Recent Investigation and Enforcement Trends

I. Overview of the False Claims Act
II. Government Agencies / Contractors Involved
III. Targeted Enforcement Actions
IV. Recent Settlements and Decisions
V. Mitigating Risks
I. Overview of the False Claims Act

The False Claims Act, 31 U.S.C. § 3729, et. seq., authorizes the United States, or private parties, known as “relators”, acting on behalf of the United States, to recover monetary damages from parties who submit, or cause others to submit, fraudulent claims for payment by the federal government.

Key Points:
- Liability for submitting, or causing to be submitted, a false or fraudulent claim for payment; making or causing to be made a false record or statement in order to secure payment of a claim; or conspiring to get a false or fraudulent claim paid.
- Materiality: The falsehood was material to the decision to pay the claim.
- Scienter: “knew or should have known”; “deliberate ignorance” of truth or falsity; “reckless disregard” of the truth or falsity of the claim.

No Specific Intent Needed
Overpayments
“REVERSE” FALSE CLAIMS

- Penalties can be imposed on anyone who “knows of an overpayment” and fails to report and return it.
- Under this law, the retention of an overpayment beyond 60 days constitutes an “obligation” within the meaning of the FCA.
- Became effective upon enactment of the Health Reform Law on March 23, 2010.

Qui Tam Relators

- The federal False Claims Act is a *qui tam* statute, meaning that private citizens (“relators”) may file complaints alleging violations of the FCA under seal on behalf of the U.S. Government and may receive at least 15%, but not more than 30%, of any amount recovered, depending on whether the government intervenes.
- Once a whistleblower files a suit, the Department of Justice must decide whether to “intervene” (i.e., take over and prosecute the suit).
- If the government does not intervene, the case is unsealed and the whistleblower may proceed on his/her own.
The False Claims Act
EXAMPLES AND TYPES OF FALSE CLAIMS ACT ALLEGATIONS

- Inadequate documentation of services performed
- Billing for goods or services not provided
- False certifications
- Billing for services that are of such poor quality they are deemed "worthless."
- Billing for the same procedure more than once
- Upcoding

Hospice Enforcement
OTHER KEY RISK AREAS

- Levels and Locations of Care
- Medical Necessity Eligibility and Appropriateness for Benefit
  - Admissions
  - Long lengths of stay
  - Stability and failure to discharge clinically ineligible patients
- Documentation
  - Adequacy of physician attestations, clinical documentation, financial records, and other documents that support claims for reimbursement
  - Timeliness and completeness of physician referrals, plans of care, hospice certifications and face-to-face evaluations
- Marketing Practices
  - Payments tied to admissions and census goals
  - Kickbacks to referral sources
I. Government Agencies / Contractors Involved

Federal Departments:
- Department of Justice (DOJ)
  - Offices of the United States Attorneys (USAO)
- Federal Bureau of Investigation (FBI)
- Department of Health and Human Services (HHS)
  - Office of Inspector General (OIG)
  - Office of Audit Services (OAS)
  - Office for Civil Rights
  - Office of Evaluations and Inspections (OEI)
  - Center for Medicare and Medicaid Services (CMS)
    - Center for Program Integrity (CPI): “Serves as CMS’ focal point for all national and State-wide Medicare and Medicaid programs and CHIP integrity fraud and abuse issues.” (CMS/CPI Functional Statement)
State Government Agencies
CONCERTED EFFORTS TO COMBINE AND POOL RESOURCES

State Departments:

- Office of the Attorney General
  - Medicaid Fraud Control Unit - “conducts criminal investigations of Medicaid providers who are suspected of cheating the Medicaid Program.” [https://www.oag.state.tx.us/forms/mfcu/](https://www.oag.state.tx.us/forms/mfcu/)

- Office of Inspector General
  - Health and Human Services Commission – Texas: “investigates waste, abuse and fraud in all health and human services programs in the State of Texas.” [https://oig.hhsc.state.tx.us/AboutOIG/Types.aspx](https://oig.hhsc.state.tx.us/AboutOIG/Types.aspx)
  - Medicaid Provider Integrity (Provider Investigations) – Texas: “investigates activities relating to the prevention, detection, and investigation of provider waste, abuse, and fraud in the Medicaid and Children’s Health Insurance Plan (CHIP) programs.” [https://oig.hhsc.state.tx.us/enforcement/mpis.aspx](https://oig.hhsc.state.tx.us/enforcement/mpis.aspx)

Enforcement Environment
GOVERNMENT INVESTMENTS IN FRAUD ENFORCEMENT ACTIVITIES

Investments in State-of-the-Art Technologies
- CMS Fraud Prevention System
  - Identified or prevented $454 million in improper payments in FY 2014
  - 10-to-1 return on investment

Investments to Increase Collaboration
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Medicare Fraud Strike Force
- Healthcare Fraud Prevention Partnership (HFPP)
The Contractors

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
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<tr>
<td>Medicare Administrative Contractors (MACs)</td>
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<tr>
<td>Recovery Audit Contractors (RACs)</td>
<td>Medicaid RACs</td>
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<tr>
<td>Zone Program Integrity Contractors (ZPICs)</td>
<td>Review-of-Provider, Audit and Education</td>
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<td>Comprehensive Error Rate Testing (CERT)</td>
<td>Medicaid Integrity Contractors (MICs)</td>
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<td>State Medicaid Fraud Control Units (MFCU)</td>
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RACs: What do they do?

- Permanent program created by Tax Relief and Health Care Act of 2006
- Detect and correct past improper payments (over/under payments)
- Apply statutes, regulations, CMS coverage and billing policies and LCDs to make determinations
- 4 regions each with a different contractor
  - Region C (Texas and New Mexico) RAC Contractor: Connolly Health
- Section 6411(b) of Affordable Care Act ("ACA") expands use of RACs to all of Medicare and not just Part A and B
ZIPCs: What do they do?

- Created by Medicare Prescription Drug, Improvement and Modernization Act of 2003
  - Move away from Program Safeguard Contractor concept which divided contracts by service line (e.g., Part A, B, Home Health, etc...)
  - Part A, B, DME, Home Health and Hospice
- Detect potential fraud in a targeted way and refer to OIG/DOJ for investigation/prosecution
- Review claims on a prospective and retrospective basis
- Initiate payment suspensions
- Respond to Request for Information from law enforcement
- Recommend administrative action against providers (e.g., exclusion, revocation of provider number, collection of overpayment)
- Zone 4 (Texas and New Mexico) ZIPC Contractor: Health Integrity

Top ZIPC Issues

- Billing for services not furnished
- Pattern of overutilization
- Vacant supplier/provider location
- Medically unnecessary services
- Stolen provider / beneficiary info
- Schemes of collusion (e.g., kickbacks)

• "OIG November 2011 Report: Zone Program Integrity Contractors’ Data Issues Hinder Effective Oversight"
Medicaid RACs

- States / RACs MUST:
  - Coordinate audits with other auditing entities
  - Report fraud to Medicaid Fraud Control Units
  - Set limits on number and frequency of medical records for review
  - Adhere to 3 year look-back period
  - Maintain 1 FTE Medical Director who is a M.D. or D.O.
  - Hire certified coders unless state determines not needed
  - Develop education and outreach programs
  - Incentivize RACs to detect underpayments

III. Target Enforcement Actions
Health Care Enforcement

2016 OIG WORK PLAN
FY 2015:

Expected Recoveries:
• $3 billion
  ➢ $1.13 billion in audit receivables
  ➢ $2.22 billion in investigative receivables

Exclusions:
• 4,112 individuals and entities

Civil/Criminal Actions
• 925 criminal
• 682 civil

OIG’s Hospice Work Plan
GENERAL INPATIENT CARE

The OIG will:

- Review the use of the general inpatient care level of the Medicare hospice benefit.
- Assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
- Review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary.
- Review beneficiaries’ plans of care and determine whether they meet key requirements.
- Determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.
- Increase oversight of certification surveys and hospice-worker licensure requirements.
Recent Settlements and Decisions

- **October 7, 2015** - Serenity Hospice and Palliative Care, a hospice operating in Phoenix, Arizona agreed to pay $2.2 million to resolve civil allegations that it violated the federal False Claims Act by submitting false bills to Medicare for hospice services.

- **October 2, 2015** - Guardian Hospice of Georgia LLC, Guardian Home Care Holdings Inc. and AccentCare Inc. (collectively Guardian) agreed to pay $3 million to resolve allegations that Guardian knowingly submitted false claims to the Medicare program for hospice patients who were not terminally ill.

- **September 10, 2015** - Alive Hospice, Inc. paid over $1.5 million to reimburse the government for alleged overbilling of Medicare and TennCare for hospice services.
Recent Settlements and Decisions

- **September 3, 2015** - St. Joseph Hospice Entities, which consists of 13 hospice facilities in Mississippi, Louisiana, Texas and Alabama, and Patrick T. Mitchell, its majority owner and manager, agreed to pay the United States $5,867,518 under the False Claims Act to resolve allegations that they submitted false claims for delivery of continuous home care hospice services to patients who were not entitled to receive continuous care hospice level treatment.

- **August 24, 2015** - A Dallas woman who stole the identity of a registered nurse and used that identity to work at several Dallas-Fort Worth (DFW) area hospice companies, where she saw and purportedly treated 243 hospice patients, was sentenced this morning, announced U.S. Attorney John Parker of the Northern District of Texas.

- **July 28, 2015** - Paula Kluding, the owner of Prairie View Hospice, Inc., was sentenced to serve three years in prison for committing Medicare fraud. As part of her sentence, Kluding was also ordered to pay $2,519,813.33 in restitution to Medicare. Kluding will also spend three years on supervised release following her release from prison.

- **June 18, 2015** - Covenant Hospice Inc. agreed to pay $10,149,374 to reimburse the government for alleged overbilling of Medicare, Tricare and Medicaid for hospice services. Covenant Hospice Inc. is a non-profit hospice care provider which operates in Southern Alabama and the Florida Panhandle.

- **February 18, 2015** - The United States settled civil fraud claims under the False Claims Act against Compassionate Care Hospice of New York and Compassionate Hospice Group Ltd. related to the submission of fraudulent claims for reimbursement by Medicare and Medicaid, for hospice nursing services not adequately provided by Compassionate Care Hospice of New York.
Recent Settlements and Decisions

- **February 6, 2015** - Good Shepherd Hospice Inc., Good Shepherd Hospice of Mid America Inc., Good Shepherd Hospice, Wichita, L.L.C., Good Shepherd Hospice, Springfield, L.L.C., and Good Shepherd Hospice - Dallas L.L.C. agreed to pay $4 million to resolve allegations that they submitted false claims for hospice patients who were not terminally ill. Good Shepherd is a for-profit hospice headquartered in Oklahoma City which provides hospice services in Oklahoma, Missouri, Kansas and Texas.

V. Mitigating Risks
Compliance Program Activities

Develop and implement an **effective** corporate compliance program

- Ensuring Effectiveness
  - An effective compliance program is dynamic and evolves
  - One size does not fit all – an effective program is tailored to a provider’s structure and operation
  - Track guidance for government views as to what is necessary
    - HHS-OIG Compliance Program Guidance
    - Federal Sentencing Guidelines
    - Recent CIAs
  - Know your fraud and abuse risk areas – they change

Audit and Monitor High Risk Areas

- Develop and adhere to a work plan that sets forth a schedule and scope of internal reviews
- Consider periodic external reviews by independent third parties
- Identify and refund overpayments within 60 days

Evaluate Your Data to Identify Trends and Investigate Outliers

- Review hospice metrics: live discharges, lengths of stay > 180 days, primary diagnosis
- Hospice cap overpayment trends
Top Denial Reason Codes
JURISDICTION 11 – HOME HEALTH AND HOSPICE
JULY – SEPTEMBER 2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Code Description</th>
<th>Count of Claims Denied</th>
<th>Percent of Claims Denied to Total Claims Denied by Bill Type</th>
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<td>Not Hospice Appropriate</td>
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http://palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM%20Home%20Health%20and%20Hospice~Articles~Denial%20Reason%20Codes~9TGLY61142?open&navmenu=||

**Compliance Program Activities**

**AUDITING AND MONITORING**

- Consider Engaging Legal Counsel to Conduct Or Direct Auditing Activities You Want Protected By Privilege
  - Compliance effectiveness review
  - Targeted internal investigations
- Utilize Legal Counsel to Monitor and Manage Financial Relationships
- Ensure Background and Exclusion/Debarment Checks Are Regularly Conducted
  - Not only employees, but also independent contractors and vendors
  - Check both HHS-OIG LEIE database and GSA’s SAM database (www.sam.gov)
  - Also state Medicaid excluded provider lists
Compliance Program Activities

**TRAINING AND EDUCATION**

- **Designate a specific individual to be responsible for tracking and understanding regulatory changes and disseminating information to appropriate staff**
- **Importance of documentation training hospice staff**
  - Certification of plans of care
  - Certification of terminal illness
  - Face-to-face visits
- **Focused training for marketing staff on interactions with referral sources and beneficiaries**
- **HHS-OIG HEAT Provider Compliance Training Initiative resources**

Other Risk Mitigation Actions

- **Track and log compliance questions, complaints and issues raised through the compliance program, steps taken to follow up, how issues were resolved, including corrective and preventative actions**
- **Implement systems to ensure timely certifications, F2F visits, therapy reassessment visits**
  - EHRs can have features built-in to flag patients with upcoming requirements
  - Schedule IDGs sufficiently in advance to help monitor key timing requirements
- **Have means to identify disgruntled employee or contractor**
  - Publicize compliance hotline to contractors, vendors
  - Conduct and document exit interviews, reviewed by compliance officer
- **Monitor payor and contractor audits for patterns for signs of systemic issues**
  - Multiple audits of same/similar issues, multiple RAC or ZPIC audits
Government Overtures

- Vary in type and intensity
  - Contractor audits and additional documentation requests
  - Administrative subpoenas
  - OIG subpoenas
  - Civil Investigative Demands
  - Grand Jury subpoenas
  - Search warrant

- What to expect:
  - Unannounced requests
  - Clinical documentation demands
  - Rigorous data analysis
  - Potential for conflicting interpretation of Medicare guidelines