

Legal Updates

CMS Released Final ABNs

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Home Health Agencies are projected to generate an overabundance of advance beneficiary notices this year, according to CMS. However, they may be curtailed if CMS decides to grant agencies more leeway.

CMS recently issued a new form and instructions for those additional occasions when HHAs must give their Medicare patients advance word of service reductions and terminations that necessitate more notices over existing requirements. This new form goes into effect June 1. However, CMS is developing further instructions on when ABNs will be required that may be less taxing to HHAs. Its goal is to accommodate industry concerns about a heavy ABN burden while still complying with patient-notification requirements imposed by a 2004 federal appeals court decision, according to a CMS staff member.

The ABN issue has been bounced around the regulations since 1999 when CMS began its efforts to expand ABNs beyond notices to patients when HHAs deny, reduce or discontinue Medicare-paid services.

On Feb. 21, CMS posted the final revision of its home health ABN, together with 15 pages of explanations of when and how the revised format should be used.

HHAs will have up to 90 days to change from use of the former version of the HHABN to the new revised notice, which has an Office of Management and Budget (OMB) approval date of "01/2006" in its lower left hand corner. CMS has posted the revised HHABN in English and Spanish on its website at: www.cms.hhs.gov/BNI/ Forms are also at the end of this newsletter.

Enticing attendance at visiting staff meetings

Does your agency have attendance problems at staff meetings? Here are some ways other agencies have improved attendance at meetings.

A Louisiana-based agency, found a resourceful way to entice visiting staff meetings. United Home care grew attendance at staff meetings 65% among its clinicians who get paid per visit by offering annual bonuses to the members

based on the number of in-services they attend.

Employees are graded based on performance factors, including the number of in-services they attend. The higher to employee's total score, the higher his/her annual bonuses.

A Texas-based agency decided to pay per-visit clinicians on an hourly basis to increase their non-visit related tasks. This resulted in attendance at mandatory meetings doubled after the salary change. Other agencies have linked non-visit related tasks to other incentives such as educational offerings. Bigger agencies have offered continuing education credits as a way to prompt meeting attendance. However, this can be costly and should not be attempted by small home health agencies that cannot absorb the costs.

The greatest advice is to not allow staff meetings drag on! Keep on track with time and your agenda!

Bankruptcy law and Health care Bankruptcies

Several provisions of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 are specifically targeted to health care bankruptcies.

In this Act, legislation provides an exception to the automatic stay for government action to suspend a debtor from participation in the Medicare program or any other federal health care program. Moreover, health care has been added to the limited number of industries with its own special

bankruptcy provisions. New provisions address such issues as patient transfers, record retention and disposal, and quality of care.

After October 17, 2005, when most of the Act's provisions took effect, health care providers may experience fewer patient bankruptcy filings, fewer charge-offs, and increased collections. The major provisions that are likely to produce these results include: mandatory pre-bankruptcy filing credit counseling; means testing and the ability to dismiss Chapter 7 cases or convert Chapter 7 cases to Chapter 13 based on a finding of abusive filing; and increased limits on dischargeability of debt and property exemptions.

For health care business that may be faced with bankruptcy, the Act recognizes health care entities as unique businesses subject to special requirements under the Bankruptcy code. The Act attempts to afford greater protections to patients whose health care providers have filed for bankruptcy. It requires health care business trustees or debtors in possession to adopt procedures for transfer of patient records if the debtor does not have sufficient funds to store the records in the manner required under fed or state law during the course of the bankruptcy. The Act further clarifies that the Secretary of Health and Human Services need not seek relief from the automatic stay of action against the debtor when suspending any debtor from participation in Medicare and other federal health care programs. It makes it easier

for the Secretary to recoup pre-petition overpayments or terminate debtors under Medicare and other federal health care programs, may negatively affect receivables collections as well as the future availability and structure of health care financing generally.



SUGGESTED PRACTICES FOR BANKRUPTCY ACT

Even though health care providers may experience improved patient collections after the implementation of the Act due to the changes affecting consumer bankruptcies which are generally thought to make it more difficult for individuals to have their unsecured, nonpriority debts discharged, some health care providers may face some pressure to compromise their claims with individuals prior to bankruptcy or risk having their claims reduced by up to 20% in a bankruptcy case.

Health care businesses that file for bankruptcy are likely to experience increased administrative expenses associated with, among other things, disposing of patient records, transferring patients, and compensating the patient care ombudsman. This may impair the ability of health care businesses to reorganize, limit the prospective recoveries to creditors, and convince concerned lenders to limit or

deny health care financing as well as demand additional collateral to secure their health care loans.

HHS will no longer need to seek relief from the automatic stay in order to terminate health care debtors from participation in the Medicare program, increasing its leverage and its ability to assert the rights to recoup post petition amounts owed against prepetition Medicare/Medicaid overpayments.

Any sale, transfer, or other disposition of property of a health care business in a bankruptcy case will need to comply with all applicable non-bankruptcy law. States' attorneys general, who have been increasingly active in health care transactions in recent years, are given explicit standing to intervene in health care bankruptcies on issues relating to the sale, use, lease or disposition of property.

FL Home Care Company Sued for Failure to Provide Care

The Florida Attorney General recently sued a home care organization alleging deceptive and unfair trade practices in the sale of contracts for its services to senior citizens in the state. The state alleges that InTrust Homecare, the home health agency, took more than \$146,000 from several dozen elderly Florida residents but never contracted or paid for any of the home care services it promised to provide. The product was not a contract for care, but allegedly promised to make available personal

care, housekeeping, meals, and laundry services for a preset price, which skirts around the regulations. InTrust was not a home care company and therefore could not provide care and services directly. The lawsuit also alleges InTrust sold similar contracts to residents of California, Virginia, and Illinois.

Update on False Claims Act Recoveries

According to Taxpayers against Fraud, nearly \$1 billion was recovered in the first quarter of fiscal year 2006 alone. In the first three months of FY 2006, health care False Claims Act recoveries have included a \$704 million settlement with Serono inc. for the allegedly illegal marketing of Serostim, a \$124 settlement with King Pharmaceuticals, a \$40 million settlement with Erlanger Medical Center in Tenn. and a \$62.55 million settlement with Tenet Healthcare.

"To put this into perspective, the \$17 billion recovered from companies cheating the U.S. government [since 1986] represents a stack of \$100 bills more than 16 miles high," TAF says.



Reg Alert: Labor Certification for the Permanent Employment of Aliens in the US

The Department of Labor is publishing a Notice of Proposed Rulemaking with request for comments to enhance program integrity and reduce the incentives and opportunities for fraud and abuse related to the permanent employment of aliens in the US. The DOL is proposing to eliminate the current practice of allowing the substitution of alien beneficiaries on permanent labor certification applications and resulting certifications. In addition, the DOL is proposing a 45-day period for employers to file approved permanent labor certifications in support of a petition with the Dept of Homeland Security. Next, the proposed rule expressly prohibits the sale, barter, or purchase of permanent labor applications and certifications, as well as other related payments. Finally, the proposed rule includes provisions highlighting existing law pertaining to submission of fraudulent or false information, clarifying current DOL procedures for responding to possible fraud, and adding procedures for debarment from the permanent labor certification program. Interested persons are invited to submit written comments on the proposed rule on or before April 14, 2006.

Third Party Billing Practices

Many home health agencies have been contacted by someone

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wanting to do their billing. This trend has prompted the OIG along with the Healthcare Billing and Management Association to review drafts of their Model Compliance Guidance for Third Party Billing Companies, which are not subjected to the NPRM process. Third party billing companies that operate ethically can provide a valuable service to providers and suppliers who seek out their help in submitting claims correctly and efficiently. These firms vary greatly, performing a wide variety of services from simply formatting claims for submission to Medicare and private insurance companies to managing the entire "business end" of provider practices. However, improper third party billing practices can pose a significant threat to Medicare. Billing companies that engage in behavior that gives rise to false claims can be held accountable under the False Claims Act. Under current regulations, CMS reviews these arrangements only when new Medicare providers or suppliers ask that their payments be made to an agent. These reviews have led to an increase in the number of third party billing contracts that comply with existing laws and regulations. However, when billing companies assist in preparing bills or coding, but do not actually receive payment, they generally are not regulated. Billing arrangements for providers who entered the program before 1996 are not reviewed, and our overall ability to monitor third party billing practices is quite limited.

For email transmission of this newsletter, send your email address to pbmlaw@msn.com

P & B Bits O' News

 Liz just came back from Vegas and is now headed to Cabo San Lucas in March!!

 Join us in congratulating Lauren for taking her bar exam in Feb!

 **Coming soon...**Market Policies & Procedures Manuals co produced by Pearson & Bernard and Heitzman Ullery, Inc.

Upcoming Conferences



**Liz--Power Home Health Referrals
Orlando, FL May 10-12
Sponsored by ...Home Health Line
Call (866) 620-5939 or register online
at: www.powerreferrals.com**

**Liz—Owner/Administrator Seminar
Cabo San Lucas March 28-31
Sponsored by Medicare Training &
Consulting
Call Jim Plonsey at (708) 895-0381 to
register**

*“Most of the things worth doing in the world had
been declared impossible before they were done”*

Justice Louis D. Brandeis

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