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SNFs Beware: Scrutiny of Therapy Minutes to Increase Following Episcopal Ministries FCA Settlement

False Claims by Therapy Providers in Skilled Nursing Facilities

Recent settlements between skilled nursing facilities (SNFs) and the Department of Justice (DOJ) illustrate that SNFs must ensure that they do not cause false claims to be submitted to Medicare. SNFs that contract with outside rehabilitation therapy providers will continue to be held liable for false claims submitted to Medicare for unreasonable or unnecessary services by outside providers. Of critical importance is that using outside providers will not absolve SNFs from liability for failing to prevent outside provider practices designed to inflate Medicare reimbursement.

Increased enforcement in this area comes as no surprise, given that Medicare Part A SNF overpayments cost Medicare $1.5 billion in 2009.[1] According to the 2012 report, 25% of all SNF claims billed to Medicare in 2009 contained errors. A large number of these claims were for ultrahigh therapy.[2]

Resource Utilization Groups and Assignment Process

The Medicare Part A SNF benefit covers skilled nursing, rehabilitation services and other services for up to 100 days. To qualify for the SNF benefit, a beneficiary must be hospitalized for at least 3 consecutive days within 30 days of admission to a SNF, and the SNF admission must be related to the cause of hospitalization.

SNF payment by Medicare is calculated based on a prospective payment system that is tied to a range of resource utilization groups (RUGs). RUGs are assigned based on a beneficiary's minimum data set (MDS) assessment. Many of the items on the MDS require assessment during a "look-back period." Reimbursement is primarily driven by therapy minutes during the look-back period, which corresponds to a range of RUG levels. There are five levels of therapy RUGs, ranging from low to ultrahigh. According to a 2012 report by the U.S. Department

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of Health and Human Services Office of Inspector General (OIG), "if [a] beneficiary received 45 minutes of therapy during the look-back period, he or she is categorized into a low-therapy RUG, whereas if the beneficiary received 720 minutes, he or she is categorized into an ultrahigh therapy RUG."[3] Medicare reimbursement is highest for beneficiaries who qualify for the ultrahigh level. As a result, SNFs benefit when residents fall into the ultrahigh RUG.

Recent False Claims Act Settlements

In September 2014, Episcopal Ministries to the Aging, Inc. (Episcopal Ministries) agreed to a $1.3 million settlement to resolve allegations that it submitted false claims to Medicare for unreasonable or unnecessary rehabilitation therapy provided by RehabCare Group East Inc. (RehabCare) at William Hill Manor in Easton, Maryland.[4] The DOJ alleges that Episcopal Ministries submitted false claims for rehabilitation therapy for financial reasons rather than out of medical necessity based on a personal care plan. The DOJ alleges that Episcopal Ministries and William Hill Manor failed to prevent RehabCare from providing high levels of therapy that were unreasonable or unnecessary during the look-back period. Providing high levels of therapy during the look-back period allowed Episcopal Ministries, William Hill Manor and RehabCare to maximize reimbursement rates while providing just enough therapy to qualify for the ultrahigh RUG, irrespective of whether therapy was medically necessary.

Also in September of 2014, Life Care Services LLC, an Iowa-based manager of SNFs, Care Purchasing Services LLC, a group purchasing organization, and CoreCare V, LLP, which operates a SNF in California under the name ParkVista, agreed to settle similar claims for a total of $3.75 million.[5] The settlements resolve allegations that the organizations sought inflated Medicare reimbursement based on rehabilitation therapy that was unnecessary or unreasonable, and that was dictated by financial considerations rather than individualized needs.

Do Not Become an Enforcement Target

Each SNF should actively watch for the following warning signs to ensure that they do not become an enforcement target. These warning signs are concerning primarily because they indicate that therapy is being provided for financial reasons and not based on an individual assessment of medical necessity and in accordance with an individual's care plan.

- Residents are placed in the ultrahigh RUG unless it is not tolerable.

- Residents receive just enough therapy minutes to be classified in the ultrahigh RUG.
- Residents tend to receive increased therapy minutes on the last day of the look-back period.
- Therapy minutes are estimated or rounded up.
- Residents are receiving intense therapy up to the end of their lives or show no signs of improvement.

While some warning signs, taken alone, are not necessarily violative of the False Claims Act, SNFs should be concerned with the presence of any red flags. The DOJ is particularly interested in cases in which SNFs provide the minimum number of therapy minutes to qualify for the ultrahigh therapy RUG, only to significantly reduce the number of therapy minutes provided thereafter. This type of manipulation is more difficult to accomplish now because the Centers for Medicare and Medicaid Services implemented changes requiring SNFs to provide notice when the therapy actually provided no longer accurately reflects the RUG classification.

SNFs would be well advised to have legal counsel negotiate and closely review contracts with outside providers to minimize the risk that they will be held liable for inappropriate outside provider practices designed to inflate Medicare reimbursement. If you would like us to negotiate or review your contracts with outside providers, or if you have any other questions about the subject of this e-Alert, please contact Rob Heath or another member of Reinhart's Post-Acute Care and Long Term Services team.

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[1] U.S. Department of Health and Human Services Office of Inspector General, Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More than a Billion Dollars in 2009, available here.
[2] *Id*.
[3] *Id*.
[4] Maryland Skilled Nursing Facility Agrees to Pay $1.3 Million to Resolve Allegations that It Submitted False Claims for Rehabilitation Therapy, U.S. Attorney's Office District of Massachusetts, available here.
[5] Three Companies to Pay $3.75 Million for Submitting False Claims for Rehabilitation Therapy, U.S. Attorney's Office District of Massachusetts,

available here.

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