Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENTS FOR REFERRALS OF PARENTERAL NUTRITON PATIENTS

A MANAGEMENT ADVISORY REPORT

JULY 1993

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. This report was prepared in the Health Care Branch under the direction of Penny R. Thompson, Chief.

Cathaleen A. Ahern, Project Leader

Lewis Morris, Deputy Chief Counsel, Office of General Counsel, Inspector General Division

For additional copies of this report, please contact the Health Care Branch at (410)966-3138.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENTS FOR REFERRALS OF PARENTERAL NUTRITION PATIENTS

A MANAGEMENT ADVISORY REPORT

JULY 1993 OEI-12-92-00461

INTRODUCTION

PURPOSE To alert the Health Care Financing Administration (HCFA) to payments being made to End-Stage Renal Disease (ESRD) facilities for referrals of parenteral nutrition patients.

BACKGROUND The Office of Evaluation and Inspections recently released a report on inappropriate payments for total parenteral nutrition (TPN), a "high-tech" form of artificial nutrition used by a small number of patients who lack functioning intestinal tracts. (See OEI-12-92-00460.) In the course of that inspection, we discovered that parenteral nutrition is used in ESRD facilities, in a way that does not comply with Medicare's coverage policies for this very expensive therapy. (When parenteral nutrition is infused at the same time as a patient is being dialyzed, the therapy is called "intra-dialytic parenteral nutrition" (IDPN).)

We recommended that HCFA instruct the specialty carriers who process claims for TPN to adhere to a strict interpretation of the coverage guidelines, and that HCFA review research concerning the clinical appropriateness of IDPN. The HCFA agreed with these recommendations.

While we reported on the use of IDPN in that report, we limited our discussion to coverage and clinical issues, rather than payment. In this management advisory report, however, we wish to alert HCFA to a serious kickback vulnerability identified in our research.

METHODS We examined a one-percent random sample of patients on whose behalf Medicare paid claims for parenteral nutrients or supplies in 1991. When we found that half the sample consisted of ESRD patients, we conducted a telephone survey of 93 randomly-selected ESRD facilities, inquiring about their use of IDPN, patient selection criteria, their choice of a supplier, and other issues. The respondent was usually a head nurse or other clinician, rather than a business officer. This survey forms the basis of what we are reporting here. The extent of use and clinical criteria for use of IDPN were discussed in the TPN report referred to above.

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

FINDINGS

Almost half the ESRD facilities we surveyed were using IDPN

The table below displays the use of IDPN in the facilities surveyed. Forty-five of the 93 facilities use IDPN. The 55 for-profit facilities (33 of which use IDPN) had 2.9 percent of their patients on IDPN; the 38 not-for-profit facilities (12 using IDPN) had 1.5 percent on IDPN. [1] The overall rate was 2.4 percent.

Facility	Stations	Census	No use	Past use	Current use	Patients
For-profit; 55	869	4126	12	9	33	109
Not for-profit; 38	534	2592	17	10	12	51
Total 93	1,403	6,718	29	19	45	160

As discussed in our earlier report, patients receiving IDPN account for more than half the number of patients with TPN claims, and one-third of the payments.

Some IDPN suppliers are paying ESRD facilities to administer their parenteral nutrients

In most cases, facilities arranged for IDPN to be supplied by an outside source. The outside supplier billed Medicare for the nutrients and supplies. Four hospital-based or -affiliated facilities procured the nutrients from the hospital's pharmacy. One large chain of dialysis facilities also is a supplier of IDPN. It supplied its own facilities, and was identified as the supplier of 21 of the facilities currently using IDPN (including 7 it owns). Two other facilities also reported that their parent company supplied their nutrients.

We asked the 45 facilities currently using IDPN whether their supplier paid the facility directly or indirectly for administering IDPN (usually this was characterized as "payment for the nurse's time" or "an administration fee.") The table on the following page displays the answers we received. Of the seven respondents who answered "yes," only one was aware of the amount ($60 per infusion, or $180 per week per patient.) Of the facilities not currently using IDPN, one said it had been paid $25 an infusion (or $75 per week per patient); a second facility was looking for a supplier and expected to be paid a per-bag or per-infusion fee.

[1] The designation of two facilities as for-profit is a correction of the table in our earlier report, in which they were incorrectly recorded as being not-for-profit.

Response to query about fee, rebate or payment	# Responding
Don't know about payments	21
Yes, facility receives payment	7
Believe facility is paid	2
Payment in kind (refrigerator)	1
No, facility receives no payment	1
Hospital supplies nutrients	4
Same parent company	9
Total	45

We obtained a copy of the "IDPN Service Agreement" used by the major supplier referred to above. The supplier's cover letter to the agreement says the service agreement is used to "allow us to reimburse your unit (on a fee for service basis) for the staff time required to administer IDPN and monitor the patient." The agreement itself shows $30.00 as the fee per parenteral therapy treatment. The fee is noted to be negotiable should Medicare increase or decrease its reimbursement rates for the therapy in question by more than 15 percent.

These payments appear to be illegal as well as unreasonably high

We believe that these fees may represent inducements intended to influence the selection of an IDPN supplier and to encourage the placement of additional patients on IDPN. As such, the payment would be in violation of the Medicare and Medicaid Anti-kickback statute, which prohibits the offer or receipt of remuneration to induce the referral of Medicare-reimbursed items or services. Our concern is heightened by the amount of these "administration" fees -- $75 to $180 per patient per week for the 5 to 7 months we found the average IDPN patient to be receiving nutrients.

The fees raise questions about the reasonableness of Medicare's reimbursement for IDPN, if over $9,000 a year can be paid for "administrative costs" when Medicare's reimbursement for IDPN is $30,000 to $40,000 per patient year. Dialysis facilities are paid a composite rate per treatment for dialysis, including supplies, laboratory tests, and certain drugs. The prospectively-set base rate ranges from $126 in a free-standing facility to $130 dollars in a hospital facility and is adjusted for area wage levels. Thus a $25-per-infusion administration fee would represent an additional 20 percent of HCFA's base payment. The IDPN nutrients and supplies themselves would account for another $230 paid on average per infusion. This payment is made to the IDPN supplier, not the facility. Our earlier report discusses why IDPN should cost less (rather than more, as it currently does) to administer than TPN, due to bulk purchasing, streamlined administration, and other economies.

CONCLUSION

We are concerned that the illegality of offering or receiving payments for referrals is not well understood by some ESRD facilities. We intend to alert the provider and supplier communities to the prohibition on payments for referrals through this MAR and other communication. The HCFA may wish to issue clarifying instructions as well.