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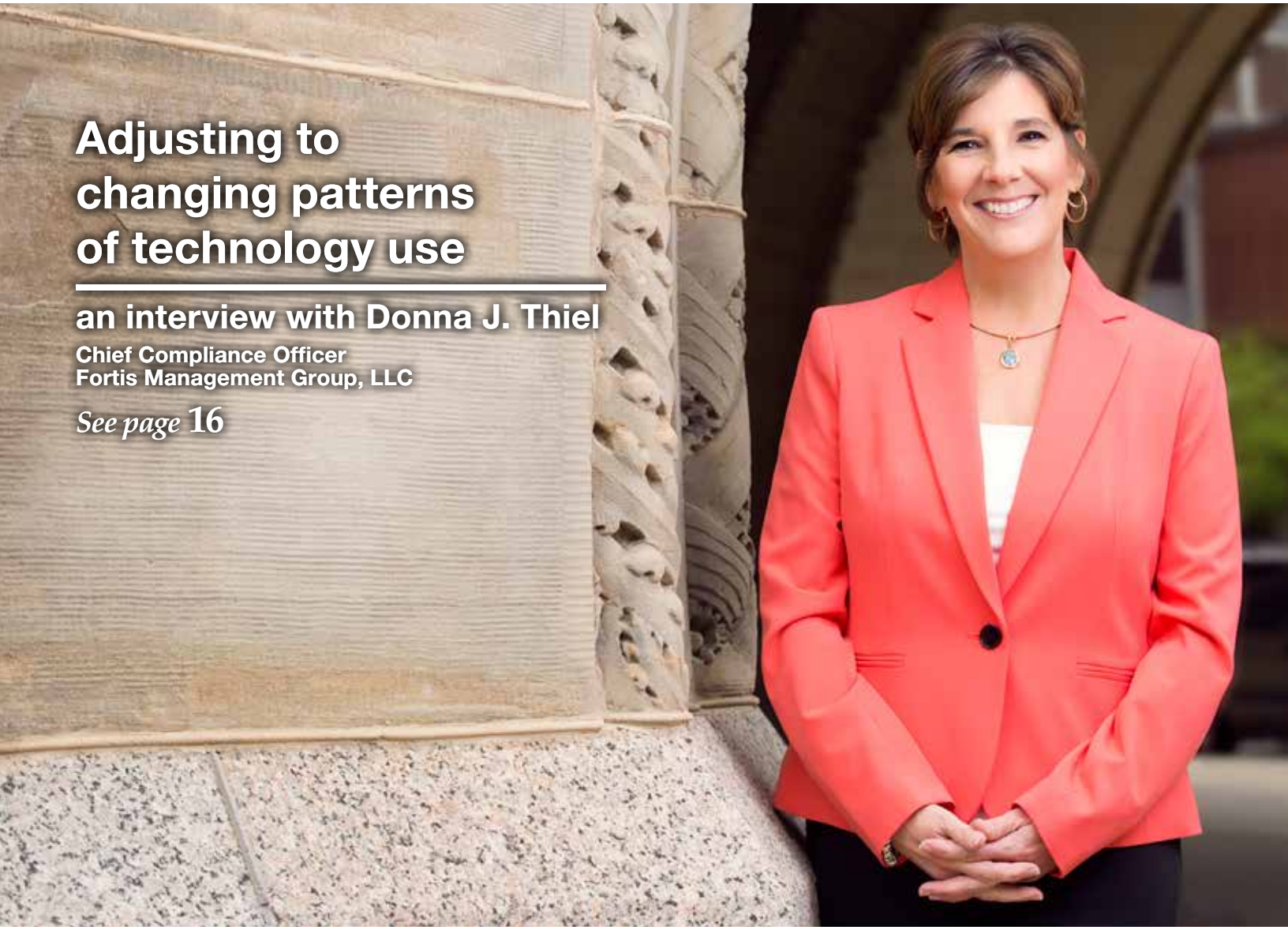

Adjusting to changing patterns of technology use

an interview with Donna J. Thiel

Chief Compliance Officer
Fortis Management Group, LLC

See page 16

by Tom Ealey

Fraud in therapy billing: Here we go again

» The federal government is really serious about therapy False Claims Act cases, committing major resources and filing major litigation. There is also a potential for criminal charges.

» Whistleblowers and their private legal counsel are common and can be very aggressive.

» Revenue generation cannot trump standards of care, as in "reasonable and (medically) necessary."

» False Claims Act therapy cases usually stem from a top-down push by a stock-driven corporate culture, and there is an appearance of executives overriding the corporate compliance program.

» In long-term care, everything is documented in great detail, including the evidence needed by the federal government for a false claims action.

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Therapy services are an integral part of the long-term care (LTC) plan, and therapists are an integral part of the care team. Therapy can have considerable value both for rehabilitation patients (e.g., post-operative hip replacement) and for LTC residents. Medicare reimbursement allows therapy for residents with varied payment sources, and the Office of Inspector General (OIG) is determined to guard the Medicare checkbook.

Ealey

The federal Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a program begun in 2009 to bring a major force against healthcare fraud and abuse. The HEAT is on!

A little history

In the 1990s, a new revenue model for LTC facilities evolved. Making money in routine LTC services has always been difficult; it is a tough way to make a living. There is no easy or simple day in LTC facilities.

In the 1990s, entrepreneurial-minded providers and therapists determined there was profit in LTC in Medicare ancillaries, specifically therapies. Physical, occupational, and speech therapies are very valuable services for both the rehab population and the LTC population in LTC facilities. So if therapy is good, wouldn't more therapy be better? And more profitable? A new model was born. Problem is, greed tends to overwhelm both ethics and common sense, and the new model turned into a California gold rush model of therapy gone wild.

The gold rush was on

In an eight-year period (1989–1997), total Medicare nursing home reimbursements increased by about 600%, and the increase was not driven by a commensurate census increase. The Sun Health Group of companies[1] was the exemplar of the therapy-gone-wild model. Sun grew from a small, regional chain organization to an international powerhouse in just a few years, then

melted down into bankruptcy in 1999, after the passage of the Balanced Budget Act.[2]

Cost-plus reimbursement plus increases in therapy were good for providers, not so good for the taxpayers. Providers large and small took advantage of Medicare.

One resident profile from an independent facility chart audit 20 years ago is still burned into my mind. He was elderly, very frail, and had very little cardiac function. According to this therapy records, he was getting many hours of vigorous physical therapy multiple times a week, plus speech and occupational therapy. The resident had passed many months before the audit, but the nurses could not remember him receiving such therapy and were certain he could not have tolerated the physical therapy.

In recent court filings, the federal government claims fraud involving intensive therapy for dying LTC facility residents. If the therapy was not delivered, it was fraud. If the therapy was delivered, this could qualify as fraud *and* physical abuse. This is not acceptable. The federal government is using whistleblowers, audit contractors, criminal investigators, and data analytics to comb claims and profile providers. This is serious.

The Balanced Budget Act of 1997

Congress eventually noticed the gold rush. Soon Congress had had enough. The Balanced Budget Act of 1997 included a new prospective payment system (PPS) and caps on therapy services. The therapy caps became a political soap opera—we could fill a small book with the political machinations and history around the cap.

The PPS system is immensely complicated, so we borrow a reasonably concise explanation from a legal filing, the United States' Amended Compliant in Intervention in the *Kindred Care* case[3] (more on *Kindred* below):

*B. **Medicare Reimbursement for SNF Care***

20. Under its prospective payment system ("PPS"), Medicare pays a SNF a daily rate for each day of skilled nursing and rehabilitation services provided to a patient. See 63 Fed. Reg. 26,252, 26,259-60 (May 12, 1998). The rate is based, in part, on the patient's anticipated "need for skilled nursing care and therapy." Specifically, the daily PPS rate that Medicare pays a SNF depends on the Resource Utilization Group ("RUG") to which a patient is assigned, and each distinct RUG is intended to reflect the anticipated costs associated with providing nursing and rehabilitation services to beneficiaries with similar characteristics or resource needs. There are five general rehabilitation RUG levels for those beneficiaries that require rehabilitation therapy: Rehab Ultra High (known as "RU"), Rehab Very High ("RV"), Rehab High ("RH"), Rehab Medium ("RM"), and Rehab Low ("RL").

21. The rehabilitation RUG level to which a patient is assigned depends upon the number of skilled therapy minutes and the number of therapy disciplines the patient received during a seven-day assessment reference period (also known as the "look back period.

Here we go again

In 2014, the *Wall Street Journal* published a brutal article about therapy in LTC.[4] The article was updated online in August 2015. The article delves into the highly desired "ultra high" patient classification and some of the shenanigans used to reach the ultra high classification.

Statistics indicate a steady rise in the distribution of therapy classifications. Some of this is likely due to a shift in resident census toward rehabilitation residents, but more than likely, some of the rise is due to reimbursement strategies.

The *WSJ* article also documents a case similar to my 1996 resident, a very frail resident who was documented as receiving immense amounts of therapy. The Department of Justice and the CMS OIG were already very aware of the trend and were already bringing litigation.

Reasonable and necessary

Perhaps the most used, but the least understood, phrase in Medicare reimbursement is "reasonable and necessary" language.[5,6,7] In a skilled nursing facility (SNF) add *skilled* to the phrase. In daily usage throughout the healthcare system, the phrase is often written as "reasonable and *medically* necessary."

In LTC, another rule is clear: *If it is not properly documented, it never happened.* This includes initial evaluations, the Plan of Care (PoC), all medical records, and all government filings. A service is not skilled just because a licensed therapist provided the service, nor is a service necessary because a physician signed an order. Subbing out therapy to a contract therapy company does not relieve the facility of responsibility for an accurate RUG and accurate billing.

And for full disclosure, in LTC a great many orders are written by nurses and therapists after a telephone consultation with the physician, and the order is signed later, because the physician is only occasionally in the building. In itself, this is neither good nor bad, but this process does not modify or eliminate the facility's responsibility for "reasonable and necessary."

Medicare will also not pay for non-covered service (e.g., dental, vision, cosmetic) or many experimental devices.

The litigation complaints provide a useful and concise primer on the legal definitions of reasonable and necessary. The following is an excerpt from the First Amended FCA complaint in the *Kindercare* case, filed by the *qui tam* counsel:

> 13. Physical, occupational and speech therapy for skilled nursing facility patients are covered services under the Medicare program but Medicare coverage guidelines state that the therapy "must be reasonable and necessary for the treatment of the patient's condition: this includes the requirement that the *amount, frequency, and duration* of the services must be reasonable." CMS Skilled Nursing Facility Manual Section 214.3A1 Furthermore, The Social Security Act provides that *no Medicare payment may be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury..."* 42 U.S.C. Section 1395y(a)(1)(A). To lawfully bill Medicare for services, documentation regarding such services *must adequately establish reasonableness and medical necessity.* Congress has conditioned payment for many Medicare items and services on a certification signed by a physician attesting that the item or service is medically necessary. The Defendant Kindred/RehabCare's own Code of Conduct states that the False Claims Act applies to Medicare and Medicaid program reimbursements and prohibits, among other things "billing for unnecessary services. (Emphasis added)

Settled litigation

In January 2016, Kindred Healthcare and its subsidiaries RehabCare Group and RehabCare Group East settled a False Claims Act action in which the United States joined two therapist *qui tam* relators (whistleblowers).[8] The combined companies agreed to pay $125 million to settle the litigation. In addition a number of SNFs entered into separate settlements for billing unnecessary therapy services provided by the Kindred group.

The key claim was that the defendants provided "unreasonable and unnecessary"

services to Medicare patients and billed for therapy that never occurred. This included presumptive placement of residents in the highest therapy levels, rather than using individual evaluations to determine the level.

The claims also included manipulating "assessment reference periods" (a practice known in the industry as "ramping"), providing therapy after recommended therapy discharge dates, "minute shifting" between therapy specialties (i.e., physical, occupation, and speech) to reach targets regardless of what the resident really needed, misreporting initial evaluation time, rounding and misreporting minutes of service, and reporting of services allegedly provided to residents who were sleeping or in palliative care.

Reading a corporate integrity agreement (CIA), which is an integral part of an FCA litigation settlement, is an instructive exercise, sort of a primer on how compliance is supposed to work. Many CIAs are online and can be easily accessed.

Pending litigation

In April 2015, the federal government intervened with *qui tam* relators in three false claims actions and filed a consolidated suit against HCR Manorcare (a group owned by The Carlyle Group, a private equity company) with about 280 facilities in about 30 states.[9]

In October 2015, the federal government intervened with *qui tam* relators in three false claims actions and filed a consolidated complaint against SavaSeniorCare LLC, an operator of about 200 facilities in more than 20 states.[10]

The Department of Justice points out in both case announcement press releases that these are allegations only and no liability has been determined. However, the allegations are very similar to the *Kindred* case, and the complaints are brutally detailed as to the alleged misconduct.

A tip for executives and compliance officials: Email is the best friend of prosecutors. It is stunning what business executives and healthcare providers will document in their emails.

What's a compliance officer to do?

The cited cases and others of the same kind seem to have one thing in common—the corporate culture not only allowed bad conduct, but encouraged or even ordered bad conduct in therapy and related billing. Such a culture breeds whistleblowers and litigation.

In March 2016, CMS published data on 2013 SNF RUG statistics, and looking at the narrative and data, the implications were very clear—more audits and more litigation.[11] Because a compliance officer may have no direct control over organizational culture, we focus elsewhere.

First, the initial therapy assessment has to be accurate and honest. Second, everything has to pivot off of the Plan of Care. In LTC, the PoC is a crucial process in delivering quality care by an interdisciplinary team. The care planning meeting is a place the resident, his/her family, and representatives of care departments can discuss and coordinate care.

Ramping and minute-shifting cannot be allowed. Bouncing between modalities (i.e., physical, occupational, speech) to generate minutes is not acceptable. Planning therapy for revenue generation purposes is not acceptable. Providing unneeded therapy to dying residents is fraud, or worse. Elaborate real time systems to monitor and track minutes may indicate intent to manipulate the system.

A compliance program should imitate the federal government approach, using both individual chart audits and targeted data analytics to watch for billing manipulation. The simplest analytics program may be to monitor RUG classifications by facility,

watching for excessive use of the highest (i.e., Rehab Ultra High, RU) category. Monitor both current numbers and three-year trends.

Given the prevalence of frustrated employees filing *qui tam* actions, Compliance must be receptive to employee complaints and concerns, and compliance personnel must try to get the ear of senior corporate officers.

Using a therapy contractor does not eliminate or modify the facility's and organization's responsibility for billing integrity, but may make compliance work more complicated. The compliance program must be meticulous, precise, and tactful, especially when bad news is being delivered to your superiors. There is one advantage to using email for bad news—emails are harder to put through a shredder. Compliance officers may have to battle their own bosses, a terrible and stressful situation. Best advice here: When the subpoenas are delivered, be certain you can be proud of the thoroughness and integrity of your work.

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3. *United States ex rel Halpin and Fahey v. Kindred Healthcare, Inc. et. al.* Case No. 1:11cv12139-RGS (District Court, Massachusetts). Available at http://1.usa.gov/1sZ4que
4. Christopher Weaver, Anna Wilde Mathews, and Tom McGinty: "How Medicare Rewards Copious Nursing Home Therapy" *Wall Street Journal*, Updated August 16, 2015. Available at http://on.wsj.com/1RJqiha
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7. Jacqueline Fox: "The Hidden Role of Cost: Medicare Decisions, Transparency and Public Trust" *University of Cincinnati Law Review*, vol. 79, October 17, 2011. Available at http://bit.ly/1UaZfgn
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9. *United States ex rel. Ribik v. ManorCare Inc., et. al.*, Case No. 1:09cv13-CMH-HCB (Eastern District Virginia); *United States ex. Rel. Slough v. HCR Manorcare et al.*, Case No. 1:14cv1228 (Eastern District Virginia); and *United States ex rel. Carson v. HCR Manorcare, et al.*, Case No. 1:11cv1054 (Eastern District Virginia).
10. *United States ex rel. Hayward v. SavaSeniorCare LLC, et al.*, Case No. 3:11-0821 (Middle District Tennessee); *United States ex rel. Scott v. SavaSeniorCare Administrative Services, LLC*, 3:15-0404 (Middle District Tennessee); and *United States ex rel. Kukoyi v. SavaSeniorCare LLC et al.*, Case No. 3:15-1102 (Middle District Tennessee).
11. CMS: Medicarex Skilled Nursing Facility (SNF) Transparency Data (CY2013). March 9, 2016. Available at http://go.cms.gov/1r0EZ9C