clarity of the report, we suggest that more precise terminology be used to discuss enteral nutrition services. We suggest that the report be amended in the following instances as indicated:

   Page iii, third paragraph, line 4: Replace "enteral claims" with "claims for enteral nutrition services."

   Page 2, first paragraph, line 3: Replace "enteral nutrients" with "enteral nutrition services."

   Page 2, second paragraph, line 2: Replace "enteral nutrients" with "enteral nutrition services."

   Page 6, first full paragraph, line 1: Replace "enteral nutrients" with "enteral nutrition services."

Page 6, first full paragraph, line 5: Replace "enteral services" with "enteral nutrition services."

Page 6, fourth paragraph, line 3: Replace "enteral policy" with "the policy for providing coverage for enteral nutrition services."

Page 9, paragraph at bottom of page, line 3: Replace "nutrients" with "enteral nutrition services."

Page 10, first full paragraph, lines 4 and 7: Replace "enteral nutrition" with "enteral nutrition services."

Page 10, last paragraph, line 1: Replace "enteral" with "enteral nutrition services."

Page 10, last paragraph, line 4: Replace "enteral services" with "enteral nutrition services."

Page 11, second paragraph, line 5: Replace "enteral service claim" with "claims for enteral nutrition services."

COMMENTS OF THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: FEB 23 1995

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities," (OEI--06-92-00864)

We reviewed the subject report which examines the appropriateness of allowing Part B payment for nonprofessional services included in the extended care or skilled nursing facility benefit. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendations.

Attachment

IG	✓
SAIG	
PDIG	✓
DIG-AS	
DIG-EI	✓
DIG-OI	
AIG-CFAA	
AIG-MP	
OGC/IG	
EXSEC	✓
DATE SENT	2/24

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
"Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities (SNF)"
(OEI-06-92-00864)

OIG Recommendation 1

HCFA should develop a regulation or legislative recommendation, as appropriate, to establish an enforceable requirement for SNFs to provide covered services within the Part A payment rate.

HCFA Response

We concur. We developed a legislative proposal that includes a SNF bundling requirement. This proposal would require SNFs to provide all nonprofessional services or supplies furnished to their patients, thus no payment would be made under Part B.

This program change should help to control overutilization of these services and result in reduced cost-sharing for beneficiaries since they would no longer be required to pay deductibles and coinsurance. This would also assist HCFA in tracking the cost of care in SNFs and developing a SNF prospective payment system.

OIG Recommendation 2

HCFA should clarify the Residents' Rights regulations, CFR 42 483.10, as to whether the care and services defined as included in the Medicare and Medicaid rate are required to be provided by the facility.

HCFA Response

We do not concur. The regulation is clearly related to both Medicare and Medicaid beneficiaries. Requiring the facility to include these services in its Part A bill could be accomplished only through legislation to prohibit outside suppliers from billing for unbundled services under Part B. We do believe, however, that it would be prudent to clarify 42 CFR 483.35 (Dietary Services) to include parenteral and enteral nutrition.

Additional Comments

We believe the report would be more helpful to its congressional readers if it began with a clear statement along the following lines:

"The current fragmented manner in which Medicare payment is made for SNF residents is a result of statutory provisions originally intended to ensure access to care. This report amply demonstrates that the ability of a SNF to make use of both Part A and Part B to underwrite care to its residents results in increased program expenditures and waste and may dissipate the SNFs incentives to oversee the total package of care the resident receives."

"Changes in Medicare payment rules to ensure that Medicare's SNF payments are appropriate would need to be made in the law. Given the longstanding nature of the current business practices of SNFs and the Part B suppliers, statutory change is the only way that change could be effectively implemented."

Background Section:

- The first sentence is misleading. Part A SNF stays are dependent on a specific set of conditions necessary for coverage that may result in up to 100 days of covered care per benefit period.

- The following statement is made: "The intent of this benefit is to shorten hospital stays while still providing coverage for a patient who requires regular nursing and professional intervention." It is incorrect to state that the intent of the benefit is to provide coverage for regular nursing and professional intervention. SNF coverage is dependent upon the need for skilled services on a daily basis following a prior 3-day qualifying hospital stay, which as a practical matter can be furnished only in a SNF.

- Please define "nonprofessional institutional service."

- The sentence, "Thus, payments should not be made under Part B for these services," is a conclusion and should not appear in the background section. Section 1819(b)(4)(A)(iv) of the Social Security Act currently allows for payment of certain services under either Part A or Part B.

Introduction:

- The conclusion that "separate payments for these services under Part B would seem inappropriate" is the purpose of the report, not the background.

- The report's reliability and validity could be enhanced with a more detailed discussion on the methodology utilized to select claims, how the data base of valid and reliable claims was developed, how a statistically valid sample size was determined, what data elements were utilized in the analysis, which files within the common working file were utilized, and how the matching of Part A to Part B stays was performed.

Findings:

- The ability of SNFs to provide services under arrangements does not remove responsibility from the SNF for the overall care provided to a beneficiary. It does allow the facility, to the extent allowed by law, to determine what costs will be subject to the SNF routine cost limit.

- Please state the source of the figures relating to payments to SNFs for enteral services, surgical dressings, and incontinence care items.

- To tie resident rights and quality of care issues to a loophole in the law that specifically allows for payment of these services (enteral nutrition, incontinence care, and surgical dressings) under the Part B benefit is fallacious. Further, there has been no violation of resident rights if the facility has informed the resident of facility charges as specified under 42 CFR 483.10(b)(6). Further, the report does not demonstrate that payment of these services under Part B has caused a negative outcome relating to quality of care nor has it presented a factual basis to promote this finding.

- Similarly, the statement that the practice of billing incontinence care services under Part B may have the appearance of compromising the quality of care provided is not substantiated and not supported by factual analysis.

- Failure to include incontinence services under Part A is not a failure to observe resident rights if the facility has informed the resident of facility charges as specified under 42 CFR 483.10(b)(6).

Discussion:

- These services are considered ancillary costs under Part A and are paid in full and are not included in the SNF routine cost limit. How will inclusion of these expenditures as ancillary costs under Part A reduce Medicare costs? SNFs are required to act as prudent purchases for these specific services.

- Is the OIG indicating that these services should not be paid as ancillary costs, but be subject to the SNF routine cost limit? If so, we believe that it is unlikely that SNFs would act as prudent purchasers without increasing their costs over the limit, when they are able to apply for exceptions to the SNF routine cost limits. In view of this, it is unclear where the cost savings to the program are to come from.

- Did the OIG question if the intermediaries' edits were turned on to check for incorrect coding? To speculate that it is lack of knowledge by suppliers is not recognizing the universe of potential problem areas that are directly program related. The OIG may wish to consider this issue more closely and make recommendations for improvement.

COMMENTS OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

IG	V
SAIG	✓
PDIG	✓
DIG-AS	✓
DIG-EI	✓
DIG-OI	
AIG-CFAA	
AIG-MP	
OGC/IG	✓
EXSEC	✓
DATE SENT	3/16

MAR 13 1995

To: June Gibbs Brown
Inspector General

From: Assistant Secretary for
Planning and Evaluation

Subject: OIG Draft Reports on Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities

We have reviewed the draft inspection report entitled, "Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities". The report discusses Medicare coverage of non-professional services in skilled nursing facilities (SNFs) and highlights concerns with current coverage policies that permit coverage of these services under either Parts A or B on behalf of persons residing in SNFs. While we generally agree with the findings in this report, we have the following comments.

A footnote indicates that the scope of the report is limited to persons residing in SNFs during a Part A covered stay (p. 14, footnote 2). We believe this information to be significant and recommend the scope of this report be incorporated in the text of the report rather than only referenced as a footnote.

While providing no evidentiary basis, the report suggests that allowing Part B coverage for services may have a negative impact on the quality of care. For example, the report states that "allowing suppliers to provide enteral services appears to raise quality of care concerns" (p. 6). Further, the report in several instances implies that allowing for Part B coverage for SNF residents relieves SNFs of their responsibilities (e.g., pp. i, 4, 6, etc.). These claims should either be substantiated or eliminated from the report.

The report states that "[p]aying for these services and supplies under Part A could save Medicare money and reduce improper incentives for providers" (p. 9). The report also indicates that in 1992 beneficiary liability for these services under Part B was almost $20 million and acknowledges that these costs, now paid by beneficiaries, would shift to the program if they were shifted to Part A. The report fails to indicate why or how saving would accrue under the proposal, but instead identifies the basis for added Medicare costs. The rationale that SNFs would be prudent purchasers is hardly compelling. Finally, given the absence of Part A fee schedules or cost limits for some of these services, Part A payments may not be less than Part B payments. In sum, the report needs to clarify its claim that Medicare could save money if Part B payments were prohibited for persons residing in SNFs during a Part A covered stay.

One recommendation advanced in the report is that HCFA develop a regulation or legislative proposal that would require SNFs "to provide covered services within the Part

A payment rate." While we generally agree with the thrust of this recommendation, we suggest it be clarified. As discussed in the report, SNFs may be considered suppliers of non-professional services and, as such, may bill Part B. Thus, a recommendation requiring SNFs to "provide" covered services will not be sufficient to prohibit Part B payments for nonprofessional services. In addition, given that the report is limited to persons residing in SNFs during a Part A covered stay, we recommend the recommendation be modified accordingly. This recommendation could be rewritten as follows:

> Prohibit entities other than the SNF from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care and surgical dressing and limit Medicare coverage of these services to Part A.

The intent of the recommendation to clarify that residents' rights include the SNF's obligation to provide care and services is unclear. Why this recommendation is needed and its effect need to be explained. Although current residents' rights requirements do not explicitly provide a right to receive needed care and services provided by the facility, elsewhere in the regulations there is a requirement that facilities provide needed services (e.g., 483.25). The report provides no evidence that facilities have failed to provide needed services. If the intent of this recommendation is to prohibit beneficiary financial liability for enteral nutrition, incontinence care, and surgical dressings, it should be modified to require inclusion of these services in the facility's Part A payment (and therefore not payable under Part B) and, by so doing, exempt residents from charges for these services.

David T. Ellwood

Prepared by: Susan Manfredi 690-7862 and Jennie Harvell 690-6445