

## The Elder Justice Task Force and DOJ Investigations: Is Your Client at Risk?

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This year, the U.S. Department of Justice (DOJ) launched ten regional 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.<sup>[1]</sup> These task forces are comprised of 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, Long Term Care Ombudsman programs, and law enforcement. The Elder Justice Task Forces' purpose is "to coordinate and enhance efforts to pursue nursing homes that provide grossly substandard care to their residents."

With the government's sights fixed on skilled nursing facilities operating in the ten districts referenced above, several potential signs of trouble may indicate an investigation is underway or forthcoming. First, the facility may receive a letter suspending Medicare/Medicaid payments.<sup>[2]</sup> This section allows a state Medicaid agency to suspend Medicaid payments without prior notice to the provider based on a "credible allegation of fraud." Second, the facility may receive a Civil Investigative Demand (CID).<sup>[3]</sup> Finally, facilities with a pattern of consistently low rankings on quality indicator reports, poor survey history, and/or "excessive" therapy billing are also at risk of being investigated.

Quality Indicator Reports are based on the Minimum Data Sets (MDS) Reports prepared for residents by skilled nursing facilities. The MDS information is electronically transmitted from facilities to the state MDS database. This information then feeds into the national MDS database at the Centers for Medicare & Medicaid Services (CMS). Ultimately, the information entered into the MDS Report determines a resident's resource utilization group (RUG) category, which is used to calculate the per diem reimbursement rate paid to the facility for residents whose care is covered under Medicare Part A.<sup>[4]</sup> Facilities use CMS' quality measure/indicator (QM/QI) report to analyze their processes and patient outcomes, as well as to compare their QM/QI scores to other facilities in their region and nationwide. The DOJ reviews these QM/QI scores, too, and sees consistently low scores at a facility as a potential indicator of elder abuse. Moving forward, the Elder Justice Task Forces will almost certainly be looking for facilities that consistently rank at or near the bottom tier (<25%) on Quality Indicator Reports. A pattern of survey "F Tags" in one or more key areas—e.g., pain management, physical restraints, psychotropic medications, pressure ulcers, falls, catheter use/urinary tract infection prevention, staffing (skill level and ratios), poor/missing documentation, and inconsistent charting, and inadequate (cookie cutter and missing) resident care planning—also may lead to an investigation.

The DOJ in recent years has increased its policing efforts under the False Claims Act (FCA) in two main areas: (1) quality of care (a/k/a "worthless services") and (2) "excessive" therapy billing (a/k/a "medically unnecessary services"). The former category is based on 42 U.S.C. § 1396r, which 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.” Although a worthless services claim is a variation of a false claim allegation, it is a separate and distinct claim under the FCA. To prevail on a worthless services claim, the government must prove that a facility’s alleged violation of applicable standards of care was “so deficient that for all practical purposes it is the equivalent of no performance at all.”<sup>[5]</sup> This standard of proof requires evidence that the facility made a knowing presentation of a claim that is known to be false, as opposed to a presentation that is made negligently or by virtue of an innocent mistake.<sup>[6]</sup>

While the government is pursuing facilities for not providing sufficient services to residents, it is simultaneously applying heightened scrutiny to what it deems to be “excessive” therapy billing. As referenced previously, a resident’s RUG level dictates the Medicare reimbursement rate. In the context of therapy billing, there are five general RUG levels: (1) Ultra High (RU); (2) Very High (RV); (3) High (RH); (4) Medium (RM); and (5) Low (RL). According to CMS, the RU classification is supposed to be reserved for the most clinically complex patients who require rehabilitative therapy well beyond the average amount of service time. In recent years, the DOJ has taken the position that therapy providers with disproportionately high percentages of RU therapy patients could be providing medically unreasonable, unnecessary, and unskilled therapy services to increase reimbursement rates. In a high-profile case filed in the Eastern District of Tennessee, the government alleged that the defendant-provider set aggressive RU therapy targets, punished therapist employees for failing to meet these targets, and ignored therapists’ recommendations that compromised their ability to meet these targets.<sup>[7]</sup> After years of litigation, the parties apparently reached a settlement in principle, and the action has been stayed at the parties’ request until September 2016. Based on the Life Care case and others, it appears the government views the following factors as potential signs of “excessive” therapy billing: (1) high percentage of patients with RU RUG scores and long lengths of stay without significant, measurable progress; (2) poor/missing documentation; (3) pattern of providing minutes within 2% of the minimum number of therapy minutes required for a particular RUG level; and (4) pattern of increasing/decreasing remaining therapy disciplines’ minutes of therapy when one discipline discharges/evaluates to maintain a higher RUG level without supporting clinical documentation.

In view of the increased attention being paid to quality of care and therapy billing issues and the six, seven, and eight figure settlements required to resolve these claims,<sup>[8]</sup> it is critical that all long term care providers closely monitor their survey and QI/QM report results to verify that the level and quality of services being provided are in line with other providers in the region. Therapy billing practices and RUG classifications also should be reviewed to ensure the therapy services being provided are not only necessary, but also patient-specific and properly documented.

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[1] U.S. Department of Justice, Press Release, *Department of Justice Launches 10 Regional Elder Justice Task Forces*, Mar. 30, 2016, available at <https://www.justice.gov/opa/pr/department-justice-launches-10-regional-elder-justice-task-forces>.

[2] See 42 C.F.R. § 455.23.

[3] See 31 U.S.C. § 3733.

[4] Part A of Medicare generally covers: (1) hospital care; (2) skilled nursing facility care; (3) nursing home care; (4) hospice; (5) home health services, see <https://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited Aug. 6, 2016).

[5] *United States ex rel. Mikes v. Straus*, 274 F.3d 687, 703 (2d Cir. 2001).

[6] *Cf. United States v. Houser*, 754 F.3d 1335, 1349 (11th Cir. 2014) (finding claims for provisions and services were submitted to Medicare despite not being provided to residents) with *Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001) (accounting errors that led to inaccurate claims for reimbursement were not “false claims” absent proof that facility was aware of errors prior to submission).

[7] See *United States v. Life Care Ctrs. of Am., Inc.*, Civil Action Nos. 1:08-CV-251 & 1:12-CV-64 (E.D. Tenn).

[8] FCA penalties paid in conjunction with corporate integrity agreements executed in 2014 and 2015 ranged from six to eight figures: \$750,000 (Foundation Health Services, June 2014); \$3.3 million (CF Watsonville, May 2015); \$17 million (Hebrew Homes, June 2015); and \$38 million (Extendicare Health Services, Inc., Oct. 2014).

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