- Medicare covers an unlimited number of visits per patient;
- Beneficiaries pay no co-payments except on medical equipment;
- Patients don't receive explanations of benefits (EOBs) for bills submitted for home health services; and
- There is limited direct medical supervision of home health services provided by non-medical personnel.

The OIG has learned of several types of fraudulent conduct, outlined below, which have or could result in improper Medicare reimbursement for home health services.

False or Fraudulent Claims Relating to the Provision of Home Health Services

The government may prosecute persons who submit or cause false or fraudulent claims for payment to be submitted to the Medicare or Medicaid programs. Examples of false or fraudulent claims include claims for services that were never provided, duplicate claims submitted for the same service, and claims for services to ineligible patients. A claim for a service that a health care provider knows was not medically necessary may also be a fraudulent claim.

Submitting or causing false claims to be submitted to Medicare or Medicaid may subject a person to criminal prosecution, civil penalties including treble damages, and exclusion from participation in the Medicare and Medicaid programs. OIG has uncovered the following types of fraudulent claims related to the provision of home health services.

Claims For Home Health Visits That Were Never Made And For Visits to Ineligible Beneficiaries

OIG has uncovered instances where home health agencies are submitting false claims for home health visits. These include:

- · Claims for visits not made.
- Claims for visits to beneficiaries not homebound.
- Claims for visits to beneficiaries not requiring a qualifying service.
- Claims for visits not authorized by a physician.

One home health agency billed Medicare for 123 home health visits to a patient who never received a single visit, and submitted claims for beneficiaries who were in an acute care hospital during the period the agency claimed to have provided home visits. Another agency provided a home health aide to a beneficiary so mobile that he volunteered at a local hospital several times a week.

A third agency claimed nearly \$26 million during one year in visits that

were not made, visits to patients that were not homebound, and visits not authorized by a physician. OIG interviews indicated that beneficiary signatures were forged on visit logs and physician signatures were forged on plans of care. This agency had subcontracted with other entities to provide home health care to its patients, and claimed that the subcontractors falsely documented that visits were made and services were provided.

Medicare permits a home health agency to contract with other organizations, including agencies not certified by Medicare, to provide care to its patients. However, the agency remains liable for all billed services provided by its subcontractors. The use of subcontracted care imposes a duty on home health agencies to monitor the care provided by the subcontractor.

Home health agencies, as well as the physicians who order home health services, are responsible for ensuring the medical necessity of claims submitted to Medicare. A physician who orders unnecessary home health care services may be liable for causing false claims to be submitted by the home health agency, even though the physician does not submit the claim. Furthermore, if agency personnel believe that services ordered by a physician are excessive or otherwise inappropriate, the agency cannot avoid liability for filing improper claims simply because a physician has ordered the services.

## Fraud in Annual Cost Report Claims

In addition to submitting claims for specific services, home health agencies submit annual cost reports to Medicare for reimbursement of administrative, overhead and other general costs. For these costs to be allowable, Medicare regulations require that they be (1) reasonable, (2) necessary for the maintenance of the health care entity. and (3) related to patient care. However, the OIG has audited cost reports which include costs for entertainment, travel, lobbying, gifts, and other expenses unrelated to patient care such as luxury automobiles and cruises. One home health agency claimed several million dollars in unallowable costs during one cost reporting year. These included utility and maid service payments for the owner's condominium, golf pro shop expenses, lease payments on a luxury car for the owner's son at college, and payment of cable television fees for the owner's mother.

Medicare also requires home health agencies to disclose in their cost reports the identity of related parties with whom they conduct business, in order

to adjust costs that are likely to be inflated by health care providers who self-deal (i.e., purchase goods or services from related companies). A related party issue exists when there is common control or common interest between the provider and the organization with whom it is doing business. OIG has investigated home health agencies which failed to disclose ownership or other relationships with entities with whom they contracted for accounting services, management/ consulting services, and medical supplies. These agencies billed Medicare unallowable amounts for marked-up supplies and services.

Paying Or Receiving Kickbacks In Exchange For Medicare or Medicaid Referrals

Kickbacks in exchange for the referral of reimbursable home health services is another type of fraud that OIG has observed. The Medicare program guarantees freedom of choice to its beneficiaries in the selection of health care providers. Because kickbacks violate that principle and also increase the cost of care, they are prohibited under the Medicare and Medicaid programs. Under the anti-kickback statute, it is illegal to knowingly and willfully solicit, receive, offer or pay anything of value to induce, or in return for, referring, recommending or arranging for the furnishing of any item or service payable by Medicare or Medicaid.

OIG is aware of home health providers offering kickbacks to physicians, beneficiaries, hospitals, and rest homes in return for referrals. Kickbacks have taken the following forms:

- Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home health agency.
- Disguising referral fees as salaries by paying referring physicians for services not rendered, or in excess of fair market value for services rendered.
- Offering free services to beneficiaries, including transportation and meals, if they agree to switch home health providers.
- Providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals.
- Providing free services, such as 24 hour nursing coverage, to retirement homes or adult congregate living facilities in return for home health referrals.
- Subcontracting with retirement homes or adult congregate living facilities for the provision of home