Federal Update – Healthcare Fraud, Waste, and Abuse

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Overview

• Understanding the role of the HHS OIG
• Recent cases and audits relating to current trends in Healthcare Fraud, Waste, and Abuse
  – Home Health Services
  – Hospice
  – Lab Tests
  – Chiropractic Services
  – Managed Care Risk Adjustments
  – Opioids
• Compliance Program

What does the HHS OIG oversee?

Mission: To protect the integrity of HHS programs and the welfare of the people they serve.

Vision: To drive positive change in HHS programs and in the lives of the people served by these programs.

Values: To be relevant, impactful, customer focused, and innovative.
Scope of HHS

- $1 trillion in spending, including grants and contracts, for HHS programs administered by agencies such as:

OIG Jurisdiction

“Conduct . . . audits and investigations relating to the programs and operations of [HHS] . . . .”

Inspector General Act § 2
(Pub. L. No. 95-452, codified at 5 U.S.C. App. § 2)

OIG Jurisdiction

What CAN we investigate, audit and evaluate?

- Recipients of HHS funds - “Follow the $$”
- Internal operations/employee misconduct
- Anyone acting in collusion
- Oversight of agency programs and operations
Who is the HHS OIG?

- Began in 2007
- Miami, Los Angeles, Detroit, South Texas, Brooklyn, Louisiana, Tampa, Chicago, and Dallas
- As of June 30, 2016:
  - Opened 1,522 cases
  - Obtained 2,185 criminal convictions
  - Recovered $1.98 Billion

Where is the HHS OIG?

- 1,550+ employees
- 70+ offices
Home Health Services

Requirements:

• Homebound AND in need of:
  — skilled nursing,
  — physical therapy, or
  — speech-language pathology
• Doctor must certify NEED for services
• Must be reasonable and necessary

Things To Look For:

• Admissions based on marketing, not medical necessity
• Orders signed by a physician who is NOT the patient’s primary-care physician
• Re-admissions without any change in the patient’s condition

• Kickbacks
• Medically unnecessary services
• Services not rendered
• Services provided by unlicensed provider
Kickbacks

- **Anti-kickback statute**
  - 42 U.S.C. § 1320a-7b(b)
  - Prohibits offering, giving, or asking for or receiving anything of value to induce or reward referrals of Federal health care program business

- **Stark law**
  - 42 U.S.C. § 1395nn
  - Safe Harbors

Hospice

- Medicare pays a daily rate for each day a patient is enrolled in the Hospice benefit
- Payments are made based on the level of care required to meet the patient's and family's needs
- **Levels of Care:**
  - Routine home care (RHC) (higher payment rate for first 60 days, reduced payment for 61 days and over)
  - Continuous home care
  - Inpatient respite care
  - General inpatient care

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**Table 1: FY 2017 Hospice Payment Rates for RHC**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2017 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
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</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$199.55</td>
<td>$130.95</td>
<td>$59.62</td>
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<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$145.82</td>
<td>$102.94</td>
<td>$42.88</td>
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<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$964.63</td>
<td>$662.80</td>
<td>$301.83</td>
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<tr>
<td></td>
<td>Full Rate &lt; 24 hours of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bedside rate=$48.49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$178.97</td>
<td>$122.55</td>
<td>$56.42</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$754.94</td>
<td>$487.54</td>
<td>$264.40</td>
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</tbody>
</table>
Hospice

• Place patients in hospice who are not terminally ill
• Bill for higher reimbursed level of care
• Falsify records – false certifications, re-certifications, election forms, revocation forms, back dating of documents, and care notes
• Make beneficiaries appear sicker than they really are
• Kickbacks

Lab Tests – Urine Drug Screening

• For some codes, only 1 unit of service may be billed per visit regardless of number of drug classes tested
• Providers were paid for more than 1 unit of service due to:
  – Units billed on different claims or different claim lines
  – Units billed with a modifier not supported by documentation
• Overpayments identified for repayment and, in some cases, CIAs used and CMPs assessed

Chiropractic Services

Audit Referrals for Investigation and Legal Action

• Los Angeles
  – Reported stolen car with medical records
  – Pled guilty to healthcare fraud & filing false police report

• New York
  – Submitted claims for services that were not medically necessary or provided as claimed
  – Exclusion
Chiropractic Services

Nationwide Review

- $359 million paid in 2013 for unallowable services
- Recommended that CMS determine if there should be a limit to the number of services

Managed Care Risk Adjustments

- Determined whether monthly payments for some beneficiaries were supported by medical records
- Issues:
  - Records did not support diagnosis indicated
  - Provider signature/credentials were missing
- Identified invalid risk scores and overpayments

Opioids

Spending on Part D benefits projected to rise from 14% to 17% of total Medicare spending
**Opioids**

**Medicare**
- $8.4 billion spent on controlled drugs (6%)
- $129 billion spent on non-controlled drugs

**Medicaid**
- $50 billion

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**Opioids**
- Most pharmacies bill 3% schedule II and 5% schedule III
- Approximately 80% of heroin users started with prescription opioids
- Future costs:
  - Substance abuse programs
  - Hepatitis C
  - HIV

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**Opioids**
- Drug-Induced Overdose Deaths in 2014:
  - More than motor vehicle crashes
  - More than firearms
  - More than suicide
- Drug-Induced Overdose Deaths in 2015:
  - 52,404

[Source: CDC]
Opioids

- Drug poisoning deaths involving Heroin:
  2011: 3,036
  2015: 12,989

- Drug poisoning deaths involving prescription opioids:
  1999: 4,030
  2015: 22,598

Source: CDC

Heroin Overdose Deaths 2015

Compliance Program Basics
What is a compliance program?

Reactive Proactive
Compliance Program Basics
Seven Fundamental Elements
1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Internal monitoring
6. Enforcement of standards
7. Prompt response

time for questions