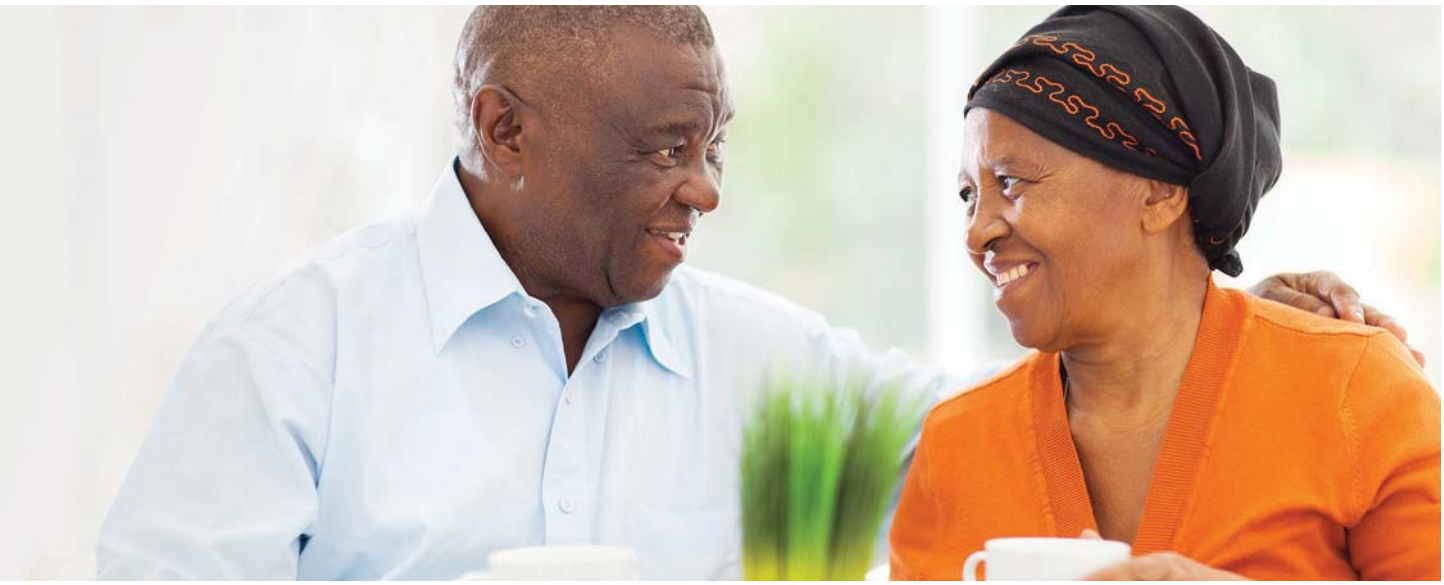
# Nursing Home Toolkit

## Program Integrity and Quality of Care–An Overview for Nursing Home Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES



## Content Summary

This booklet is written for nursing home providers that participate in the Medicaid program. It explains what fraud, waste, and abuse are and the common types of fraud in the nursing home environment. This booklet also discusses improper payments and government anti-fraud efforts.

After addressing common program integrity issues, the booklet covers quality of care in the nursing home, such as quality of life, resident rights, and resident freedom from fraud and abuse. The booklet concludes with information on how to report concerns and problems in the nursing home.

As a nursing home provider, you can improve the quality of life for the people you serve. By providing a caring environment, you can help residents feel safe and secure, which may offer their family members peace of mind.

Nursing homes are a necessary service for many Americans. However, since 1996, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) has identified a number of problems with billing by nursing facilities that participate in Medicare and Medicaid, including submitting inaccurate, medically-unnecessary, and fraudulent claims.[1, 2, 3, 4, 5] Many nursing facilities receive payment from both Medicare and Medicaid for services provided to their residents. Therefore, Centers for Medicare & Medicaid Services (CMS) guidance for nursing facilities may address concerns in both the Medicare and Medicaid programs.[6] These concerns include quality of care, submitting accurate claims, the Federal Anti-Kickback Statute and False Claims Act, and other areas of risk. Understanding fraud, waste, and abuse can help providers avoid errors that could cause problems for themselves or the facilities in which they work.

As with the Medicare program, Medicaid fraud, waste, and abuse, as well as the quality of the care provided, are major concerns. This booklet provides an overview of Medicaid provider program integrity rules and discusses nursing home quality of care services.

## Definitions of Fraud, Waste, and Abuse

- **Fraud**

  Fraud is "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."[7]

- **Waste**

  Waste is not defined in Medicaid program integrity rules but "is generally understood to encompass the over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act."[8] Examples of waste include a provider ordering more medical supplies than the beneficiary needs or ordering excessive laboratory tests.

- **Abuse**

  Abuse is careless or unprofessional business and health care practices that result in unnecessary or excessive charges to Medicaid, billing and receiving payment for medically-unnecessary services, and substandard care. It can also include beneficiary behavior (for example, doctor shopping) that unnecessarily increases costs to Medicaid.[9, 10]

Neither waste nor abuse requires provider intent to illegally profit from the Medicaid program, but penalties may still apply. On the other hand, fraud involves intent and is a crime. Waste and abuse may not be done intentionally, but such conduct harms everyone involved by increasing the cost of health care and raising red flags about program integrity or potential fraudulent behavior. Providers found to have defrauded the Medicaid program may be subject to civil liability,[11] criminal liability,[12] Civil Monetary Penalties,[13] and exclusion[14] from participation in Medicaid or Medicare. Penalties and fines are reported on the Nursing Home Compare report.[15]

## Types of Fraud, Waste, and Abuse

- **Billing for Unnecessary Services or Items**

  Medicare and Medicaid cover only medically-necessary services or supplies. For Medicaid, each State defines medical necessity. Under 42 C.F.R. § 440.230(d), States may "place appropriate limits on a service based on such criteria as medical necessity."[16] Physicians are responsible for ensuring authorized services meet the definition of medical necessity in the States in which they practice. When a physician signs billing documents, he or she certifies the truth, accuracy, and completeness of the claims.[17] A provider who knowingly bills Medicaid for unnecessary services or items may be found to have committed fraud. In 2011, a former nursing home administrator pled guilty to charges of defrauding the Medicaid program out of $2.2 million. She allegedly exaggerated residents' diagnoses, conditions, and required services. She also allegedly reported providing treatments for the exaggerated diagnoses, including suction and oxygen treatments, and treatments for cancer and infections that were not required. She was ordered to repay Medicaid and is excluded from participating in Federally funded health care programs.[18]

- **Billing for Services Not Rendered**

  Medicare and Medicaid cover only the services and supplies provided. Providers should only bill for the services or items authorized by their State's Medicaid program and for services actually furnished to beneficiaries. Some fraudulent providers bill Medicaid for a covered service or item they never provided or ordered. These providers may create false records in an attempt to justify the bills. For example, a former nursing home administrator was convicted of defrauding Medicare and Georgia Medicaid by billing them for $32.9 million in worthless services. Between 2004 and 2007, the defendant billed Medicaid and Medicare for food, medical care, and other services for nursing home residents. Evidence presented at the trial showed conditions at the nursing homes were very poor, including no nursing or housekeeping supplies, food shortages, poor sanitary conditions, hazardous physical environment, and inadequate staffing. The former nursing home administrator was sentenced to 20 years in prison, followed by 3 years of supervised released. In addition, he was ordered to pay more than $6.7 million in restitution to Medicaid and Medicare.[19]

- **Upcoding**

  Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a level of complexity higher than the service actually provided or documented in the file.[20, 21, 22] For example, a licensed clinical social worker (LCSW) allegedly billed Medicaid for 45 to 50 minutes of individual therapy when he provided less than 30 minutes of counseling services. The LCSW also allegedly billed Medicaid for individual psychotherapy services for separate family members when he provided one group therapy session to the family members at the same time. The clinical social worker entered into a civil settlement with Federal and State governments in which he will pay $210,000 and will be excluded from Medicare, Medicaid, and all other Federal health care programs for 5 years.[23]

- **Unbundling**

  According to the Medicaid National Correct Coding Initiative Policy Manual, "Procedures should be reported with the most comprehensive [Current Procedural Terminology] CPT code that describes the services performed. Physicians must not unbundle the services described by a [Healthcare Common Procedure Coding System] HCPCS/CPT code."[24] For example, a laboratory might receive an order for a panel of tests on a patient. Instead of appropriately bundling the tests and billing for them together, the laboratory might attempt to increase its income by billing for each test separately.

- **Kickbacks**

  Section 1128B of the Social Security Act, commonly known as the Anti-Kickback Statute, prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (in kind or in cash) to induce or in return for referring individuals for any item or service for which payment may be made under Federal health care programs.[25, 26] For example, a pharmaceutical service company and generic pharmaceutical manufacturer allegedly engaged in unlawful kickback schemes. The service company allegedly solicited and received $8 million from the pharmaceutical manufacturer in exchange for the service company's purchase of $50 million in generic drugs from the manufacturer and for pushing nursing home residents to use those drugs. The service company also allegedly paid $50 million to nursing homes in exchange for long-term contracts to refer residents to them for their drug purchases. The two companies entered into settlements to return $112 million to State and Federal governments for Medicaid and Medicare programs. They also entered into Corporate Integrity Agreements with the HHS-OIG that will monitor future practices.[27]

- **Medical Identity Theft**

  Medical identity theft is "the appropriation or misuse of a patient's or [provider's] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services."[28] Protecting the medical and personal identity of health care professionals and residents is the responsibility of the nursing home.

Visit the HHS-OIG website at https://oig.hhs.gov/fraud/enforcement/criminal/ to read about other provider fraud prosecutions and settlements.

## Anti-Fraud Efforts

> "CMS is committed to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients. … [They] hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues [and] … provide effective support and assistance to States."[29]

These efforts often identify improper payments and prompt criminal fraud investigations. Improper payments are those that should not have been made or that were made in an incorrect amount (overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Such payments "include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided."[30] Thus, improper payments may be a result of fraud, waste, and abuse.[31] Medicaid uses the following audits to identify improper payments:

- CMS Payment Error Rate Measurement program, which measures and reports improper payments in Medicaid and identifies common errors;[32]
- Audit Medicaid Integrity Contractors, which contract with CMS to perform audits and identify Medicaid overpayments;[33] and
- Medicaid Recovery Audit Contractors, which contract with States to audit providers and identify overpayments.[34]

## Rule of Eights

One aspect of billing that results in overpayments is misapplying the rule of eights. Generally, if a treatment represented by a 15-minute CPT code lasts at least 8 minutes but no more than 22 minutes, you must bill that as one unit of the CPT code. In other words, when the treatment lasts at least 8 minutes beyond a multiple of the 15-minute CPT code, the provider can round up to another unit of the CPT code if that is the only treatment. However, if a provider performs four treatments represented by four different 15-minute CPT codes, but the treatments only last 8 minutes each (that is, 32 minutes of treatment time), the provider can only use enough CPT codes to cover 32 minutes of treatment, or two CPT codes. In other words, a provider can only use as many CPT codes as it takes to cover the actual time spent on treatment.[35, 36]

# Quality of Care

Nursing home providers are responsible for submitting accurate and fully documented claims to maintain program integrity. They are also responsible for providing quality care for all residents that creates and sustains "an environment that humanizes and individualizes each resident."[37]

The Social Security Act requires each nursing home to protect and promote the rights of its residents, including the right to free choice; the right to be free from restraints; and the right to ensure dignity, privacy, confidentiality, and respect.[38] All nursing homes "… must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial needs of each resident …."[39] Additionally, Medicaid covers custodial care in nursing homes, while Medicare does not.[40] Thus, a resident's health and quality of life should not decline due to his or her stay in a nursing home without a medical reason.

## Resource Utilization Groups

Many States use Resource Utilization Group (RUG) levels to bill for nursing home therapy and nontherapy services. RUG payment levels and codes are derived from the Minimum Data Set, which CMS uses to determine the amount and scope of treatment a patient needs to meet their goals.[41] The OIG has had an ongoing concern about abusing RUGs for providing too many or more expensive services than patients need or want.[42, 43] A 2015 OIG report suggests payment for services should be more closely tied to beneficiary characteristics rather than a standardized amount of therapy.[44]

## Examples of Inadequate Care

Some examples of inadequate quality care may include malnutrition, pressure ulcers, uncontrolled pain, and the use of hypnotic and antipsychotic medications when no clinical indication is documented.[45]

"It is often asserted that the quality of care in nursing homes is impaired because staffing is inadequate, staff is insufficiently trained, and turnover is high, especially for certified nurse assistants.[46, 47] Inadequate staffing is one of the most common complaints about nursing home care."[48]

The Social Security Act requires certain staffing levels for registered nurses and licensed practical nurses. Specifically, Medicare- and Medicaid-certified nursing homes are required to have a registered nurse as the director of nursing; a registered nurse on duty at least 8 consecutive hours a day, 7 days a week; and 24-hour licensed nursing services (registered nurse or licensed practical nurse) available.[49, 50]

Quality care means the care provided to the member should be necessary and correct; meet acceptable standards of practice; meet the individualized preferences and needs of the resident; and be given with respect.[51]

## Residents' Rights

Nursing home residents with Medicaid coverage have rights and protections under the law. These include, but are not limited to, the right to:

- Be treated with dignity and respect;
- Manage his or her own money or choose someone else to manage it, including the nursing home;
- Use his or her own personal belongings as long as it does not affect others and as space and safety permit;
- Be given privacy and confidentiality;
- Be informed about services, patient condition, and medications;
- Refuse medications and treatments;[52]
- Participate in decisions and care planning;[53]
- Participate in making choices in care; and
- Make independent choices, including choosing a physician.[54]

## Care and Discharge Planning

A 2013 OIG report found that for over one-third of all nursing home stays, the nursing home did not have a compliant care plan or did not provide services in accordance with the care plan. Almost as many did not have compliant discharge plans.[55] As indicated in the previous section, the resident has the right to participate in their care planning, to be fully informed about what to expect from their treatment, and to be informed about how long they expect to be under the plan of care. Nursing homes should work closely with service providers, the patient, and their family to ensure they develop a complete and practical plan of care. This can help avoid unnecessary services and provide a means of accountability for the nursing home staff.

# Abuse and Neglect of Residents in a Nursing Home

Not only do nursing home residents deserve quality care, but more importantly, they deserve to live free from fear of abuse and neglect. In most cases, nursing home staff members provide care and services that are helpful and appropriate to the residents. However, at times appropriate care may not be provided. It is important to understand the difference between abuse and neglect, to recognize the signs, and to know how to report it if there is a concern.

Neglect is the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."[56] On the other hand, "abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."[57] Residents have the "right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."[58]

Many nursing home residents keep money in an account at the nursing home called a Resident Trust Account. The nursing home is responsible for managing this account appropriately. One form of abuse is misappropriation or misuse of property or funds that belong to the nursing home resident. This involves nursing home staff misplacing or misusing the resident's money or personal property without consent.[59]

Some possible signs of physical or emotional abuse and neglect may include:

- Weight loss;
- Lack of bathing;
- Too much or not enough medication;
- Unnecessary restraints (physical or medicinal);
- Lack of fall and injury precautions;
- Fear, anxiety, or depression;
- Bruises, wounds, or broken bones;
- Sores due to lack of position changes;
- Soiled undergarments or bedding;
- Verbal mistreatment; and
- Missing personal property.

If abuse or neglect is suspected, the resident should be given an appropriate medical examination, by a third party if necessary, to determine whether abuse or neglect has occurred and the extent of any treatment or therapy necessary to address concerns. If abuse or neglect has occurred, then the Administrator or Director of Nursing is responsible for investigating causes or removing the resident to a safe harbor until such time as the offenders are identified, reprimanded, reported, or retrained, as appropriate.

## Report Suspect Acts

If you have concerns about the treatment of a nursing home resident, you can contact your local ombudsman. Contact information should be provided on signs posted throughout the nursing facility. To find one in your area, visit http://theconsumervoice.org/get_help on the National Consumer Voice for Quality Long-Term Care website.[60]

Report any abuse of a nursing home resident to your State's Medicaid Fraud Control Unit (MFCU). Contact information for MFCUs is available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/contact-directors.pdf on the HHS-OIG website. It is the agency's job to investigate allegations of patient abuse in nursing homes.

Office of Inspector General
U.S. Department of Health and Human Services
ATTN: Hotline
P.O. Box 23489
Washington, D.C. 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: https://forms.oig.hhs.gov/hotlineoperations/

## Conclusion

Nursing homes are a needed resource. Fraud takes valuable resources from needed services. Nursing home providers can assist in stopping fraud, waste, and abuse by understanding the common types of fraud.

Each nursing home resident has the right to quality care, which includes specific rights and freedom from abuse and neglect. If you have concerns or suspect problems in the nursing home, report them.

To see the electronic version of this booklet and the other products included in the "Nursing Home" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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