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How the government targets medical necessity fraud

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Health-care providers are generally familiar with medical necessity as a sometimes-pesky insurance issue. However, fraud cases are another dimension to medical necessity – and one that should not be ignored. The more that is known about this fraud, the more likely they can be stopped before they start.

The Medicare statute prohibits payments for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury." It is up to the secretary of the U.S. Department of Health and Human Services to decide whether a service is "reasonable and necessary." And, while there are legitimate coverage disputes as to medical necessity, there is also rampant fraud involving it.

The government has been bringing more and varying medical necessity fraud cases than ever before under the False Claims Act. The FCA is one of the only statutes allowing a private person to stand in the shoes of the government to bring a lawsuit on its behalf for its losses. For his or her efforts, the FCA whistleblower can receive between 15 percent and 25 percent of the government's recovery in intervened FCA cases.

In the health-care realm, some of the most typical medical necessity fraud cases involve:

- Long-term care hospitals and inpatient rehabilitation facilities
- Unlawful distribution of controlled substances
- Skilled nursing or therapy services
- Durable medical equipment
- Ambulance fraud

There have also been FCA cases involving a wider range of medically unnecessary services, including: spine surgeries; vein treatment; vision; dental; home health care; in-patient admissions; mental health services; lab tests and even hospice care.

Skirting the rules

A common thread in these cases is an initial decision to skirt the rules and regulations regarding medical necessity.

In one example, the government reached a $32.7 million settlement with Vibra Healthcare LLC, a national hospital operating some 36 long-term care and inpatient rehabilitation facilities in 18 states, over allegations that Vibra violated the FCA by billing for medically unnecessary therapy services.

Vibra ignored mandatory regulations. Long-term care hospitals and inpatient rehabilitation facilities are supposed to require clinicians to document therapy in the form of weekly progress reports and discharge notes supporting medical necessity. The Centers for Medicare & Medicaid Services requires that rehabilitation therapy and services be reasonable and medically necessary. To indicate medical necessity, the provider is required to attest that the therapy services are both a) reasonable and necessary; and b) that there is documentation of medical necessity in the medical record.

What went wrong? For five years, Vibra allegedly admitted patients who showed no signs or symptoms qualifying for admission to a long-term care facility. It compounded the fraud by then extending patient stays without regard to medical necessity, qualification, or quality of care.

In some instances, Vibra allegedly ignored the recommendations of its own clinicians, who expressly noted that patients were ready and appropriate for discharge. In its press release, HHS' Office of the Inspector General noted that proving "medical necessity is fundamental if health providers wish to claim taxpayer funds for medical care."

In another example, Life Care Centers of America, Inc., a large, skilled nursing facility (SNF), agreed to pay $145 million to resolve allegations that it violated the FCA by knowingly causing SNFs to submit false claims to the government for rehabilitation therapy services that were not reasonable, necessary, or skilled.

Life Care allegedly developed a corporate-wide policy to place all Medicare patients in the Ultra-High Resource Utilization Group level, regardless of medical need, ultimately providing unreasonable and unnecessary therapy. As in the Vibra case, Life Care also allegedly kept patients longer than necessary to continue billing for rehabilitation therapy, even after the treating therapists recommended discontinuing therapy.

Particular attention

CMS has emphasized that manipulating therapy minutes based on financial gain rather than patient need is fraud. The government tends to pay particular attention to cases involving patient harm, as can often result from medical necessity cases. The consequences are steep. In Life Care's case, not only did it pay a steep fine, but it also entered into a five-year chain-wide Corporate Integrity Agreement requiring continued, independent monitoring to ensure compliance and avoid future patient harm.

In many cases, things go from bad to worse when records are falsified. The falsification of medical records is often done to justify medical necessity and hide the underlying fraud. However, there is no fool-proof cover up. The falsification of records, simply evidences intent, adding an arrow to the government's quiver. In both of these cases, truthful medical notes by honest practitioners contradict the fabrications and highlight the fraud for the government.

The common themes in these cases are: (1) a disregard for medical necessity rules and regulations; (2) policies putting reimbursement over clinical judgment and medical necessity; (3) falsification of records or symptoms to cover up the fraud; and (4) patient harm. Eventually, most of these schemes are uncovered when a whistleblower comes forward or patients file medical malpractice suits, tipping off the government.

Fraud schemes cannot survive with only one rogue employee. They require multiple people to be aware of and encourage the fraud. At the same time, they can be stopped or avoided altogether with strong compliance programs, internal audits and anonymous hotlines employees can call to report the beginnings of fraud.

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