

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Law-Enforcement Observations About Home-Health Fraud
Wednesday, January 4, 2017
Conference Call Only
Moderator: Jill Darling

Operator: Good afternoon. My name is (Virgil) and I will be your conference operator today. At this time, I would like to welcome everyone to the Law-Enforcement Observations about Home-Health Fraud conference call.

All lines had been place on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press "Star" then the number One on your telephone keypad. If you would like to withdraw your question, press the Pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you (Virgil). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's special open door forum, Law-Enforcement Observations about Home-Health Fraud. Before we dive into today's presentation, I do have one announcement.

This Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

So now I will hand the call over to Jennifer McMullen.

Jennifer McMullen: Thank you. This is Jennifer McMullen in the Center for Program Integrity. We want to thank you for joining us today. Home-health agencies - - home-health agency services are a critical part of the health care continuum and instrumental in helping a patient with Medicare benefits to recover after an illness or injury.

The Medicare Home-health benefit allows beneficiaries who are deemed homebound to receive certain medically necessary services in their home which is a preferred setting for many beneficiaries. In Fiscal Year 2015, the improper payment rate for home-health plans was 59 percent. For Fiscal Year 2016, the improper payment rate was reduced to 42 percent.

CMS is continuing to take actions to further reduce the home-health improper payment rate and encourage accurate billing such as implementing policy clarifications, conducting a probe and educate process and introducing a pre-claim review demonstration. Additionally, reports from the Office of Inspector General and Government Accountability Office show evidence of fraudulent billing within the home-health benefit.

As a result, law enforcement agencies are also taking actions. On this call, Stephen Lee, a District U.S. Attorney for the Northern District of Illinois will discuss his observations on vulnerabilities in home-health. I'll now turn the call over to Stephen.

Stephen Lee: Hi everyone. Again, good morning and good afternoon to everyone on the call. Thank you for having me here. As Jennifer said, my name is Stephen Lee and I'm an Assistant United States Attorney in the Northern District of Illinois which is the federal district covering Chicago and surrounding area.

I focus primarily on healthcare fraud and I work on multiple cases involving home-health fraud specifically including cases involving doctors, nurses, home-health agencies, home visiting physician companies and marketers of various kinds. As many of you on the line know, home-health fraud has become a widespread problem and I'm happy to share some overall observations on what we have seen in the course of our investigations to help address this problem.

As you -- hopefully most of you on the line knows there are some slides that are available online. You could go find them on the link which is attached to the notice. I'm now turning to the second slide of the presentation. So, I want to begin with just kind of quickly going over the Medicare requirements for home-health services.

And I do want to point out, these are all set out in the Medicare Benefit Policy Manual chapter 7 which is available online and which doctors and nurses working in home-health should be familiar with. One of the basic requirements for home-health services that are covered by Medicare is that the patient is confined to the home.

And the Medicare Benefit Policy Manual has a specific definition of what it means to be confined to the home for these purposes and that definition is laid out on the second slide of the presentation and it's set out in the Medicare Benefit Policy Manual. It's a two-part criteria and the Medicare regulations also give examples of the kinds of patients who would be considered confined to the home and some helpful I think -- and I think some helpful explanations to help people make accurate determinations as to whether patients are confined to the home.

Another requirement for home-health services that are paid for and covered by Medicare is that the patient actually have a need for reasonable and necessary skilled nursing services. And I think that's an important component of this as well. As I'll get to later on, we've seen through our investigations a lot of patients getting home-health services that are paid for by Medicare but which actually are really just basic routine checkups of a patient's blood pressure and vital signs, which are not things that are generally considered reasonable and necessary skilled nursing services that Medicare will pay for.

So those are the two big -- those are two of the requirements for home-health services and again these are all set out in far more detail in the Medicare Benefit Policy Manual. So, I want to talk about how this system of home-health that Medicare will pay for is vulnerable to fraud, waste and abuse. And I want to talk about some of the reasons -- step back a little bit and talk about some of the vulnerabilities in the home-health system.

First of all -- and I've said this in trials in my -- in various arguments I made to juries, pointing this out. But Medicare trusts physicians and nurses to provide accurate diagnoses of their patients and to order services that the patient actually needs. And Medicare generally does not verify claims or conditions before making payment. So, there's a lot of trust placed in doctors and the nurses to submit accurate information and to only order things that the doctor has actually exercised his or her medical judgment into believing the patient actually needed and qualified for.

So that is something -- there's a lot of trust placed in doctors and nurses and that trust can be abused. And what we've seen are -- another vulnerability is when we have physicians and nurses out there who -- a variety of things. First of all we've seen physicians and nurses who have financial incentives to keep patients on home-health services, even when the patient doesn't qualify for them.

We've seen cases where doctors, they want to say the patient is sicker than the patient actually is, so this way they can order services themselves that they can get paid for. We see nurses who are paid on a per visit basis and thus have financial incentive to keep a patient on home-health services even when the patient doesn't need them anymore because then they'll lose the money that they get for making those visits.

We also see a lot of physicians and nurses out there who have been given bad training, who have been mistrained into how to fill out charts and who have also received bad training regarding the requirements for home-health services. For example, we've seen instances where people either don't have understanding of the basic requirements for home-health services or have an inaccurate understanding of the requirements for home-health services.

Through the cases we've seen here, I've heard of people telling people that some patients are homebound as long as there's a cane in the house, even if the patient doesn't use the cane. I've heard people try to convince others that a patient is considered homebound if they have depression, even if that depression is controlled. I've heard people say that people -- patients will

qualify for skilled nursing services as long as they take at least three medications.

All things which are far away from the Medicare definition of confined to the home and the Medicare requirements for skilled nursing services. And so that's a vulnerability that we have where physician and nurses are ordering services and billing Medicare based on improper standards, sometimes the results of negligence or carelessness, sometimes the result of fraud.

We also see a vulnerability in the home-health system because we see a lot of times there are patients who are misled as to their qualification for home-health services. We've seen cases where patients are basically told that as long as they're on Medicare, they're entitled to home-health services and they should get those home-health services, even if without any regard to whether they actually are confined to the home or actually have any need for skilled nursing services.

And I think this problem of patients not understanding what is being said and done in their name is exacerbated by the lack of checks that we sometimes see in other parts of the healthcare system. Home-health is an area that Medicare will cover 100 percent of if a patient is said to qualify for these services. So, there are no co-pays or deductibles that would show -- make the patient have any kind of financial stake in the service that are being done.

So again, this is something -- this is a vulnerability -that I think some people can take advantage of in order to basically bill for Medicare for home-health services even if the patient doesn't qualify or need them. And we'll talk about how these vulnerabilities can be taken advantage of but as we said earlier in the call, Medicare has estimated a very high percentage of improper payments in home-health, 59 percent in the 2015 report period.

So in terms of these vulnerabilities, we've seen here -- through the course of our investigations here, we've seen what I considered two general types of schemes that take advantage of the system. And both types turn the system upside-down because what you see happening is that ultimately rather than a doctor making the decisions, medical decisions for his or her patients, that a

patient qualifies for home-health services and need those services and supervises them.

What we see in both of these types of schemes is we see non-physicians making decisions about a patient for financial reasons to benefit themselves and getting doctors ultimately to simply sign off on a document and make it appear that decisions are being made by physicians for medical reasons. And both these types of schemes result in Medicare paying for large amounts of an unnecessary services.

So, I'm now turning to slide five and this is kind of -- it shows kind of the first type of scheme that I was referring to. And this involves a home-health agencies or marketers showing up to doctors and offering them illegal kickback payments in order to get patient referrals, and we see this in a variety of ways.

We see marketers showing up to doctors with two envelopes, one filled with cash and other filled with all the orders that they want the doctor to sign. We also see home-health agencies offering these payments by disguising the payments in some ways, sometimes as medical directorships, when the doctor really isn't supposed to do anything other than refer patients. And they'll keep getting those directorship payments as long as they keep referring a good number of patients.

And obviously, there are some problems with this kind of -- with this kind of setup. First of all, these kinds of payments can violate the Anti-Kickback Statute. Second of all, people who pay kickbacks tend to be associated with fraud. After all, stepping back and thinking about it for a moment, if someone is willing to violate one federal law in order to get a patient from a doctor, it's not surprising when that person will then go on and violate other federal laws to make more money using that patient.

And doctors who get cash along with orders tend not to look at the orders very carefully. So what we see here is a lot of times doctors when they get that envelope of cash and that envelope with orders, they don't look very closely at

that -- those orders and they just sign off on whatever is being asked of them, and they could end up authorizing improper services for patients.

It maybe that the doctor might have had some legitimate idea that a patient maybe qualified for service initially, but we also will see patients continue to get services for long extended periods, far beyond the time when they might actually get qualified for them. I'm turning to slide six.

This is the second type of scheme that we've seen and this is one that I think is maybe one that is newer in the broader scope of home-health. And so we see here in this type of scheme is we see home-health agencies using marketers or telemarketers to find patients often going behind the back of the patient's primary care physician. And how this works, first of all we often see a home-health agency again using some kind of marketer, telemarketer to find patients.

So, we see marketers going to churches or apartment buildings to try to sign up people for some kind of unspecified program or we see telemarketers making unsolicited calls, looking for people who are Medicare. And we see these marketers and telemarketers offering these Medicare beneficiaries the benefit of free nurses coming to their homes without any discussion of the actual requirements for home-health services.

And that's how we see a lot of patients' kind of getting suck into this system in the first place. So, we see patients who are healthy, who are going to a primary care physician, who had no change in the medical conditions that would necessitate them receiving home-health services. But suddenly, getting caught up in home-health because someone signed them up somehow, often under misleading or false pretenses.

The second step is that the marketer, telemarketer once they have that patients' information will then refer the patients to the home-health agency that retain them rather than leaving the choices of home-health services or which home-health service provider, rather than letting that patient's primary care physician or the patient themselves make that choice.

Third, we see that the home-health agency once they have that patient, they need to get some kind of doctor to sign off on those home-health services that they want to provide. We've seen instances where the agency might try to get the patient's primary care physician to authorize services but often this might not work because the primary care physician would have ordered those services already if the primary care physician believed the patient qualified for and needed home-health services.

So in those cases, instead we've seen home-health agencies rather than going to the primary care physician, they will go find some other doctor who will say that the patient is confined to the home. And often we see them finding some physician who will also have a financial incentive to say the patient is confined to the home, even if the patient is not. And a lot of those cases, we've seen physicians that being -- physicians who work at companies that do primarily home visits with patients and who get most of their patient referrals from home-health agencies.

So in this situation, we've seen that those physicians have a financial incentive in saying the patient is confined at home because first, they can use this patient to build their own services to Medicare sometimes unnecessarily. And second of all, because they will certify patients for home-health services because this way they can get more referrals from those home-health agencies that they are depending on.

And so as a result of this scheme, this can all end up in a situation where the patient may continue going to their primary care physician without any difficulty and on a regular basis while sometimes without the primary care physician's knowledge, a home-health agency is seeing the patient following orders signed up on by some other doctor. And so this is a situation that can be problematic.

First of all -- going through the very steps of the procedure, first of all having marketers or telemarketers listing patients in this way and having those marketers or telemarketers referring patients directly to the home-health agency, that can be problematic and it can violate the Anti-Kickback Statute,

particularly depending on the payment arrangements that are made and the kind of disclosures that are made along the way to the patients.

You also had instances where -- so that can be a problem in terms of the use of the marketer, telemarketer. In terms of the home-health agencies use of the home visiting physician, that could be problematic because when you have home-health -- when you have services being authorized when patients don't need them, especially when there are pressures on the physicians one way or another to certify patients as being confined to the home even when they're not.

Okay, turning to slide seven, we've seen -- once these patients -- that's how -- what I just talked about is how the patients kind of get into the system in the first place, even if there may not be a need for the patients to receive home-health services and even if the patient is not confined to the home. But what we see happening afterwards is we see various things going on both with the nursing agencies and the nurses as well as the physician side, particularly the home visiting physicians that are involved in some of this activity.

So, I'm going to go through some of the things we were seeing in those areas. First of all from the nursing agencies, we see multiple things going on that are problematic. First of all, we see nurses lying about patient's conditions in their assessments in order to make the patients appear sicker than they actually are.

And we see nurses doing this because this way it can help make the services appear to be legitimate and necessary because they'll say things like how the patient has knowledge deficits, that a patient is confined to the home, the patient is suffering massive pain. The patient can't bathe themselves or dress themselves. Those are -- those are things that -- those -- we see a lot of times, false statements in those regards being made on nursing assessments in order to help conceal the fact that these services aren't really necessary.

This also can be a way to help increase the payments from Medicare to the home-health agencies. As many people on the call know, the system for exactly what Medicare will pay for an episode of nursing services is

complicated. But generally speaking the sicker a patient appears to be in the assessments, the more the Medicare will pay for -- for an episode of home-health services. We also see nurses and nursing agencies create false documentation to make the system appear to be legitimate.

So, we'll see things that even when the home-health agency has gotten the patient from a doctor -- from a marketer rather than a doctor and even when the home-health agency is making the decision themselves and simply finding some doctors sign off on things after the fact, we see agencies and nurses create false documentation to make it looked like the doctors are the ones ordering these things. Like creating fake orders, telephone orders, making it appear that the doctors, the nurses had a telephone conversation with the doctors ordered the nurses to -- to begin or continue with home-health nursing services, even when there was no such telephone conversation.

And that kind of false documentation make things look legitimate and appropriate if there's an audit down the road. But a lot of the time, that can just help cover up the fact that it's not really operating the way it should be operating. Another thing we've seen is we've seen nurses creating false documentation regarding nursing visits. This can go in multiple ways. We see sometimes nurses will create fake visit notes to make it appear that the visit happened when the visit didn't even happen at all.

We'll see nurses go into patients and asking patients to please sign multiple visit notes and then later on going off and just filling it in to make it looked like there was a visit when no visit happened. We also see nurses lying in the visit notes, even when the visit actually did happen and lying about what actually happened during the visit.

So, we'll see nurses going to do a visit with the patient, spending a short amount of time. They're basically just checking their vital signs and chitchatting and then leaving but their visit notes will make it looked like they spent a lot of time doing teaching and training about conditions that the patient had for a very long time.

And you'll create these weird situations where you'll see that when you flip through the note, it makes it looked like they're teaching the patient every week or every other week about basic things that the patients already have like hypertension or diabetes on and on for years. But, that helps make it look like the nurses are actually doing something during the visits rather than just doing the basic checkups, so that's another kind of lie or false documentation that nurses will create to support nursing visit notes.

And another thing we've seen in our investigation is we've seen this instance where nursing agencies will keep a patient on for multiple episodes of home-health services and then they'll discharge the patients. And then they'll wait a short amount of time and then they'll readmit the patients at the same agency or at a related agency even when there was no intervening change to the patient's medical condition.

And we see this happening -- and in doing that, we see nursing agencies and nurses lying about the patient's conditions and creating false documentation to make it appear that these discharges and readmissions are happening based on some kind of need when really it's being done as a way to continue keeping a patient on home-health services for what ultimately can be extended periods of time without trying to set off certain red flags. And I'll go into this in a little more detail later on with a specific patient example, kind of walk through at this particular example of how this scheme works.

On the home visiting physician side, we've seen various problems on that side as well. So first of all, we see that a lot -- some of these companies will get most of their patients from home-health agencies. And thus, there's the expectation that they will -- once they get the patient, they will certify the patient for home-health services and refer the patient back to the home-health agency that referred the patient to them in the first place.

So there's kind of -- there's this helpful symbiotic relationship between the two. Both of them wanting to say that a patient is confined to the home or sicker than the patient may actually be, so that both of them can bill their respective sets of claims to Medicare.

Because you see in these instances, the skilled nursing agency may bill Medicare for home-health services but then you'll see the home visiting physician company billing Medicare for unnecessary home visits with the patient, unnecessary tests, unnecessary services such as care plan oversight. All which adds up to what can be huge amounts of money very quickly.

So, the first thing is that these companies -- one thing we've seen with some of the companies we've investigated is that they'll first of all will help agencies bill Medicare false or improper nursing services by having doctors working at those companies, signing orders for patients who do not qualify for nursing services, and we see this happening in various ways. Some of the doctors worked in these companies are completely in on it. They understand the requirements for home-health services and they are just going along with this because this is the way to keep their job and so they are going to forth and lying and putting false statements into patient charts to help this whole thing work. We see other doctors who are involved who are mistrained and don't know what they're doing. We see some doctors who have said that they did not understand that there wasn't any definition of confine to the home, even after they've authorized millions of dollars of home-health services.

We've seen doctors who did not understand -- who claimed at least to (say) that they don't -- or did not understand that there's a requirement of services actually being reasonable and necessary. Again, even though they authorized huge amounts of Medicare payments for home-health services. So on this side, we've seen doctors -- we've seen all kinds of doctors involved in this but a lot of times we see doctors signing -- ultimately comes down to doctors signing orders for patients who do not qualify for these services.

We've also seen these companies billing Medicare for unnecessary services such as monthly home visits that are scheduled automatically, even when the patient has no need for those services, even when the patient -- there's no need for the visit to be done at the patient's home. And we've also seen companies billing these visits as if they were far more complicated than they actually were.

We've seen multiple companies here, they'll basically schedule automatically monthly visits with patients and bill each visit -- have the visit conducted -- the visits will usually be short and routine in nature because the patients -- not much is changed in the month since the patient was last seen. And there's not much going on with the patient but then the companies will bill these visits at the highest or the second highest level, CPT code 99350 or CPT code 99349, resulting in greater payments by Medicare.

We also see companies performing unnecessary diagnostic tests on patients. We've seen companies that basically will have a checklist and automatically order basically any test that they can bill for and on as frequent a basis that they think they can get away with such as ordering echocardiograms automatically every certain number of months, ordering other kinds of tests. We also see companies billing Medicare for things like care plan oversight which is a service that can be billed for legitimately but there are multiple requirements that go along with that. But we see companies billing care plan oversight on an automatic basis, treating every patient they have as meeting the requirements for care plan oversight. And we see companies creating fake documentation to support the care plan oversight or we also see companies adding false information to patient charts to, again, to make patients look sicker than they actually are.

All right, so I now want to go through kind of an example of how this can work, taking a specific patient from an actual case and this might be helpful to kind of really explain some of the things I'd been talking about. So I'm now looking at slide 9, again which is available -- the slides are available online and what's on the screen or what's on slide 9 are portions of a home-health certification order, a Form 485, for a particular patient connected to one home-health agency in one criminal case.

And this case ultimately involved one home-health agency, a home visiting physician company and some doctors as well as some marketers. And the result of this case overall, two home-health agency owners, three nurses, one doctor who operated a home visiting physician company, two doctors who took kickbacks, two marketers and the office manager for another doctor were

all convicted in connection with this case on healthcare fraud or kickback charges.

More specifically, both the nurse who signed this 485 and the doctor who signed this 485 pled guilty to healthcare fraud and both ultimately agreed to cooperate with the government about what they knew about this matter. Both acknowledged that there were never any kind of verbal orders between the nurses and the doctor as was made to look -- as this chart is made to look like.

And what really was going on was this home-health agency simply sent 485s to the doctor after the fact with the understanding and expectation that he would simply sign-off on everything they asked him to, which he did do. So, this order concerned a healthy patient who was on Medicare but regularly worked out at the gym and actually worked at some point.

And he started getting home-health services from this agency not because he was discharged from a hospital and not because there had been any kind of change in his medical condition that necessitated these services, what happened was that he was recruited by a marketer who worked for this home-health agency. And this marketer went around looking for people who are on Medicare and with this patient, the marketer went to a food pantry and just asked around who there had a Medicare card.

This patient said he did and the marketer offered him a small amount of money in order to sign up to start receiving a home nurse. The patient agreed, not knowing there's anything that might be improper about this or not knowing what the requirements for home-health services would be. And the marketer then took this patient's information and referred the patient to the home-health agency that paid him for each patient referral and for every time that the home-health agency would discharge and readmit the patient. This agency then referred this patient to that doctor who admitted signing everything that home-health agencies sent over to his office and the agency began billing Medicare what turned out to be years of home-health services, and by the time of this order, Medicare had already been paying for more than a year of home-health services for this patient.

I'm now turning to the next slide, slide 10, and this is a summary of some of the billing claims data regarding this patient and some of the files, and this is an example of how this patient was cycled through the system to that admission-discharge-readmission scheme I talked about earlier and how the patient was cycled through all that in order to get more money out of Medicare.

So, what you see here is how this patient was initially admitted in May of 2010 and then got three episodes of home-health services ending in October 2010 and then was discharged, and then about two months later, the patient was admitted again for new cycle of home-health services and, again, got three episodes of home-health services. All of which were for, according to the 485, observation and assessment of basic chronic conditions, and then at the end of those three episodes, the patient was discharged and a letter was created for the file saying the patient was discharged.

Now, this letter was never sent to the patient. The patient was never told that he'd ever had been discharged from the services or that he was discharged because goals had been met. Those were all things that were created to make the file look right if anyone happened to look at the file, but the patient was simply told that Medicare required some kind of break in the services and that's why the nurse had to stop coming for a little while and then the nurse will come back.

Now, this is something that we've seen in several of our investigations and this itself is a red flag because there is nothing in, to just be clear, there is nothing in the Medicare regulations that says that patients who actually need home-health services should occasionally stop getting those services and take a break even if they actually need it and the Medicare Benefit Policy Manual specifically Chapter 7 Section 30.5.1 it supposedly says that Medicare does not limit the number of continues episodes for patients who continue to be eligible.

So, what we see here happening if the patient is discharged and then later readmitted in part to make it look like the home-health agency has actually done something for the patient because if a person is kept on home-health

services for extended period of time years continuously without any kind of break it might raise questions about whether home-health agency is actually providing any kind of reasonable care in this way.

So, what this has done is to discharge periodically in and then readmit to help make it look like they've helped the patient's condition improve enough that they can discharge the patient and then wait a little while and then lie about the patient and make the patient look sick, again. So, again, what you see happening is the patient is discharged in June 2011 and then two months later, the patients readmitted for (neuro-psycho) home-health services and is kept on (for a number of) three episodes going on to February 2012, and then about two and half months later, the patient is, again, readmitted for more observation assessment and the cycle began, again, they stop here because law enforcement agents execute a search warrant on this agency in the summer of 2012, thus stopping some of the activity that was going in this agency.

Now, I'm going to turn to the next slide, slide 11, and it does give some of the examples of how nurses -- how we've seen nurses lying in some of the nursing assessments, and the nurse who prepared this nursing assessment was one of the nurses who was convicted of health care fraud. This nurse also pled guilty and agreed to cooperate with the government and he admitted that he had been trained by his employers to fill out charts the same way automatically regardless making certain statements, whether or not they were true, and he admitted putting -- thus, putting false information into charts.

So, he was trained to basically always say that the patient had a knowledge deficit of their disease process, which is designed to help make it look like the patient actually needed teaching and training on a regular basis even though patient didn't. The nurse was trained to check off certain boxes on the nursing assessment to say that the patient was homebound because he needs assistance for all activities or is dependent upon adaptive devices. Again, not -- regardless of whether it is actually true and often when it wasn't, but this was just something he was trained to do to make the patient look sicker than the patient actually was and to make the services appear to be legitimate. And again, the nurse is also trained to say things like the patient always had a

certain amount of pain and to say things like the patients were incontinent even when those things weren't true

Turn to slide 12. This is an example of other false information that nurse was trained to put into charts and then they should -- that nurse did put into the charts even when it wasn't true and this is something that I want to show because it kind of help show how the cycling works and also how we can kind of see how these patterns develop that are indicative of fraud. So, as people who are familiar with the assessments will know there is a section of the assessments or what's called the activities of daily living and that's a section where nurses assess patients to determine whether are there -- they need any kind of assistance with basic activities such as dressing themselves, bathing themselves, using the bathroom by themselves.

And what we've seen is that some nurses are trained and some nurses will do lie in those assessments to make patients appear to be less independent than they actually are and to make it appear these patients are in need of massive assistance when they don't, and so we've seen things generally speaking, the number zero is associated with the patient not needing assistance or something such as dressing themselves or bathing themselves, and the higher the number the one, the twos and threes that is associated with greater levels of dependence on other people.

So, what you see here looking at the graph in the bottom right of slide 12, you see how the nurse lied regularly in nursing assessments to make the patient appear to need assistance dressing himself every time that the nurse readmitted the patient to home-health services and how the patient -- the nurse -- but how the nurse then made it seemed and did say accurately and become a discharge that the patient was able to dress himself by himself. So, this was a way to, again, to make it so the patient appears sicker than they actually were, to make it appear that the patient benefited from the nursing services they received over the multiple episodes of home-health that they had received and the Medicare paid for and is designed to be a way to help the scheme go on.

And this is something where -- and these are things that when you look at the file and it is true, it might help make it appear legitimate but when we got out

and talk to patients, and we ask a patient, "Did your ability to dress yourself go up and down like this over the course of the past few years, like the nurses claimed in the assessments." They know that's not true and I did had one patient just burst out -- I've had patients be massively offended by all the statements that those nice nurses were making about them all these years once they realized what's going on.

I've also had nurses -- I've also had patients -- I have one patient who just burst out laughing every time we would ask her about some of these assessments because they were so ridiculous and so untrue, but these are ways that we've seen nurses lying in nursing assessments in order to -- in order to make the services appear legitimate and to get more money out of Medicare.

OK. I want to turn now to -- I have summarized some of the red flags that I think we've seen in the course of our investigations. First of all, we've seen a lot of times when there are -- we've seen problems when admissions are not based on any kind of actual change in the patient medical condition or any kind of discharge from a hospital or nursing facility, but based simply on the patient being solicited by some kind of marketer. You know, we'll ask the patients why did that nurse started coming to see you, and they'll have -- they'll just remember some marketer or some vague phone call and that's not the kind of surgery or medical problem or hospitalization that generally is associated with actually necessary home-health services.

Another red flag we've seen are -- is when the home-health orders are being signed by physicians who are not the patient's primary care physician that is something that's possible but that's something that can be problematic, especially when the PCP has no idea this is going on with their patient. Another red flag is when we see multiple episodes of observation and assessment of chronic stable conditions. There have been many instances where we see problems where the agency will be billing Medicare for month after month, year after year of observation and assessment of patient's hypertension, diabetes, basic routine checkups when there is no need for them.

And, again, we've -- coming back to talked about before, we see a big red flag when we see a discharge followed by a readmission soon afterwards without

any kind of intervening change in the patient's medical condition. In one search that we did, we even found a chart where the home-health agency had planned -- when they had planned to discharge the patient in the future and when they plan to readmit the patient. Obviously, things that show that this was not based on any kind of actual need or based on even the patient's actual medical condition which is based on the scheme that they had they were executing.

Another thing we see which is a red flag is when there is we see inconsistencies in the patient's treatment and in the claims associated with that patient such as when we see a patient is receiving home visits in skilled nursing on a regular basis during the same period of time when they are going to visit their PCP at the primary care physician's office and that's something that we can see obviously by talking to patient, but we can also see that just looking at the claims data because we see when someone is supposedly confined to the home for a two-month period, but then we see the patient doing office visits with a primary care physician that's something that is possible but that's also something that can be a red flag.

And we found that sometimes we'll call the PCP and asked them if the patient was confined at home during that period, and they'll say, "No," and they had no idea that the patient is receiving home-health services at that same time. And I guess, we'll point out in terms of these kind of red flags obviously we have -- in terms of these investigations, there are multiple ways that we can do these investigations, multiple sources of information we have.

Obviously one thing people often will call us, call law-enforcement or the Medicare contractor report problems, but we can see things from the data as well, and we can see certain problem areas such as these red flags I've just talked about. Some of the things are -- can actually be kind of obvious once you know what to look for and these are things that can obviously will attract our attention.

OK. In terms of slide 14, I just want to talk a little bit about, obviously, some the consequences and some of the issues involved here. So, there are many -- multiple federal laws that prohibit some of the activities that I've just talked

about knowingly and willfully submitting a false and improper claim can be health care fraud and knowing willfully causing a false improper claim to be submitted can be health care fraud. So, even if someone is not the one actually pressing the button to submit the claim to Medicare, even if someone is not the one actually lying on the patient chart, that person could still be responsible for health care fraud if they are knowingly and willfully participating in that overall scheme.

So, someone who trains a nurse to lie in nursing assessments, that person can be responsible for health care fraud just as that nurse can be. Knowingly and willfully putting false information to a patient file in a health care matter that can be a crime. Paying-for-patient referrals can violate the Anti-Kickback Statute and it may violate state laws, depending on your state. Penalties for violating these kind of laws can include imprisonment, civil liability, forfeiture and restitution, and there are obviously collateral consequences that might follow from these kind criminal actions which I think is something that medical professionals, I think, don't think about as much when they should.

A doctor or a nurse who gets involved in this kind of activity, they can face suspension for Medicare, they can lose their professional licenses, they can even face immigration consequences if they are not a U.S. citizen. These are serious matters in addition to criminal penalties, and it is something that I think people should think about. I find that especially when you talk like kickback cases, I find that the benefit of those cash payments, it wasn't worth the doctor's license that the doctor spends his or her professional career earning and keeping and it's something that unfortunately by the time that cases get to the agencies I work with in my office, it may sometimes -- it's something they maybe should have thought of long before that.

And I want to close here my discussion by talking about some disclosure and that's something that's recommended, and also in some instances, required and is recommended in large part because it can help show -- we obviously -- we encourage people to report problems and to correct their own mistakes and their own improper claims and voluntary self-disclosure can help us determine on the criminal side how to proceed with the case. Voluntary self-disclosure can help show that someone who is acting in good faith and just made a big

mistake or that someone lacked criminal intent, which is a big issue -- was obviously an important issue for criminal prosecutions and how we approach cases here.

And we see at the flipside someone who fails to disclose improper claims, someone who fails to correct bad conduct or improper claims that can help establish that case of criminal intent. Someone who knows, that someone who learns that the company has been doing improper claims and just continues to do it, nonetheless because they just what to change things that person -- whether or not that person had criminal liability before they learned, and probably didn't have criminal liability before they learned, that person is involved criminally from that point onwards if they know that their company is submitting improper claims and they continue to participate in that nonetheless.

And I want to end my talk here by just talking how important reporting is. We obviously have a lot of resources in terms of investigating these kind of cases, but we obviously benefit from people calling us and telling us about things that they themselves are observing in the field. And so there's many ways for people to do that. You can contact your local Medicare contractor, you can call the OIG HHS hotline, you can contact the FBI. There are many ways for people to report wrongdoing that you seek out there.

And when you report information, the more specific you can be the better, the more -- the better the more we can work with. And I encourage people to think about this a lot as they go about things. If you're a doctor and some home-health agency you never heard of before is trying to get you to sign a 485 per patient who does not qualify for home-health services, don't just throw that fax away, you can report it. That could be something that can help us deal with that home-health agency.

On the flipside, if you're a home-health agency and you're being told by a doctor that he or she won't refer patients once you pay the doctor, you can report that. These are things that can help us do our investigations more effectively and efficiently, and we welcome that kind of help out there for those of you out in the field. Because obviously we know through our

investigations, we know of -- obviously we see a lot of problems out there, but we also know there are a lot of doctors, a lot of home-health agencies and nurses out there who are trying to do the right thing, and we know that those of you who are trying to do the right thing.

You also are being hurt by the doctors in the home-health agencies and the nurses out there who are violating the law. We know that it's harder for you to operate in the field if other people are cheating the system and defrauding government. And so we welcome your help in trying to do with that.

And so with that, I know we have a little bit time for some questions. So, I want to hand it back to Jill and happy to take any questions that people might have.

Melanie Combs-Dyer: Mr. Lee, this is Melanie Combs-Dyer. I'm the director of the Provider Compliance Group and first, I'd like to thank you for participating today and sharing with all of us all the important information that you included in your slides. And second, I want to sneak in a quick question before we open it up to the public. As you know, we began a pre-claim review demonstration in Illinois in August. I'm just curious, have you yet seen any change in behavior either on the part of ordering physicians and practitioners or on the part of home-health agencies yet.

Stephen Lee: I think we've -- it's obviously a little early to tell for sure. We have heard some anecdotal information about agencies changing their behavior as a result of the Pre-Claim Review Program. For example, basically recognizing that some patients don't qualify, and thus, not submitting claims for those patients in the first place. So, that's something that's one instance we've heard about, but it's -- but in general, we have found that there's a lot of people out there who are -- we see a lot of people out there in this area who are -- who know what's going on and who are all participants in defrauding government.

We also see incidents where a lot of people just don't they've been -- they've been trained badly by others over the years and this program could help correct some of that stuff. I think that's actually very valuable. I think that if people can this -- I think it's a useful way for people to learn more about the

requirements and help correct some of the bad training that I think we've seen out there in the field.

Melanie Combs-Dyer: Thank you.

Jill Darling: All right. Thank you, Stephen. (Virgil), we'll open up for a short Q&A, please.

Operator: Certainly. At this point, I would like to remind everyone, in order to ask a question, press "Star" then the number One on your telephone keypad. And if you'd like to withdraw your question, press the Pound key. Your first question comes from the line of (Jessie Wicks) from (PNS Inc.). Your line is open.

(Jessie Wicks): Hello?

Melanie Combs-Dyer: Yes, go ahead. (Jessie), do you have a question for us? OK. Operator, I think we'll take other -- next person on the line.

Operator: Your next question comes from the line of (Renee Ezer) from (Mansion) Home Care. Your line is open.

(Renee Ezer): Hello. I'm concerned though, is there other things that CMS is doing to prevent this other than just the pre-claim review?

Melanie Combs-Dyer: This is Melanie Combs-Dyer, and yes, there are a number of things that we have been doing over the years. We have put out a number of MedLearn Matters articles and other educational materials to providers. We spent a year doing what we call a probe and educate program where every home-health agency in the country was requested to send in five medical records to the MAC and records were reviewed and then the provider would -- or the home-health agency was given an opportunity to participate in an educational call with the MAC.

That process is being repeated now in all the states except the ones where pre-claim review is going to be in place. So, that is not happening right now in Illinois, but it's happening in all of the other state. So, yes, CMS is

undertaking a number of activities to help prevent improper payments in the home-health benefits.

(Renee Ezer): So, what are they doing with utilizing the technology itself?

Melanie Combs-Dyer: Do you mean with trying put out MedLearn Matters articles or put out videos ...

(Multiple Speakers)

(Renee Ezer): No, no. I mean ...

(Multiple Speakers)

(Melanie Combs-Dyer): ... to help educate home-health agencies?

(Renee Ezer): ... you received claims -- you received claims from primary care providers and you will receive claims from homecare. Why wouldn't technology be setting up red flags for you?

Melanie Combs-Dyer: We certainly do encourage our MACs to use data analysis to identify the claims that are the ones that are most likely to contain improper payments, but with a 59 percent error rate, there's an awful lot of wrong claims that are out there.

Operator, I think we're ready for our next question.

Operator: Your next question comes from the line of (Elizabeth Buckley) from Trinity Health. Your line is open.

(Elizabeth Buckley): Thank you. My question is I sort of what the previous caller had asked and you mentioned that 59 percent improper payment rate, and I think probably most will agree that a lot of those improper payments are more erroneous or mistakes or due to a lack of very good physician documentation that we get when you get referrals from physician, not necessarily fraud.

So, I think my question is for the agency to basically train their staff to do improper documentation and fill out paperwork erroneously, how do we think

that pre-claim review is really going to get to the root of that, and in relationship, the amount that it penalizes the agencies who are really doing right thing?

Melanie Combs-Dyer: This is Melanie and I'll start with that and then I'll ask Mr. Lee if he wants to add to that, I think that the biggest benefit coming from the Pre-Claim Review Program is going to be exactly what Mr. Lee said earlier, and that is helping to identify those home-health agencies that have been making mistakes. Perhaps, they've been doing it inadvertently. They didn't understand or perhaps someone was mistrained at the home-health agency. I think that by helping those home-health agencies, remember what the rules are and bill correctly, that may be one of the biggest positive benefits coming out of the pre-claim review demonstration.

Mr. Lee, do you have anything you would add to that?

Stephen Lee: Yes. I mean, I think, as I was saying earlier, obviously a huge part of how the system works is trusting that people are putting accurate information. That is a huge part of the problem when you see people just lying in the forms, lying about the patient condition. But you also have people who are just -- but we also recognize that there are people who were just doing this wrong and so that's an issue that we have always have to deal with as we investigate cases.

We do recognize there's a difference between a mistake and a crime. Someone can make a mistake that cost a lot of money -- the government a lot of money but it's still just a mistake. So, we do -- and that's some -- and there are some limitations to what can be done various things. It may be that someone who is lying and maybe the Pre-Claim Review Program is limited in catching some of the lies and maybe that's something -- but it -- but there are -- that's why there's other obviously multiple mechanisms going on. There's the Pre-Claim Review Program, there's obviously investigations. And so hopefully as result of all these things kind of going on, hopefully there will be improvement out there.

(Multiple Speakers)

Jill Darling: Operator, we'll take one last question.

Operator: Your next question comes from the line of Theresa Gates from Beyond Home-health. Your line is open.

Theresa Gates: Hi. Good afternoon. I have a question related to the 59 percent improper payment rate and kind of touching on the last question. There is definitely within that 59 percent some technical recordkeeping problems that have obviously been grouped in with fraudulent behavior and criminal actions, yet that collateral consequences for those technical recordkeeping issues are grave right now, especially in ZPIC world where they're not been suspected of fraud, but yet face tremendous consequences collaterally. And that has to do with payment suspensions or prepayment review.

How has that been addressed? I know that has been brought up to CMS as a problem and how is that being addressed right now as far being lumped in with fraudulent activity when there is just the market-keeping technical issues that are needing to be addressed as well but not at that severity level?

Melanie Combs-Dyer: This is Melanie, again. I'll start that one and then turn it over to Mr. Lee. We do recognize that the vast majority of the 59 percent improper payment rate does not represent fraudulent activity. It represents the mistakes; it represents people who are experiencing sloppy documentation on the part of the ordering physician. There are lots of things that are going on in addition to fraud in the home-health space.

Nonetheless, it needs to be corrected. And CMS is taking a number of corrective actions to try to fix that. I mentioned earlier the Probe and Educate Program that we've had underway for a year and half now. The Pre-Claim Review Program I think will prove to be very beneficial at reminding providers what the rules are, getting them to bill correctly, giving them multiple opportunities without having to get into the appeal process to correct the documentation and resubmit it. We really do believe that if we can continue with our Pre-Claim Review Program in a number of states we can really help to correct and bring down that 59 percent improper payment rate.

Mr. Lee, would you want to add anything?

Stephen Lee: Just I guess in terms of -- obviously, it's hard to know in terms of the distinction between kind of sloppy paperwork and criminal activity and what is fraud, what is waste, what is just improper. Obviously, from a criminal point of view, a lot of goes to actually what's state of mind was of the people who were involved with this. But I'll say that, I think we've seen some instances here where the paperwork is sloppy and is sloppy because there is fraud going on but people either lie only so much or don't lie enough. But I think we have seen cases where sloppy paperwork is associated with a criminal activity.

So, that is the issue. So, I think this is something where it's just -- is helpful to kind of sort through all these issues. Because you'll have sometimes is the doctor will be -- he won't write that much in the form because the patient doesn't actually qualify in the first place. And that's why in hindsight, the paperwork will look sloppy and incomplete but it's actually because of the claim just wasn't good.

And so anyway, there's multiple issues involved, and obviously, hopefully the Pre-Claim Review Program will have some effect, as well as the other actions that are being done by other aspects of ...

(Multiple Speakers)

Theresa Gates: And I -- yes, and I appreciate that. The Probe and Educate -- the face-to-face Probe and Educate was a great opportunity for agencies to come together and reeducate their staff and do some training, and we did see a reduction and some denials of face-to-faces. However, that did not correlate to the increase in the ZPIC and payment suspension and improper payments and that's why I'm a little confused. You have a lot of technical recordkeeping issues that those companies that have a one record out of five on a face-to-face -- and this is in Florida. There are a lot of agencies, a lot that did very well on that the Probe and Educate for face-to-face but yet still are facing suspension issues for in technical recordkeeping. So, they didn't really correlate. And we're a little confused, especially in the State of Florida. So, that was why I brought that up.

Melanie Combs-Dyer: Thank you, Ms. Gates. We really appreciate your comments...

Theresa Gates: You're welcome.

Melanie Combs-Dyer: ... and we'll certainly take them under advisement as we try to consider where to continue our Probe and Educate process. And I think at this point, I'll call it time and turn it back over to Jill. Thank you very much.

Stephen Lee: Thanks, everyone.

Jill Darling: Thank you, Melanie, (Jennifer) and Stephen. That concludes today's call. Thank you very much.

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