Outline

- OIG Hospice Risk Areas
- Hospice/Nursing Home Relationship
- OIG Home Health Risk Areas
- OIG Hospice and Home Health Work Plans
- Marketing Practices and Compliance
Hospice Risk Areas

The OIG has identified 28 risk areas for hospices. These risk areas are explained in great detail in the footnotes to the OIG Model Compliance Program Guidelines for Hospices issued 1999 and found at:

www.oig.hhs.gov/fraud/complianceguidance.html

Hospice Risk Areas

1. Uninformed consent to elect the Medicare Hospice Benefit
2. Admitting patients to hospice care who are not terminally ill.
   a) Certification of Terminal Illness 42 CFR § 418.22
   b) Face-to-Face Encounter – 42 C.F.R. § 418.22 (a)(4)
   c) “Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the certification.” 418.22(b)(2)
   d) Admission to Hospice 42 C.F.R. § 418.25
3. Arrangement with another health care provider who a hospice knows is submitting claims for services already covered by the Medicare Hospice Benefit
4. Under-utilization
5. Falsified medical records or plans of care.
Hospice Risk Areas (cont’d)

6. Untimely and/or forged physician certifications on plans of care.
7. Inadequate or incomplete services rendered by the Interdisciplinary Group (IDG).
8. Insufficient oversights of patients receiving more than six consecutive months of hospice care.
9. Hospice incentives to actual or potential referral sources (e.g., physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation, including improper arrangements with nursing homes.
10. Overlap in the services that a nursing home provides, which results in insufficient care provided by a hospice to nursing home residence.

11. Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately-paid professionals.
12. Providing hospice services in a nursing home before a written agreement has been finalized.
13. Billing for a higher level of services than was necessary.
14. Knowingly billing for inadequate or substandard care.
15. Pressure on a patient to revoke the Medicare Hospice Benefit when the patient is still eligible for and desire care but the care has become too expensive for the hospice to deliver.
Hospice Election & Discharge From Hospice

Election of Hospice Care 42 C.F.R. § 418.24:
1. Only revocation by beneficiary or discharge by hospice can terminate election.
2. 90-90-60-etc. periods effective as long as patient:
   • remains in care of hospice
   • does not revoke the election to receive hospice care
   • is not d/c by hospice pursuant to § 418.26

Discharge from Hospice Care 42 C.F.R. § 418.26
1. patient moves out of service area or transfer to another hospice
2. hospice determines that patient is not longer TI
3. For cause
   • patient’s behavior is “disruptive, abusive or uncooperative” so that hospice cannot provide care
   • threat from family
   • drug dealing by family

Suggested actions:
1. Develop policy on discharge for cause
2. Regulations require:
   a. notice to patient of d/c for cause
   b. serious effort to resolve problem
   c. d/c not due to patient use of hospice services
   d. document all above in medical record
Hospice Risk Areas (cont’d)

16. Billing for hospice care provided by unqualified or unlicensed clinical personnel.
17. False dating or amendments to medical records.
18. High-pressure marketing of hospice care to ineligible beneficiaries.
19. Improper patient solicitation activities, such as “patient charting.”
20. Inadequate management and oversight of subcontracted services, which results in improper billing.
21. Sales commissions based upon length of stay in hospice.  
   (productivity bonus to bona fide employee based on written criteria for bonus and policy that admissions are on based on eligibility of patient and no nexus to LOS)
22. Deficient coordination of volunteers.
23. Improper indication of the location where hospice services were delivered.
   - Combined Statistical Area (CBSA) old MSA
24. Failure to comply with applicable requirements for verbal order for hospice services.
25. Non-response to late hospice referrals by physicians.
26. Knowing misuse of provider certification numbers, which results in improper billing.
27. Failure to adhere to hospice licensing requirements and Medicare conditions of participation.
28. Knowing failure to return overpayments made by Federal health care programs.
Hospices and Nursing Homes - Barrier vs. Collaboration

Two independent regulatory schemes with different goals:

**COPs for Hospice**: 42 C.F.R. Part 418 –
“Palliative care is patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering...[by] addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.”

**COPs for NH**: 42 C.F.R. Part 483 –
“highest practicable physical, mental and psychosocial well-being”

- Two different reimbursement schemes. Room v Board issue.
- Patient is both a Nursing Home (NH) Resident and a Hospice Patient. Resident Assessment Instrument Minimum Data Set (RAI/MDS).
- NH Medical Director vs. Hospice Medical Director.
- Hospice Election Issue
Collaboration

Nursing Home/Hospice Contracts

• Routine Hospice Care
• Inpatient Hospice Care
  • pain control and symptom management that cannot be managed elsewhere
  • respite purposes for caregiver breakdown (for hospice patients admitted from the community)
  • 24-hour RN not required for respite § 418.108(b)
  • Patient access and family-like areas
  • Hospice also provides care

• Hospice can contract and purchase hospice non-core services from NH: PT, OT, ST, hospice aide, meds and supplies related to TI.

• Cannot contract for Hospice core services: RN, SW, Physician, Counseling – dietary, bereavement and spiritual. Waivers.

• Cannot provide continuous care services to patients in a skilled nursing facility. MLN JA 6778

42 C.F.R. §418.112 (c)

Written Agreement Between the Hospice and the NH

• The hospice and NH must both sign the written agreement.
• These agreements must include nine specific provisions dealing with the following:
  • Communication between NH and hospice;
  • Notification of changes in patient's status;
  • Hospice responsibility for determining care level;
  • NH responsibility to furnish room and board;
  • Specific delineation of the hospice's responsibilities;
  • Provision specifying NH personnel can be used only to the extent that a patient's family would be used in implementing a plan of care;
  • Hospice abuse reporting requirements;
  • Delineation of the provision of bereavement services; and
  • Hospice responsibility to provide hospice services at the same level as if in the community.
NH Reporting Obligations Under the Hospice COPs: 42 C.F.R. 418.52(b)(4)

1. Immediate reporting to Hospice Administrator of any alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse, including, injuries of unknown sources, and misappropriation of patient property by anyone furnishing services on behalf of the Hospice.

2. Immediate notification to Hospice by NH if:
   a) there is a change in patient's mental, social or emotional status
   b) clinical complications appear suggesting a need to alter the Plan of Care
   c) a need to transfer the patient from the Skilled Nursing Facility arises.
   d) a hospice patient dies.

3. SSA § 1150B and S&C 11-30-NH – Hospice must report reasonable suspicion of a crime that results in serious bodily injury within 2 hours and suspicion of other crimes not resulting in serious bodily injury within 24 hour to authorities. Reports must also be made to the state survey agency.

OIG – Hospice/Nursing Home Issues

1. 1998 OIG Special Fraud Alert – “Fraud and Abuses In Nursing Home Arrangements With Hospice”

2. Medicare Advisory Bulletin on Hospice Benefits – 11/2/05

3. “Special Advisory Bulletin Regarding Provision of Gifts and Other Inducements to Medicare Beneficiaries,” 8/30/02

4. OIG Advisory Opinions 00-03; 00-07; 01-19; 03-04; 08-07

5. Medicare Hospice Care For Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements, 2009
### OIG Reports – Hospice/Nursing Home Issues

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### Home Health Risk Areas

The OIG has identified 31 Risk Areas for home health agencies.

Department of Health & Human Services Office of the Inspector General Compliance Program Guidance for Home Health Agencies – 8/7/98

Home Health OIG Risk Areas

1. Billing for services or items not actually rendered.
2. Billing for medically unnecessary services.
3. Duplicate billing
   • Submitting the same claim twice
   • Submitting a claim for the same services to different payors at the same time
   • Mistake vs. systemic or repeated double billing.
4. False Cost Reports
5. Failure to Refund Credit Balances to Medicare or Other Payor Sources.

Home Health OIG Risk Areas

6. Home Health Agency incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulations
7. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.
   • Physician ownership of home health agency (designated health services - DHS).
   • DHS include clinical laboratory services, physical, occupational and speech therapy, radiology services, DME and supplies, home health services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, and prosthetic devices and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.
Home Health OIG Risk Areas

**Stark Three-Step Analysis:**
- Is there a referral from a physician for a DHS?
- Does the physician (or an immediate family member) have a financial relationship with the entity providing the DHS?
- Does the financial relationship satisfy an exception?

**Sanctions Under Stark**
- **Denial.** CMS will not pay claims for improperly referred DHS.
- **Refund.** Entity has duty to refund to individual.
- **Civil Monetary Penalties.**
  - $15,000 for knowingly presenting or causing another to present improper claim, plus an assessment of 3x the amount claimed.
  - $100,000 for “scheme” to circumvent.
- **Exclusion.**
- **Potential False Claims Act Liability.**

**Home Health OIG Risk Areas**

9. Billing for services provided to patients who are not homebound.
10. Billing for visits to patients who do not require a qualifying service.
11. Overutilization and underutilization.
12. Knowingly billing for inadequate or substandard care.
13. Insufficient documentation to evidence that services were performed and to support reimbursement.
15. Billing for services provided by unqualified or unlicensed clinical personnel.
16. False dating of amendments to nursing notes.
Home Health OIG Risk Areas

17. Falsified Plans of Care.
18. Untimely and/or forged physician certifications on plan of care.
19. Forged beneficiary signatures on visit slips/logs that verify services were performed.
20. Improper patient solicitation activities and high pressure marketing of uncovered or unnecessary services.
21. Inadequate management and oversight of subcontracted services which results in improper billing
22. Discriminatory admission and discharge of patients.
23. Billing for unallowable costs associated with the acquisition and sale of home health agencies.
24. Compensation programs that offer incentives for number of visits performed and revenue generated.
24. Improper influence over referrals by hospitals that own home health agencies.
25. Patient abandonment in violation of applicable statutes, regulations and Federal health care program requirements.
26. Knowing misuse of provider certification numbers resulting in improper billing.
Home Health OIG Risk Areas

28. Duplication of services by assisted living facilities (adult homes) hospitals, clinics, physicians, and other home health agencies.

29. Knowing or reckless disregard of willing and able caregivers when providing home health services.

30. Failure to adhere to home health agency licensing requirements and Medicare Conditions of Participation.

31. Knowing failure to return overpayments made by Federal health care programs.

OIG 2011 Hospice Work Plan

Hospice utilization in the nursing facility.

- OIG will be reviewing the characteristics of nursing facilities with high hospice utilization. OIG will also be reviewing the business relationships, as well as marketing practices and materials of hospices with high nursing facility utilization.

- OIG will be reviewing appropriateness of hospice inpatient claims.

- OIG will review services provided by hospices and nursing facilities to hospice patients residing in the nursing facilities. Reviews will include services provided by hospice aides, coordination of care, services to be provided by each entity, and payment arrangement.

- OIG will be reviewing appropriateness of Medicare Part D payments with respect to coverage of drugs under the Part A benefit as well as duplicate payments.
OIG 2012 Hospice Work Plan

- OIG will review claims for inpatient stays where the beneficiary was transferred to hospice care – OIG will review the relationship (financial or common ownership) between the acute care hospitals and hospices
- OIG will review hospice marketing materials and practices and financial relationships between hospices and nursing facilities
- OIG will review the appropriateness of the use of GIP
- OIG will review drug claims under Part D
- OIG will review Medicaid payments to determine if the hospice services complied with the federal reimbursement requirements

OIG 2011 Home Health Work Plan

- OIG will review Part B payments for services and medical supplies provided to beneficiaries in home health episodes.
- OIG will assess the accuracy of HHRGs for claims submitted in 2008.
- OIG will review the process by which CMS ensures accurate and complete OASIS data submission.
- OIG will review compliance with PPS billing requirements.
- OIG will analyze HHA profitability trends from cost reports to determine whether payment methodology should be adjusted.
- OIG will review HHA enrollment program integrity efforts.
- OIG will review the health survey records of home health workers who provide services to Medicaid beneficiaries.
OIG 2012 Home Health Work Plan

- OIG will review the timeliness of surveys, outcomes of the surveys, and nature and follow-up of complaints.
- OIG will review oversight by CMS of OASIS data submitted.
- OIG will review OASIS data for episodes in which OASIS data were not submitted or for which claim billing codes are inconsistent with OASIS.
- OIG will review claims to identify home health agencies that exhibited questionable billing in 2010.
- OIG will review reduction in payment errors by MACs as well as fraud and abuse prevention and performance efforts by MACs.
- OIG will review home health payments to determine whether incorrect wage indexes were utilized to calculate the payments.

OIG 2012 Home Health Work Plan (cont’d)

- OIG will review compliance with PPS requirements.
- OIG will review cost report data trends to determine whether the home health PPS payment methodology should be adjusted.
- OIG will review the health screening records of home health workers who provide services to Medicaid beneficiaries.
- OIG will review HHA claims to determine whether beneficiaries have met eligibility criteria.
- OIG will review CMS policies and practices for reviewing the sections of Medicaid State plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements for home health services. OIG will also identify the number of States that violate Federal regulations by inappropriately restricting eligibility for home health services to homebound recipients.
### Federal and State Anti-Kickback Law

Prohibits, among other things, remuneration in return for ordering, or for arranging for or recommending the purchase or order of, any item for which payment may be made in whole or in part under a federal healthcare financing program. 42 U.S.C. 1320a-7B(b).

Comply with federal safe harbor for 25 different business relationships. For example, safe harbors for space rental, personal service and management contracts, equipment rental, referral services, discounts, employees, group purchasing organizations, investment interests, warranties, waiver of beneficiary co-insurance and deductibles, electronic and health records items and services, etc. 42 C.F.R. § 1001.952
Federal and State Anti-Kickback Law (cont’d)

Referral Issues:
- Providing staff, rental payments, meals and entertainment, training, or back-up staff to referral sources.
- Providing payments to entities or individuals to refer patients.
- Providing services for free or reduced rate to the patient, or potential patient/family.
- Providers agreeing to provide referrals to each other.
- Aides referring patients in exchange for hiring/bonus.
- Aides changing agencies and bringing patients with them from one agency to another.

OIG Fraud Alert

See OIG Special Fraud Alert Home Health Fraud at:

http://oig.hhs.gov/fraud/docs/alertsandbulletins/081095.html
Compliance Strategies: Legal Considerations

Marketing Practices Under Anti-Kickback Law:
- Free items or services contingent on purchases, or on access to referral base
- Grants
- Travel, entertainment, gifts
- Free consultants
- Continuing education

Compliance Strategies: Legal Considerations


- Civil Money Penalties for inducements
  - “Remuneration”
  - $10 per item / $50 per year
  - Five exceptions
Anti-Inducement Laws

- Patient Protection and Affordable Care Act (PPACA) § 6402 amends §1128A(a)(i)(6), definition of remuneration under CMP, to exclude “certain charitable and other innocuous programs.”
  
  a. Remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs;
  
  b. The offer or transfer of items or services for free or less than FMV if:
     i. Coupons, rebates, or other rewards from retailer;
     ii. Items offered on equal terms to general public regardless of health insurance status; and
     iii. Offer or transfer is not tied to provision of care reimbursed by Medicare or Medicaid.

- Offer or transfer of items or services for free or less than FMV by a person to an individual in financial need if not part of an ad or solicitation; not tied to care paid for by Medicare or Medicaid; and there is a reasonable connection between the item or service and the medical care being provided.


- Effective January 1, 2011, waiver of certain co-pays under Part D for first prescription under certain circumstances.
Anti-Inducement Laws (cont’d)

Compensation for Marketers

- OIG Safe Harbor for W-2 Equivalent Employees
- Marketing as part of Employee Goals and basis for Annual Evaluations
- Policy Describes Bonus Criteria – Include Compliance with Admission Criteria

What are the Hazards of Marketing?

1. Misinformation is provided.
2. Untrue/unsustainable “promises” are made.
3. Inconsistent messages are given.
4. Unethical or illegal inducements are offered.
5. Competitors or others are slandered.
6. Legal consequences.
Privacy Concerns in Marketing

1. Patient expectations of privacy from health care providers.
3. Photos, references to cases.
4. HIPAA and state privacy laws.
5. Obtain an authorization from patient for marketing.
6. Contracts with vendors should contain clause requiring prior written approval for press release, media ads, or any form of publicity or marketing about contract arrangement. HITECH Business Associate Agreement requirement.

Good Marketing Practices

1. Market what you do.
2. Have scripts for problematic situations.
3. Train staff to know kickback risks.
4. Policy regarding gifts/items/space/services.
5. Don’t exaggerate, and don’t dump on the competition.
6. Don’t promise services.
7. Back-up your quality measures.
8. Welcome compliance officer review.
9. Audit your marketers and their accounts.
Compliance Program – Address Marketing Issues

1. Compliance Standards & Procedures.
2. Steps to Detect and Prevent Offenses.
3. Oversight Responsibilities – Compliance Officer.
4. Due Care in Delegating Discretionary Authority.
5. Employee Training.
7. Enforcement & Discipline.

Strategies for Compliance

1. Compliance Standards & Procedures.
2. Steps to Detect and Prevent Offenses.
3. Oversight Responsibilities – Compliance Officer.
4. Due Care in Delegating Discretionary Authority.
5. Employee Training.
7. Enforcement & Discipline.
When a Marketing Policy Goes “Wrong”

1. Conduct internal investigation under attorney client privilege and enact plan for correction.
2. Reach out and repair the damage.
3. Re-examine priorities.
4. Resist inappropriate marketing demands from referral sources.
   - SNF demands aide, TV, (GIP Level of Care, continuous care from Hospice in exchange for referrals of residents to hospice).
   - Discharge planner of hospital demands expensive gift during holiday season.

Marketing: Legal Guidance

1. Attorney-Client Privilege – Consultants.
3. Health Care Attorney Expertise.
4. OIG Fraud Alerts and Bulletins.
5. Advisory Opinions.
Who Can You Contact for Help?

1. Federal:
   a. CMS – condition of participation violation, i.e., steering and patient choice, admission.
   b. OIG – risk areas, inducement, kickbacks.
   c. FTC – "unfair or deceptive acts or practices in or affecting commerce."

2. State:
   a. Department of Health – state laws, i.e., steering and patient choice, admission.
   d. Consumer Protection.

3. Private Action:
   a. Informal with Health Care Attorney.
   b. Formal with Health Care Attorney:
      – Lawsuit for tortuous interference with business, libel, contract dispute.