Compliance Today - February 2021
Conditions of participation vs. conditions of payment

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It is important to understand the difference between a Medicare condition of participation and a Medicare condition of payment when it comes to reviewing and determining the best way to handle a potential documentation, coding, and/or billing issue. Of course, this discussion is fact specific and will need to involve the advice of your legal counsel, but it is helpful for compliance officers to be aware of a few things, such as when something is an overpayment and when they are at risk of submitting a false claim.

Some courts have dismissed False Claims Act suits after determining that the allegations involved conditions of participation rather than conditions of payment and therefore did not involve false claims for purposes of the False Claims Act.[1]

An example of a requirement that appears to have changed from a condition of participation to a condition of payment is in home health. Effective January 13, 2018, the plan of care condition of participation under 42 C.F.R. § 484.60 also appears to have become a condition for payment under the home health benefit, 42 C.F.R. § 409.43 . This would mean that all the elements must be in the plan of care or Medicare payment will be denied.[2]

For hospitals, the conditions of participation are found at 42 C.F.R. § 482 . The conditions for Medicare payment are found at 42 C.F.R. § 424 .

Conditions for Medicare payments

> **[42 C.F.R. § 424.5] Basic conditions.**
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> (a) As a basis for Medicare payment, the following conditions must be met:
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> (1) *Types of services*. The services must be -
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> (i) Covered services, as specified in part 409 or part 410 of this chapter; or
>
> (ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with [42 C.F.R. §§ 405.332–405.334], pertaining to limitation of liability.
>
> (2) *Sources of services*. The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.

> (3) *Beneficiary of services*. Except as provided in [42 C.F.R. § 409.68], the services must have been furnished while the individual was eligible to have payment made for them. ([42 C.F.R. § 409.68] provides for payment of inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)
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> (4) *Certification of need for services*. When required...
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> (5) *Claim for payment*....
>
> (6) *Sufficient information*.

1 Saul Ewing Arnstein & Lehr LLP, "Conditions of participation vs. conditions of payment – a recent trend in False Claims Act cases," JD Supra, October 1, 2014, https://bit.ly/3gFma00.
2 HomeCare, "Home Health Condition of Payment Update," news release, January 11, 2019, https://bit.ly/30LEpuO.