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Health, Education and Human Services Division

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September 5, 1995

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

We recently issued a report about abusive billing practices for therapy services furnished to nursing home residents who are covered by Medicare.[1] In that report, we identified a number of methods that therapy providers used to maximize Medicare payments and made recommendations to the Secretary of Health and Human Services designed to remedy the problems through better controls. Subsequently, your office asked us to suggest how our recommendations could be implemented legislatively if the Subcommittee decided to do so. Noting that proposals have been made to require nursing homes to bill for all services furnished to residents rather than allowing outside suppliers to bill Medicare directly, your office also asked that we address how such a requirement could be accomplished legislatively.

Therapy services--physical, occupational, and speech--are covered under both part A and part B of Medicare, and nursing home residents can have their therapy paid under either part depending on the circumstances. If the resident qualifies for Medicare skilled nursing facility services, part A pays for necessary therapy. However, most nursing home residents do not qualify for skilled nursing facility care, and those that qualify usually only do so for relatively brief periods--the average covered stay was about 38 days in 1994, with an absolute limit of 100 days. Most other nursing home residents, including those dually eligible for Medicaid, have Medicare-covered therapy services paid by part B.

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[1] Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

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The majority of therapy services for nursing home residents are furnished by either nursing home-employed therapists or independent rehabilitation agencies that send employees to the nursing home. Medicare pays both nursing homes and rehabilitation agencies on a reasonable-cost basis for their services regardless of whether part A or part B pays. Under part B, the services may be billed by either the nursing home or the rehabilitation agency when the latter actually provides the services.

Our report identified widespread examples of very high charges for therapy services and the use of shell companies to inflate the reported costs of services. While Medicare has general reimbursement rules that can be used to remove excessive charges and costs from its final payment for therapy services,[2] applying these rules can be time consuming and resource intensive. Moreover, it did not appear that the rules were actually being applied. The one exception was in a case in which a specific rule applied--a salary equivalency limit on physical therapy services furnished by outside suppliers. This rule is much easier to apply than the general cost principles, and we noted that Medicare costs for physical therapy were growing more slowly than those for occupational or speech therapy.

To remedy the problems found, we recommended that explicit limits be established on the amount Medicare would recognize as reasonable for therapy services furnished to nursing home residents and that nursing homes and suppliers be required to bill for defined units of service. We also recommended that Medicare strengthen its certification requirements for rehabilitation agencies by requiring them to demonstrate their suitability as vendors before being given billing rights. This would also help prevent the establishment of shell companies whose purpose is primarily to submit claims to Medicare.

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[2]For example, the related organization principle can be used to remove excessive costs attributed to setting up a shell company to bill Medicare. Also, the prudent buyer principle can be used to eliminate from nursing home costs the effects of excessive charges by outside therapy suppliers.

LIMITING MEDICARE PAYMENTS AND STRENGTHENING CERTIFICATION REQUIREMENTS

If the Subcommittee should decide to implement these recommendations legislatively, there are several alternatives. First, Medicare law could be amended to require the Department of Health and Human Services (HHS) to establish the requirements we recommended. This option would require HHS to go through the rule making process in essentially the same way as if it administratively imposed the requirements. On the basis of past experience, this is a lengthy process and could take several years.

Second, the law could be amended to establish an upper limit on the amount that Medicare will recognize as reasonable for therapy services. Establishing an upper limit ensures savings because nursing homes and rehabilitation agencies with costs below the limit would only be paid their costs. Moreover, HHS could still use its other cost reimbursement principles in cases where costs are below the limit but contain unreasonable costs.

There are at least two possible ways to set the upper limit. The limit could be set at the amount established under Medicare's part B fee schedules for therapy services. The amounts vary geographically. For example, the Maryland carrier has three localities, and the amount for individual speech therapy ranges from $30.61 to $32.08 and occupational therapy from $20.16 to $23.56. Amounts in Arkansas are $27.36 and $18.07 for speech and for occupational therapy, respectively. An advantage of this method is that the necessary information already exists and the requirement could be implemented immediately.

Alternatively, the limits could be established as the salary equivalence for occupational and speech therapists, the method currently used for physical therapy. Medicare's actuarial staff have compiled data on occupational and speech therapist wages, benefits, and expenses that estimate costs ranging from about $35 to $47 per hour in the Continental United States. Alaska and Hawaii rates were between about $54 and $59 per hour.

Establishing an upper limit would implement our recommendation to set an explicit limit on the amount Medicare will recognize as reasonable for therapy services. It would only partially implement our recommendation to define what billable therapy units are, because the procedure codes for occupational and speech

therapy do not define the amount of time the codes cover. The codes could be later modified to add time units. The third recommendation--strengthening certification requirements--could be implemented by amending the sections of the law relating to therapy suppliers.

UNIFIED BILLING FOR NURSING HOME RESIDENTS

Proposals have been made to require nursing homes to bill for the services provided to their residents. Such a requirement would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services. For this same reason, unified billing would also assist Medicare if our recommendations were implemented.

Such a proposal could be implemented legislatively by amending the law to require nursing homes to bill for all services that nursing homes are authorized to furnish to residents, whether payment is sought from part A or part B. In effect, outside suppliers would have to have agreements with nursing homes under such a provision. Without an agreement, the supplier could not bill Medicare directly because the law would prohibit this, and the nursing home could not bill because it would not be financially liable or medically responsible for the care.

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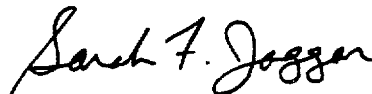
We hope this addresses the questions posed by your office. We will be glad to assist your office in drafting specific legislative language, if the Subcommittee desires.

If you have any questions about this letter, please contact Thomas Dowdal, Assistant Director, on (202) 512-7123.

Sincerely yours,



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