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# MDS Alert

## Reimbursement: OIG Cracking Down On Fraud

**One focus is overbilling therapy claims.**

The **office of inspector General** (OIG) of the **U.S. Department of Health and Human Services** (HHS) is actively pursuing Medicare and Medicaid fraud across the country. In its November 2017 report "Top Management and Challenges Facing HHS," OIG points to SNFs' rampant overbilling of therapy claims.

The report admits that some of the payment policies have created financial incentives for facilities to drive up the costs of their Medicare billing without actually improving the quality of care that they provide beneficiaries.

"OIG found that Medicare payments to SNFs for therapy greatly exceeded SNFs' costs for that therapy, creating incentives to bill for unnecessary therapy. Indeed, OIG's work showed that SNFs have increasingly billed for the highest levels of therapy even though the characteristics of their beneficiaries did not change," the report says.

The OIG report says the **Centers for Medicare and Medicaid** (CMS) is looking to improve the delivery of care and also reimbursement. "CMS is also studying the extent to which Medicare payment rates for therapy at SNFs should be reduced by evaluating claims data and outlining potential new payment models for SNFs," the report says.

"HHS has reported that the improper payment rate exceeded 10 percent for both Medicare Fee-for-Service and Medicaid," the report said, before listing ways it plans to address the fraud.

**OIG Arrives at Settlements**

On March 22, the Baltimore **U.attorney's** announced in a press release that it reached an agreement with four SNFs and two consulting companies to resolve allegations of fraudulently billing Medicare for therapy provided for Medicare and Tricare beneficiaries. The U.S. Attorney's Office says that the six entities have agreed to pay $6 million total to resolve the allegations. The case was handled by Assistant United States Attorney Allen Loucks and Investigator Steven Capobianco.

"The settlement agreement was announced by Acting United States Attorney for the District of Maryland Stephen M. Schenning and Maureen Dixon, Special Agent in Charge of the Office of Inspector General for the Department of Health and Human Services.

"The civil settlement resolves a lawsuit filed under the whistleblower provisions of the False Claims Act, which permits private parties to file suit on behalf of the United States for false claims and obtain a portion of the government's recovery. The civil lawsuit was filed in the District of Maryland," the press release says.

The case concerned a four-year period (Jan. 1, 2010, to Jan. 31, 2014) where the six entities billed Medicare for services they either did not deliver or which were deemed to be medically unnecessary.

"The amount of skilled therapy is counted in minutes of therapy provided, and the United States alleged that the four SNFs and the two consulting companies falselyreported the number of minutes of skilled therapy that was delivered or that was medically necessary. Increasing the number of minutes in many instances brought the patient into a category that resulted in higher compensation for the SNF. The United States alleged that the consulting companies and the SNFs put systems in place to maximize Medicare and Tricarereimbursement and that caused the submission of claims for therapy services that were either not provided or that were unnecessary," the press release says.

The claims resolved by this settlement are allegations only, and there has been no determination of liability. Four of the six entities denied the allegations.

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**Other Schemes Trap Wrongdoers**

If you're aware of any fraud schemes going on at your facility, you can alert your local regional Office of Inspector General. **Bruce Ginsburg**, founder and trial attorney at **Ginsburg & associates trial Lawyers** in Philadelphia, describes in a blog post some of the schemes fraudulent facilities may be using.

**Upcoding Schemes**

Facilities practicing upcoding schemes typically use inappropriate procedure codes for the items or services rendered, Ginsburg says. "This is a type of billing fraud by the use of excessive procedure codes to be reimbursed at a higher rate."

Other dishonest practices, like unnecessary and unperformed therapies or presumptive or estimated therapies bring about extra - unwarranted -reimbursement in much the same way.

**Service Schemes**

This is the simplest and common form of violation of the False Claims Act by SNFs includes fraudulent facilities reporting services or medications that were not actually provided to the beneficiaries, Ginsburg says.

Other examples include falsification of medical records without providing proper medication or the inflation of recorded hours for service and medication reimbursements, he adds.

**Kickback Schemes**

Some SNFs are also getting fined for violating Kickback Laws, which prohibit both the receipt and payment of improper referral fees, Ginsburg says. SNFs can be prosecuted for issuing receipts that indicate referrals for services with an entity while in a referral relationship prohibited by Medicare or Medicaid.

"These improper relationships may include the provided contracts for lucrative Medicare and Medicaid patient transports in exchange for receiving free or heavily discounted ambulance transport for other patients," Ginsburg says.

Other examples of practices that could violate Kickback Laws are billing initial evaluations as therapy or unnecessarily boosting the amount of therapy for a beneficiary, he adds.

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