

Release of Report and Alert on Home Health Fraud Highlights Increased OIG Scrutiny of Home Care Agencies

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OIG Delivers Home Care a One – Two Punch

On June 22, 2016, the Office of Inspector General (“OIG”) issued two communications that underscore its continued focus on fraud in home health care, along with the role of physicians as “gate keepers” in authorizing Medicare-covered services and facilitating improper billing across the care spectrum.

First, in its report entitled “Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases” ([the “Report”](#)) the OIG examined 2014—2015 Medicare home health claims data and identified certain home health agencies (“HHAs”), supervising physicians, and geographic areas associated with Medicare claims having “characteristics similar to those observed by OIG in cases of home health fraud.” OIG highlighted five characteristics commonly found in OIG-investigated cases of home health fraud, and found that 5% of HHAs and 1% of supervising physicians were “statistical outliers” for these characteristics. OIG also identified geographic “hotspots” in which there was a high prevalence of outliers. While the OIG offers the caveat that these characteristics are “not necessarily indicative of fraudulent activity,” they do “warrant greater scrutiny,” according to OIG.

Second, in a companion alert entitled “Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians” ([the “Alert”](#)), the OIG warns about possible fraud associated with the compensation arrangements between HHAs and physicians, under which the physician, in a position to make referrals to the HHA, is paid to serve as “medical director” at a level above “fair market value,” and without providing *bona fide* services to the agency. The OIG noted that in the past year, the Federal government obtained criminal convictions and reached civil settlements with HHAs and physicians that defrauded Medicare by “making (or accepting) payments for patient referrals, falsely certifying patients as homebound, and billing for medically unnecessary services or for services that were not rendered.”

The Report as well as the Alert foreshadows increased OIG scrutiny and underscores the need to review and remediate any improper arrangements or billing practices -- before the next round of OIG action.

The Report

OIG identified 562 HHAs -- 5%-- and 4,502 physicians who supervise home health care --1%-- as statistical outliers on two or more characteristics commonly found in OIG-investigated cases of home health fraud. OIG noted that while there was no finding of fraud and there may be “legitimate explanations” for why these providers were outliers, “further scrutiny” of such conduct is warranted. OIG also determined that there were 27 geographic “hotspots” in 12 States with statistical outliers in two or more of the characteristics. According to the OIG, 119 physicians and one HHA were outliers in New York, Northern New Jersey and Long Island.

Below are the five characteristics identified by OIG as correlated with home health fraud:

1. High Percentage of Episodes for which the Beneficiary had No Recent Visits (6 months) with the Supervising Physician

470 HHAs and 16,789 physicians were identified as outliers on this characteristic. OIG explained that, based on its prior fraud investigations, this characteristic may signal that the supervising physician “did not appropriately evaluate the beneficiary’s medical condition” before certifying eligibility for home care and may evidence the use of “recruiters” to collect Medicare numbers for use in fraudulent billing.

2. High Percentage of Home Health Episodes that were Not Preceded by a Hospital Or Nursing Home Stay (Within 30 Days)

1,751 physicians were found to be outliers. OIG acknowledged that beneficiaries may legitimately require home care in situations other than upon a discharge from an institutional care setting. Nevertheless, OIG noted that this characteristic may indicate that the home health ordered by the physician is not medically necessary, citing the situation of recruiters soliciting unqualified patients from the community for home care services.

3. High Percentage of Episodes with a Primary Diagnosis of Diabetes or Hypertension

483 HHAs and 7,937 physicians were identified as outliers on this characteristic. According to OIG, past investigations have revealed HHAs and physicians providing medically unnecessary care, with a disproportionate mix of those patients reported to have diabetes or hypertension as their primary diagnosis.

4. High Percentage of Beneficiaries with Claims from Multiple HHAs (3 or more HHAs within 2 years)

OIG cited 770 HHAs and 7,510 physicians as outliers on this characteristic. This characteristic is common in home health fraud because, OIG has found, “recruiters” move beneficiaries from agency to agency “to avoid suspicion or obtain more favorable financial arrangements for fraudulent billing.”

5. High Percentage of Beneficiaries with Multiple Home Health Readmissions in a Short Period of Time (under 2 years)

778 HHAs and 3,822 physicians were outliers. OIG explained that it has previously uncovered situations where HHAs and physicians tried to hide the lengthy duration of home care covered by Medicare by “periodically discharging and re-enrolling” their beneficiaries.

OIG’s Follow Up

OIG intends to further investigate and audit the “outliers” and to continue closely watching the geographic “hotspots” for potential home health fraud. OIG warns that it looks forward to “continued collaboration with CMS, DOJ, States and private-sector partners” to fight home health fraud, waste, and abuse.

The Alert

In the Alert, the OIG expressed its concern that HHAs may be rewarding physicians for referrals by hiring and paying them as “medical directors” under “sham” arrangements. The federal Anti-Kickback Statute (“AKS”) prohibits both the offering and receiving of payments, directly or indirectly, for referrals of patients insured by a Federal health care program. 42 U.S.C. § 1320a-7b. Consequently, both the HHA and the physician can be liable, regardless of who instigates the kickback arrangement.

The Alert in particular cautions that suspect compensation arrangements between a HHA and a physician employed as medical director may violate the AKS so long as one purpose is to remunerate the physician for his or her past or future referrals, noting the potential for “corruption of medical judgment, patient steering, increased costs to Federal health care programs, and unfair competition,” irrespective of the quality of care. The Alert advises that HHAs and physicians ensure that their arrangements are genuine and that the associated compensation reflects “fair market value” and is “commercially reasonable” -- the hallmarks of the “personal services” safe harbor (42 C.F.R. § 1001.952(d)) under the AKS.

The Alert is another iteration of the continued oversight of providers’ business relationships with physicians. Notably, last year, OIG issued a similar alert about physician compensation arrangements, highlighting recent settlements with physicians who entered “questionable medical directorship” with providers. Moreover, in October of last year, the Department of Justice settled Stark law-related claims against the Tuomey Healthcare System. *U.S. ex rel. Drakeford v. Tuomey*, 792 F.3d 364 (4th Cir. 2015). The Department of Justice alleged that Tuomey had illegally billed the Medicare program for hospital services referred by physicians who were tainted by improper financial relationships with the hospitals. After judgment in the amount of \$237 million was sustained on appeal, the parties settled for \$72.4 million.

In addition to suspect compensation arrangements, the Alert points to other types of home health fraud uncovered by the government: (i) HHAs have often billed Medicare for medically unnecessary nursing services provided to patients who were not confined to the home; (ii) physicians have “upcoded patient visits;” (iii) physicians billed for oversight services that were not provided; and (iv) physicians falsely certified patients as confined to the home when they were not actually homebound.

Take Aways for Providers

With continued focus on fraud and abuse in the home health industry, HHAs should consider steps to minimize risks going forward. In particular, providers can incorporate the five characteristics

identified by the OIG into their compliance reviews and audit plans. Should those reviews find high “outlier” rates with respect to any of these characteristics, HHAs should examine the record support for representative claims, to verify that the services were medically necessary and to determine whether any of the claims were improper and should be refunded or self-disclosed. Additionally, HHAs should review their contracts with physicians, particularly medical directors, to confirm that the compensation terms are based on fair market value and are commercially reasonable, and that the physicians are actually providing the services they were ostensibly hired to perform. Depending upon the results of the reviews, HHAs may need to investigate further to determine the root cause and scope of any potential concerns and take additional remedial action to prevent recurrences.

With the Report and OIG’s companion Alert, the OIG has now given HHAs a roadmap of its “red flags” for home health fraud. Providers who do not follow this roadmap in their compliance activities may be exposed to future OIG action and the risk of False Claims Act liability.

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