A Look Back at Hospice Audits and Prosecutions in 2020 -- Are You Ready for 2021?

(December 28, 2020): Let's face it, we are all glad to have 2020 behind us. From an enforcement standpoint, COVID-19 greatly impeded the Federal government's ability to investigate and prosecute civil and criminal violations of law. The numbers speak for themselves. Between February 2020 and April 2020, new criminal prosecutions had dropped by 80%.[1] Although the final numbers from May to December 2020 are still pending, it is anticipated that the number of prosecutions will still fall far short of where they were in 2019. Why did this occur? The answer is fairly straightforward – the number of civil and criminal referrals sent to Federal prosecutors at U.S. Attorney's Offices around the country dropped precipitously when much of our country effectively shut down, and took other steps to stop the spread of COVID-19. Although prosecutions as a whole were way down in 2020. The government hasn't put investigations on hold. With respect to administrative reviews, private sector program integrity contractors working for the Center for Medicare and Medicaid Services (CMS) have moved forward with audits of hospice claims around the country. On the civil side, both Federal and State prosecutors have continued to investigate alleged hospice agency violations of the False Claims Act. Finally, as we recently saw in the Southern District of Texas, criminal hospice-related prosecutions have continued to be held. This article examines the various hospice audits, investigations and prosecutions that have taken place in 2020.

I. Criminal Prosecutions of Hospice Related Violations:

In mid-December 2020, after a month-long trial during the height of COVID-19, a Federal jury in South Texas convicted the owner of a chain of hospices and a business partner of conspiracy to commit health care fraud, conspiracy to commit money laundering and conspiracy to obstruct justice as well as six counts of health care fraud. The hospice owner was also convicted of one count of conspiracy to pay and receive kickbacks. The hospice owner was subsequently ordered to serve 20 years in prison and pay $120 million in restitution. This case is noteworthy in several respects.

First, this is one of the first Federal criminal prosecutions of hospice-related crimes that has been tried before a jury. The fact that this case went forward during the height of COVID-19 as a jury trial is nothing short of remarkable. As a review of the Indictment reflects, the defendants in this

case were charged with multiple violations of criminal law. Charges included, but were not limited to, the following:

Conspiracy to Commit Health Care Fraud (18 U.S.C. §1349): In this case, the government alleged that the hospice owner and several other individuals ***provided hospice and home health services through a number of affiliated entities to Medicare beneficiaries, knowing that the services were medically unnecessary and did not comply with Medicare's reimbursement requirements***. The defendants were also alleged to have falsified or caused the falsification of patient records and other documentation in connection with these claims.

Health Care Fraud (18 U.S.C. § 1349): The government alleged that the *"in connection with the delivery of and payment for health care benefits, items and services, **did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting interstate commerce**. . . and to obtain by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of Medicare,"* all in violation of 18 U.S.C. §1347.

Obstruction of Criminal Investigations of Health Care Offenses (18 U.S.C. §1518): The government alleged that FBI agents met with one of the defendants and advised him that they were conducting an investigation into the individual's involvement in referring patients in exchange for illegal kickbacks. The FBI agents also advised the defendant that making a false statement to a Federal agent was a Federal crime. During the subsequent interview, the defendant denied ever receiving kickbacks and payments in exchange for patient referrals. ***The defendant subsequently had a telephone call with an individual who was a confidential informant working for the government. During that call, the defendant is alleged to have told the informant "that they would have to take steps to conceal the kickbacks that the informant had paid to the defendant in exchange for patient referrals***. The defendant later instructed the confidential informant to provide a false and misleading statement to the FBI in the event that the informant was interviewed in order to conceal the kickback payments made to the defendant.

Obstruction of Justice (18 U.S.C. §1512): The government alleged that in response to a Grand Jury investigation, the ***Custodian of Records for one of the entities investigated produced patient records that contained various false and fictitious records that the defendants' co-conspirators manufactured and created at the direction of two of the defendants***.

False Statement (18 U.S.C. §1001): The government alleged that when questioned about

kickbacks, one of the defendants ***made a materially false, fictitious and fraudulent statement to FBI agents when he stated that he did not receive kickbacks and payments in exchange for patient referrals***.

Commenting on the subsequent conviction of the defendant, a DOJ official noted stated that the owner of the chain of hospice agencies had ***"funded his lavish lifestyle by exploiting patients with long-term, incurable diseases by enrolling them in expensive but unnecessary hospice services***."

It is also worth noting that the OIG's Special Agent in Charge for the Dallas Region stated that the defendant's conduct in this case had effectively prevented patients from accessing curative care.

II. Civil False Claims Act Cases Brought Against Hospice Agencies:

Overall, settlements and judgments under the Federal civil False Claims Act **[2]** are anticipated to be at historic lows when comparing Fiscal Year (FY) 2020 to previous years. While the DOJ has not released the final numbers, we anticipate that the total will fall far short of the $3 billion achieved during FY 2019. That doesn't mean however, that False Claims Act cases haven't continued to be filed, investigated and, in some cases, settled by the government. For example during 2020, hospice False Claims Act settlements included, but were not limited to the following:

Middle District of Florida: In a case originally brought by a whistleblower under the False Claims Ac's qui tam provisions, a Florida hospice agreed to pay **$3.2 million** to resolve allegations that is knowingly submitted false claims to the Medicare, Medicaid and TRICARE programs for hospice care that did not qualify for reimbursement. More specifically, Federal prosecutors in this case alleged that the Florida hospice billed for services provided to patients that were not terminally ill. The government also alleged that the hospice fraudulently billed for higher levels of care than were medically necessary.

State of Georgia: In a case brought under Georgia's ***False Medicaid Claims Act*** provisions, a whistleblower alleged that an Atlanta-based hospice had submitted false claims to both Medicare and the Georgia Medicaid programs for patients that were not terminally ill and therefore did not qualify for coverage and payment. After investigating the case, the defendant hospice company agreed to pay **$1.75 million** to resolve the allegations.

III. Audits of Hospice Claims Remain Ongoing by UPIC Contractors Around the Country:

Unified Program Integrity Contractor audits (also known as UPIC audits) of your hospice are serious business and can result in civil and criminal referrals to law enforcement. [3] Unlike their predecessors,[4] UPIC program integrity contractors are authorized to audit both Medicare and Medicaid claims. Perhaps most importantly, the goal of the UPIC program is to identify and report evidence of fraud to law enforcement authorities. As the Centers for Medicare and Medicaid Services (CMS) expressly states in its Medicare Program Integrity Manual, Section 4.2:

> ***"The primary goal of the UPIC is to identify cases of suspected fraud, waste and abuse, develop them thoroughly and in a timely manner**, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. Payment suspension and denial of payments and the recoupment of overpayments are examples of the actions that may be taken in cases of suspected fraud. Once such actions are taken, **cases where there is potential fraud are referred to LE [Law Enforcement] for consideration and initiation of criminal or civil prosecution, civil monetary penalties (CMP), or administrative sanction actions**."* [5]

On or about March 30, 2020, CMS instructed Recovery Audit Contractors (RACs) and other program integrity contractors to place most fee-for-service claims audits on hold. During this period, ***most*** administrative enforcement activities were suspended. During this period, UPICs continued to conduct data mining and other targeting activities, it just held off sending out requests for records to health care providers and suppliers. In August 2020, CMS rescinded its administrative audit hold order. Since that time, a number of hospice agencies around the country have received requests for records and billing information. In light of the preliminary targeting work already conducted by UPICs, we anticipate that the number of audits initiated against hospices will continue to rise throughout 2021.

IV. Responding to a UPIC Audit of Your Hospice:

UPIC audit and administrative enforcement activity has steadily increased since August 2020, despite the fact that the spread of COVID has continued unabated throughout the country. Possible administrative actions that a UPIC might take with respect to your hospice agency include:

- **Unannounced site visits**.
- **Prepayment review**.

- **Postpayment audit**.
- **Revocation of an agency's billing privileges**.
- **Suspension of payments**.
- **Referral to law enforcement for criminal investigation and prosecution**.

If your hospice agency is audited by a UPIC, we strongly recommend that you contact an experienced health care attorney before you turn over the medical records and claims materials requested. ?Your attorney can usually contact the UPIC and obtain an extension of time for you to assemble the records at issue and review them for completeness. ?

If documents are missing, try and locate a copy of the information that is needed in your records. For instance, is a complete copy of the referring physician's notes in the files? Are supporting hospital records in the file?? If any information appears to be incorrect, take care when making a correction. ***NEVER*** backdate a document.

To the extent that amendments, corrections or delayed entries must be made in a hospice record, it is essential that you comply with the requirements set out in Chapter 3, Section 3.3.2.5 of the CMS Medicare Program Integrity Manual.[6] A third party reviewing your records cannot be misled as to when information was corrected, revised or added.

V. Hospice Risk Areas:

As reflected above, hospice agencies (and the individuals associated with them) are under law enforcement's microscope. To reduce your hospice agency's level of regulatory risk, it is essential that you ensure that medical necessity, documentation, coding and billing practices fully comply with applicable statutory and regulatory requirements. It is equally important for you to carefully examine your marketing and business practices.[7] In the event of an investigation, one of the first assessments conducted by the Federal agents will be to determine how referrals to the hospice are generated. Common hospice risk areas examined by law enforcement have included the following:

Falsely diagnosing a patient as terminally ill and admitting the patient into hospice.

Falsification of physician certification documents and other medical records in order to make it appear that a patient qualifies for hospice, when in fact he or she is not eligible for hospice care.

Failure to document that a bona fide face-to-face examination of the patient took place.

Billing for higher levels of hospice care, such as "Continuous" or "Crisis Care," when such services were either not provided or were not medically necessary.

Providing an inadequate level of care than is needed to care for terminally ill patients.

Failure to properly advise patients that they were effectively waiving certain Medicare covered services if they elect to enter hospice.

Failure to order needed medications in order to keep costs at a minimum.

Engaging in illegal marketing practices in order to generate referrals.

Paying physicians and others kickbacks and other illegal payments for referrals.

Other improper hospice billing practices identified by UPICs and law enforcement investigators have included: (a) Pressuring a patient to refuse or relinquish the Medicare Hospice Benefit when the patient is still eligible for and desires care but has become too expensive; (b) Billing for hospice care provided by unqualified or unlicensed clinical personnel; (c) Knowingly misusing provider certification numbers, resulting in improper billing; and (d) Failure to adhere to hospice licensing requirements and Medicare conditions of participation.

Knowingly failing to return overpayments made by Federal health care programs.

Falsifying diagnosis and / or procedure codes. Diagnosis and procedure codes for hospice services reported on the reimbursement claim must accurate, and should be based on the patient's clinical condition as reflected in the medical record.

Employing individuals who have been excluded from participation in Federal health care programs to provide administrative or clinical hospice services.

If a UPIC shows up unannounced at your hospice tomorrow, would you be ready? Have you reviewed your business and clinical practices to ensure that your admissions meet applicable medical necessary requirements? Now is the time to conduct an honest assessment of your documentation, coding and billing and marketing practices. Don't wait until the government is already auditing your claims.

NATIONWIDE Representation: 1 (800) 475-1906

Need help? Give us a call. A number of our health lawyers are also Certified Professional Coders (CPCs) and / or Certified Medical Reimbursement Specialists (CMRSs). Our attorneys have extensive experience representing hospice agencies in connection with UPIC and other program integrity audits. Additionally, several of our attorneys have held significant positions as Federal prosecutors with the U.S. Department of Justice. To the extent that a civil or criminal investigation has been initiated by the government, our attorneys will diligently work to obtain a favorable outcome in your case. For a free consultation, please give us a call: 1 (800) 475-1906.

[1] TRAC

[2] 31 U.S.C. §§ 3729 – 3733. For a more detailed discussion of the False Claims Act, we recommend you see our **overview** of the statute.

[3] A detailed discussion of the Unified Program Integrity Contractor audit process can be seen on our website at the following **link.**

[4] For instance, Zone Program Integrity Contractors (ZPICs) were only authorized to audit Medicare claims while Medicaid Integrity Contractors (MICs) were only authorized to audit Medicaid claims.

[5] CMS Medicare Program Integrity Manual, **Section 4.2.**

[6] Chapter 3**,** Section 3.3.2.5 of the CMS Medicare Program Integrity Manual.

[7] In examining the compliance needs of hospice agencies, the OIG has written:

"Every compliance program should require the development and distribution of written compliance policies, standards, and practices that ***identify specific areas of risk and vulnerability to the hospice****. These policies, standards and practices should be developed under the direction and supervision of, or subject to review by, the compliance officer and compliance committee and, at a minimum should be provided to all individuals who are affected by the particular policy at issue."*

See 65 Fed. Reg. 59434, 59438 (Oct. 5, 2000) (emphasis added).