FR11- "Worthless Care": Medical Necessity and the False Claims Act

Friday, March 23
1:30 PM- 3:00 PM

Session Description

This session provides a review and update of legal issues of special importance to PA/LTC medicine providers participating in Medicare and Medicaid. The speakers will discuss key legal issues and concepts, and will guide the participants to develop and practice an approach to evaluating cases as part of ongoing quality assurance and compliance activities. This session will focus on the issues of medical necessity, false claims, and worthless care. The history and philosophy of these concepts and their application to PA/LTC settings will be discussed, along with illustrative cases, which participants will evaluate together.

Learning Objectives

- Apply the concepts of “medical necessity”, “false claims”, and “worthless care”, and their relationship to quality of care to specific case examples to evaluate medical necessity and quality of care in individual cases.
- Describe the processes by which CMS and other government-related entities evaluate ‘medical necessity’, potentially ‘false claims’, and potentially ‘worthless care’ in PA/LTC settings, what SNFs and other providers do in response, and develop strategies for proactive strategies that will empower the physician/Medical Director to provide quality care to the patients at the SNF, assist the facility to be successful in the current increasingly challenging health care environment and assist the facility.

Presenter(s): Jonathan Evans, MD, MPH, CMD; David Jackson, MD, PhD

Presenter(s) Disclosures: David Jackson, MD, PhD: Has a financial disclosure; Jackson & Associates, Inc.: President; Salary; All other speakers have reported they have no relevant financial relationships to disclose.
Worthless Care and Red Flags in Therapy
AMDA/PALTC:
New Dimensions in the Quest for Quality

Presented at
AMDA: PA/LTC Medicine
2018 Annual Convention
By

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Adj. Professor of Medicine
March, 2018

Learning Objectives
By the end of the session, participants will be able to:
• Apply the concepts of ‘medical necessity’, ‘false claims’, and ‘worthless care’, and their relationship to quality of care to specific case examples to evaluate medical necessity and quality of care in individual cases.
• Describe the processes by which CMS and other government-related entities evaluate ‘medical necessity’, potentially ‘false claims’, and potentially ‘worthless care’ in PA/LTC settings.
• Discuss proactive strategies that will empower the physician/Medical Director to provide quality care to the patients at the skilled nursing facility.

Why Are We Talking About This?
Alleviate fear
We want to know what the rules are and follow them
We want to understand the world around us
Also: quality of care, honesty, trust have to matter to us.
Bedrock of our professional ethos and much of our professional satisfaction comes from this
Bad actors undermine the public’s trust in us, and it diminishes our value to others as well

Why are CMS, DOJ Talking about this?
Medicare Policy Goals:
Provide access to quality care through affordable health care insurance for seniors (Medicare)
Provide timely payment to practitioners/providers as an incentive to provide medically necessary services to Medicare beneficiaries
Be good stewards of taxpayer dollars
Move payment toward payment for value (Quality/cost)
Prevent/monitor wrongdoing (but usually have to do so after payment has already been made)

Speaker Disclosures
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Jonathan Evans, MD, MPH, CMD has no financial relationship(s).

Government Tools
Make expectations explicit through contract (Conditions of Participation)
NH Regulations are all part of contract
Evaluate Claims, claims data (retrospective)
Data mining
Look for outliers
Audits
Objectives

1. Understand the concepts of medical necessity, false claims, and worthless care, in relationship to quality of care
2. Apply those concepts to specific case examples to quality of care to specific case examples
3. Become familiar with the processes CMS and other government-related entities use to evaluate medical necessity, potentially false claims, and potentially worthless care in post acute
4. Understand how PA/LTC providers and medical directors may be asked to participate productively in these processes to provide clinical insight and interpretation and help to resolve concerns

Medical Necessity

The legitimate reason for which health care services should be provided
Medical justification for the provision of any health care services (visits, tests, procedures, therapies, etc) by licensed practitioner
100% of all health care costs result from our signatures!
Explicit documentation is the standard means by which medical necessity is assessed
Often fairly obvious, objective
Eye of the beholder to some extent
Worthless and worthwhile are value judgments

False Claim

“31 U.S.C. 3729(b). In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that her or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided.”

False Claim

Billing for services not rendered or product provided (includes upcoding, inappropriate coding)
Misrepresenting the nature of the patient’s condition (i.e. DRG creep)
Ungrouping services or products billed
Billing for medically unnecessary services
Duplicate billing
Falsifying records to meet or continue to meet the conditions of participation
The concept of a false claim is changing over time

False Claims and Quality

The quality of a product or service may be so poor that it bears little resemblance to the product or service agreed to, making a claim for such a poor product or service a false one
A product or service can be of such poor quality that it is essentially worthless
Cheeseburger analogy

Worthless Care

This concept has only recently been tested in court
Care that is of no value (Steak dinner analogy)
An extension of the concept of a false claim applied more broadly across a facility or company
What does worthless care look like?
Somewhat subjective
You know it when you see it?
Ageism, public attitudes toward NH residents may make pursuing such claims more difficult
Quality Spectrum and False Claims/Worthless Care

- Spectrum from good to bad
- Bad enough an invisible threshold crossed: neglect and/or worthless (i.e. no value) for an individual
- Time to Answer a call bell: 5 minutes. 20 minutes. 1 hour. 5 hours. Never
- At what point is that neglect?
- Extend to worthless care, at point was that care worthless?
- Enough of these issues, then worthless care overall

Worthless Care Case: 94 Year old woman with AD, Hip Fracture

Admitted to SNF from hospital s/p right hip fracture
Pt. was to be non-weight bearing on right leg.
The order was entered into the computer incorrectly, however, and she was made non-weight bearing on the left leg, such that she was instructed to put all of her body weight on the left leg during physical therapy and while attempting to ambulate in her room. She fell three times during the first three days of her SNF stay. Physical therapy was discontinued after 20 days due to poor progress.
She remained in the facility for long-term care. On day 42, she was seen in follow-up by the orthopedic surgeon who noticed a surgical nail protruding from the previous right hip incision site. An x-ray identified an impacted, comminuted, open fracture. She was hospitalized for surgery and intravenous antibiotics.

External Review of LTC

1. CMS Medicaid Integrity Program: New Part of the Affordable Care Act.
2. Only major hiring in US DHHS is in the investigation of fraud and abuse related offices.
3. April 2010: With the passage of the Affordable Care Act, CMS established the Center for Program Integrity.
4. The ACA calls for major increases annually for the next decade in the recovery of payments made to providers under Medicare and Medicaid that were not medically necessary, were not reasonable and/or were fraudulent.

Do You See a Pattern? HHS puts its money where its goals are!

External Review of LTC

Limitations / Issues with Data Mining

1. Lack of adequate risk adjustment techniques/tools.
   A) Lack of consideration of “soft” variables e.g. Patient/family wishes and beliefs, quality of life
   B) Pace of change in both patient population and technology has left us with no or outdated outcomes data bases.
   C) Audit processes employed by the government does not have any mechanism to provide any level of “due deference” to the physician at the bedside or to deal with the uncertainty inherent in clinical decision making.

External Review of LTC

Tools for Federal Review of Skilled Therapy
1. Surveys (State and Fed. “Look-Behind”)
2. “Big Data” / Data Mining – Leads to…
   a) Audits (ZPIC, RAC)
   b) DOJ Investigations
3. False Claims Act (Civil and Criminal)
6. Corporate Integrity Agreements (CIAs) IRO and/or Quality Focus

External Reviews of LTC

DATA MINING IN LTC SKILLED THERAPY

PEPPER Reports: Program for Evaluating Payment Patterns Electronic Report
Sent to SNFs quarterly. An opportunity for proactive review and action
Use of the PEPPER report data to identify risk areas and to respond rapidly, before the Federal government or its contractors initiate an audit or investigation.
CMS monitors data on Six areas related to therapy in the SNF as part of its ever expanding data mining efforts.
1. Therapy days for patients with high ADL scores (Therapy High ADL).
Response to High Risk Areas: (Continued)

2. Non-Therapy, High ADL: Non-therapy days for patients with high ADL scores.

3. COT Assessment (Change of Therapy Assessment): The number of assessments that are COT divided by the total; number of all assessments done within the episodes of care ending in the report period.

4. Ultra High (Percentage of total therapy days that are in Ultra High intensity RUGs). THIS METRIC IS A VERY INTENSE INTEREST OF FEDERAL REVIEWERS.

5. Therapy (Therapy days as a percentage of all RUGS days of services billed within episodes of care that ended during the reporting period).

6. 90+ Days: (Episodes of care that exceeded 90 days of skilled services).

Another high visibility area

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**False Claims Act:**
Initially adopted under Pres. Lincoln (Lincoln’s Law)

Liability under the federal False Claims act occurs when a defendant: 1. knowingly presents causes to be presented on faulty or fraudulent claim for payment
2. Knowingly makes, uses causes to be made or used, record statement material to a false/fraudulent claim
3. Conspires with authors to commit a violation of the False Claims Act
4. Knowingly makes, uses or causes to be later used, false record statement to conceal ovoid or decrease application to the federal government.

Who is responsible for submission of a false claim under the law?
It is not just the entity or person who physically submitted the claim. The law is clear. “Knew or should have known” and “Reckless disregard”:

It is not enough simply not to be the person or entity that physically submitted the bill for a false claim. The law states it applies to anyone who submits a false claim or causes a false claim to be submitted. The standard is did you know or should you have known about the issue or did you recklessly disregard warnings about a problem.

How should we manage such an area of focus- and not just therapy!

REMEMBER: These areas of interest are also real opportunities to empower quality improvement activities.

1. Clinical staff must make clinical decisions. Ensure that non clinical staff are not making, facilitating or impeding clinical care decisions e.g. setting a process where therapy staff must obtain administrator or business office manager authorization for therapy treatment frequency for patients with a Medicare managed care plan.

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False Claims: continued:

It is not necessarily “bad” to be an outlier, but it is worthy of exploration and analysis to ensure that there is adequate rationale that supports the pattern noted – or that the facility has taken appropriate steps to address any problems that were identified in the area where the outlier situation was identified in the PEPPER report.

Remember, FCA actions can be initiated by internal “whistle blowers” and have two very strong penalty tools:
A) Treble damages
B) Exclusion from Federal health care programs
How should we manage such an area:

2. Patient treatment decisions should be made based on clinical patient needs and published or contracted payor source directed parameters. Ensure that revenue or census enhancement strategies do not lead to under delivery of care e.g. limiting a patient’s therapy treatment frequency under Medicare B solely to facilitate a 60 day wellness period in anticipation of renewed Medicare days if patient readmitted to hospital for qualifying Medicare stay.

False Claims: continued:

3. Facility projections for clinical service related financial and utilization outcomes should be based on facility specific patient characteristics identified through historical data or quantifiable and recognized projections of future service provision and not based on outcome levels required to achieve regional projections, revenue desires or to mitigate unrelated market, practice or industry factors.

4. Patient care delivery should be at frequency and duration that is optimal for patient recovery and as outlined in patient’s plan of care. Ensure that therapy treatment frequencies are not manipulated or structured to ensure most optimal payment without regard to impact on care delivery.

5. Therapy plans of care should reflect treatment frequencies, treatment durations and modality provision that are optimal for patient recovery and not dictated by payment categorization. E.g. adjusting plans of care to include 6 and 7 day a week therapy during payment categorization periods and then decreasing frequency during non-categorization periods.

6. For all patients, ensure that all patient length of stay decisions are clearly communicated to patient, family and caregiver and that any requests from patient, family and caregiver to discharge from facility at a time sooner or later than team designated time is discussed in full with all stakeholders (including attending physician) and that any concerns by any stakeholder are adequately addressed and documented. Attending physician should be included in all discussions and explanations to stakeholders.

7. This is particularly important for Medicare and private insurance stays, but LOS for Medicaid patients is also worthy of review (Does the patient still require the level of care available at the facility or is a lesser level of care more appropriate? ).

8. The amount of therapy (or any service or treatment) provided to each patient should be based on the medical status of each patient, as determined by clinicians with direct day to day involvement in the patient’s care process (i.e. physician, RN, social worker), the evaluating therapist’s assessment, the treating therapist’s daily assessment of patient response to treatment and the therapy director’s clinical expertise as a subject matter expert (as indicated).

9. Therapy treatment parameters on the patient-specific level should not be “templated” (use the same wording for all patients) or cut and paste. It should not be managed remotely by those not involved in that patient’s care and should not be subject to influences unrelated to patient treatment plan and individual patient response to or need for treatment.

Arrows in Your Quiver:

1. Do it right the first time: The single most valuable tool.

2. Initiate a robust Quality Improvement program to include reviews of therapy programs.

3. Review, investigate and respond to the information in the Quarterly PEPPER Reports on therapy patterns in your SNF.
Things NOT to do or say!!

1. "Our Medicare Part B rates are low. We need to have therapy rescreen every resident."

2. "Our length of stay is too short. Can't therapy keep residents on caseload longer?"

3. "We can’t lose this admission. We need to find something to skill this patient for”.

4. "We are going to miss a RUG, can’t therapy provide extra minutes?”

5. "Everyone can benefit from therapy”.

6. "Our RUG rates have to improve, this is costing us money.”

The US DOJ has recently entered into agreement with a large national LTC company with a major fine ($140 million) and a 5-year CIA related to an allegation by DOJ that skilled therapy was systematically provided that was unnecessarily intense and/or prolonged. This tool has been in use for the past 15 years.

Therapy is not the only area where Quality and Compliance is important. It is a prime example of what CMS and DOJ are focused on. This is an expensive service whose costs are increasing rapidly and where there is often a split in responsibility (e.g. the facility team and a therapy contractor). The government does not care. Both parties will be held responsible if there are problems identified by the government reviewers.

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Add JE slides on Medical necessity and worthless care

Common Issues Identified in Problematic Cases

1. **Prolonged duration** of skilled rehabilitation services without any improvement being documented in the records will raise potential issues of inappropriately prolonged provision of and billing for skilled services under Medicare.

   A) This is particularly of concern when the involved patient **exhibits significant clinical decline** during the continued skilled rehabilitation services. If there are situations where such prolonged skilled services are clinically indicated, there is a particular need to include detailed documentation about the rationale for the provision of such services.
Common Issues Identified in Problematic Cases

2. We see some cases where patients were repeatedly described as lethargic and difficult to get to participate in the skilled therapy sessions.
   A) Such a patient must have very detailed progress notes that “make the case” for why such services are being continued.

3. There are multiple times one sees cases involving the care of patients whose medical condition appears to be declining and moving towards Terminal status.
   A) Some of these individuals were referred for hospice evaluation and others were referred appropriately to Palliative Care programs.
   B) However, several of the cases we reviewed involved patients who were undergoing severe clinical decline, who continued to receive skilled rehabilitation services until the day before or the day of the death of the patient. In these cases, there was no referral to Hospice or to Palliative Care.

4. End of Life Issues:
   Hospice is an entitlement under Medicare. If family/resident are opposed to such referral, it should not occur. In these cases, clear documentation of the circumstances is needed.
   A) In such cases, prompt referral to Palliative Care can be useful.
   B) Involving the attending physician or Medical Director in establishing a palliative care program (not formal Hospice, but with much more interdisciplinary and physician involvement in supporting the resident and family (and staff) through the process of active dying).
   C) In residents in terminal decline, it is often difficult to ascertain the reasons for continued rehabilitation. If there is justification for the skilled services in these situations, there is a substantial threshold that the documentation by the therapist must overcome.

5. We reviewed several cases with clear documentation of discussion of hospice or “comfort care only” while the resident was at the acute care hospital. However, there was no mention of either consideration of such referral or of the reason why such referral was not made at the SNF.
   A) When there are differences between the documentation at two sites of care, it is helpful to have an explanation of the reasons why the current Plan of Care - without Hospice or Comfort Care in place – is in the best interest of the resident and not simply something that has fallen between the cracks.

6. Therapists appear to be optimistic professionals. While this can be a real strength, we observed multiple examples where the assessment of rehab potential appeared to be overly optimistic.
   A) In most cases, the form used by the therapists for the initial Plan of Care and Short and Long term goals has a place to document rehabilitation potential. On some forms we have seen, the only two choices were Excellent and Good. There was no option for “Fair” or “Poor”.

7. Some residents may have limited rehabilitation potential, but potentially be a candidate for a limited trial of (e.g.) two weeks to explore whether the resident will benefit.
   A) Many residents have, in reality, guarded or unclear rehab potential. Skilled Rehab needs to have forms that will foster more thoughtful and accurate descriptions of the real clinical situation and the rationale for the provision of skilled services to each individual resident.
**Red Flags in Therapy**

**AMDA/PALTC**

### Common Issues Identified in Problematic Cases

8. Some residents received *100 days of Part A skilled services* (or very close to 100 days) and then were discharged from skilled care – and not reassessed for evaluation of Part B skilled services.

A) While some residents can reach their maximal level of performance at or near the 100-day mark, any such case is almost certain to *generate close examination* by external reviewers.

B) Such reviews will likely focus on *alleged inappropriate provision of skilled services* in circumstances where there is "no reasonable likelihood of benefit" to the resident. When such a situation occurs and therapy is continued, expanded documentation by therapy and the physician on the reasons for such continued care could help deflect such concerns.

9. We have also seen differences in rehab assessments done at the hospital and at the SNF. Uniformly, the resident is described as having more severe deficits when assessed at the SNF than are described at the hospitals.

A) Could lead to allegations that the deficits are "exaggerated" at the SNF to enhance the case that the declines are substantial enough to justify skilled rehabilitation.

B) There can be reasons why a resident might have a modest decline between hospital and SNF evaluations (e.g. 1 to 3 days without rehabilitation, the stress of the transfer, etc.). When there is such a difference, the documentation would be strengthened if the difference were noted and explained in the SNF record.

10. We have reviewed multiple cases where description of the **Prior Level of Function (PLOF)** was not detailed or adequately quantitative.

A) If the PLOF description is, as we have seen, “Assist with ADLs” and there is no description of the level of assistance required or “admitted from hospital”, then it can be *more difficult to claim the current level of function has clearly declined from the PLOF prior to the qualifying hospitalization.*

B) There **MUST** be a clear statement that the current level of function has significantly declined directly related to the illness that led to the qualifying hospitalization.

11. **MISSING RECORDS**: We have encountered a number of records where substantial portions were missing.

A) Missing records can lead to an allegation that the missing records contain the most incriminating evidence that, if present, would support some allegation of wrongdoing or inappropriate billing practice.

12. In some records, we noted **substantial differences** in the description of the level of assistance required by a resident between that documented in the *nursing notes* and that contained in the *therapy notes*.

A) When there is such a discrepancy, the facility must *determine which description is accurate*.

B) Provide more *education for nursing staff* to ensure that they do not use language that is technically inaccurate or fail to document the often reasonable explanation for the differences (e.g. after a long session of therapy, the resident may be tired and unwilling to do as much as he/she is capable of when not as tired).

C) One must **document the reasons why such differences exist** in the medical record.

13. There are many cases where one could question the intensity of the skilled services provided. All of the cases reviewed appear to have at least some period of time when **Ultra High intensity** was provided. This is a major area of interest to the Federal government!

A) While it is clear that assessment of the issue of "minute creep" is very difficult in any individual case, analysis of a facility’s or a system's percentage of Ultra High Days of Care, when compared to some normative average data (e.g. State or National averages or, if available, to normative data from similar facilities with similar admission case mixes) can be very useful.
14. When notes are illegible, they either provide no useful information or (worse) lead to errors in interpretation of the content of the note.

B) This is true for all the disciplines involved, but clearly is most severe in the physicians’ progress notes. If a physician’s handwriting is illegible, he/she must be counseled and either agree to utilize typed/dictated notes or take effective action to make their handwriting legible.

C) The Therapy notes are often difficult to read as well. On many forms, there is not enough space to write legibly all the data called for in that space. “Function follows Form”.

15. Are resident referrals to outpatient Home Health Care Skilled Therapy clinically appropriate? Does a pattern of such referrals to a HHC/Therapy entity create either the appearance of or an actual conflict of interest?

A) We have observed a number of such cases. Is there a real or perceived issue of “self dealing” generated by a pattern of referrals?

Recommendations:

16. We propose consideration of several recommendations:

A) Consider developing guidelines and additional proactive educational programs concerning the documentation required if one is to continue skilled therapy after (e.g.) two weeks or more of therapy without measurable progress. Cases that raised this issue represented 25% of the Category II and III residents in this series. Documentation from both the therapist and the attending physician would be helpful in these cases.

B) Emphasize the necessity of documenting as detailed as possible descriptions of the PLOF in the initial therapy evaluation. Without this, the rationale for “skilling” the resident is significantly weakened. Seeking, through phone calls to family and/or friends and use of other communication tools, to obtain these data are worthwhile efforts and should be encouraged.

Recommendations (continued):

C) Consider proactive steps to get ahead of any possible RAC Audit/External Review issues. Create as much “Arms Length” independence as possible and document the provision of choice of HHC therapy providers for residents (as practicable).

D) End of Life Issues: There are opportunities to strengthen the end of life issues and related documentation. We have seen this issue in about 10% of the cases we have reviewed.

1. Consider Expanded use, where indicated, of well constructed and thoughtful Palliative care programs and increased emphasis on following up on hospital record references to an expressed interest in hospice care by resident/family could both enhance the effectiveness of such programs.

E) Additionally, it is clear that there are completely appropriate cases where skilled therapy is rendered and a resident dies unexpectedly during the therapy. However, Providers could benefit by creating increased focus on recognition of the occurrence of clinical decline - and clear documentation across the disciplines - don’t just write “Nursing notified”.

1. Consider increasing the use of “putting therapy on hold”, while one sees if the resident’s mental status and/or medical condition improves enough to permit the resident to participate effectively in a skilled care program.

2. When a decline in functional abilities is noted by therapy, it often appears to be a harbinger of a significant clinical issue that is noted by nursing several days later. Enhanced communications and follow up between therapy and nursing in these cases would be beneficial.

F) Therapy professionals should make an effort to access all relevant records from the skilled rehabilitation professional at the acute care hospital, as part of their initial therapy assessment. When there are differences between the description of the resident at the hospital and the level of deficits seen at the SNF, there should be explicit documentation of the differences by the SNF professionals.

1. Documentation of possible explanations for these differences would also help create a more “Bullet-proof” record and, more importantly, could help create an optimally effective transition in skilled therapy from the hospital to the SNF.
Red Flags in Therapy  AMDA/PALTC

Recommendations (cont.):

G) It appears, from our experience, that it would be worthwhile for facilities - and all disciplines - to demand that all professionals produce legible progress notes.

1. As noted above, this is a Quality of Care and a Risk Management issue - and one the Joint Commission and Tort attorneys are scrutinizing ever more closely. Facilities must begin to enforce reasonable standards of legibility for any handwritten note. Moving to dictated or electronic typed notes will occur over time. Until that is available and used, establishing reasonable standards for legible handwriting and enforcing them will be an important - and cost effective - effort.

Your Role as a Practitioner

Person-Centered goals: help patients/families understand, decide

Identify /shape expectations

Practitioners have a responsibility to be actively involved: Pay attention to what’s going on in patient’s rehab

Day To Day Responsibilities for Practitioners

Order therapies when appropriate
Say why you made the referral (medical necessity)
help identifying needs, goals, monitor progress, identify/modify barriers (pain, acute illness, depression, etc)
communicate, certify, recently, pay attention to rehab progress notes, clarification orders
Analogy: ordering a consultation, ordering a medication
Pay attention to how much rehab your patient is getting and why, monitor progress, speak with therapy staff.
Ask questions (i.e. how does therapist or director decide how many minutes of therapy or duration?) (i.e. dose of rehab)
Advocate for your patient to make sure they get the care they want and you feel they need

QAPI

Routinely review CASPER reports (QMs/Qis)
Look online (medicare.gov) if not routinely shared with you
PEPPER reports
Regular dialogue with therapy staff about your patient
Communicate concerns

Summary

We all have a responsibility to ensure that patients get what they need, avoid what they don’t
The trust that people place in us depends upon it
Be an advocate for patients and their care
We are responsible for overseeing the care and treatment we order
Ask questions (of everyone: patient, family, providers
We never need to fear doing a good job