

**HEALTH CARE COMPLIANCE
ASSOCIATION
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***Enforcement & Compliance in Home Health –
Hospice – Nursing Home***

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Part I: The False Claims Act

31 USC § 3729 – The False Claims Act (“FCA”) sets forth seven bases for liability. The most common ones are:

1. Knowingly presenting, or causing to be presented, to the Government a false or fraudulent claim for payment
2. Knowingly making, using, or causing to be made or used, a false record or statement material to get a false or fraudulent claim paid
3. Conspiring to commit a violation of the False Claims Act
4. Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or avoiding or decreasing an obligation to pay or transmit money or property to the government

Obligation defined as an established duty, whether or not fixed, arising...from retention of any overpayment

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Elements Of An FCA Offense

The Defendant must:

- Submit a claim (or cause a claim to be submitted)
- To the Government
- That is false or fraudulent
- Knowing of its falsity
- Seeking payment from the Federal Treasury
- Damages (maybe), related to any Federal payments, not just Federal Health Care Program payments

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Knowing & Knowingly

- No proof or specific intent to defraud is required
- The Government need only show person:
 - had “actual knowledge of the information”; or
 - acted in “deliberate ignorance” of the truth or falsity of the information; or
 - acted in “reckless disregard” of the truth or falsity of the information.

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Qui Tam Actions & Government Intervention

- A private person (“Relator”) may bring a False Claims Act action under the *qui tam* provisions of the FCA – The Whistleblower
- Government may intervene in a suit brought by Relator
- The relationship between Relator and Government

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FCA Statistics

- If the Government intervenes and obtains recovery, the Relator receives between 15% and 25% of the proceeds
- Since 1986, of all of the *qui tam* actions filed, the average yearly intervention rate has been about 20-25%
- Approximately \$3 billion in health care FCA recoveries in FY 2010; a 25% increase from 2009
- Recoveries have increased (higher penalties and greater publicity); \$6.8 billion since 2009 and over \$30 billion (in excess of \$20 billion in health care) overall since 1986
- Highest number of False Claims Act filings during 2014 (in excess of 700 new cases)
- Whistleblower protection is provided to those that take lawful actions in furtherance of the *qui tam* suit, including investigation, initiation, testimony for, or assistance in the action (Anti-Retaliation Provision and Cause of Action)

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Recent False Claims Act Amendments

- ❑ Liability for overpayments and failure to return a known overpayment within 60 days from identification-return of known overpayment an affirmative and express obligation
- ❑ Claims for payment from government contractors, grantees or other recipients if money is spent on government's behalf or to advance a government program or interest
- ❑ Materiality requirement for False Claims Act liability

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Recent False Claims Act Amendments

- ❑ Two types of actionable false claims:
 - Factually false
 - Legally false
- ❑ Increase in the per claim penalty
 - Minimum – from \$5,500 to \$10, 781
 - Maximum – from \$11,000 to \$21,563

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Hospice Care and The False Claims Act

- ❑ DOJ has stepped up enforcement of the False Claims Act against hospice organizations
- ❑ Common allegations against hospice providers:
 - False certifications
 - Admitting those who do not qualify
 - Deceptive admission practices
 - Falsifying documents
 - Services inconsistent with Plan of Care
 - Enrolling beneficiaries without proper documentation
 - Providing inadequate services.

Hospice Care and The False Claims Act

- *United States ex rel. Fowler and Towl v. Evercare Hospice, Inc.* (D. Colo.)
- *United States v. VITAS Hospice Services, LLC* (W.D. Mo.)
- *United States ex rel. Willis v. Angels of Hope Hospice, Inc.*, (M.D. Ga.)
- *United States v. Hospice Care of Kansas, LLC*, (D. Kan.)
- *United States ex rel. Paradies et al. v. AseraCare Inc. et al.*, (N.D. Ala.)
- *United States ex rel. Michaels v. Agape Senior Community Inc. et al.* (D. S.C.)
- *United States v. Odyssey HealthCare, Inc.* (E.D. Wisc. 2009)

Home Health Care and The False Claims Act

- Common allegations against home health agencies:
- Performing medically unnecessary procedures
 - Billing for services not rendered
 - Billing unskilled services as skilled
 - Falsifying documents
 - Double billing visits under different categories
 - Up-coding routine treatments
 - Billing for services not provided by certified HH aides
 - Failing to return overpayments timely
 - Billing for services to patients who are not homebound

Home Health Care and The False Claims Act

- *United States v. Amedisys, Inc. et al.* (E.D. Pa.)
- *United States v. University of Pennsylvania Health System* (E.D. Pa.)
- *United States v. ResCare Iowa Inc.*, (N.D. Iowa.)
- *United States v. Nurses' Registry and Home Health Corp. et al.*, (E.D. Ky.)
- *United States v. J.W. Enterprises, Inc. et al.*, (M.D. Tenn.)

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Nursing Home Care and The False Claims Act

- ❑ Failure of Care and Medically Unnecessary Services
 - *Mikes v. Strauss*, (Court of Appeals 2001)
 - Knowing request of federal reimbursement for procedure with no medical value violates FCA irrespective of any certification.
 - Performance of service so deficient that for all practical purposes it is equivalent to no performance at all.
 - *Chesbrough v. VPA, P.C.*, (Court of Appeals 2011)
 - If provider submits claims that it knows were not just of poor quality but had no medical value, then it would effectively submit claims for services not actually provided, which would amount to a false or fraudulent claim.
 - *U.S. ex rel. Absher v. Mornence Meadows Nursing Ctr.*
 - Nursing home provided some care therefore no "worthless service" claim because not the equivalent of no performance of services at all.
 - *U.S. v. Houser*, (Court of Appeals 2014)
 - Criminal liability for "worthless" nursing home services.

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Nursing Home Care and The False Claims Act

Common allegations regarding therapy services in FCA cases

- Presumptively assigning patients to highest therapy level
- Overriding recommendations of evaluating therapists
- Providing excessive, medically unnecessary treatments
- Shifting treatment minutes between disciplines to achieve desired RUG
- Significantly increasing treatment minutes at the end of assessment period
- Recording "rounded" vs. actual treatment minutes
- Inappropriate use of modalities to increase treatment minutes
- Pressure from management to achieve targeted rehab levels
- Managing to therapy level minimums

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Nursing Homes and The False Claims Act

FCA Settlements in Nursing Home Therapy Cases in 2016

- ❑ 01/20/2016:
 - Kindred/RehabCare to pay \$125 million to resolve FCA allegations
 - Four SNFs using Kindred/RehabCare to pay \$8.225 million
 - RehabCare and its SNF customers are alleged to have engaged in a "broad-ranging" scheme to falsely inflate therapy claims to Medicare
- ❑ 09/09/2016:
 - Los Angeles SNF and 2 MDs pay \$3.5 million to resolve allegations they participated in a scheme to recruit patients from "Skid Row" for medically unnecessary hospital and SNF stays
- ❑ 09/19/2016:
 - North American Health Care, Inc. to pay \$28.5 million to resolve FCA allegations of submitting claims for medically unnecessary therapy services
 - Senior VP to pay \$500,000 for allegedly creating the billing scheme
 - Board chairman to pay \$1 million for allegations he reinforced the scheme

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Nursing Homes and The False Claims Act

FCA Settlements in Nursing Home Therapy Cases in 2016

- ❑ 10/24/2016:
 - Life Care Centers of America, Inc. and its sole shareholder, Forrest L. Preston, to pay \$145 million to resolve False Claims Act allegations
 - Allegations include:
 - Engaging in a systematic effort to increase Medicare and TRICARE therapy billings
 - Instituting corporate-wide policies and practices designed to place patients in highest rehab level without regard to clinical needs
 - Keeping patients on therapy services after treating therapists thought they should be discharged
 - Submitting claims for therapy services that were not reasonable, necessary or skilled
 - Unjust enrichment of the owner from these fraudulent schemes

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Nursing Homes and The False Claims Act

Other False Claims Act SNF Cases Involving Therapy

- ❑ 04/21/2015: Government intervenes in HCR Manor Care FCA lawsuits
- ❑ 10/29/2015: Government intervenes in SavaSeniorCare FCA lawsuits
- ❑ In both cases, the government consolidated three qui tam lawsuits
- ❑ Allegations in both cases involve –
 - Claims for medically unnecessary therapy
 - Pressure from top management to achieve unrealistic therapy targets
 - Delaying discharges for patients who were medically ready for discharge

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Nursing Home Care and The False Claims Act (Cont'd.)

- ❑ *US v. NHC Health Care Corp.*, (W.D. Mo. 2001)
 - Long-term care facility alleged to have provided care to residents so insufficient and negligent that the claims for reimbursement amounted to fraud
 - Resident 1 suffered dehydration and digitoxicity, severe back pain, weight loss, pressure sores
 - Resident 2 had pressure sores, weight loss, was not helped with ADL
 - Family complained of lack of sufficient staff and proper care
 - Court found a reasonable jury could conclude that Defendant did not have enough staff to properly care for residents as promised under Medicare/Medicaid agreements.

Federal Anti-Kickback Statute

- ❑ Prohibits any person or entity from knowingly and willfully offering, making, soliciting, or accepting remuneration, in cash or in kind, directly or indirectly, to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-reimbursable medical goods or services
- ❑ "Remuneration" is broadly defined
- ❑ A person need not have actual knowledge of the statute or specific intent to commit a violation in order to violate the AKS

Hospice and the Anti-Kickback Statute

- ❑ Common allegations against hospice providers:
 - Obtaining referrals for hospice services through incentives and kickbacks
 - Providing incentives such as gifts or free services to referral sources
 - Paying kickbacks to employees based on referrals
 - Incentivizing patients to stay in hospice care by providing them gifts
 - Physicians referring to hospices in which they have an ownership interest
 - Arrangements to transfer patient care from physicians to hospice eliminating the cost of care.

Hospice and the Anti-Kickback Statute

- *United States ex rel. Smallwood v. Thi of Mich. LLC* (N.D. Ala.)
- *Druding v. Care Alternatives, Inc.* (D. N.J.)
- *United States ex rel. Cordingley and Jones v. Good Shepherd Hospice, Mid America Inc.*, (W.D. Mo.)
- *United States v. Eugene Goldman* (E.D. Pa.)

Home Health and the Anti-Kickback Statute

- ❑ Common allegations against home health agencies:
 - Purchasing beneficiary information and creating fake files
 - Paying kickbacks/bribes to recruit beneficiaries
 - Paying physicians to falsely certify HH care
 - Paying physicians for sham positions as inducement to refer
 - Receiving payments in exchange for referrals
 - Illegal remuneration to physician's spouse.

Home Health and the Anti-Kickback Statute

- *United States v. Minhas* (E.D. Mich. 2016)
- *United States v. Davis et al.* (E.D. La. 2016)
- *United States v. Alvarez et al.* (S.D. Fla. 2016)
- *United States ex rel. Simony v. Recovery Home Care, et al.* (M.D. Fla.)
- *United States ex rel. v. A Plus Home Health Care, Inc.* (S.D. Fla. 2014)
- *United States v. Tahir et al.* (E.D. Mich. 2016)
- *United States v. George* (N.D. Ill. 2016)
- *United States v. Deaconess Home Health, Inc.* (E.D. Wisc. 2015)

Nursing Homes and the Anti-Kickback Statute

- ❑ *United States ex rel. Beaujon v. Hebrew Homes Health Network, Inc., et al.* (S.D. Fla.)
 - Hebrew Homes provided skilled nursing facilities at seven rehabilitation and skilled nursing facilities in Miami-Dade County, Florida.
 - In 2015, paid \$17 million to settle alleged FCA and Anti-Kickback violations, brought by a *qui tam* Relator.
 - Largest settlement involving violations of the Anti-Kickback Statute by a skilled nursing facility.

Nursing Homes and the Anti-Kickback Statute

- ❑ *United States ex rel. Beaujon v. Hebrew Homes Health Network, Inc., et al.* (S.D. Fla.) (Cont'd)
- ❑ **Allegations:**
 - From 2006 through 2013, Hebrew Homes hired numerous physicians ostensibly as medical directors pursuant to contracts that specified numerous job duties and hourly requirements.
 - The medical directors performed almost none of the job duties listed in their contracts, but were paid the salaries provided in their contracts.
 - Paid for their patient referrals to the Hebrew Home facilities.

Nursing Homes and The Anti-Kickback Statute

"Swapping Arrangements"

- ❑ Example: SNF accepting a low price from a supplier for something covered by the Part A per diem in exchange referring to the supplier Part B business it can bill directly to Medicare
- ❑ 11/30/2015: Regent Management Services L.P. Settlement
 - This Texas SNF company paid \$2.7 million to settle civil FCA allegations that it received kickbacks from ambulance companies in exchange for rights to Regent's more lucrative Medicare and Medicaid transport referrals.
 - This settlement is the first in the nation to hold accountable the medical institution as opposed to the ambulance in this kind of "swapping" arrangement

Nursing Homes and the Anti-Kickback Statute

- ❑ **"Swapping Arrangement" Cases**
 - *U.S. ex rel. Jamieson v. McKesson*, (N.D. Ms. 2012) (Improper Discount Arrangements)
 - *U.S. ex rel. McDonough v. Symphony Diagnostics*, (S.D. Ohio 2012) (Discounts for Part A Services in return for more lucrative Part B Services)
 - *U.S. v. Shaw*, (D. Mass. 2000) (Improper Discount Arrangements)
 - *Klaczak v. Consolidated Medical Transport*, (N.D. Ill. 2006) (Discounts for Part A ambulance services in return for Medicare Part B transports)
 - *U.S. ex rel. Gale v. OmniCare*, (N.D. Ohio 2010); *U.S. ex rel. Pasqua v. Kan-Di-Ki LLC* (C.D. Calif. 2010); *U.S. ex rel. Ruscher v. OmniCare*, (S.D. Tex. 2013); *U.S. ex rel. Silver v. OmniCare*, (D. NJ 2011) (Discounted Part A for Part B services, and forgiveness of debt for Part A in return for Part B. services)

Home Health, Hospice and Nursing Home Fraud and Abuse

Civil Monetary Penalties and Affirmative Exclusions

- ❑ OIG has the authority to levy administrative penalties and assessments and exclude providers from federal health care programs for:
 - Filing false or improper claims
 - Violations of the AKS
- ❑ OIG has pursued HHAs, hospices and nursing homes who employed individuals who were excluded from participation in federal health care programs.

Home Health and Hospice Fraud and Abuse

CMP and Affirmative Exclusion Cases

- *United States v. Choice Home Health Care Inc. et al.* (Texas 2016)
- *United States v. Accurate Home Care, LLC* (Minn. 2015)
- *United States v. Ambulatory Health Care Services, LTD* (Ill. 2015)
- *Pinnacle Hospice Care* (Colo. 2016)
- *Hospice of the Valley* (Ariz. 2016)
- *Arizona Hospice CEO* (Ariz. 2015)
- *Premier Hospice and Palliative Care, LLC* (Ind. 2014)

Nursing Homes Fraud and Abuse

CMP and Affirmative Exclusion Cases

- ❑ 01/16/2017: Deseret Health Group and Jon Robertson (Robertson), Bountiful, Utah, agreed to be excluded from participation in all Federal health care programs for a period of thirty years
- ❑ OIG allegations included failure to:
 - Provide adequate care planning and assessments of residents
 - Provide medications, treatments, laboratory tests, etc. prescribed by physicians
 - Follow appropriate pressure ulcer, infection control and fall protocols
 - Avoid medication errors
 - Provide a safe living environment for residents

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Risk Areas and Compliance Strategies

Challenges Faced in Multi-Year Claim Audits

- Dates of service may encompass six years or more
- Locating medical records may be difficult
 - Multiple episodes of home health admits
 - Long lengths of hospice enrollment
- Need for thorough evaluation of record completeness
- Issues with changes in medical record practices
- Backlog of ALJ appeals increases importance of record completeness

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Risk Areas and Compliance Strategies

Changing Regulations and Guidelines: HHAs

- Physician certifications
 - Face to Face (F2F) encounter: January 1, 2011
 - F2F enforcement deferral until April 1, 2011
- Homebound status
- Caring Hearts v. Burwell, No. 14-3243, 2016 BL 171256, (May 31, 2016)*
 - Changes in homebound status not in force in 2008 were applied retroactively
 - *"This case has taken us to a strange world where the government itself – the very 'expert' agency responsible for promulgating the 'law' no less – seems unable to keep pace with its own frenetic lawmaking."*

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Risk Areas and Compliance Strategies

Changing Regulations and Guidelines: Hospices

- Physician certifications
 - Prior to 10/01/2009
 - Effective 10/01/2009: Physician's narrative
- Face to Face (F2F) encounter: January 1, 2011
 - Enforcement deferral until April 1, 2011
 - Physician's narrative must include findings from the F2F encounter

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Risk Areas and Compliance Strategies

Changing Regulations and Guidelines: Nursing Homes

- ❑ FY 2011:
 - MDS 2.0 to MDS 3.0
 - RUG-III to RUG-IV
 - Changes to the delivery and reporting of therapy services
- ❑ FY 2012:
 - Changes to scheduled PPS assessment windows
 - Revised definitions of modes of therapy delivery
 - Changes to group therapy rules
 - New Change of Therapy (COT) Assessments
 - "Clarification" of End of Therapy (EOT) assessment rules

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Risk Areas and Compliance Strategies

Identifying Areas of Payment Vulnerabilities

- ❑ Comprehensive Error Rate Testing (CERT) Program
- ❑ Medicare Regional Home Health and Hospice Intermediary
- ❑ General Accountability Office (GAO)
- ❑ Office of Inspector General (OIG)
- ❑ Program for Evaluating Payment Patterns Electronic Report (PEPPER)

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Risk Areas and Compliance Strategies

CERT Program

- ❑ Audits random sample of Medicare Fee-For-Service (FFS) claims for payment accuracy
- ❑ Estimates error rate overall and by type of service
- ❑ FY 2015 estimated total FFS error rate is 12.1% (\$43.3 billion)
- ❑ Publishes a Improper Payments Report and Supplementary Appendices annually
- ❑ Improper payment rates for FY 2015:
 - Home health agencies: 59.0% (\$10.1 billion)
 - Hospices: 10.7% (\$1.4 million)
- ❑ CERT Error Rates for SNF Services
 - FY 2015 Medicare FFS Improper Payment Rates:
 - SNF Inpatient: 10.4%
 - SNF Inpatient Part B: 19.4%
 - SNF Outpatient: 46.5%

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Risk Areas and Compliance Strategies

OIG Publications

- ❑ *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases* (HHS OIG Data Brief, June 2016, OEI 05-16-00031)
- ❑ Noted fraud cases often involve high % of:
 - Episodes for patients who had no recent visit with supervising physician
 - Episodes not preceded by hospital or nursing home stay
 - Episodes with primary diagnosis of diabetes or hypertension
 - Beneficiaries with claims from multiple HHAs
 - Beneficiaries with multiple readmissions over short timeframe

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Risk Areas and Compliance Strategies

OIG Publications: HHAs

- ❑ *Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians* (June 22, 2016)
- ❑ Warns HHAs and physicians to carefully evaluate compensation arrangements for compliance with AKS
- ❑ Identifies that criminal convictions and civil settlements have been obtained with both HHAs and physicians for the following:
 - Making (or accepting) payments for patient referrals;
 - Falsely certifying patients as homebound
 - Billing for medically unnecessary services or for services that were not rendered

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Risk Areas and Compliance Strategies

OIG Publications: Hospices

- ❑ *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (March 2016, OEI-02-10-44491):
- ❑ Analyzed a sample of all General Inpatient (GIP) stays billed by hospices in 2012
- ❑ Found 1/3 of GIP stays to be unsupported (> \$250 million)
- ❑ OIG's recommendations for CMS:
 - Increase its oversight of hospice GIP claims;
 - Ensure the physician is involved in the decision to use GIP
 - Conduct prepayment reviews of lengthy GIP stays

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Risk Areas and Compliance Strategies

OIG Publications: Nursing Homes

- 12/2010: Questionable Billing by SNFs” (OEI-02-09-00202)
- 11/2012: Inappropriate Payments to SNFs Cost More Than a Billion Dollars in 2009 (OEI-02-09-00200)
- 06/2015: SNF Billing for Changes in Therapy: Improvements Are Needed (OEI-02-13-00611)
- 09/2015: The Medicare Payment System for SNFs Needs to be Reevaluated (OEI-02-13-00610)

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Risk Areas and Compliance Strategies

GAO Publications

- ❑ MEDICARE; Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data (GAO-16-394, April 2016)
- ❑ Found 1/3 of GIP stays to be unsupported (> \$250 million)
- ❑ OIG’s recommendations for CMS:
 - Increase its oversight of hospice GIP claims;
 - Ensure the physician is involved in the decision to use GIP
 - Conduct prepayment reviews of lengthy GIP stays

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Risk Areas and Compliance Strategies

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

- ❑ Identified "target areas" that have been determined to be at high risk for improper payments for specific provider types
- ❑ Compares individual provider data to that of providers in the same state, same jurisdiction and in the country
- ❑ PEPPER for individual provider is not available to the public – it may only be accessed by an authorized provider official.

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Risk Areas and Compliance Strategies

PEPPER for HHAs

- Released annually in mid-July
- Reflects trends for most recent three years
- Website includes instructional materials to help interpret results
- For July 2016, HHA target areas are as follows:
 - Average case-mix rate
 - Average number of episodes per beneficiary
 - Episodes with 5 or 6 visits
 - Non-LUPA episodes
 - High therapy utilization episodes
 - Outlier payments
- As of 09/20/2016, only 21% of HHAs had accessed their July 2016 PEPPER.

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Risk Areas and Compliance Strategies

PEPPER for Hospices

- Released annually in mid-April
- Reflects trends for most recent three years
- For April 2016, hospice target areas are as follows:
 - Live discharges – no longer terminally ill
 - Live discharges - revocations
 - Live discharges – with LOS 61-179 days
 - CHC provided in ALF
 - RHC provided in ALF
 - Claims with a single diagnosis coded
 - Claims with no GIP or CHC
- As of 09/20/2016, only 55% of hospices had accessed their July 2016 PEPPER.

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Risk Areas and Compliance Strategies

PEPPER for SNFs

- Released annually in mid-April
- Reflects trends for most recent three years
- Website includes instructional materials to help interpret results
- For April 2016, SNF target areas are as follows:
 - Therapy RUGs with high ADLs
 - Non-therapy RUGs with high ADLs
 - Change of Therapy (COT) Assessments
 - Ultra-High Therapy RUGs
 - 90+ Days Episodes of Care
- As of 01/23/2017, only 56% of SNFs have accessed their PEPPER

Risk Areas and Compliance Strategies

Other Reasons for Continued Claim Audits

- ❑ Medicare FFS improper payment rate is mandated by law to be less than 10%
- ❑ OIG is required to report on various agency improper payment rates, including Department of Health & Human Services (DHS)
- ❑ *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did not Fully Comply for Fiscal Year 2015 (A-17-16-5200, May 2016) :*
 - CMS did not achieve an improper payment rate of < 10%
 - Primary causes were insufficient documentation and lack of medical necessity

Recent Medical Necessity Enforcement: Hospice

❑ Level of Care

- **Covenant Hospice (June 2015)** \$10 million paid for billing general inpatient care rather than routine home care.
- **St. Joseph Hospice (September 2015)** \$5.86 million paid for alleged billing of continuous home care hospice, rather than routine home care.

Recent Medical Necessity Enforcement: Home Health

❑ Res Care Iowa (February 2015)

- Agreed to pay \$5.63 million to resolve claims it violated the FCA by submitting false home healthcare billings to Medicare and Medicaid.
- Between 2009-2014, the company failed to obtain required physician: certifications of medical necessity, order for specific types and amount of services and, after 2011, face-to-face documentation.

❑ Careall Companies (November 2014)

- Agreed to pay \$25 million.
- Allegedly overstated severity of patient medical conditions, billed for medically unnecessary services, and billed for non-homebound patients.

Recent Medical Necessity Enforcement: Home Health

- ❑ **Amedisys (April 2014)**
 - Allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound, and otherwise misrepresented patients' conditions to increased Medicare payments.
 - Alleged management pressure on nurses and therapists to provide care based on the financial benefits, rather than the needs of patients.
 - Paid \$150 million to resolve claims.

United States of America, et al. v. AseraCare, Inc., et al.

- ❑ Qui Tams alleging that AseraCare admitted patients to hospice that were not terminally ill
- ❑ District Court (N.D. Ala.) bifurcated trial into 2 phases:
 1. Phase One on the falsity element of Government's False Claims Act claim
 2. Phase Two on the other elements of the Government's FCA Claim
"Falsity cannot be inferred by reference to AseraCare's general corporate practices unrelated to specific patients. A claim is either false or not without evidence of corporate practices unrelated to that claim."
- ❑ **Phase I Jury Verdict:** On October 13, 2015, the jury largely sided with the government in Phase I of the two part trial and found that 104 of the 121 submitted claims were objectively false.

United States of America, et al. v. AseraCare, Inc., et al.

- ❑ **November 2, 2015:** court formally vacated the jury's verdict, granted AseraCare's motion for a new trial and reopened summary judgment arguments.
- ❑ **March 31, 2016:** the court granted summary judgment in favor of AseraCare, finding that "contradiction based on clinical judgment or opinion alone cannot constitute falsity under the FCA as a matter of law."

United States of America, et al. v. AseraCare, Inc., et al.

- "When two or more medical experts look at the same medical records and reach different conclusions about whether those medical records support the certifying physicians' COTIs, all that exists is a difference of opinion. This difference of opinion among experts regarding the patients' hospice eligibility alone is not enough to prove falsity...."

United States of America, et al. v. AseraCare, Inc., et al.

- **US Appeal to the Eleventh Circuit**
 - Appealing whether the district court erred in granting summary judgment to AseraCare and granting AseraCare a new trial
 - US says district court's ruling based on a fundamentally flawed view of what it means for a claim to be "false" under the False Claims Act
 - US view:
 - A claim is false if it is not reimbursable by Medicare
 - A hospice claim is only reimbursable by Medicare if provider has sufficient documentation in medical record to support terminal diagnosis
 - Jury properly relied on documentation in medical records to determine if claim is false
 - Evidence of good faith disagreement is relevant to scienter but does not negate falsity.

U.S. ex rel. Wall v. Vista Hospice Care, Inc.

- **June 20, 2016, court (N.D. Tex.) granted summary judgment in favor of the hospice**
 - Rejected Relator's attempt to use statistical sampling finding:
 - "the underlying determination of eligibility for hospice is inherently subjective, patient-specific, and dependent on the judgment of involved physicians."

Agreed with AseraCare district court that the opinion of one medical expert alone cannot prove falsity without further evidence of an objective falsehood.

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OIG Special Fraud Alert June 19, 2015

- ❑ Physician Compensation May Result in Significant Liability
 - Looking at doctors on the receiving end of the kickback
- ❑ The OIG emphasized a shift in government enforcement to actions against individual physicians rather than actions primarily targeting affiliated provider entities.

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OIG Special Fraud Alert June 2016

- ❑ **Improper Arrangements and Conduct Involving Home Health Agencies and Physicians**
 - Government is stepping up its enforcement of home health providers and the physicians they do business with
 - Concern that home health companies are paying physicians for referrals
 - Concern that physicians are soliciting payments in return for their referrals
 - In some instances disguised as payments for medical director services
 - OIG concerned that such arrangements compromised medical judgment, result in patient steering, overutilization, and unfair competition.

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Medical Directors

- ❑ Number of Medical Directors
- ❑ Fair Market Value of Services Actually Provided
- ❑ Evidence of work being done
- ❑ Like to Referrals

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Marketing Practices

- Payments tied to admissions or census goals raise a red flag
- Employees involved in admissions should not receive census based payments
- Be careful how you talk about census goals

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Recent Enforcement: Physician Relationships

- Nurses' Registry, Vicki House and Estate of Lennie House (July, October 2015)**
 - \$17 million settlement to resolve allegations of billing for medically unnecessary home health care services and services tainted by kickbacks.
- A Plus (June 2013 – February 2015)**
 - Home health agency, two owners, and seven physicians and spouses agree to pay over \$3 million.
 - Alleged Stark/Anti-Kickback violations based on payments to physicians' spouses for sham marketing positions to get referrals.

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Recent Enforcement: Physician Relationships

- Good Shepherd Hospice (February 2015)**
 - Agreed to pay \$4 million to resolve allegations that the company submitted false claims for hospice patients who were not terminally ill.
 - Among other things, allegedly hired medical directors based on their ability to refer patients, focusing particularly on medical directors with ties to nursing homes, which were seen as an easy source of patient referrals.
- Amedisys, Inc. (April 2014)**
 - Agreed to pay \$150 million to settle negotiations stemming from 7 *qui tams* between 2008 and 2010. Included Stark/Anti-Kickback claims based on relationship with Georgia Oncology practice where Amedisys allegedly provided patient care coordination services at below-market rates.


