

# **Complying in Home Health**

*Agencies must be diligent in avoiding fraud and abuse allegations.*

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Home health agencies, as all types of healthcare providers, must include strict compliance with the Medicare and Medicaid fraud and abuse statutes along with providing quality patient care among their top organizational objectives. Today's healthcare providers must operate in an environment where the United States Government has prioritized healthcare fraud as a chief law enforcement endeavor. Within this vigilant enforcement initiative, home health agencies will likely witness a disproportionate share of scrutiny. Therefore, home health agencies must continue to recognize and adapt to trends in the enforcement effort.

## **An Intense Focus on the Home Health Industry**

A primary reason for the increased government scrutiny of home health providers is the growth of the industry. From 1982 to 1996, the number of home health agencies participating in the Medicare program has increased over 300 percent from 3,125 in 1982 to over 9,800 in 1996. The number of Medicare beneficiaries receiving home health services and the average number of visits per beneficiary have also dramatically increased.

The government has responded to the increase in Medicare expenditures for home health services with a greater degree of scrutiny. In June of 1995, the Office of Inspector General issued a special fraud alert for home health fraud. This alert served to identify home health practices that were particularly vulnerable to abuse. The Office of Inspector General then issued compliance program guidelines for home health agencies in August of 1998. However, the government does not intend to be alone in focusing its attention on home health providers. The government is ensuring that both

physicians and patients are also equipped to recognize and report home health fraud and abuse violations.

The Office of Inspector General has initiated at least two activities thus far this year to ensure that patients and physicians are able to identify and report home health fraud and abuse violations. In February, the American Association of Retired Persons and the Department of Health and Human Services announced the “Who Pays? You Pay” campaign. This campaign is aimed at educating Medicare beneficiaries about how to recognize fraud and abuse violations. The program is expected to educate hundreds of thousands of beneficiaries this year alone. Fighting fraud and abuse in the Medicare home health benefit is a prominent component of this campaign.

Similarly, the Office of Inspector General has identified physicians as a promising source for the disclosure of home health fraud. In January the Office issued a special fraud alert entitled “Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services.” The fraud alert warns physicians that they may be held liable for making knowingly false certifications for home health services or making certifications with a reckless disregard for the truth. The Office also urges physicians to report any “suspicious activity in connection with the solicitation or completion of certifications to the OIG.” With this increased level of attention, it is important for home health agencies to be prepared to recognize and eliminate possible violations before they are reported by others.

### **Recognizing the Trends in Fraud and Abuse Enforcement**

A common compliance issue faced by home health agencies is raised by the Medicare and Medicaid Anti-kickback provisions. The Anti-kickback statute makes it a felony to solicit, offer or receive a kickback, bribe or rebate, in cash or in kind, in connection with furnishing Medicare or Medicaid covered services or referring a patient to a provider of these services. The penalties for violating the statute are severe. In addition to a felony conviction, violators are subject to mandatory exclusion for at least five years and may be subject to a fine of up to \$25,000, five years imprisonment or both.

The Anti-kickback statute, at least in the United States Court of Appeal for the Third Circuit, may be violated if it is found that just one reason for providing or offering remuneration is to induce referrals. Furthermore, that court held that providers may be found in violation regardless of whether the government suffers pecuniary damages as a result of the improper conduct. To avoid violations of the Anti-kickback provisions, home health agencies must carefully monitor their professional relationships with physicians, hospitals, and any other providers who may refer patients to them or to whom the agencies refer patients.

Obviously, paying a sum of money to a physician for each patient referral or certification to a home health agency is an Anti-kickback violation. But it must be remembered that the statute can be violated for remuneration in “cash or in kind.” Prohibited inducements, therefore, could include gifts, the promise or increased likelihood of return referrals, free services or those discounted in price, or other valuable items. It is particularly important for home health agencies to examine their relationships with physicians as home care services are not reimbursable without a physician’s certification. Any benefits conferred to physicians should be of minimal value and in no way related to the volume or value of referrals that they provide.

Home health agencies may also want to provide services to other health care providers as a way of fostering a positive professional relationship and illustrating the abilities of their personnel. For example, a home health agency may send a nurse to perform discharge planning functions at a hospital or a skilled nursing facility. The nurse’s services are valuable and, if offered for free or at a discounted rate, could be found to be an improper inducement to obtain referrals from the provider.

In addition to ensuring outside relationships are proper, healthcare providers must ensure that their compliance programs and policies are effectively communicated internally to their employees. Compliance education, however, must not be limited to upper management or personnel who submit Medicare or Medicaid billing. Disseminating information is vital because detection of possible violations is more likely if all employees are provided with an

appropriate level of education. In addition, employees must be made aware of the importance of their individual compliance with the fraud and abuse provisions and the possible ramifications of their running afoul of them.

Employee education is particularly important for home health agencies. Their employees provide services with very little supervision. Agencies must rely on the time and service logs that are submitted by their personnel who conduct home visits. If an employee does not record services accurately, both the employee and the home health agency could be in violation of the fraud and abuse provisions.

A common trend of cases appearing before Department of Health and Human Services Departmental Appeals Boards involve home health employees who are excluded from participating in the Medicare and Medicaid programs. The cause of exclusion is that the employees submitted false activity and service reports to their employers. In turn, the home health agencies use the false service logs to submit improper claims to Medicare and Medicaid.

Employees must be informed that even though they may have no knowledge that the patients they were seeing were Medicare or Medicaid beneficiaries, the intentional submission of false service forms may give rise to a criminal conviction and exclusion. The fact that only the employers and not the employees may directly seek reimbursement also will not excuse the employee from liability. The home health agency employer will be penalized at least monetarily. The agency will not be allowed to retain the reimbursement obtained for improper claims.

The employer may also face civil monetary penalties for the conduct of the employee who submits false claims. An intent to defraud on the part of the employer is not required. Providers who should know they are submitting false or fraudulent claims include those who act with reckless disregard or deliberate ignorance of a claim's truth or falsity. The civil monetary penalties may result in fines of up to \$10,000 per service falsely claimed, three times the amount claimed and possible exclusion from participating in the Medicare and Medicaid programs. It is incumbent upon home health agencies to

ensure that their employees are educated to comply with the fraud and abuse provisions and that they are reasonably monitored to verify their compliance.

Home health agencies must also monitor their patients in their compliance efforts. The homebound status of patients continues to be an important issue for home health agencies to address. To receive reimbursement for home care services provided to Medicare or Medicaid beneficiaries, the beneficiaries must be confined to the home. The condition of home confinement must be documented by a physician before services are provided. However, a home health agency must not rely solely on a physician's certification. Agencies must verify the initial physician certification and periodically evaluate the patient to ensure that he or she is homebound at the time services are provided.

Each home care patient should be evaluated according to the following questions to assist in ensuring homebound status:

- Is a trip outside of the home medically contraindicated?
- If medically contraindicated, is there appropriate documentation to verify this finding?
- Are the patient's excursions outside of the home infrequent and primarily for medical purposes?
- Does leaving the home require a taxing and considerable effort on the part of the beneficiary?
- Does the patient require the aid of a supportive device (e.g. crutches, cane or wheelchair) to leave the home?
- Does the patient refrain from taking trips outside of the home that are frequent or of a long duration?

Consideration of the above questions is helpful in determining the homebound status of a home health patient. If the questions as they pertain to each patient can be answered affirmatively and documented, a home health agency will have a useful tool to justify the propriety of services if the patient's homebound status is subsequently questioned.

The compliance activities described above are merely illustrative of the wide-ranging preparation that home health agencies must undertake to prevent fraud and abuse violations. As the activities illustrate, each type and size of healthcare provider faces unique circumstances in compliance. Currently, it appears that home health agencies are operating in a more complex fraud and abuse environment than most other types of providers. However, by utilizing diligent education and compliance efforts, the risk of committing violations may be substantially reduced.

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