Home and Community-Based Services

Preventing Fraud, Waste, and Abuse in Medicaid Home Health Services and Durable Medical Equipment

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

Fighting the inappropriate loss of Medicaid health care dollars through fraud, waste, abuse, and other improper payments is a high government priority. Home health agencies and durable medical equipment (DME) providers offer services and supplies vulnerable to fraud. Physicians can play a significant role in the fight against fraud, waste, and abuse in all areas of Medicaid, including home health and DME. While the specific requirements for home health and DME can vary from State to State, all States require furnished services to be medically necessary. Physicians should know the rules for home health and DME services as required by State Medicaid programs.

Physicians should be aware of practices that are fraudulent or determined to be abusive or wasteful. Examples of home health fraud include falsely attesting to the medical necessity of home health services, accepting compensation for ordering specific services irrespective of medical necessity, or physicians signing plans of care for Medicaid beneficiaries not under their care. Examples of DME fraud, waste, and abuse include physicians selling medically unnecessary prescriptions and DME companies recruiting patients and billing Medicaid for more expensive equipment than what they delivered.

Medicaid made an estimated $29.12 billion in improper payments in fiscal year 2015. That was 9.78 percent of the total payments and more than double the 2013 improper payment amount.[1, 2] The percentage had steadily decreased from 2008 through 2013, but turned upward in 2014.[3, 4] The Government Accountability Office recently emphasized the need for increased oversight on managed care expenses even before the improper payments began to increase.[5]

Medicaid has been designated a high-risk program, "particularly vulnerable" to improper payments from fraud, waste, and abuse.[6] Fighting the inappropriate loss of health care dollars is a priority for the government, and physicians can play a significant role in the fight against it in all areas of Medicaid, including home health services and durable medical equipment (DME). As integral partners protecting public health care programs and benefits, all physicians should be aware of practices that are fraudulent, wasteful, or abusive.

Medicaid Home Health Services

Medicaid home health services are mandatory under Section 1902(a)(10)(D) of the Social Security Act.[7] States also cannot deny or reduce services based on a beneficiary's diagnosis or condition. A 2013 report identified 11 States that, at the time, had such restrictions in place.[8] The regulations for home health services were recently amended, effective July 1, 2016. These home health services include:

- Skilled nursing services;
- Home health aides; and
- Medical supplies, medical equipment, and appliances suitable for use in any setting in which normal life activities take place. The amendment contains additional stipulations on what qualifies as DME.[9, 10]

A State may also furnish optional services through its Medicaid home health State plan benefit.[11] Most States furnish services through Federal waivers. The services included in a waiver should not duplicate services that the State plan furnishes. However, through a waiver a State may augment the services furnished under the State plan.[12] Physicians should be sure to understand the specific requirements for furnishing services in the States where they practice.

Each State Medicaid program has the flexibility to determine the amount, scope, and duration of the home health services it furnishes to meet the needs of its beneficiaries.[13] All furnished home health services should be medically necessary, as provided in each State's plan for medical assistance and supporting guidelines. Physicians play a vital role in ensuring the medical necessity of Medicaid home health services. They are responsible for developing a plan of care for the services patients receive.[14] The beneficiary's

medical record should include documentation supporting the medical need and clinical rationale of the services.[15, 16]

A physician should review home health services every 60 days.[17] Some States require the physician to review the beneficiary's plan of care and determine the medical need for certification of continued or additional services prior to reauthorizing ongoing services or authorizing additional services.[18]

Home Health Fraud, Waste, and Abuse

The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) recently released a report on questionable billing issues in home-health agencies.[19] Physicians should be aware of fraudulent, abusive, or wasteful home health activities. Some examples include:

- A personal care and respite service provider and the office staff conspired to submit claims for services not delivered and altered company records, including time sheets;[20]
- A home health care provider paid for beneficiaries' DME, such as walkers and canes, that Medicare did not cover; paid for monitoring services for some beneficiaries; and gave beneficiaries gifts, all in exchange for signing up for his home health services. The same provider also paid kickbacks to staff at senior living facilities for referring these beneficiaries;[21] and
- A personal care assistant billed a Medicaid waiver program for services she never delivered and claimed dates of service during times she was traveling abroad. She was sentenced to 5 years probation for false claims and mail fraud.[22]

The Affordable Care Act authorized the Centers for Medicare & Medicaid Services (CMS) to impose "a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers" for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[23, 24] CMS does work with State Medicaid agencies (SMAs) to determine the availability of services in an area before imposing an enrollment moratorium. As of this publication, several geographic regions had moratoria on home-health services providers. The moratoria are reviewed every 6 months, may be extended in 6-month increments as needed (decisions published in the Federal Register[25]), and are not subject to judicial review.[26, 27]

Medicaid Durable Medical Equipment Coverage

Mandatory benefits under Medicaid home health services include the coverage of "medical supplies, equipment, and appliances suitable for use in the home."[28] These services are often called DME. Just as physicians play an important role in certifying that home health services are medically necessary, they play an equally important role in certifying the need for DME.

All DME benefits furnished to a Medicaid beneficiary must be necessary and ordered by a physician. Each State requires documentation justifying the medical need for DME and supplies ordered. States may have a prior authorization process for some equipment, such as an oximeter or electronic nebulizer. States may also require a Certificate of Medical Necessity (CMN) containing additional clinical justification for certain kinds of equipment, such as a customized wheelchair or an air-fluidized bed.[29] It is important for physicians to know and understand the requirements for the States where they practice so they meet criteria and can assist in the fight against fraud, waste, and abuse.

DME Fraud, Waste, and Abuse

The following are examples of DME fraud, waste, and abuse:

- A DME supply company owner purchased authentic and forged physician orders and used them to bill Medicare and Medicaid for DME never delivered to the beneficiaries. The owner also upcoded the claims to receive more money;[30]
- A DME business owner and associates used a marketing firm to obtain Medicare and Medicaid numbers from beneficiaries to bill for power wheelchairs and other items that were never prescribed, or prescribed and never delivered;[31]
- A supplier of adult urinary incontinence supplies overbilled Medicaid for delivering fewer items to the beneficiary than he billed to Medicaid, for supplies the beneficiary did not want or that had not been prescribed, and for the largest size possible of adult diapers without regard to the size of the beneficiary;[32]
- A DME company billed for setup of and training on continuous and bi-level positive airway pressure units by unlicensed technicians. The State law required respiratory therapists to perform those tasks;[33] and
- A wheelchair company owner was originally convicted in 2014 on two counts of making false statements to Washington Medicaid for repairing wheelchairs with used parts, painting them, falsifying serial numbers, and selling them as new.[34] In 2016, the same owner was ordered to pay a $2.7 million settlement for the conviction and was not allowed to discharge that debt in a separate bankruptcy hearing.[35]

How Physicians and Other Providers Can Promote Program Integrity

Physicians ordering home health services and DME play an important role in promoting integrity to minimize and prevent fraud, waste, and abuse in Medicaid programs. The following are key points for providers to remember.

1. **Confirm eligibility:** Verify the Medicaid eligibility status of patients at the time of service.
2. **Include identifiers:** If required by the State when ordering services or supplies, the ordering provider's signature and National Provider Identifier (NPI) should be included on the CMN or other prior authorization form.[36, 37]
3. **Order appropriately:** Order according to the medical needs of the beneficiary within the limits set by the State.
4. **Maintain organized records:** Keep patient records organized and up-to-date, and confirm that the patient's condition warrants the service requested in the CMN or prior authorization request.
5. **Educate staff:** Providers should educate staff on the issues and schemes that constitute fraud, waste, and abuse.
6. **Practice within scope:** Always document the medical necessity of the service(s) ordered. If a medically unnecessary service is billed or if the documentation does not justify medical necessity, it may be considered a false claim.
7. **Protect yourself:** Be on the alert for other professionals who may make inappropriate requests, such as a "quick signature" on a document for a patient never seen, asking for additional patient services because of convenience rather than medical necessity (for example, ambulance transportation instead of a medivan), asking for beneficiary medical identifiers when there is no specific need, or offering to provide remuneration for beneficiary referrals.

Fraud and Abuse: How Do You Report Them?

To report fraud and abuse:

- Contact your State Medicaid Fraud Control Unit or SMA. Contact information can be found on the CMS website at:

  https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html

- Contact the HHS-OIG:

  Office of Inspector General
  U.S. Department of Health and Human Services
  ATTN: Hotline
  P.O. Box 23489
  Washington, DC 20026
  Phone: 1-800-HHS-TIPS (1-800-447-8477)
  TTY: 1-800-377-4950
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov
  Website: https://forms.oig.hhs.gov/hotlineoperations/

To see the electronic version of this booklet and the other products included in the "Home and Community-Based Services" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

1 U.S. Department of Health and Human Services. (2015, November 13). FY 2015 Agency Financial Report (p. 193). Retrieved March 2, 2016, from http://www.hhs.gov/afr/fy-2015-hhs-agency-financial-report.pdf

2 U.S. Government Accountability Office. (2014, May). Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures (p. 2). Retrieved March 8, 2016, from http://gao.gov/assets/670/663306.pdf

3 Payment Accuracy Integrity Group. Medicaid. Click "Historical" tab over graph. Retrieved March 8, 2016, from https://paymentaccuracy.gov/tracked/medicaid-2015

4 U.S. Department of Health and Human Services. (2015, November 13). FY 2015 Agency Financial Report (p. 24). Retrieved March 8, 2016, from http://www.hhs.gov/afr/fy-2015-hhs-agency-financial-report.pdf

5 U.S. Government Accountability Office. (2014, May). Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures. Retrieved March 8, 2016, from http://gao.gov/assets/670/663306.pdf

6 U.S. Government Accountability Office. (2011, March 9). Medicare and Medicaid Fraud, Waste, and Abuse. Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments. Statement of Kathleen M. King. Director, Health Care. Retrieved March 8, 2016, from http://www.gao.gov/assets/130/125646.pdf

7 Social Security Act § 1902(a)(10)(D). State Plans for Medical Assistance. Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

8 U.S. Department of Health and Human Services. Office of Inspector General. (2013, July 1). Memorandum Report: Some States Improperly Restrict Eligibility for Medicaid Mandatory Home Health Services. Retrieved March 8, 2016, from http://oig.hhs.gov/oei/reports/oei-07-13-00060.asp

9 Home Health Services. 42 C.F.R. § 440.70(b). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.1.112.9&rgn=div8

10 Federal Register Vol. 81, No. 21. U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2016, February 2). Part 440—Services: General Provisions. (p. 38). Retrieved March 8, 2016, from https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01585.pdf

11 Social Security Act § 1915(c). Provisions Respecting Inapplicability and Waiver of Certain Requirements of This Title. Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

12 Social Security Act § 1915(c)(4)(B). Provisions Respecting Inapplicability and Waiver of Certain Requirements of This Title. Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

13 Sufficiency of Amount, Duration, and Scope, 42 C.F.R. § 440.230(b), (d). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.2.112.5&rgn=div8

14 Home Health Services, 42 C.F.R. § 440.70(a)(2). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.1.112.9&rgn=div8

15 Social Security Act § 1902(a)(30)(A). Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

16 Sufficiency of Amount, Duration, and Scope, 42 C.F.R. § 440.230(d). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.2.112.5&rgn=div8

17 Home Health Services, 42 C.F.R. § 440.70(a)(2). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.1.112.9&rgn=div8

18 Medical Necessity. (1996, March 18). Medicaid [Formerly NMAP] Services, 471 Neb. Admin. Code § 9-002.02(3). Retrieved March 8, 2016, from http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-09.pdf

19 U.S. Department of Health and Human Services. Office of Inspector General. (2012, August). Inappropriate and Questionable Billing by Medicare Home Health Agencies. Retrieved March 8, 2016, from http://oig.hhs.gov/oei/reports/oei-04-11-00240.pdf

20 U.S. Department of Justice. The U.S. Attorney's Office. Eastern District of Virginia. (2014, September 17). Medicaid Provider and Wife Convicted of Health Care Fraud. Retrieved March 8, 2016, from https://www.justice.gov/usao-edva/pr/medicaid-provider-and-wife-convicted-health-care-fraud

21 U.S. Department of Justice. The U.S. Attorney's Office. Southern District of Ohio. (2014, August 7). Columbus Home Health Operator Sentenced for Fraud. Retrieved March 8, 2016, from https://www.justice.gov/usao/ohs/news/08-07-14.html

22 U.S. Department of Justice. U.S. Attorney's Office. Southern District of Illinois. (2016, February 11). O'Fallon Woman Sentenced for Healthcare Fraud. Retrieved March 16, 2016, from https://www.justice.gov/usao-sdil/pr/ofallon-woman-sentenced-healthcare-fraud

23 Patient Protection and Affordable Care Act. (2010, March 23). § 6401 Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP. Retrieved March 8, 2016, from https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

24 Social Security Act. § 1866(j)(7) Temporary Moratorium on Enrollment of New Providers. Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title18/1866.htm

25 Federal Register Vol. 81, No. 21. U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2016, February 2). Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of the Extended Temporary Moratoria on Enrollment of Ground Ambulance Suppliers and Home Health Agencies in Designated Geographic Locations. Retrieved March 8, 2016, from https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01835.pdf

26 Moratoria on Newly Enrolling Medicare Providers and Suppliers. 42 C.F.R. § 424.570. Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=b32a4434eb5cfbb77fe0de7308ebf829&mc=true&node=se42.3.424_1570&rgn=div8

27 Social Security Act. § 1866(j)(7)(B) Limitation on Review. Retrieved March 8, 2016, from https://www.ssa.gov/OP_Home/ssact/title18/1866.htm

28 Home Health Services, 42 C.F.R. § 440.70(b)(3). Retrieved March 8, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fc386c61abf3fc11a176e9ee077368&node=42:4.0.1.1.9.1.112.9&rgn=div8

29 Medicaid Certification of Medical Necessity Forms. (2014, June 7). Medicaid Services, 471 Neb. Admin. Code § 7-007.01. Retrieved March 8, 2016, from http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-07.pdf

30 U.S. Department of Justice. The U.S. Attorney's Office. Southern District of Texas. (2013, June 6). Stafford DME Owner Heads to Federal Prison for Health Care Fraud and Identity Theft. Retrieved March 8, 2016, from https://www.justice.gov/usao-sdtx/pr/stafford-dme-owner-heads-federal-prison-health-care-fraud-and-identity-theft

31 U.S. Department of Justice. The U.S. Attorney's Office. Southern District of Texas. (2013, July 11). RGV DME Owner Gets 12 Years in Federal Prison for $11 Million Health Care Fraud Scheme. Retrieved March 8, 2016, from https://www.justice.gov/usao/txs/1News/Releases/2013%20July/130711%20-%20Herrera.html

32 U.S. Department of Justice. U.S. Attorney's Office. Southern District of Texas. (2012, February 9). Former DME Company Owner Lands in Federal Prison. Retrieved March 8, 2016, from https://www.justice.gov/archive/usao/txs/1News/Releases/2012%20February/120209%20Essien.html

33 U.S Department of Justice. U.S. Attorney's Office. District of Connecticut. (2016, January 12). Connecticut Medical Equipment Company Pays $600,000 to Settle False Claims Act Allegations. Retrieved March 16, 2016, from https://www.justice.gov/usao-ct/pr/connecticut-medical-equipment-company-pays-600000-settle-false-claims-act-allegations-0

34 Washington State. Office of the Attorney General. (2014, September 29). Attorney General Wins Medicaid Fraud Conviction Over Wheelchairs Plus President. Retrieved March 16, 2016, from http://www.atg.wa.gov/news/news-releases/attorney-general-wins-medicaid-fraud-conviction-over-wheelchairs-plus-president

35 Washington State. Office of the Attorney General. (2016, March 1). AG Secures $2.7 Million Medicaid Fraud Judgment Against Wheelchairs Plus President. Retrieved March 16, 2016, from http://www.atg.wa.gov/news/news-releases/ag-secures-27-million-medicaid-fraud-judgment-against-wheelchairs-plus-president

36 South Carolina Department of Health and Human Services. (2015, January 1). Durable Medical Equipment Provider Manual, p. i. In DME 001 row, click "Medicaid Certificate of Medical Necessity Equipment/Supplies". Retrieved March 8, 2016, from https://www.scdhhs.gov/internet/pdf/manuals/dme/Forms.pdf

37 Texas Medicaid & Healthcare Partnership. (2009, January 1). Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request. Retrieved March 8, 2016, from http://www.tmhp.com/Provider_Forms/PA_Forms/F00038_Medicaid_Cert_Med_Nec_HFCWCS_Initial.pdf

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