Law-Enforcement Observations About Home-Health Fraud

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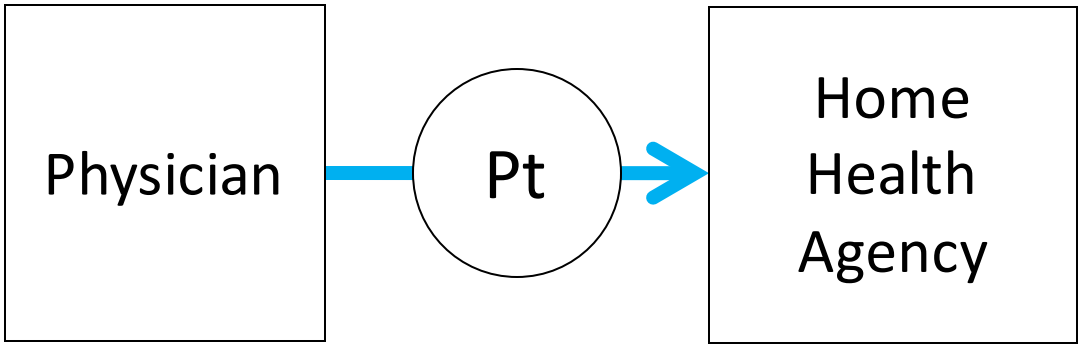
Medicare's Home-Health System



- Medicare requirements
  - Patient is confined to the home
    - "First, the patient must either (a) because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, OR (b) have a condition such that leaving his or her home is medically contraindicated.
    - "Second, there must exist a normal inability to leave the home, AND leaving home must require a considerable and taxing effort."
  - Patient requires skilled nursing services
    - Skilled nursing services generally are not necessary for basic maintenance and observation

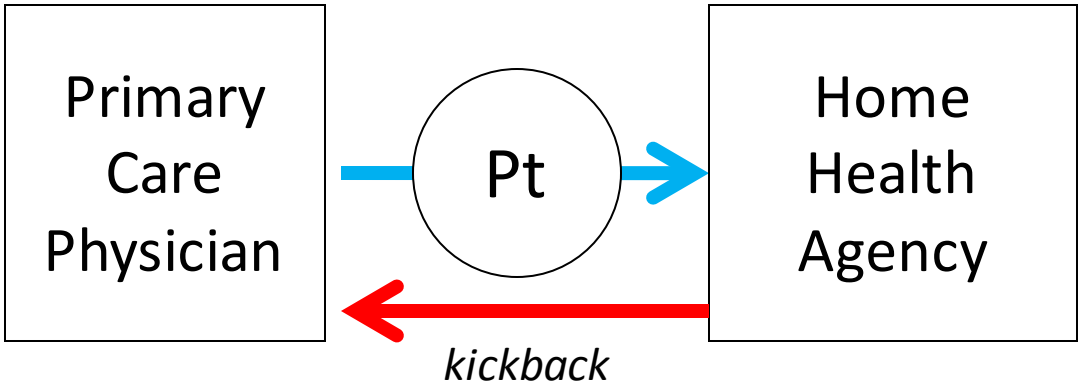
Vulnerabilities in the Home-Health System

- Medicare trusts physicians and nurses to provide accurate diagnoses and to order necessary services, and generally does not verify claims or conditions before making payment
- Physicians and nurses who (1) have financial incentives to keep patients on home-health services, (2) have been trained to fill out charts improperly, and/or (3) have not been properly trained regarding requirements for home-health services
- Patients are misled as to their qualifications for home-health services
- Medicare found a 59 percent improper payment rate in home-health payments in 2015

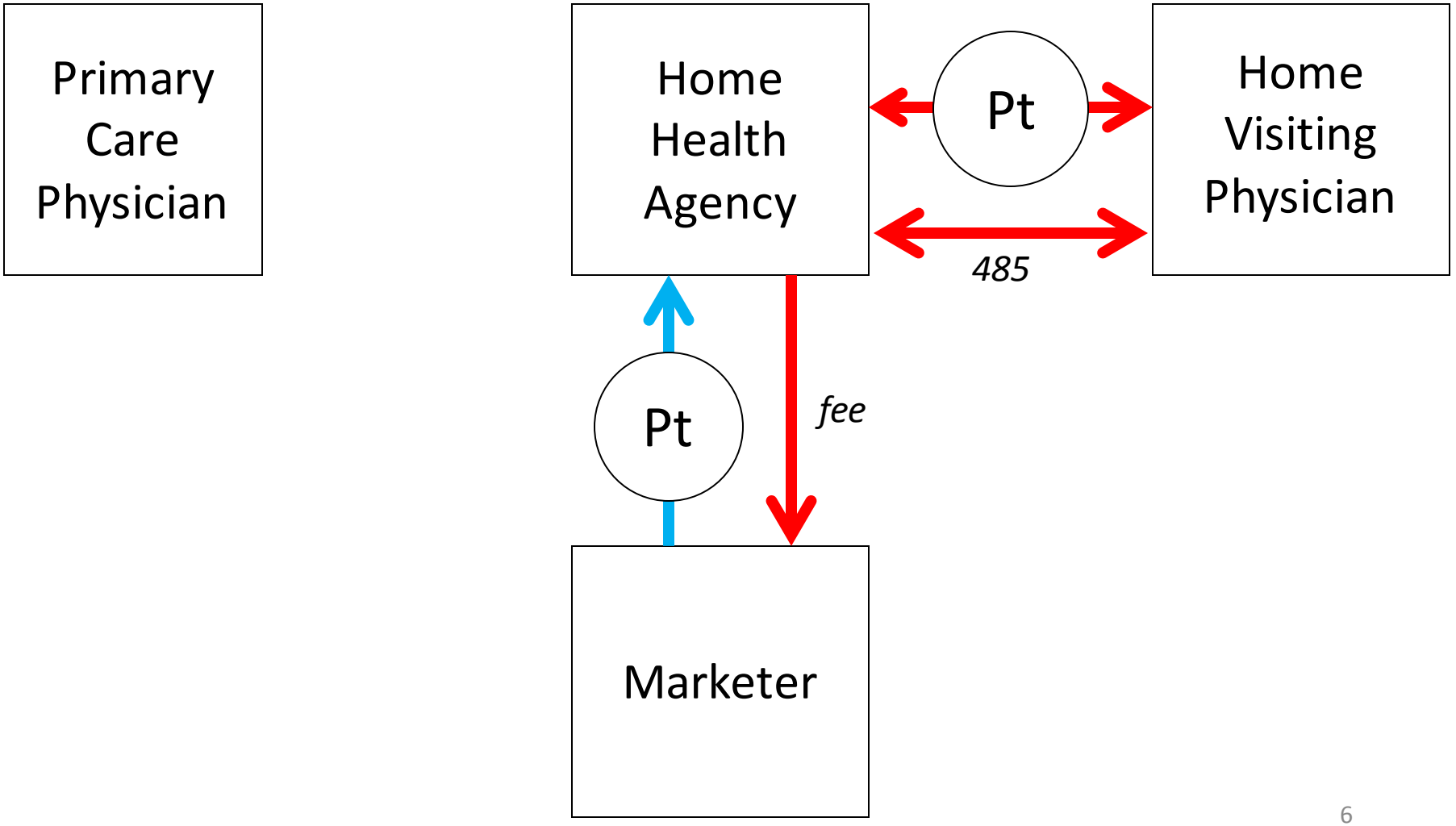
Vulnerabilities in the Home-Health System

- Two general types of schemes
- Both types turn the system upside-down because non-physicians end up making decisions for financial reasons and get doctors to simply sign off on documents that make it appear that decisions are being made by physicians for medical reasons
- Both types result in Medicare paying for large amounts of unnecessary services

Kickbacks to Primary-Care Physicians



Physician-Shopping by Home Health Agencies



Schemes to Defraud – Nursing Agencies

- Nurses lie about patients' conditions in assessments in order to make patients seem sicker than they actually are
- Agencies create false documentation to indicate that doctors and nurses are discussing patients' conditions and care, such as fake telephone orders
- Nurses create fake documentation regarding visits to make routine checkups appear to be necessary
- Agencies discharge patients and then re-admit them at the same agency or a related agency even when there is no intervening change in the patient's medical condition

Schemes to Defraud – Home Visiting Physicians

- Companies that get most of their patients from nursing agencies with the expectation that some doctor will certify the patients for nursing services
- Companies help agencies bill Medicare by having doctors sign orders for patients who do not qualify for nursing services
- Companies bill Medicare for unnecessary services, such as home visits that are automatically scheduled on a monthly basis, tests, care plan oversight
- Companies use non-physician employees to create documentation supporting services that are not necessary and/or not rendered, such as adding false information to patient charts

Improper Certifications by Physicians

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

SN TO DO SKILLED OBSERVATION AND ASSESSMENT OF PATIENT'S CARDIOVASCULAR, PERIPHERAL VASCULAR, RESPIRATORY, GI, GU AND MUSCULOSKELETAL STATUS. SN TO ASSESS PATIENT'S HYDRATION AND NUTRITIONAL STATUS; HOME ENVIRONMENT AND SAFETY CONDITIONS. SN TO ASSESS/MONITOR PATIENT'S COMPLIANCE WITH MEDICATIONS AND PRESCRIBED DIET. SN TO MONITOR THE PATIENT'S VITAL SIGNS EVERY VISIT AND TO NOTIFY THE MD OF ANY SIGNIFICANT FINDINGS. SN TO INFORM MD IF SYSTOLIC BP IS >160MM/HG OR <90MM/HG; IF DIASTOLIC BP IS >90MM/HG OR <50 MM/HG; HEART RATE OF >120 OR < 50; TEMP. ELEVATION OF 100 F; RESPIRATION >28 OR <14 BREATHES PER MINUTE. SN TO NOTIFY MD OF ANY SIGNIFICANT CHANGES IN THE PATIENT'S CONDITION. ALL LAB WORKS PER MD'S ORDER... (See Addendum)

SN 2 WK 3 WK(s)
SN 1 WK 6 WK(s)

22. Goals/Rehabilitation Potential/Discharge Plans

SN: PATIENT WILL DEMONSTRATE UNDERSTANDING OF THE NATURE OF HYPERTENSION. PATIENT WILL BE ABLE TO DEMONSTRATE UNDERSTANDING OF ANTI-HYPERTENSIVE MEDICATIONS, ITS MODE OF ACTIONS, AND ADVERSE SIDE EFFECTS. PATIENT WILL COMPLY WITH THE PRESCRIBED MEDICATIONS AND DIET. PATIENT WILL BE FREE OF ANY HYPO/HYPERTENSION SIGNS AND SYMPTOMS. PATIENT WILL DEMONSTRATE TECHNIQUES TO CONSERVE ENERGY. ... (See Addendum)

23. Nurse's Signature and Date of Verbal Order SOC Where Applicable

[redacted] 08/25/2011

25. Date HHA Received Signed POT

RECEIVED 9/20/11

24. Physician's Name and Address

[redacted]

26. 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.

27. Attending Physician's Signature and Date Signed

[redacted] 9/9/11

28. 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.

Example Patient – Admit-Discharge-Readmit

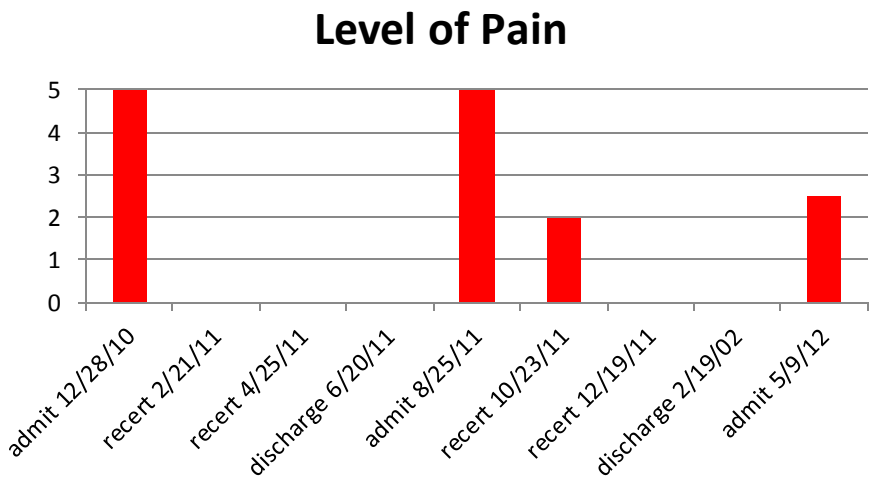
From Date	Thru Date	Lead diagnosis	Orders for Discipline and Treatments (485)	Medicare payment	Discharge letter disposition
5/6/10	7/4/10	Chronic obst asthma NOS	N/A	$2,385.38	
7/5/10	9/2/10	Chronic obst asthma NOS	N/A	$2,385.38	
9/3/10	10/31/10	Hypertension NOS	N/A	$1,791.95	N/A
12/28/10	2/25/11	Osteoarthros NOS-l/leg	SN to do skilled observation and assessment …	$1,890.94	
2/26/11	4/26/11	Hypertension NOS	Continue observation and assessment …	$1,890.94	
4/27/11	6/20/11	Hypertension NOS	Continue observation and assessment …	$1,514.01	Discharged, goals met
8/25/11	10/23/11	Osteoarthros NOS-l/leg	SN to do skilled observation and assessment …	$2,282.60	
10/24/11	12/22/11	Hypertension NOS	Continue observation and assessment …	$2,282.60	
12/23/11	2/19/12	Chronic obst asthma NOS	Continue observation and assessment …	$1,661.34	Discharged, goals met
5/9/12	7/7/12	Osteoarthros NOS-l/leg	SN to do skilled observation and assessment …	$2,511.34	

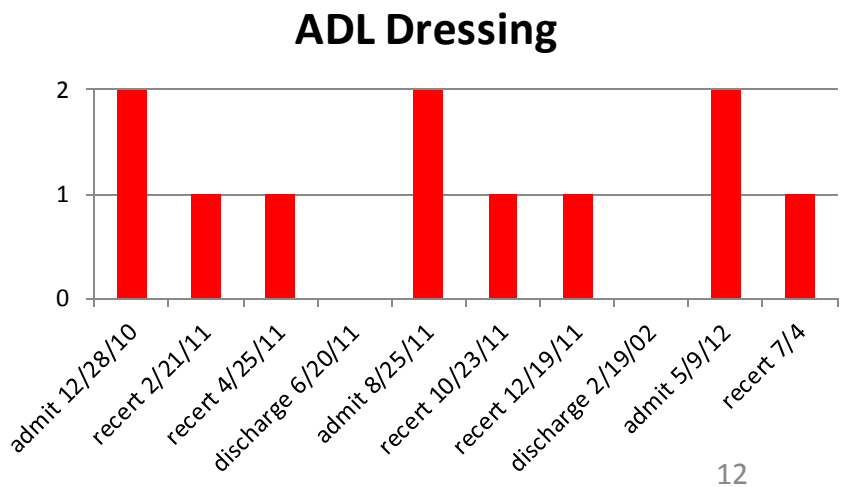
Example Patient – False Assessments

	OASIS 5/9/12
Primary reason for home health	"Patient has knowledge deficit of disease process, medication administration, medication …"
Homebound reason	X for "Needs assistance for all activities" X for "Severe SOB, SOB upon exertion" X for "Dependent upon adaptive device"
Pain	Intensity: "hurts little bit." Experiencing pain: X for "yes" Frequency: X for "daily but not constantly"
Urinary incontinence	"Patient is incontinent." When: X for "occurs during day and night"

Example Patient – False Assessments

Category	Admit 12/28/10	Recert 2/21/11	Recert 4/25/11	Discharge 6/20/11	Admit 8/25/11	Recert 10/23/11	Recert 12/19/11	Discharge 2/19/12	Admit 5/9/12
Level of pain	5	0	0	0	5	2	0	0	2-3
Grooming	2			0	2			0	2
Dressing	2	1	1	0	2	1	1	0	2
Bathing	2	2	1	0	3	2	1	0	2
Toileting hygiene	2			0	2			0	2





Red Flags

- Admissions that were not based on a change in the patient's condition or on a discharge from a hospital or nursing facility, but on marketing
- Orders signed by a physician who is not the patient's primary-care physician
- Multiple episodes of observation and assessment of chronic conditions
- Discharges followed by re-admissions without any intervening change in the patient's condition
- Inconsistencies in the patient's treatment, such as a patient receiving home visits and skilled nursing while going to visit their PCP at the PCP's office

Health-Care Fraud and False Statements

- Knowingly and willfully submitting or causing to be submitted false and improper claims is health-care fraud (18 U.S.C. § 1347)
- Knowingly and willfully putting false information in a patient file is a crime (18 U.S.C. § 1345)
- Paying for patient referrals violates the Anti-Kickback Statute (42 U.S.C. § 1320a-7b) and may violate state laws
- Penalties can include imprisonment, civil liability, forfeiture and/or restitution
- Collateral consequences can include suspension from Medicare, loss of professional license, immigration consequences

Self-Disclosure Protocol

- Self-disclosure is recommended and also required
  - Providers that self-disclose generally pay a lower amount than providers when resolving a government-initiated investigation
  - Section 1128j(d)(2) of the Affordable Care Act establishes civil liability for any overpayments retained more than 60 days after the overpayment was identified or when a corresponding cost report was due
- Voluntary self-disclosure can help establish that a provider was acting in good faith or lacked criminal intent, whereas failure to disclose can help establish bad faith or criminal intent