

Rules and Regulations applicable to housecall physicians: a guide to staying out of trouble

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Background:

Although mandated as part of the OBRA 89 legislation, home visit resource-based relative value units (RVUs) for physician work were never scored and approved until 1998, essentially doubling the reimbursement to physicians from historical averages. Numerous problems remain, however, in the attempts by a growing number of physicians to achieve valid reimbursement for their services. Most of these problems are due to the office-based mentality of the AMA and CMS officials wherein no real community standard of care exists for the practice of comprehensive medical care in the home environment, and the patient population served is, by their very nature, incapable of active political pressure.

There are three major, remaining financial pressures making the housecall fiscally risky for physicians. First, current work RVUs and the applied, but never scored, practice RVUs for physician home visits specifically exclude the entire cost of physician time and expenses of travel to and from a patient's residence.

Secondly, home visits specifically attract, and are appropriate for, an indigent care population of Qualified Medical Beneficiaries who are dually-eligible for Medicare and Medicaid (over 50% of patients in most housecall practices). Since Medicaid programs rarely allow a home visit fee over 80% of the Medicare allowable fee, physicians must not only write off the travel expenses, but the 20% co-pay for over half of their patient visits.

Thirdly, housecall practices attract patient requests for services from rest homes, or "domiciliary" visits in CMS vernacular, wherein the existing family of visit codes used has never been upgraded by the scoring process mandated in 1989. These visit codes allow approximately \$100 less per visit to the physician performing essentially the same service to the same patient in their private residence. We are optimistic that the AAHCP-sponsored efforts in 2005 will go far in correcting this anomaly.

Numerous other problems remain in the reimbursement system, but the intense public demand from an aging demographic and physician satisfaction in a home-based delivery system has created significant pressures to stress ethical, if not legal risks for the unwary physician.

Anti-Kickback Risks:

A full-time housecall physician can make an average of 8 home visits daily delivering quality medical care using portable lab and other testing instrumentations, including portable Xrays. The Stark Final Rule (66 FR 856, 01/04/2001) provides specific guidance for medical groups of home care physicians with regard to:

1. Establishing the ancillaries exemption from self-referral rules for medical groups
2. Defining what, in fact constitutes a medical group
3. Describing what level of supervision is required for employees of physicians or groups performing “incident to” services
4. Describing the specific exceptions to such rules for housecall physicians.
5. Describing what legal financial relationships may still be available between physicians and DME companies.

Ancillary Exemption:

Any physician personally performing a test medically reasonable and necessary in the treatment of a patient is exempt from application of the prohibition upon self-referrals. In addition, a W-2 employee of that physician or group acting under appropriate supervision rules for reimbursement may perform such tests on behalf of the physician.

For example, a physician drawing blood and performing a portable lab test under his, or his group’s CLIA certificate during a home visit is not making a self-referral. However, a physician ordering an Xray done by an employee of another organization with which he has a financial relationship (i.e. receives remuneration in cash or in services) has made a prohibited referral, even if no cash is directly received by the physician from the Xray proceeds. In addition, some State regulations (e.g. California) may place restrictions on phlebotomy by physician’s employees in a patient’s residence.

Since lab instruments such as the iSTAT cost \$8,000 each, and a portable Xray van costs upwards of \$75,000, physicians cannot afford to travel

around with such capital costs unless there is an economy of scale. Physicians, therefore, organize in a medical group so as to share the capital expense of such equipment and other infrastructure services (transcription, billing and collections, etc). Of these, the most important is the Call Center, which aggregates patient and home health nurse calls to a central location for triage and routing to the appropriate member of the group.

If the medical group qualifies as a legal entity under Medicare rules, the ancillary services exemption applies, allowing members of the medical group to order lab and xray, as well as make cross-specialty referrals within the group without fear of making a prohibited referral.

Since the vast majority of homebound elderly and disabled will qualify for services, a full-time housecall physician will average about \$1 million in downstream referral revenues to home health durable medical equipment. Obviously, such companies are more than happy to provide benefits and relationships (such as shared use of a Call Center) to the physician, which will stress, if not break, existing rules. CMS rules have been promulgated for many years on these issues, and it is doubtful any leniency remains in their interpretation.

The Housecall Medical Group and Group Practice Requirements

By their very nature, groups of physicians making housecalls are in the field all the time and rarely have access to the sort of group behaviors normal in a typical medical arts clinic. Fortunately, the “same building” requirement for medical group status was specifically described for housecall physicians: “A home care physician whose principal medical practice consists of treating patients in their private homes meets the “same building” requirements if the physician (or a staff member accompanying the physician) provides a designated health service contemporaneously with a physician service...that is not a designated health service in the patients’s private home and the other exception requirements are met.” (66 FR 888) Thus, an ER physician moonlighting for a few housecalls a month or using personnel he does not employ for testing would preclude the physician from providing services within a bona fide medical group structure.

Specific reference is made that “A mobile van or trailer is not a building or a part of a building.” Thus, physicians walking patients out to their van for an exam or using a room in a residential care facility to examine patients are not eligible for billing the home visit codes.

However, no other concession was made for medical groups whose sole purpose is to provide housecalls. Hence, “These building rules are designed to give physicians and group practices a meaningful opportunity to provide bona fide in-office ancillary DHS to their patients, while preventing group practices from using the in-office ancillary services exceptions to operate enterprises that are functionally nothing more than self-referred DHS enterprises, providing minimal services that are not DHS so as to comply nominally with the exception and capture DHS profits.”

Other specific rules were described regarding the use of mobile units, such as a portable Xray unit. Such a unit, or mobile lab, qualifies for the ancillary services exception “only if it is used exclusively by the group practice or group practice physicians, that is it is wholly owned by the group practice (other than a security interest held by an unrelated lender or mortgagor) or is leased or subleased by the group practice on a full-time basis.” (66 FR 892) Under regulations first proposed in January 1998, “shared facilities are permitted if they comply with the supervision, location, and billing requirements of the in-office ancillary exception.”

Billing Requirements

OBRA 1993 requirements have been maintained clarifying that “in-office ancillary services that are billed by a group practice of which the referring or supervising physician is a member must be billed under a billing number assigned to the group practice.” “Billing may be done by independent third party billing companies if they are acting as agents of a solo practitioner, group practice, or entity, but the billing must be done under billing numbers assigned to the solo practitioner, group practice, or entity, and the services may not be separately billed under a billing company’s number.”

Prior to January 1, 2001, it was clear that members of a medical group had to be W-2 employees under the IRS meaning of the status to be members of a medical group and bill under a common provider number. Since housecall physicians operate as independent contractors, this increased fiscal and management burden was difficult for all but very large or subsidized (though a management services organization, for example) housecall groups. The Final Rule in January, 2001 defined that independent contractors could, in fact, be a “physician in the group” for purposes of the personal services exemption or as a supervising physician for the in-office ancillary services exemption.

The Group Practice Definition

Since 1993 it has been clearly stated in multiple publications such as defined in section 1877(h)(4) that “a group practice is a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association...”

Whereby:

+”each physician member of the group furnishes substantially the full range of services that the physician routinely furnishes, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel (the ‘full range of services’ test)”

+”substantially all of the services of the physician members of the group are furnished through the group, are billed under a billing number assigned to the group, and amounts so received are treated as receipts of the group (the ‘substantially all test’)(revised by OBRA 1993).”

+”the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined (modified by OBRA 1993)”

+”members of the group personally conduct at least 75 percent of the physician-patient encounters of the group practice...”

+”the group practice complies with all other standards established by the Secretary in regulations”

In January, 2001, special rules were added to allow physician payment in a group practice “...so long as the share or bonus is not determined in any manner that is directly related to the volume or value of referrals by the physicians....”

In 1995, the Final Rule covering clinical lab services referrals required that the group practice be a “single legal entity.” In 2001, discussion was held on expanding the group practice concept to allow multi-entity legal structures and structures owned by a single physician. However, the 2001 rule also substantiated the “unified business” concepts and expressly prohibited paying “physicians any bonus based directly on their referrals of DHS that are performed by someone else” (66FR 895). In addition, this 2001 Final Rule retained the “bright line” that a “group practice must be a single legal entity.” This entity must now:

+be recognized by the State in which the entity achieves its legal status
+must be formed primarily for the purpose of being a physician group practice.

Note that this definition of a group practice “does not include a loose confederation of physicians, a substantial purpose of which is to share profits from referrals (sometimes referred to as a “group practice without walls”, or separate group practices under common ownership or control through a physician practice management company, hospital, or health care system, or other entity or organization.” (66 FR 897).

Problems Unique to Housecall Medical Group

The complexity of these regulations and rules defies even most lawyers’ attempts to decipher an adequate legal entity within which to receive Medicare and Medicaid reimbursements for housecall services.

First, there is the CLIA license and associated rules for lab designated health services using \$8,000 instruments which may actually be needed only every 10-20 home visits.

Then, there are State and DHS restrictions on a \$75,000 Xray vehicle, only one of which is required for every 6-8 full-time housecall physicians.

Then, there are the Fair Labor State laws such as existed in California, which can mandate 30 minute breaks every 4 hours, and overtime pay for a driver/tech employee whose schedule must be merged with the physician’s daily routine.

Further, there is the fierce autonomous nature of independent contractor physicians, out of sight of any conceivable management team, and able to use the corporate practice of medicine act (which provides for absolute physician autonomy) to change any applied structure of an efficient nature.

Then, there is the inadequate reimbursement from home visit revenues, which is woefully short of providing income for legal advice, continuing management advice, tech/drivers, or even proper equipment to make housecalls on sick and frail elders.

Not the least of the problems is the “targeted” nature of home visit codes which are associated in the minds of virtually all CMS officials with fraud and abuse (not without reason) and are constantly a source for audit. The Medicare Carriers have no experience in pre or post payment screens for these unique home visits and their ancillary services, and usually apply office-based reasoning to deny charges up to the Fair Hearings level of appeals. One glaring example is the use of “frequency” to deny payment. Despite the fact that home care patients have, on average, five chronic conditions, and thus average 37 physician encounters annually according to CMS data, Carrier screeners will often find that monthly visits are too frequent to be “medically reasonable and necessary.”

Things to Watch Out For:

The combination of complex and restrictive rules which only partially allow for the unique nature of housecall medical groups, the diminutive clinical reimbursements, and the clamor for our attention by downstream vendors in home health and DME leads to a number of structures clearly intended to violate the law. Although the more recent regulations can be specifically applied to such loose structures, the easiest way for a physician to get caught is by ignoring the intent of the original Anti-Kickback Statute: if a physician receives any form of remuneration, such as cash, free transportation, free driver, subsidized office support, or merged utilization of a Call Center with a Designated Health Service, he/she is probably in violation of the law.

If I were an investigator looking for suspicious signals, I would concentrate on:

- +housecall physician support from a management company with ties to DME or home health agencies
- +physician use of a driver that is not their employee
- +physicians using vehicles they don't own or are not owned by a bona fide medical group by which they are employed
- +use of non-licensed personnel to perform lab tests or Xrays in the home when not a W-2 employee of the physician and personally supervised by the physician
- +physicians billing home visits under their own name but using joint marketing materials
- +payment of physicians which consists of more than 60% of actual collections from Medicare patients (implies a hidden subsidy somewhere)
- +use of dually-designated drivers, who also work for a DME company part-time

- +sharing of office space with a home health or DME company
- +sharing a Call Center with a home health or DME company
- +physicians claiming group status without a “standards of conduct” manual or periodic meetings for educational purposes
- +hidden financials from any or all of the physician providers
- +separate status or payment for W-2 and contractor physicians
- +most importantly, channeling or streaming by a medical group for home health or DME referrals to one or two agencies when many options are available
- +calls made by a mid-level practitioner with no corporate or formal business relationship with their physician supervisor

Perhaps any one of the above situations can be legally and ethically explained, or even supported financially by a large group with high-volumes of new patient home visits, but combinations of such characteristics will undoubtedly mark organizations designed to get around the intent of the law against prohibited referrals to the lucrative homehealth and DME industries.