

## **Fraud and Abuse Issues 2012: Fees for Face to Face and “Donations” to Referral Sources**

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As home health and hospice care continue to become more and more competitive and reimbursement continues to decline, referral sources are discovering new ways to leverage this for their own benefit. Two new examples include physicians requesting "administrative fees" to complete face to face paperwork and referral sources seeking "donations" from providers to defray the cost of capital equipment and other improvements. Providers need to understand the risks in these arrangements in order to avoid entering into arrangements that place them in violation of the Anti-Kickback Statute and/or the Stark Law.

### **ADMINISTRATIVE FEES FROM DOCTORS**

Many physicians object to the "burdens" placed upon them by the new face to face requirements. They are upset, because face to face has added an additional documentation requirement and this additional requirement takes time. CMS has responded to these objections by clarifying that a physician's staff may complete the face to face documentation from the physician's dictation and that the physician's electronic health record system can generate the paperwork from selections made within the system. These concessions were intended to clarify the physician's role and reduce the burden placed on physicians by the face to face rule.

Nevertheless, even with these changes, physician complaints have continued. Some physicians have begun addressing this burden by requesting home health provider pay an "administrative fee" for the physician's completion of the face to face paperwork. This administrative fee is supposed to compensate the physician for his or her time in completing the additional face to face paperwork.

Although a request for compensation in this situation causes many agencies a great deal of concern, many agencies are hesitant to refuse, for fear of losing the physician's referrals. Paying these fees is problematic for several reasons. The first issue is that CMS already reimburses physicians for certifying and recertifying home health plans of care ("POCs"). The second issue is that providing remuneration, such as these administrative fees, to a referral source raises Anti-Kickback Statute issues. When that referral source is a physician, the payment raises Stark Law issues as well.

Physicians can bill Medicare for certifying and recertifying a patient's plan of care. There are two specific codes a physician can use. The first, G0180, allows a physician to bill for the initial certification, and G0179, allows the physician to bill for recertifications. These codes reimburse at a rate that reflects CMS' assessment of the physician's time and effort to certify and recertify. In many cases, the physician will bill for the face to face visit itself as an office call with the patient. For more complex cases in which oversight requires more of the physician's time, the physician can bill Medicare for care plan oversight ("CPO"). CPO requires the physician to document time spent on specific services related to CPO to a total of 30 minutes within the same calendar month. Thirty minutes spent over the course of two separate calendar months will not satisfy this requirement.

CPO is not appropriate in every home health case. It is only appropriate in complex multi-disciplinary cases involving regular physician development and or revision of POCs, review of subsequent reports and patient status, review of related laboratory and other studies, communication with other health professionals not involved in the physician's practice, etc. This means that the physician cannot bill for CPO, simply because of face to face.

These codes provide a means for physicians to recover some reimbursement for the time spent certifying, recertifying and, in some case, overseeing POCs. It also makes it clear that CMS has considered the physician's effort and determined what it considers to be an appropriate level of reimbursement. When a physician asks you to pay an administrative fee, you should inquire whether the physician is aware of the ability to bill for certification, recertification and, in certain cases, care plan oversight. This may end the discussion. If it does not, explaining the fraud and abuse risks linked to this payment should.

The problem with a request for an "administrative fee" from the physician is that the "administrative fee" is remuneration being provided to the physician by a home health agency to which the physician refers Medicare patients. Providing remuneration to a physician referral source implicates the Anti-Kickback Statute and Stark Law.

The Anti-Kickback Statute prohibits providing anything of value, known as remuneration, to a referral source if even one purpose of the remuneration is to generate or reward referrals. The "administrative fee" requested by physicians is something of value. Providing this fee violates the "one purpose test", because the agency is willing to pay the "administrative fee" out of a concern that if they do not pay it, they will lose the referrals. This means at least one purpose of the administrative fee is to induce or reward referrals.

The payment of remuneration may be allowed under the Anti-Kickback Statute if the arrangement falls into one of the Anti-Kickback Statute's safe harbors. The safe harbor most often relied upon for payments to physicians and other outside professions is the personal services safe harbor. If the "administrative fee" can fit into this safe harbor, then the physician and the home health agency can avoid the Anti-Kickback Statute issues. Paying the

"administrative fee" will not fit into the personal services safe harbor, because the payment of the fee would fail to meet all of the elements of the safe harbor.

The Stark Law prohibits the referral of designated health services, which includes home health services, by a physician to an entity with which that physician has a financial relationship. A financial relationship can be a compensation arrangement or an ownership interest. Paying the administrative fee could be construed as a compensation relationship. Paying the administrative fees creates a financial relationship and the Stark Law would apply to any resulting referrals. The penalties for violating the Stark Law are not criminal, but include denial of reimbursement for services referred in violation of the Law.

Providers should also remember that claims for services that are generated by an arrangement that violates the Anti-Kickback Statute or the Stark Law are "false claims" for purposes of the False Claims Act ("FCA"). This means that any claims for services provided to patients where an agency has paid an "administrative fee" for the face-to-face certification could be subject to the FCA. The FCA allows not only recovery of the claims, but penalties of \$5,500 - \$11,000 per claim, as well as interest, treble damages and attorneys' fees. The risks of paying these "administrative fees" far outweigh any benefit of receiving the referrals.

### **DONATIONS TO A REFERRAL SOURCE**

Another new wrinkle in the world of home health and hospice fraud and abuse is the "fund raising" efforts of some referring providers. Some hospitals have been approaching not-for-profit hospices and suggesting that the not-for-profit hospice's related foundation make a donation to the hospital. The hospice to which the request is made is usually the only target of the fundraising effort or is aware that the only targets being solicited are entities to which the hospital refers patients.

The hospice receiving the request is usually left with the impression that failing to agree to the donation will have a negative impact on future referrals. When the hospice raises concerns about fraud and abuse, the hospital making the request states that the Anti-Kickback Statute does not apply to "donations." The hospital's cavalier approach to donations is not an accurate representation of the Department of Health and Human Services, Office of Inspector General's ("OIG") position on charitable contributions. When approached about making such a contribution, hospices and home health agencies should carefully consider the circumstances before making a "charitable contribution."

OIG has recognized that charitable efforts are a key piece of maintaining the "health care safety net," but OIG does not simply approve any arrangement described as a charitable or fund raising effort. OIG considers "charitable contributions" between potential referral sources to be a potential source of remuneration and reviews them as it reviews other forms of remuneration contributed between providers. OIG has issued numerous opinion letters on provider fund raising efforts and other charitable arrangements. These letters have been one place that OIG has expressly recognized the importance of charity, while, at the same time, analyzing the arrangement for potential Anti-Kickback Statute violations. Because OIG clearly considers charitable contributions to be a potential source for illegal remuneration, home health and hospice providers must carefully consider the fraud and abuse implications of any charitable request when they are approached by referral sources about donations.

There is one OIG Advisory Opinion that discusses the concept of a charitable contribution between providers under circumstances similar to the facts outlined above. (AO 07-07). In this opinion, a not for profit long term care provider ("the Facility") was seeking donations to assist it with implementing a new long term care model designed to "de-

institutionalize" nursing home residents. The Facility engaged in a "wide ranging" fund raising effort that included going outside of the health care community and contacting private individuals and businesses in the community. As part of its community wide effort, the Facility contacted a related not for profit hospital system and the system's not for profit charitable foundation. The Facility, the hospital system, and the foundation were all "related," because they shared directors, physicians, and had common origins.

The Facility solicited a \$100,000 contribution from the hospital system's foundation. This contribution was in line with contributions received from other entities of similar size and financial resources that were not a potential source or recipient of referrals. The foundation was willing to provide the donation, but intended to do so through a written grant that would have several conditions. The conditions included a prohibition on requiring referrals to the hospital system and a prohibition on tracking referrals to the hospital system or business generated by the hospital system.

When OIG analyzed the arrangement to determine if the arrangement implicated the fraud and abuse laws, OIG did not consider the fact that this was a donation from a not-for-profit foundation to another not-for-profit entity controlling. OIG considered this to be remuneration between providers who could be a source of referrals to each other. OIG was especially concerned about the potential for referrals from the Facility to the hospital system and analyzed the proposal as it does other arrangements involving remuneration. Ultimately, the OIG determined that the relationship could implicate the Anti-Kickback Statute, but that it would not impose penalties for this arrangement.

In making its determination that it would not impose sanctions, the OIG evaluated both the circumstances surrounding the solicitation and making of the donation and the relationship

between the parties after the donation. The OIG relied upon several facts about the circumstances surrounding the solicitation and making of the donation itself in concluding the arrangement would not be subject to sanctions. The OIG noted the donation from the foundation was unrestricted and neither the hospital nor its foundation exerted any influence over the use of the funds. It was also important that the donation itself was solicited as part of a broader, community based campaign to raise funds and the donation from the foundation made up only a small part of the fundraising efforts. This community-wide fundraising effort included solicitations to and donations from businesses and organizations in the community, both inside and outside the health care industry, in addition the donation that was the subject of the opinion request. The outreach also included individuals in the community. Finally, the donation from the foundation was a similar amount to donations made by organizations of a similar size and with similar financial resources.

The circumstances surrounding the donation approved in this opinion letter are much different from the referral source that solicits a targeted donation from a home health or hospice provider. In the scenario described at the beginning of this article, the provider was approached by a referral source and asked to make a donation, not as part of a larger community wide fundraising effort, but as a targeted effort. The only entities from which donations were sought were entities that received referrals from the hospital. There was no outreach beyond this group of referral recipients to a broader swath of the community. Furthermore, this request was, at least impliedly, linked to the continued receipt of referrals from the requesting provider. The circumstances of such a donation are significantly different and call into question the legitimacy of the "donation."

After examining the circumstances surrounding the donation, the OIG opinion then examined several factors related to the donation itself. The OIG noted that the donation was a one time fixed amount and that this amount was not determined based upon volume or value of referrals generated or otherwise determined in a manner that varied with the volume or value of business generated for the hospital system. The OIG also stated it was important that the donation did not require the Facility to purchase items or services from the hospital system. OIG stated that, as a provider that is paid on a per diem basis, the Facility had an incentive to be a prudent purchaser of items and services, regardless of the source of the donation.

Finally, as with many of these types of arrangements, OIG relied heavily upon the additional safeguards that were expressly included in the written grant from the foundation. These restrictions included a prohibition on the Facility requiring its staff and physicians referring to the health system; a prohibition on the Facility tracking referrals to the health system; any payments by the Facility to physicians or others affiliated with the health system would be limited to fair market value for arm's length transactions; and residents of the Facility would be advised of their freedom to choose providers.

In contrast to the arrangement outlined in the advisory opinion, the arrangement outlined at the beginning of this article contained no safeguards. The arrangement appears to be just the opposite, because the request implied that continued referrals are contingent upon hospice making the donation.

The OIG opinion letter also recognized that the donation to the Facility by the health system furthered the health system's charitable mission, because the Facility was attempting to develop an "affordable and innovative" senior care center in a medically underserved area. The fact that the entities were "related" in the sense that they shared physicians, directors and origins



was not surprising to OIG. OIG stated that this was expected, as was the fact that the entities would do business together.

Ultimately, OIG concluded that, because of the nature and purpose of the fundraising, the methods used in raising the funds, the breadth of donors, the charitable mission of the entities, and the controls put in place in the written grant, it would not impose penalties on the providers. None of these factors are present in the targeted donation solicitation.

There is one other key distinction between the approved arrangement and the scenario outlined above. That distinction is the direction of the remuneration. In the advisory opinion arrangement, the remuneration was flowing from the referral source, the health system. OIG's concern in that situation was the potential for the donation to generate referrals back to the health system, even though the Facility was not a referral source to the health system in the same manner the health system was a referral source to the Facility. In the scenario outlined above, the donation was sought by and would be provided to the referral source. Because the remuneration is going to the referral source, instead of coming from the referral source, it is even more likely the home health or hospice provider's donation would be linked to referrals and, therefore, be in violation of the Anti-Kickback Statute

The bottom line for providers is that you can make charitable contributions to further your charitable mission of providing health care. However, the fact that a donation is characterized as charitable does not mean that OIG will not scrutinize the arrangement when it involves a referral source. Providers must consider the circumstances surrounding the donation and safeguards related to the donation to ensure compliance with federal fraud and abuse laws as well as not-for-profit and similar IRS requirements.

## **CONCLUSION**

As the home health and hospice industries become more and more competitive, home health and hospice providers will need to be even more vigilant to avoid questionable referral relationships. Providers should say no to requests for "administrative fees" from physicians for completing face-to-face paperwork and be prepared to explain why such requests are problematic. Home health and hospice providers should also carefully consider requests for "charitable contributions" from referral sources. OIG has recognized the importance of such requests to the health care safety net, but such relationships are scrutinized like all other arrangements with referral sources that include remuneration. Home health and hospice providers should not simply assume because something is considered a "donation" or a "charitable contribution" it does not create fraud and abuse problems. Providers that wish to make such donations should carefully consider the arrangement in light of federal fraud and abuse laws.