



LEGAL ISSUES

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Medicare Therapy Services: Finding the Right Balance

The Department of Justice (DOJ) actively pursues fraud not only in the housing and mortgage industries but in other industries as well — including among health care providers. The False Claims Act (FCA) allows the federal government to recover funds from improperly received reimbursements or billing to governmental programs, including those by health care providers: the DOJ recovered \$19.3 billion in health care fraud claims from January 2009 through September 2016.

Health care providers are frequently alarmed by the DOJ announcements of large fines and settlements from FCA cases. In recent years, FCA allegations have often involved the provision of unnecessary medical care — specifically, skilled therapy services provided to Medicare beneficiaries. As the DOJ's vigorous enforcement efforts continue to prevent abuse of governmental funds in the health care space, we should examine how the *Jimmo v. Sebelius* settlement slightly shifted the legal focus in the skilled therapy area.

Jimmo v. Sebelius

A brief discussion of the history of Medicare benefits as applied to skilled therapy may be helpful to begin. In the years before the *Jimmo* settlement, health care providers and Medicare beneficiary advocates protested the restrictive interpretation by the Centers for Medicare & Medicaid Services of skilled therapy, which would be covered only if the delivered therapy was producing continuing improvement in the patient's condition. In January 2011, Medicare beneficiary advocates filed suit against CMS in the case known as *Jimmo v. Sebelius*, and a settlement was reached in 2013. As part of the agreement, CMS was required to issue new information about skilled therapy coverage: therapy to prevent further deterioration or to preserve current capabilities would be covered as well. The previous requirement that continuing improvement was a necessity had been eliminated, and beneficiaries who were unable or unlikely to improve were no longer denied coverage.

CMS has posted a webpage on the *Jimmo* settlement (www.cms.gov/Center/Special-Topic/Jimmo-Center.html) that provides extensive information about the case and the maintenance coverage standard. After the suit was settled, Medicare beneficiaries received maintenance coverage therapy, and providers received reimbursement for those types of services.

False Claims Act Enforcement

In recent years both corporations and individuals have been pursued by the DOJ for FCA activities, and the DOJ continues to announce new cases and settlements almost every day. Some of these cases have included therapy services, although they usually pertain to services delivered before 2013, the date of the *Jimmo* settlement agreement.

Among the recent examples of health care providers making the news, the chairman of the board and a senior vice president of reimbursement of North American Health Care Inc. (NAHC) paid \$1.5 million (collectively) and the corporation paid a total of \$28.5 million

to settle FCA allegations brought by the DOJ. The NAHC allegedly delivered medically unnecessary rehabilitation therapy to inpatients at skilled nursing facilities between January 2005 and December 2011.

The Life Care Centers of America settlement also occurred in 2016. Life Care and its owner, Forrest Preston, agreed to pay \$145 million to settle a DOJ lawsuit. The allegations included Life Care's corporate policy of pushing SNF inpatients into the ultra-high reimbursement category for Medicare Part A services. "Ultra-high" is based upon 720 minutes involving at least two types of therapy (physical, speech, or occupational) delivered 5 days a week. This was alleged to be excessive, unnecessary therapy for residents that was not based upon their individual needs. The government rewarded the former employees who had brought these practices to light with a total of \$29 million as whistleblowers.

Only time will tell whether the DOJ's FCA actions related to therapy services

Palliative Specialists Urge Collaboration With Geriatric Care

Randy Dotinga

Palliative care and geriatric care share plenty in common, but the two fields aren't always on the same page. It's time for a better relationship to improve patient well-being toward the end of life, palliative specialists told colleagues at the 2017 World Congress of Gerontology & Geriatrics, presented by the International Association of Gerontology and Geriatrics.

"I do not feel the specialties are the same. There's a lot in geriatrics about valuing old people, and there's a lot in palliative care about the progression and complexities of symptom management. It's about respecting the differences as well the similarities," said Irene J. Higginson, PhD, director of the Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation at King's College London.

Diane E. Meier, MD, FACP, director of the Center to Advance Palliative Care, explained that palliative care doesn't just focus on those who are dying. "It now encompasses the care of all people with serious and chronic illness that affects quality of life," she said.

Palliative care is especially important because chronically sick people are responsible for so much of health spending in the United States, Dr. Meier said.

She pointed to a study by the Agency for Healthcare Research and Quality that found that 22% of health care spending — an average of \$90,061 per person — was attributable to 1% of the population in 2008. People in poor and fair health made up a large percentage of health care spending overall ("The Concentration and Persistence in the Level of Health Expenditures over Time," Statistical Brief 354, January 2012; <https://goo.gl/zEuvQV>).

Many people assume that much of this spending goes to care for dying people, but that's a "widely held myth," Meier said. She pointed to a 2012 Institute of Medicine report that notes that "not all deaths result in high spending, and not all high spending occurs near death." Indeed, the report estimates that only 13% of \$1.6 trillion in health spending goes to care in the last year of life (Health and Medicine Division, National Academy of Sciences, "Dying in America," 2014; <https://goo.gl/4S3nwC>).

Research proves that palliative care works, said Dr. Higginson. She led a 2014 study that linked early palliative support for breathlessness in respiratory patients to a higher likelihood of survival compared with a control

group. "A short-term burst of palliative care helped," she said, at no overall increase in cost (*Lancet Respir Med* 2014;2:979-987).

Dr. Higginson coauthored a 2013 Cochrane Library review that examined 23 studies and found that "home palliative care increases the chance of dying at home and reduces symptom burden in particular for patients with cancer, without impacting on caregiver grief" (*Cochrane Database of Syst Rev* 2013;6:CD007760).

A more recent Cochrane Review of seven studies found that "early palliative care interventions may have more beneficial effects on quality of life and symptom intensity among patients with advanced cancer than among those given usual/standard cancer care alone" (*Cochrane Database Syst Rev* 2017;6:CD011129).

Despite research findings like these, palliative care isn't always embraced as a crucial part of helping the ill, not just the dying, said Luc Deliens, PhD, director of the End-of-Life Care Research Group at Vrije Universiteit Brussel and Ghent University in Belgium. "Palliative care is often still terminal care in many countries in Europe," he said. "Many of the palliative needs of residents throughout

their illness are not addressed in a timely manner."

"Early integration of palliative care alongside life-prolonging treatments needs to be the model in nursing homes. Everyone should have basic skills in general palliative care."

What can be done? "Early integration of palliative care alongside life-prolonging treatments needs to be the model in nursing homes," Dr. Deliens said. "Everyone should have basic skills in general palliative care. If there are symptoms or other needs, you might need specialized palliative care services. In order to implement that kind of care at nursing homes, you need to change the culture." 

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will decrease in the post-*Jimmo* settlement era. Now that the published CMS interpretation permits maintenance therapy for inpatient and outpatient Medicare beneficiaries, the benefits for the SNF residents themselves have been positive. Many providers now are delivering needed physical, speech, and occupational therapy to individuals to prevent their further decline, maintain their current capabilities, and provide the strengthening and other needed therapies to decrease falls and regain activities of daily living.

Recommendations for Facilities

A review of the reported FCA settlements and cases highlights several common factors. For instance, the policies/practices of these companies consistently focus on reimbursement rather than on individual beneficiary needs; to this end, they encourage that therapies continue even when the therapists recommend otherwise. The following recommendations may assist facility leadership in avoiding allegations of excessive therapy.

- The clinical documentation must be reviewed on a periodic basis to ensure that the documentation supports the services rendered and the billing submitted for such services. Understanding the complexities of therapy services for Medicare beneficiaries — and particularly for beneficiaries in the skilled nursing setting — will ensure compliance with the requirements and avoid allegations of improper billing. Skilled therapy must support, maintain, and assist in the individual's
- Therapy plans of care must be based upon an individual's needs as determined by a thorough evaluation. One component of the facility quality review process should be a periodic review of the therapy services and needs for each therapy recipient.
- Before approving the plan of care, the attending physician must review the therapy plan to ensure that it reasonably meets the needs of the individual. Attending physicians can be an active partner to ensure the delivery of appropriate therapy services and ensure that without a signed order the care should not be delivered.
- Therapy services must not be driven by a percentage of revenue needs rather than the specific needs of individuals. When health care services are based on revenue rather than health care need, the regulators will apply heightened scrutiny.
- The professional judgement of the therapy and nursing staffs should be heeded. These staff have been professionally trained to understand the needs and tolerances of patients.
- Any financial incentives that an outside contracted therapy company may receive to increase therapy services should be required to undergo periodic review for quality data with a company leader.
- The appropriate checks and balances must be in place before billing for the rendered therapy occurs. If the therapy was part of a Part A stay, the required Minimum Data Set (MDS) must be locked and submitted before billing.
- Periodic pre- and post-billing audits must ensure that billing is completed in an accurate and timely manner, and within the requirements.

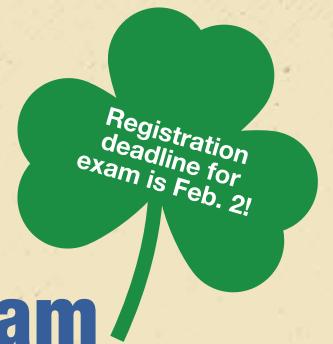
rehabilitation through an understanding of their abilities and expansion of their current capabilities. Medicare therapy must be medically necessary, with supportive documentation of service delivery.

Post-acute care leaders must advocate for the needs of the individual beneficiaries in their care, while balancing the complexities of medical necessity and billing requirements. Again, time will be the test of whether the FCA cases turn the focus away from the unnecessary

therapy area for services that have been provided since 2013. 

This column is not to be substituted for legal advice. Ms. Feldkamp practices in various aspects of health care, including long-term care survey and certification, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, OH.

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