

HOME HEALTH COMPLIANCE: IDENTIFYING POTENTIAL FRAUD AND ABUSE VIOLATIONS

By

Cherilyn G. Murer, J.D., C.R.A.
President/C.E.O.
The Murer Group

Today's healthcare providers must comply with a growing array of legal and compliance issues while simultaneously improving the quality of their care in a competitive environment. During the 1980's, most providers, both individual and institutional, would have identified malpractice liability as their most significant pecuniary threat. Now, however, it is likely that most would identify the United States Government as that threat. The government has declared fraud and abuse in the federal health programs to be a chief law enforcement priority. It has also indicated that home health agencies are likely to attract a large share of its scrutiny. Therefore, it is particularly vital for home health agencies to have the ability to recognize and prevent potential fraud and abuse violations.

Increased Government Attention for a Growing Industry

The most significant reason for the increased government scrutiny of home health providers is the growth of the industry and the increased utilization of its services over the past two decades. In 1982, 3,125 home health agencies participated in the Medicare program. By 1996, the number of home health agencies participating in the Medicare program had increased over 300 percent to over 9,800. In addition to the number of providers, the number of Medicare beneficiaries receiving home health services and the average number of visits per beneficiary have also dramatically increased during that period.

The increase in Medicare expenditures for home health services coupled with a more vigilant healthcare fraud and abuse detection effort by the government has made the home health industry a likely target for investigators. This is apparent by the government's compliance publications and programs which pertain specifically to the home health industry. 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. In addition, initiatives have been taken to disseminate information so that others may assist the government in combating fraud and abuse.

The Office of Inspector General has introduced two activities 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 in its first year. Fighting fraud and abuse in the Medicare home health division is a significant component of the campaign.

Similarly, the Office of Inspector General has identified physicians as a likely 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 to the OIG any suspicious activity in connection with the solicitation or completion of certifications. With this increased level of attention, it is important for home health agencies to be prepared to recognize, address and eliminate possible violations before they are reported by others.

Avoiding Common Compliance Pitfalls

Relationships with other Providers

Because of their dependence on patient referrals, a common compliance issue faced by home health agencies is 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. Civil penalties may be levied as well. Providers who are found liable in a civil action may be penalized treble damages plus \$50,000 per violation.

To avoid violating 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. Clearly, 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 professional services to other health care providers as a way of fostering a positive 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 that provider.

Educating Employees in Compliance

In addition to ensuring that relationships with other providers 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. The wide dissemination of 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 financial and professional consequences of their running afoul of them.

Employee education is particularly important for home health agencies. Their employees typically provide services with less direct supervision than the employees of other types of providers. When seeking reimbursement, home health 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 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 used 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 federal health program 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 does not have to be proved. 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.

Assessing Patients to Ensure Homebound Status

As Medicare and Medicaid beneficiaries increasingly are the source for reporting fraud and abuse violations, home health agencies must carefully evaluate, treat and document activities regarding patient care as part of 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 an excursion outside of the home medically contraindicated?
- ✓ If medically contraindicated, is there adequate documentation to verify this finding?
- ✓ Are the patient's trips outside of the home infrequent?
- ✓ Are trips outside of the home primarily for medical purposes?
- ✓ Is a taxing and considerable effort on the part of the patient required for him/her to leave the home?
- ✓ Would the patient be considered homebound even if a car or other convenient mode of transportation was available to him/her?
- ✓ Does the patient require a supportive device (e.g. crutches or cane) to leave the home?

Source: Murer Consultants, Inc. 1999

Evaluating home health patients by the above questions is helpful in determining their homebound status. The more questions that can be answered affirmatively and then documented will provide a home health agency with a valuable tool to illustrate homebound status. Documented support for the finding may then be used to justify the propriety of services if the patient's homebound status is subsequently questioned.

The compliance issues discussed here are merely illustrative of the wide-ranging preparation that home health agencies must undertake to prevent fraud and abuse violations. Each type and size of healthcare provider faces unique circumstances in compliance and, therefore, must tailor a compliance program to fit its individual needs. Currently, home health agencies are operating in a more vigilant fraud and abuse environment than most other types of providers.

However, through diligent agency-wide education, compliance program development and monitoring, the risk of committing fraud and abuse violations may be significantly reduced.

About the Author: Cherilyn G. Murer, J.D., C.R.A., is C.E.O. and founder of The Murer Group, a legal-based healthcare management consulting firm in Joliet, Illinois, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727 3355 or viewed on website: <http://www.murer.com>.

This article can also be found on Rehab Management Magazine, June/July 1999 Issue, or visit there website at <http://www.rehabpub.com>