What Every Provider Needs to Know About DOJ Investigations

Presenters:
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Elder Justice Task Force

- DOJ press release on 3/30/16

- Announced launch of ten Elder Justice Task Forces in the following Districts: Northern District of California, Northern District of Georgia, District of Kansas, Western District of Kentucky, Northern District of Iowa, District of Maryland, Southern District of Ohio, Eastern District of Pennsylvania, Middle District of Tennessee and the Western District of Washington.”
Elder Justice Task Force

• The Elder Justice Task Forces will include representatives from the U.S. Attorneys’ Offices, state Medicaid Fraud Control Units, state and local prosecutors’ offices, the Department of Health and Human Services (HHS), state Adult Protective Services agencies, LongTerm Care Ombudsman programs and law enforcement.

• Purpose: “to coordinate and enhance efforts to pursue nursing homes that provide grossly substandard care to their residents.”
Potential Signs of Trouble

• Letter suspending payments under 42 CFR 455.23

• Civil Investigative Demand (CID)

• Pattern of Reports and Surveys Suggesting Poor Quality of Care and/or “Excessive” Therapy Billing
§ 455.23 Suspension of Payments in Cases of Fraud

(a) Basis for suspension:

• (1) The State Medicaid agency **must** suspend all Medicaid payments to a provider after the agency determines there is a **credible allegation of fraud** for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

• (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.

• (3) A provider may request, and must be granted, administrative review where State law so requires.
Notice of Payment Suspension

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
Nashville, Tennessee 37243

Provider: [Redacted]

Dear Provider:

All TennCare program payments to the above identified provider(s) are immediately suspended pursuant to 42 CFR § 455.23.

The reason for suspending payments to the above provider(s) is: a credible allegation of fraud has been made against the provider(s). These allegations concern the forging of Pre-Admission Evaluation forms of Medicaid eligible recipients.

The payment suspension is for a temporary period. The payment suspension will not continue after either of the following: (i) the agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider(s), or (ii) legal proceedings related to the provider(s) alleged fraud are completed.

This payment suspension is applicable to all Medicaid claims submitted by the identified provider.

The Provider may submit written evidence for consideration by the Bureau of TennCare in deciding to continue or end the payment suspension. This written evidence for consideration should be submitted to:

Program Integrity
310 Great Circle Road
Nashville, TN 37243

Further, this payment suspension entitles you to appeal rights under TCA § 71-5-118. To file an appeal of this payment suspension you must do the following:

• Your written appeal must be received no later than thirty-five (35) days following the date of this notice.

Ramsey “Burt” Leathers/Provider Appeals
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Hearings are conducted according to state law. (Tennessee Uniform Administrative Procedures Act, TCA § 4-5-101 et seq., and Tennessee Department of State Rules 1360-0401-01 et seq.)

Sincerely,

[Signature]

Dennis J. Gravely, JD
Director Program Integrity
310 Great Circle Rd
Nashville, TN 37243
615-507-6696
31 U.S. Code § 3733 — Civil investigative demands

(a) In General
(1) Issuance and Service. - Whenever the Attorney General, or a designee (for purposes of this section), has reason to believe that any person may be in possession, custody or control of any documentary material or information relevant to a false claims law investigation, the Attorney General, or a designee, may, before commencing a civil proceeding under section 3730(a) or other false claims law, or making an election under section 3730(b), issue in writing and cause to be served upon such person, a civil investigative demand requiring such person:

(A) to produce such documentary material for inspection and copying,
(B) to answer in writing written interrogatories with respect to such documentary material or information,
(C) to give oral testimony concerning such documentary material or information, or
(D) to furnish any combination of such material, answers or testimony.
Civil Investigative Demand

July 13, 2015

Dear [Redacted],

Accompanying this letter is a subpoena addressed to you returnable to the U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations, 404 James Robertson Pkwy, Suite 1504, Nashville, Tennessee, before my designee, Special Agent (SA) Pat Petty. The subpoena has been issued pursuant to the authority provided to the Inspector General under Public Law 95-452 (see 5 U.S.C. Appendix 3 Section 6 (a)(4)), as amended by Public Law 106-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is “required by law” (see 45 C.F.R. §§ 164.512(e), 164.103), and will be used for “health oversight” activities by the Office of Inspector General (OIG), which meets the definition of a “health oversight agency” (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before July 30, 2015 to:

Sincerely,

Derrick L. Jackson
Special Agent in Charge

Enclosure
Other Factors of DOJ Interest

- Poor survey history
- Consistently low rankings on quality indicator reports
Quality Indicator Reports

• Based on Minimum Data Set (“MDS”) Reports prepared for residents by LTCs

• Government looks for facilities that consistently rank in the bottom tier (<25%) based on QI Reports
Areas of Focus

• What is the Government focused on, i.e. what should providers be focused on?
  – Quality of Care (aka “Worthless Services”)
  – Therapy Billing (aka “Medically Unnecessary Services”)

• What are the Government’s goals?
  – To build a case under the False Claims Act (“FCA”)
  – Obtain reimbursement for allegedly false claims paid to nursing home
Worthless Services

• 42 U.S.C. 1396r requires nursing facilities to provide residents with a clean, safe and sanitary environment to maintain or support “the highest practicable level of physical, mental and psychosocial well-being of every resident.”

• Worthless Services = distinct claim under the FCA; derivative of “false claim” allegation

• Requires proof that facility’s alleged violation(s) of applicable standards of care were “so deficient that for all practical purposes it is the equivalent of no performance at all.” U.S. ex rel. Mikes v. Straus, 274 F.3d 687, 703 (2d Cir. 2001).
What Are “Worthless Services”?

- Requires knowing presentation of what is known to be false, as opposed to negligence or innocent mistake.

Examples of “Worthless Services”:
- Knowledge that claims for provisions and services were submitted to Medicare despite not being provided to residents. *US v. Houser*, 754 F.3d 1335, 1349 (11th Cir. 2014).
- Billing for tests known to have “no medical value” because the test “is so deficient that for all practical purposes it is the equivalent of no performance at all.” *Chesbrough v. VPA, PC*, 655 F.3d 461, 468 (6th Cir. 2011).

Examples of Errors Not Amounting to “Worthless Services”:
- Accounting errors (no proof facility knew claims for reimbursement were false). *Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001)
Quality of Care – Potential Red Flags

• Pattern of Survey “F tags” in one or more key areas:
  – Pain Management
  – Physical Restraints
  – Psychotropics
  – Pressure Ulcers
  – Falls
  – Catheter Use/UTI Prevention
  – Staffing (skill level and ratios)
  – Poor Documentation/Inconsistencies in Charting
  – Care Planning (cookie cutter and missing)

• Consistent QI ranking in bottom percentile (<25%) of peer facilities
Worthless Services – Case Study #1

• *US v. Houser*
  – Federal court (Northern District of Georgia)
  – Defendant criminally convicted of Medicare fraud (and various tax-related charges)
  – Husband and wife managed two nursing homes in Rome and a third in Brunswick from 2004-2007
  – All three homes were closed by State of Georgia; approximately 300 residents total
Case Study #1, continued

- Examples of fraudulent claims:
  - Inadequate staffing
  - Failure to pay vendors
  - Diversion of funds for personal use
Worthless Services – Case Study #2

- *Extendicare Health Services, Inc.*

- Government alleged:
  - Billing for materially substandard skilled nursing services
  - Failure to provide care that met federal and state standards of care and regulatory requirements
    - Insufficient number of skilled nurses to care for residents adequately
    - Inadequate catheter care
    - Failure to follow appropriate protocols to prevent pressure ulcers or falls
Therapy Billing

• Five general RUG levels for therapy billing:
  − Ultra High ("RU") – highest reimbursement rate
  − Very High ("RV")
  − High ("RH")
  − Medium ("RM")
  − Low ("RL")

• Government must prove provider knowingly submitted false claims for medically unreasonable, unnecessary and unskilled therapy services by using (1) false statements and/or (2) false records.
Therapy Billing - Case Study #1

• *US v. Life Care Centers of America*
  – Federal court (Eastern District of Tennessee)

  – Government alleged:
    ▪ “Aggressive” Ultra-High related therapy targets
    ▪ Reinforcement of targets by corporate personnel
    ▪ Punishing employees/facilities for failure to meet targets
    ▪ Ignoring therapists’ recommendations

  – Extreme examples of “excessive” or “unnecessary” therapy
Therapy Billing – Case Study #2

- **US v. Extendicare Health Services, Inc.**

  - Government alleged:
    - 33 SNFs provided “medically unreasonable” and “unnecessary” therapy services to Medicare Part A beneficiaries
    - Therapy provided was “unreasonable” in terms of duration and quantity
    - Therapy was not “reasonable or “necessary” to improve, maintain or prevent/slow further deterioration of resident’s condition
Therapy Billing – Potential Red Flags

• High percentage of patients with high RUG scores and long lengths of stay (without significant progress)

• Poor/missing documentation

• Pattern of providing minutes within 2% of minimum required minutes for RUG level

• Pattern of increasing/decreasing remaining disciplines’ minutes when one discipline discharges/evals to meet RUG without supporting clinical documentation
Document Requests

• Documents routinely requested by Government in Worthless Services and Excessive Therapy Billing Investigations:
  – Documents that might prove poor quality of care and/or excessive therapy
  – Documents that might prove corporate incentives to promote poor quality or excessive therapy
  – Documents that might prove corporate knowledge of the issues
Document Requests — Examples

• Poor Quality of Care/Excessive Therapy
  – Patient charts
  – Hotline calls/complaints (internal and legal)
  – Incident reports, 24 hour reports, shift reports

• Corporate Incentives
  – Bonuses or incentives re: census, cost control, patient mix, therapy billing (by RUG level)

• Corporate Knowledge
  – Board of Director Meeting Minutes/Notes
  – Emails and other communications
DOJ Investigations and Enforcement Activities

- More than $3.5 billion in FCA settlements and judgments (FY2015)
  - More than 700 new FCA matters docketed (more than 600 of those matters filed by whistleblowers)
- $1.9 billion in FCA settlements with health care providers
  - Almost 200 settlements
  - Wide range of legal theories
  - $16.5 billion in health care fraud recoveries since 2009
- Increased criminal prosecution
  - Targeting geographic hot spots
  - Prosecution of licensed health care professionals
  - Prosecution of financial crimes
- Focus on compliance programs and individual accountability
Recent Settlements/Corporate Integrity Agreements

- CF Watsonville (California)
  - Alleged false claims for worthless services
  - $3.3M (May 2015)

- Hebrew Homes (Florida)
  - Alleged issues with therapy billing
  - $17M settlement (June 2015)

- Golden Living Centers (Atlanta)
  - Alleged inadequate and worthless monitoring, documentation and treatment of wounds
  - $613k (Jan. 2013)
Recent Settlements

• Extendicare Health Services, Inc. (8 states)
  – alleged (1) therapy upcoding (2) worthless services
  – $38M (Oct. 2014)

• Foundation Health Services, Inc. (Louisiana)
  – originated with central A/C failure during 2010 heat wave
  – alleged materially substandard and/or worthless services
  – $750k (June 2014)
THANK YOU!

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