

**Health Care Compliance Association
20th Anniversary at the Compliance Institute**

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**Learning the Lessons From Fraud
Enforcement Efforts in Home Health and Hospice**

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**Health Care Fraud
Is Getting Historic Levels of Attention**

Why Are Enforcement Efforts on the Rise??



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Is this new or unexpected?

Historically, any time the country has experienced a significant economic downturn, there has been a corresponding increase in enforcement efforts.

These efforts are usually focused on whatever industry is best weathering the economic storm.

Right now.... that is healthcare.

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You seem sincere, but let's see the numbers.

Health Care Fraud and Abuse Control Program collected \$19.2 billion between 2010 – 2013.

That was more than double the amount recovered in the prior four years.

The Government is still averaging over \$4 billion each year.

A good portion is the False Claims Act

2014: Nearly \$6 billion from FCA cases

2015: Over \$3.5 billion from FCA cases

It was the fourth consecutive year FCA recoveries exceeded \$3.5 billion.

I'm sure those numbers aren't incentivizing *qui tam* plaintiffs **or** their attorneys.

The Government is not your only worry

The False Claims Act – 31 U.S.C. §3729



Everyone has been Deputized and Provided an Economic Incentive

The Lincoln Law

Designed to protect the Government from fraud. Enacted during the Civil War, it was created to address fraud perpetrated by those selling supplies to the Union Army. “For sugar, [the government] often got sand; for coffee, rye; for leather something no better than brown paper; for sound horses and mules, spavined beasts and dying donkeys...” United States ex. Rel. Newsham v. Lockheed Missiles and Space Co., Inc. 722 F. Supp. 607, 609 (N.D.Cal. 1989).

A Little Knowledge is a Dangerous Thing

The FCA defines “knowledge” as:

- (1) actual knowledge;
- (2) deliberate ignorance of the truth or falsity of the information; or
- (3) reckless disregard as to the truth or falsity of the information.

Don’t take my word for it!

In September 2014, the DOJ Criminal Division announced that, for the first time, DOJ would be systematically pursuing criminal charges *in tandem* with civil FCA suits.

The threat of criminal charges works to encourage more settlements (at higher dollar amounts) in related civil cases.

Add in the Health Care Fraud Prevention and Enforcement Action Team (HEAT) and Medicare Fraud Strike Force....

Let's talk more recently...

DOJ Press Releases: March 1-2, 2016

Home health owner to pay \$1.75 million to resolve allegations that he violated the FCA by causing payment of illegal kickbacks to doctors who agreed to refer Medicare patients. The Government previously reached a settlement with the company purchasing the HHA for \$1.1 million.

A little more...

- Doctor sentenced to 51 months in prison and ordered to pay restitution of \$2,276,221 for billing Medicare for expensive orthotics that were never provided to the patients. Billing assistant received five years of probation and ordered to pay restitution of \$10,571.
- Podiatrist billed \$206,000 for nail avulsion when simply providing routine foot care. Result was 3 years of probation, 200 hours of community service, and \$618,000 in restitution to private insurance companies and the government (within 90 days).

Also excluded from the Medicare.

Okay, a bit more...

- United States' largest distributor of endoscopes and related equipment will pay \$623.2 million to resolve criminal charges and civil claims relating to a scheme to pay kickbacks to doctors and hospitals. A subsidiary will pay an additional \$22.8 million to resolve FCPA criminal charges.
- Took guilty plea from DME company owner, who had been a fugitive since 2013, for submitting \$2,579,695 in allegedly false and fraudulent claims to Medicare for equipment not legitimately prescribed by doctors and not provided to beneficiaries (over a 3 month period).

Is that really a fair sample?

61 additional press releases related to health care fraud indictments, pleas, or sentences imposed in 2016.

(To be fair... it is a leap year.)

The economy is doing better... will it stop?

Department of Justice (DOJ) Collections in Civil and Criminal Cases

2013: \$8 billion

2014: more than \$24 billion

2015: over \$23 billion

Recovering +\$7.70 / dollar spent

Would you stop?

Who's already been targeted?

Medical Transportation

Clinical Laboratories

Durable Medical Equipment

Therapy

Hospice

Home Health

Who is missing?

Let me give you a hint...

Who do all of those businesses have in common?

Nursing homes
and
Hospitals

Talk to me about the Government's approach?

Maybe it's just my background,
but something about this seems very familiar.

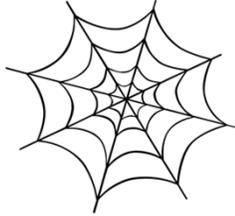


Government approach to drug cases?



WOOHOO!!!

How does that apply to health care fraud?



So who is focusing on health care fraud?

- Offices of Inspector General (OIG)
- DOJ
- Centers for Medicare and Medicaid Services (CMS)
- Medicaid Fraud Control Units (MCFU)
- HEAT and Medicare Strike force (depending on location)
- Federal/state contractors (fiscal intermediaries)
- Tricare
- State agencies (Medicaid, Attorneys General, Licensing, etc.)

Anyone Else?

- Insurance Companies
- Competitors
- Attorneys
- Whistleblowers
- (current or former employees)
- Co-conspirators

So what should I do?



Let's Get Real:
What can I learn from the Government Playbook?

WHO?

WHEN?



HOW?

WHY?

Documentation Issues

The Government embraces the first rule of nursing and applies it to all of its health care fraud investigations...

If you didn't chart it,
you didn't do it.

Hospice Enforcement

Setting the Table



Eligibility for Hospice Care

- Medicare's hospice benefit provides palliative care to individuals who are terminally ill. Palliative care focuses on pain control, symptom management, and counseling for both the patient and family.
- In order to elect the hospice benefit, a Medicare beneficiary must be entitled to Medicare Part A services and certified as terminally ill, which is defined as a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.
- A beneficiary who elects to enroll in a hospice program waives his or her rights to all curative care related to his or her terminal illness. Medicare will continue to pay for services furnished by the patient's non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness.

What's Expected?

- Hospice care is an elected benefit covered under Medicare Part A for a beneficiary who meets all of the following requirements:
 - The individual is eligible for Part A;
 - The individual is certified as having a terminal illness with a prognosis of six months or less if the illness runs its normal course;
 - The individual receives care from a Medicare-approved hospice program; and
 - The individual signs a statement indicating that he or she elects the Hospice benefit and waives all other rights to Medicare coverage for services that are related to the treatment of the terminal illness and related conditions.

Is hospice being abused?

It depends on who you ask...

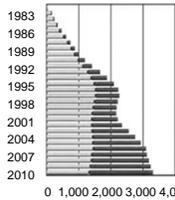
Medicare spending for hospice has notably increased.

2000: \$2.9 billion for 513,000 patients (\$5,653/patient)
2010: \$13 billion for 1,200,000 patients (\$10,833/patient)

Use of hospice doubled; payments have quadrupled.

It "might" be a coincidence that...

It correlates with the emergence of for-profit hospice.



Medicare - Certified Hospice Providers
 Not for Profit / Government
 For Profit

From National Hospice and Palliative Care Organization, Hospice Care in America, 2012 Edition.

Key Areas of Exposure: Kickbacks

Payment by a hospice to a nursing home for "room and board" provided to a hospice patient should not exceed what the nursing home otherwise would have received if the patient had not been enrolled in hospice = **Fair market value.**

- > A hospice offering free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice.
- > A hospice paying amounts to the nursing home for "additional" services that are considered to be included in government's room and board payment to the hospice.
- > A hospice referring its patients to a nursing home to induce the nursing home to refer its patients to the hospice.

Anything of value

- A hospice providing free (or below fair market value) care to nursing home patients, for whom the nursing home is receiving Medicare payment under the skilled nursing facility (SNF) benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospice services from that hospice.
- A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.
- Good old-fashioned payments for referrals.

DO NOT FORGET – LIABILITY RUNS BOTH WAYS

Admissions / Discharges

- Uninformed consent to elect the Medicare Hospice Benefit
- Admitting patients to hospice care who are not terminally ill
- Pressure on a patient to revoke the Medicare hospice
- Benefit when the patient is still eligible for and desires care, but the care has become too expensive for the hospice to deliver

Marketing

- 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
- High-pressure marketing of hospice care to ineligible beneficiaries
- Improper patient solicitation activities
- Sales commissions based upon length of stay in hospice

Billing Practices

- Billing for a higher level of care than was necessary or for inadequate care
- Billing for hospice care provided by unqualified or unlicensed clinical personnel
- False dating of amendments to medical records
- Knowing failure to return overpayments made by Federal health care programs

Clinical

- Under-utilization
- Inadequate or incomplete services rendered by Interdisciplinary Group
- Insufficient oversight of patients, in particular, those patients receiving more than six consecutive months of hospice care
- Failure to comply with applicable requirements for verbal orders for hospice services
- Non-response to late hospice referrals by physicians
- Deficient coordination of volunteers

Miscellaneous Fraud

- Untimely and/or forged physician certifications on plans of care
- Misuse of provider certification numbers
- Ignoring licensing requirements / Medicare conditions of participation
- Inadequate management and oversight of subcontracted services
- Falsified medical records or plans of care (early / false diagnosis)
- "Arrangements" with other health care providers submitting claims for services already covered by Medicare Hospice Benefit
- Payments to family members, medical directors, etc.

Focuses of Recent Government Inquiries

- Marketers touting “new” hospice benefit where you don’t have to be terminally ill (Usually homemaker services)
- New trend involving hospice with fraudulent “burial benefits” (Fraudsters often own hospice and funeral home)
- Misrepresent associations with religious entities
- Adult daycare misrepresented as hospice
- Switching patients between SNF and hospice

What About Home Health?



Big Picture Issues: Home Health Enforcement

- Origination of Patients
- Appropriateness of Patients
- Necessity of Services

Origination of Patients

Lots of possibilities, but **most** likely to focus on:

Anti-Kickback Statute – 42 U.S.C. § 1320a-7b(b)

The knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs.

Potential Participants in Kickbacks

- Owners
- Doctors
- Nurses
- Patient recruiters / Marketers
- Community leaders
- Vendors
- Competitors
- Senior Centers
- Patients

Appropriateness / Qualification of Patients

The legitimacy of these investigations spans the full spectrum. The Government has discovered it is paying for home healthcare services to...

- The able bodied
- The deceased
- The nonexistent

These cases are easy. Where it gets trickier is...

Who is eligible for home health care service?

- Under the care of the doctor with plan of care
- Certification that you need
 - Intermittent skilled nursing care
 - Physical therapy
 - Speech pathology services
 - Continued occupational therapy
- You must be homebound

“Homebound” is a regular issue

- Leaving your home is not recommended because of your condition
- Your condition keeps you from leaving home without help (utilizing a wheelchair, walker, requiring special transportation or help from another person)
- Leaving home takes a considerable and taxing effort

It’s also a regular source of Government Error

“The patient goes to the doctor...
they aren’t homebound!”

A person may leave home for medical treatment,
and short and infrequent absences for non-medical
reasons (e.g., attending religious services).

CMS Form 485

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

The form contains its own warning!

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Necessity of Services

- Excessive billing for services actually provided
 - Exceeding the patient's needs based on their acuity
- Lack of medical necessity for services provided
 - Providing unneeded services to generate income
- Billing multiple times for the same service
 - Usually involves minor modifications to the billing records
(This is a favorite of whistleblowers)

- Up-coding
 - Billing for services or items reimbursed at a higher level than the care or service provided
- Kickbacks
 - Providing anything of value to a medical professional to entice the medical professional into using specific services (referrals, tests, therapy, etc.)
- Fiction and Creative Writing
 - Billing for services / equipment that were never provided

Recycling Patients



Per Medicare, if you need more than part-time or "intermittent" skilled nursing care, you aren't eligible for home health benefits.

So What About Nursing Homes?

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or other person and includes any act that constitutes fraud under Federal or State law.
- **Waste** is not defined in Medicaid program integrity rules but "is generally understood to encompass the over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act." Examples of waste include a provider ordering more medical supplies than the beneficiary needs or ordering excessive laboratory tests.
- **Abuse** is careless or unprofessional business and health care practices that result in unnecessary or excessive charges to Medicaid, billing and receiving payment for medically-unnecessary services, and substandard care. It can also include beneficiary behavior (for example, doctor shopping) that unnecessarily increases costs to Medicaid.

- Program Integrity and Quality of Care--An Overview for Nursing Home Providers, CMS November 2015

Areas Where the Government Has Been Looking

- Upcoding through manipulation of RUGS classification
- Medically unnecessary therapy (PT and OT)
- DME schemes (Diabetic testing strips, mattress pads, & many others)
- High turn-over rate and concern regarding caregivers
- Theft of needed pain and other medications from patients
- Identity theft
- Integrity safeguards
- Counterfeit and expired drugs through secondary wholesalers

Questions you need to be able to answer

What services are being provided and why?

What DME is being ordered and why?

Why is the patient advancing / regressing?

(If you do not have an answer...
the Government will fill in the blanks)

Let's also talk about Quality of Care

Where are these cases coming from?

- Data mining (if you are an outlier – be prepared)
- Law enforcement (DOJ, OIG, AGs, MFCU) experience
- Whistleblowers – False Claims Act
- ZPICs and Recovery Audit contractors
- Competitor reports / complaints
- Reports from private industry compliance groups
- Consumer complaints
- Attorneys (personal injury, *qui tam*) or Criminals

What is the impact of your Ancillary Providers?

They can be a



OR A



Government has ENORMOUS discretion

Civil

v.

Criminal

v.

Administrative

Not to mention the framing of loss

Anything I Should Avoid?



Don't make the Government's job easy!

Early Intervention is Important

Let's be honest...

Left to its own devices,
there is no guarantee that the Government
is going to get it right...

You want to have a say in directing the who, what,
where, when, and why of an investigation.

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Preventative Healthcare Works... Try it!

Copies Available

Bloomberg BNA **Health Law Reporter**

Why Preventive Health Care to Help Keep Government Layoffs Bay



Why Preventive Health Care to Help Keep Government Layoffs Bay

By [Author Name]

As the federal government faces a budget deficit of over \$1 trillion, many are looking for ways to reduce spending. One area that has received a lot of attention is the health care system. Preventive health care, however, is a key component of a sustainable health care system. It can help reduce the need for expensive medical treatments and hospitalizations, which in turn can help reduce the overall cost of the health care system. This is particularly important for the federal government, which is one of the largest employers in the country. By investing in preventive health care, the government can help ensure that its employees are healthy and productive, which is essential for the long-term success of the government.

Just Ask!

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