Published on *The National Law Review* https://natlawreview.com

Too Old for This: Nursing Home Settles False Claims Act Allegations for $400,000

Article By:

Eva Gunasekera

Renée Brooker

The United States Department of Justice settled a case against a nursing home regarding allegations that the nursing home billed Medicare for services that were neither reasonable, necessary, nor skilled. A nursing home employee could have reported this fraud against the government and earned 15-25% of the government's recovery.

The nursing home, England Associates, L.P. DBA New London Health Center (New London) allegedly sought to bilk Medicare by manipulating therapy reimbursement levels and billing time. Therapy reimbursement levels fall into different categories, with reimbursements increasing positively corresponding with patient need or severity: High, Very High, and Ultra High levels of therapy. New London allegedly categorized patients as needing Ultra High therapy without considering whether these patients needed 720 minutes of physical, occupational, or speech therapy or not. The allegations continue with New London again disregarding patients' actual needs and supplying therapy for the minimum number of minutes to reach the threshold for billing at a certain level. Nursing home staff also allegedly increased care during certain intervals to bill for the higher intensity levels (Medicare allows for therapy to be billed in 8-minute increments). The final allegation is that the nursing home "pressure[ed] therapists and patients to complete the planned minutes of therapy regardless of patient need," including when therapy was contraindicated.

Medicare requires that the nursing services it covers are from a skilled provider, that is, someone who is a registered nurse or other licensed healthcare practitioner. The skilled nursing services are also supposed to be reasonable and necessary for the treatment of illness or injury, meaning they are appropriate for the patient given the severity and nature of their condition and in-line with acceptable medical practices. As the Special Agent in Charge of the Department of Health and Human Services Office of Inspector General (HHS-OIG) said about this case, "The provision of medical services should be based on a patient's medical needs rather than the financial interests of providers."

Medicare fraud harms taxpayers through waste and abuse of taxpayer funds. Fraudulent billing leads to more regulations, adding more administrative hoops for practitioners whose skills and bandwidth are invested in care of the vulnerable elderly. The Centers for Medicare and Medicaid Services (CMS) estimated that its changing payment methodology for Skilled Nursing Facilities (SNF) in 2022

would “result in approximately $410 million in Medicare Part A payments to SNFs in FY 2022.” Those payments should only be received as reimbursements for medically necessary services rendered by skilled professionals. Whistleblowers can keep those payments out of fraudsters’ pockets.

National Law Review, Volume XII, Number 83