HOME HEALTH CARE FRAUD

In order to receive Medicare benefits, patients of a home healthcare association (“HHA”) must be certified as "homebound,” meaning that leaving the home must involve a “taxing effort” under Medicare regulations. These and other regulations cited herein are found in Chapter 7 of the Medicare Benefit Policy Manual of the Center for Medicare Services ("CMS") regarding Home Health Care. "Homebound" is defined in Medicare regulations as follows:

> Generally speaking, a patient will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

In one of my firm’s cases that resulted in a Judgment in 2019 of $339.4 Million (one of the largest if not the largest home health care fraud cases in U.S. history), *U.S. ex. rel. Bachman v. Healthcare Liasons, et. al.*, Civil Action No. 3:13-cv-0023 (N.D. TX Judgment dated August 14, 2019), a large percentage of the patients of the HHA's receiving Medicare payments were not "homebound” in compliance with the foregoing definition, meaning that any claim submitted to Medicare for payment constituted a False Claim under the FCA. Further, the Relator in the case would often be with the medical professional driving them to home health visits, and in a significant percentage of time, Relator would note on the list of patients to be seen that day that they were “not home”, which obviously means that they were not “home bound”.

The conduct of the Defendants that owned the HHAs was so egregious that criminal charges were filed against 4 of the Defendants in our *Bachman* case. Each either pleaded guilty to conspiracy to commit Medicare Fraud and/or Medicare Fraud, or found guilty by a jury. They received prison sentences of 17, 10, 5 1nd 2 ½ (for a cooperating witness) years in prison. An investigation found that 2 doctors involved signed certification or recertifications for patients being classified as homebound without ever seeing the patient. The investigation also revealed that on many occasions, the doctors would bill Medicare for over 100 hours per day, and over 200 per day on at least one occasion!

To be reimbursed by government-funded insurance programs (Medicare or Medicaid) for home health care services, providers must also be able to document that they have actually rendered the services for which they are claiming reimbursement, and that the services were

medically necessary. In addition, providers cannot claim payment from federal health care programs for home health care services resulting from an inappropriate referral from a health care provider such as conduct that would violate the Stark Law.

Blow the Whistle on Home Health Care Fraud

Individuals with knowledge of fraud committed by home health care agencies may be able to blow the whistle on this kind of fraud using the FCA, the TMFPA and other whistleblower reward programs. Whistleblowers play a critical role in bringing this type of home health care fraud to light and holding wrongdoers accountable when they try to cheat the system.

To talk with me about your home health care fraud case, call my Dallas law offices at 214-505-0097 or contact me online. Consultations with a Dallas County Home Health Care Fraud attorney are free and confidential. I handle these types of cases on a contingent fee basis, meaning you owe me no legal fees or expenses unless I obtain a recovery for you. Our firm has considerable experience and excellent results in home health care fraud cases.

$26 Million Whistleblower Award:

An example of a multi-million award to a Whistleblower in a FCA Home Health Care Fraud Case is as follows:

> In a **settlement resolved seven pending *qui tam* suits by relators who split $26 million of the settlement funds** from a **$150 million settlement** in April of 2014, one of the nation's largest providers of home health services agreed to pay **$150 million** to settle claims that some offices of the company billed Medicare for ineligible patients and services. The violations allegedly occurred because of pressure from management to focus on the financial health of the company rather than the needs of the patients. The settlement also resolves allegations that the company violated the Anti-Kickback Statute and the Stark Law by maintaining improper financial relationships with referring physicians. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Amedisys Home Health Companies Agree to Pay $150 Million to Resolve False Claims Act Allegations (Apr. 23, 2014), http://www.justice.gov/opa/pr/2014/April/14-civ-422.html.

Criteria for Home Health Services

Pursuant to Medicaid Guidelines, the criteria for coverage for Home Health Services is as follows**:**

> **20 - Conditions to Be Met for Coverage of Home Health Services**
> **(Rev. 1, 10-01-03)**

A3-3116, HHA-203

Medicare covers HHA services when the following criteria are met:

1. The person to whom the services are provided is an eligible Medicare beneficiary;

2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program;

3. The beneficiary qualifies for coverage of home health services as described in §30;

4. The services for which payment is claimed are covered as described in §§40 and 50;

5. Medicare is the appropriate payer; and

6. The services for which payment is claimed are not otherwise excluded from payment.

For **patients** to be eligible to receive home health care, the Medicare regulations stipulate as follows:

30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services
(Rev. 1, 10-01-03)
A3-3117, HHA-204, A-98-49

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:

Be confined to the home;
Under the care of a physician;

Receiving services under a plan of care established and periodically reviewed by a physician;

Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or

Have a continuing need for occupational therapy.

These "homebound" patients of HHA's must be certified or re-certified every sixty days, a period of time in Medicare regulations and HHA practice that is referred to as an “episode”, as more fully described in Medicare regulations as follows:

HH-201

The unit of payment under home health PPS is a national 60-day episode rate with applicable adjustments. The episodes, rate, and adjustments to the rates are detailed in the following sections.

10.1 - National 60-Day Episode Rate
(Rev. 1, 10-01-03)
HH-201.1

A. Services Included

The law requires the 60-day episode to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 60-day episode rate includes costs for the six home health disciplines and the costs for routine and non-routine medical supplies. The six home health disciplines included in the 60-day episode rate are:

1. Skilled nursing services
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 60-day episode rate also includes amounts for:

1. Non-routine medical supplies and therapies that could have been unbundled to part B prior to PPS. See §10.12.C for those services;
2. Ongoing reporting costs associated with the outcome and assessment information set (OASIS); and
3. A one time first year of PPS cost adjustment reflecting implementation costs associated with the revised OASIS assessment schedules needed to classify patients into appropriate case-mix categories.

B. Excluded Services

The law specifically excludes durable medical equipment from the 60-day episode rate and consolidated billing requirements. DME continues to be paid on the fee schedule outside of the PPS rate.

10.4 - Counting 60-Day Episodes

(Rev. 1, 10-01-03)
HH-201.4

A. Initial Episodes
The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

B. Subsequent Episodes
If a patient continues to be eligible for the home health benefit, the home health PPS permits continuous episode re-certifications. At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode.

30.5.2 - Periodic Recertification
(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11) At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

A beneficiary transfers to another HHA;

A discharge and return to the same HHA during the 60-day episode.

Medicare does not limit the number of continuous episode re-certifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days.

30.5.3 - Who May Sign the Certification
(Rev. 1, 10-01-03)
A3-3117.5.C, HHA-204.5.C

The physician who signs the certification must be permitted to do so by 42 CFR 424.22.

At each certification, a physician must certify his or her approval of the plan of care ("POC") and that the patient is "homebound" per Medicare guidelines. This signature is placed by the following statement box 26 on what is known as a Medicare Form 485 wherein the physician certifies:

> "I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan."

Contact Us:

Our firm has considerable experience and excellent results in home health care fraud cases. For a free consultation please call 214-505-0097 or contact me online.