health services, to induce the facility to make referrals to the agency.

Parties that violate the anti-kickback statute may be criminally prosecuted, and also may be subject to exclusion from the Medicare and Medicaid programs.

Marketing Uncovered Or Unneeded Home Care Services to Beneficiaries

OIG has learned of high pressure sales tactics employed by some agencies in the home health community to maximize their patient population and their profits. These agencies target healthy beneficiaries on the street or in their homes and offer non-covered services, such as grocery shopping or housekeeping, in exchange for Medicare identification numbers. Physicians have also reported that some agencies attempt to pressure them to order unnecessary personal care services by informing them that their patients are requesting these services and will find another physician if their demands are not met.

¹ These abusive marketing practices can result in false claims liability on the part of agencies and/or physicians, and may also constitute illegal kickbacks.

III. Special Fraud Alert: Medical Supplies to Nursing Facilities

(August 1995)

The Office of Inspector General was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in Health and Human Services programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.

To help reduce fraud and abuse in the Medicare and Medicaid programs, the OIG actively investigates schemes to fraudulently obtain money from these programs and, when appropriate, issues Special Fraud Alerts which identify segments of the health care industry that are particularly vulnerable to abuse. This Special Fraud Alert focuses on the provision of medical supplies to nursing facilities and identifies some of the illegal practices that the OIG has uncovered.

How Nursing Facility Benefits are Reimbursed

Many nursing facilities receive reimbursement from Medicare and Medicaid for care and services provided to eligible residents. Under Medicare Part A, skilled nursing facility services are paid on the basis of cost, and compensate the provider for covered nursing stays of a limited length. For Medicaid-eligible residents, extended nursing facility stays may be reimbursed by state-administered programs financed in part by Medicaid. Nursing facility residents may be concurrently eligible for benefits under Medicare Part B. These benefits may include payment for medically necessary equipment, prosthetic devices and supplies.

Nursing facilities and their residents have become common targets for fraudulent schemes involving medical supplies. The OIG has become aware of a number of fraudulent arrangements by which medical suppliers profit from inappropriate business dealings, in the name of unwitting nursing facility residents.

Sometimes, nursing facility management and staff also are involved in these schemes.

False or Fraudulent Claims Relating to the Provision of Medical Supplies

The government may prosecute persons who submit or cause the submission of false or fraudulent claims to the Medicare or Medicaid program. Examples of false or fraudulent claims include claims for items that were never provided or were not provided as claimed, duplicate claims submitted for the same item, and claims for items that the supplier knows are not medically necessary.

Submitting or causing false claims to be submitted to Medicare or Medicaid may subject the individual or entity to criminal prosecution, civil penalties including treble damages, and exclusion from participation in the Medicare and Medicaid programs. The OIG has uncovered the following types of fraudulent transactions related to the provision of medical supplies to nursing facilities.

Claims for Medical Supplies and Equipment That Are Not Medically Necessary

 Many of the supplies and equipment used in the care of nursing facility residents are provided by the nursing facility and should be reflected in the facility's Medicare cost report. The OIG has uncovered numerous instances in which suppliers provide the nursing facility with general medical supplies such as tape, adhesive remover, skin creams and syringes, but rather than bill the facility, the supplier submits claims to Medicare Part B. The claims misrepresent that the items are medically necessary for individual beneficiaries and therefore reimbursable under Part B.

For example, one supplier billed Part B for an "oral/nasal hygiene program"

which consisted of supplies, such as saline solution, latex gloves and cotton swabs, marketed as prepackaged kits. Upon investigation, the OIG determined that these items, which were shipped to the facility in bulk quantities, were neither medically necessary, nor used for the care of the residents identified on the claims. In such a case, the supplier may be liable under criminal, civil and administrative laws for submitting fraudulent claims. The nursing facility may also be liable if the OIG determines that the nursing facility knew or should have known that the claims were false and participated in the offense.

Claims for Items That Are Not Provided as Claimed or Double Billed

 Many inappropriate transactions involve marketing of incontinence supplies. In one case, a supplier was found to have delivered adult diapers, which are not covered by Medicare Part B, and improperly billed these items as expensive prosthetic devices called "female external urinary collection devices." In another case, a supplier delivered only incontinence care products, such as lubricants and cleansers. These items are covered only as accessories to medically necessary prosthetic devices such as female external urinary collection devices. Medicare received bills for each accessory, even though the primary item was not provided.

 In some cases, multiple payments are made for particular items shipped to nursing facilities. For instance, a nursing facility ordered and accepted delivery of certain medical supplies for the facility's general use. The nursing facility appropriately claimed the supplies as expenses related to patient care on its Medicare cost report. However, the supplier also submitted separate claims to Medicare Part B on behalf of each resident in the facility. In order to receive Part B reimbursement, the supplier misrepresented its entitlement to payment, as well as the eligibility and coverage of individual beneficiaries. Other payment sources, such as Medicaid or private payers, may also have been billed by the supplier. The supplier may be liable under criminal, civil and administrative provisions if the supplier claimed falsely that the beneficiary met the required eligibility and coverage criteria. The nursing facility may also be liable for falsifying its Part A cost report if it knew or should have known of the duplicate billing and participated in the offense.