OFFICE OF
INSPECTOR
GENERAL

Fraud and Abuse in the Provision of Services in Nursing Facilities

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The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, waste and abuse 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 and other health care services to residents of nursing facilities and identifies some of the illegal practices that the OIG has uncovered.

How Nursing Facility Benefits Are Reimbursed

There were 17,000 nursing facilities in the United States, as of June 1995. An OIG study reported that in 1992, Medicare payments to nursing facilities included Part B payments of $2.7 billion and Part A payments of $3.1 billion for covered stays in nursing facilities. When the Federal share of the $24 billion spent by Medicaid is factored in, the Federal cost of nursing care reached a total of, approximately $20 billion.

Many nursing facilities receive reimbursement from both 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 for covered stays of a limited length. Nursing facility residents may be concurrently eligible for benefits under Medicare Part B. For Medicaid-eligible residents, extended nursing facility stays may be reimbursed by state-administered programs financed in part by Medicaid.

Nursing facilities and their residents have become common targets for fraudulent schemes. Nursing facilities represent convenient resident "pools" and make it lucrative for unscrupulous persons to carry out fraudulent schemes. The OIG has become aware of a number of fraudulent arrangements by which health care providers, including medical professionals, inappropriately bill Medicare and Medicaid for the provision of unnecessary services and services which were not provided at all. Sometimes, nursing facility management and staff also are involved in these schemes.

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

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, and claims for services which a person 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 health care services to residents of nursing facilities reimbursed by Medicare and Medicaid:

Claims for Services Not Rendered or Not Provided as Claimed

Common schemes entail falsifying bills and medical records to misrepresent the services, or extent of services, provided at nursing facilities. Some examples follow:

- One physician improperly billed $350,000 over a 2-year period for comprehensive physical examinations of residents without ever seeing a single resident. The physician went so far as to falsify medical records to indicate that nonexistent services were rendered.
- A psychotherapist working in nursing facilities manipulated Medicare billing codes to charge for 3 hours of therapy for each resident when, in fact, he spent only a few minutes with each resident. In a nursing facility, 3 hours of psychotherapy is highly unusual and often clinically inappropriate.
- An investigation of a speech specialist uncovered documentation showing that he overstated the time spent on each session claimed. Claims analysis showed that the speech specialist actually claimed to spend 20 hours with residents every day, far more time than possible. Further investigation revealed that some residents had never met the specialist, and some were dead at the time when the specialist claimed to have provided speech services to them.
- A company providing mobile X-ray services made visits to nursing facilities, and billed for taking two X-rays when only one was actually taken. The case also presented serious concerns about quality of care when the investigation revealed that company personnel were not certified to take X-rays.

Claims Falsified to Circumvent Coverage Limitations on Medical Specialties

Practitioners of medical specialties have been found to misrepresent the nature of services provided to Medicare and Medicaid beneficiaries because the Federally funded programs have stringent coverage limitations for some specialties, including podiatry, audiology and optometry. For instance:

- The OIG has learned about podiatrists whose entire practices consist of visits to nursing facilities. Noncovered routine care is provided, e.g., toenail clipping, but Medicare is billed for covered services which were not provided or needed. In one case, an investigator discovered suspicious billing for foot care when it was reported that a podiatrist was performing an excessive number of toenail removals, a service that is covered but not frequently or routinely needed. This podiatrist billed Medicare as much as $100,000 in 1 year for toenail removals. Investigators discovered one resident for whom bills were submitted claiming a total of 11 toenail removals.
- An optometrist claimed reimbursement for covered eye care consultations when he, in fact, performed routine exams and other non-covered services. His billing history indicated that he claimed to have performed as many as 25 consultations in one day at a nursing home. This is an unreasonably high number, given the nature of a Medicare-covered consultation.
- An audiologist made arrangements with a nursing facility and affiliated physicians to get orders for hearing exams that were not medically necessary. The audiologist used this access to residents exclusively to market hearing aids. In this case, the facility and physicians, in addition to the audiologist, could be held liable for false or fraudulent claims if they acted with knowledge of the claims for unnecessary services.

What To Look For in the Provision of Services to Nursing Facilities

The following situations ***may*** suggest fraudulent or abusive activities:

- "Gang visits" by one or more medical professionals where large numbers of residents are seen in a single day. The practitioner may be providing medically unnecessary services, or the level of service provided may not be of a sufficient duration or scope consistent with the service billed to Medicare or Medicaid.
- Frequent and recurring "routine visits" by the same medical professional. Seeing residents too often may indicate that the provider is billing for services that are not medically necessary.
- Unusually active presence in nursing facilities by health care practitioners who are given or request unlimited access to resident medical records. These individuals may be collecting information used in the submission of false claims.
- Questionable documentation for medical necessity of professional services. Practitioners who are billing inappropriately may also enter, or fail to enter, important information on medical charts.