

Hospice Fraud in South Carolina and the United States

A Review For Employees, Whistleblowers, SC Attorneys, Lawyers and Law Firms

Hospice fraud in South Carolina and the United States is an increasing problem as the number of hospice patients has exploded over the past few years. From 2004 to 2008, the number of patients receiving hospice care in the United States grew almost 40% to nearly 1.5 million, and of the 2.5 million people who died in 2008, nearly one million were hospice patients. The overwhelming majority of people receiving hospice care receive federal benefits from the federal government through the Medicare or Medicaid programs. The health care providers who provide hospice services traditionally enroll in the Medicare and Medicaid programs in order to qualify to receive payments under these government programs for services rendered to Medicare and Medicaid eligible patients.

While most hospice health care organizations provide appropriate and ethical treatment for their hospice patients, because hospice eligibility under Medicare and Medicaid involves clinical judgments which may result in the payments of large sums of money from the federal government, there are tremendous opportunities for fraudulent practices and false billing claims by unscrupulous hospice care providers. As recent federal hospice fraud enforcement actions have demonstrated, the number of health care companies and individuals who are willing to try to defraud the Medicare and Medicaid hospice benefits programs is on the rise.

A recent example of hospice fraud involving a South Carolina hospice is Southern Care, Inc., a hospice company that in 2009 paid \$24.7 million to settle an FCA case. The defendant operated hospices in 14 other states, too, including Alabama, Georgia, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Ohio, Pennsylvania, Texas, Virginia and Wisconsin. The alleged frauds were that patients were not eligible for hospice, to wit, were not terminally ill, lack of documentation of terminal illnesses, and that the company marketed to potential patients with the promise of free medications, supplies, and the provision of home health aides. Southern Care also entered into a 5-year Corporate Integrity Agreement with the OIG as part of the settlement. The qui tam relators received almost \$5 million.

Understanding the Consequences of Hospice Fraud and Whistleblower Actions

U.S. and South Carolina consumers, including hospice patients and their family members, and health care employees who are employed in the hospice industry, as well as their SC lawyers and attorneys, should familiarize themselves with the basics of the hospice care industry, hospice eligibility under the Medicare and Medicaid programs, and hospice fraud schemes that have developed across the country. Consumers need to protect themselves from unethical hospice providers, and hospice employees need to guard against knowingly or unwittingly participating in health care fraud against the federal government because they may subject themselves to administrative sanctions, including lengthy exclusions from working in an organization which receives federal funds, enormous civil monetary penalties and fines, and criminal sanctions, including incarceration. When a hospice employee discovers fraudulent conduct involving Medicare or Medicaid billings or claims, the employee should not participate in such behavior, and it is imperative that the unlawful conduct be reported to law enforcement and/or regulatory

authorities. Not only does reporting such fraudulent Medicare or Medicaid practices shield the hospice employee from exposure to the foregoing administrative, civil and criminal sanctions, but hospice fraud whistleblowers may benefit financially under the reward provisions of the federal False Claims Act, 31 U.S.C. §§ 3729-3732, by bringing false claims suits, also known as qui tam or whistleblower suits, against their employers on behalf of the United States.

Types of Hospice Care Services

Hospice care is a type of health care service for patients who are terminally ill. Hospices also provide support services for the families of terminally ill patients. This care includes physical care and counseling. Hospice care is normally provided by a public agency or private company approved by Medicare and Medicaid. Hospice care is available for all age groups, including children, adults, and the elderly who are in the final stages of life. The purpose of hospice is to provide care for the terminally ill patient and his or her family and not to cure the terminal illness.

If a patient qualifies for hospice care, the patient can receive medical and support services, including nursing care, medical social services, doctor services, counseling, homemaker services, and other types of services. The hospice patient will have a team of doctors, nurses, home health aides, social workers, counselors and trained volunteers to help the patient and his or her family members cope with the symptoms and consequences of the terminal illness. While many hospice patients and their families can receive hospice care in the comfort of their home, if the hospice patient's condition deteriorates, the patient can be transferred to a hospice facility, hospital, or nursing home to receive hospice care.

Hospice Care Statistics

The number of days that a patient receives hospice care is often referenced as the "length of stay" or "length of service." The length of service is dependent on a number of different factors, including but not limited to, the type and stage of the disease, the quality of and access to health care providers before the hospice referral, and the timing of the hospice referral. In 2008, the median length of stay for hospice patients was about 21 days, the average length of stay was about 69 days, almost 35% of hospice patients died or were discharged within 7 days of the hospice referral, and only about 12% of hospice patients survived longer than 180 days.

Most hospice care patients receive hospice care in private homes (40%). Other locations where hospice services are provided are nursing homes (22%), residential facilities (6%), hospice inpatient facilities (21%), and acute care hospitals (10%). Hospice patients are generally the elderly, and hospice age group percentages are 34 years or less (1%), 35 - 64 years (16%), 65 - 74 years (16%), 75 - 84 years (29%), and over 85 years (38%). As for the terminal illness resulting in a hospice referral, cancer is the diagnosis for almost 40% of hospice patients, followed by debility unspecified (15%), heart disease (12%), dementia (11%), lung disease (8%), stroke (4%) and kidney disease (3%). Medicare pays the great majority of hospice care expenses (84%), followed by private insurance (8%), Medicaid (5%), charity care (1%) and self pay (1%).

As of 2008, there were approximately 4,700 locations which were providing hospice care in the United States, which represented about a 50% increase over ten years. There were about 3,700 companies and organizations which were providing hospice services in the United States. About half of the hospice care providers in the United States are for-profit organizations, and about half are non-profit organizations.

General Overview of the Medicare and Medicaid Programs

In 1965, Congress established the Medicare Program to provide health insurance for the elderly and disabled. Payments from the Medicare Program arise from the Medicare Trust fund, which is funded by government contributions and through payroll deductions from American workers. The Centers for Medicare and Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

In 2007, CMS reorganized its ten geography-based field offices to a Consortia structure based on the agency's key lines of business: Medicare health plans, Medicare financial management, Medicare fee for service operations, Medicaid and children's health, survey & certification and quality improvement. The CMS consortia consist of the following:

- Consortium for Medicare Health Plans Operations
- Consortium for Financial Management and Fee for Service Operations
- Consortium for Medicaid and Children's Health Operations
- Consortium for Quality Improvement and Survey & Certification Operations

Each consortium is led by a Consortium Administrator (CA) who serves as the CMS's national focal point in the field for their business line. Each CA is responsible for consistent implementation of CMS programs, policy and guidance across all ten regions for matters pertaining to their business line. In addition to responsibility for a business line, each CA also serves as the Agency's senior management official for two or three Regional Offices (ROs), representing the CMS Administrator in external matters and overseeing administrative operations.

Much of the daily administration and operation of the Medicare Program is managed through private insurance companies that contract with the Government. These private insurance companies, sometimes called "Medicare Carriers" or "Fiscal Intermediaries," are charged with and responsible for accepting Medicare claims, determining coverage, and making payments from the Medicare Trust Fund. These carriers, including Palmetto Government Benefits Administrators (hereinafter "PGBA"), a division of Blue Cross and Blue Shield of South Carolina, operate pursuant to 42 U.S.C. §§ 1395h and 1395u and rely on the good faith and truthful representations of health care providers when processing claims.

Over the past forty years, the Medicare Program has enabled the elderly and disabled to obtain necessary medical services from medical providers throughout the United States. Critical to the success of the Medicare Program is the fundamental concept that health care providers accurately and honestly submit claims and bills to the Medicare Trust Fund only for those

medical treatments or services that are legitimate, reasonable and medically necessary, in full compliance with all laws, regulations, rules, and conditions of participation, and, further, that medical providers not take advantage of their elderly and disabled patients.

The Medicaid Program is available only to certain low-income individuals and families who must meet eligibility requirements set forth by federal and state law. Each state sets its own guidelines regarding eligibility and services. Although administered by individual states, the Medicaid Program is funded primarily by the federal government. Medicaid does not pay money to patients; rather, it sends payments directly to the patient's health care providers. Like Medicare, the Medicaid Program depends on health care providers to accurately and honestly submit claims and bills to program administrators only for those medical treatments or services that are legitimate, reasonable and medically necessary, in full compliance with all laws, regulations, rules, and conditions of participation, and, further, that medical providers not take advantage of their indigent patients.

Medicare & Medicaid Hospice Laws Which Affect SC Hospices

Hospice fraud occurs when hospice organizations, by and through their employees, agents and owners, knowingly violate the terms and conditions of the applicable Medicare and Medicaid hospice statutes, regulations, rules and conditions of participation. In order to be able to recognize hospice fraud, hospices, hospice patients, hospice employees and their attorneys and lawyers must know the Medicare laws and requirements relating to hospice care benefits.

Medicare's two main sources of authorization for hospice benefits are found in the Social Security Act and the U.S. Code of Federal Regulations. The statutory provisions are primarily found at 42 U.S.C. §§ 1395d, 1395e, 1395f(a)(7), 1395x(d)(d), and 1395y, and the regulatory provisions are found at 42 C.F.R. Part 418.

To be eligible for Medicare benefits for hospice care, the patient must be eligible for Medicare Part A and be terminally ill. 42 C.F.R. § 418.20. Terminal illness is established when "the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course." 42 C.F.R. § 418.3; 42 U.S.C. § 1395x(d)(d)(3). The patient's physician and the medical director of the hospice must certify in writing that the patient is "terminally ill." 42 U.S.C. § 1395f(a)(7); 42 C.F.R. § 418.20. After a patient's initial certification, Medicare provides for two ninety-day benefit periods followed by an unlimited number of sixty-day benefit periods. 42 U.S.C. § 1395d(a)(4). At the end of each ninety- or sixty-day period, the patient can be re-certified only if at that time he or she has less than six months to live if the illness runs its normal course. 42 U.S.C. § 1395f(a)(7)(A). The written certification and re-certifications must be maintained in the patient's medical records. 42 C.F.R. § 418.23. A written plan of care must be established for each patient setting forth the types of hospice care services the patient is scheduled to receive, 42 U.S.C. § 1395f(a)(7)(B), and the hospice care has to be provided in accordance with such plan of care. 42 U.S.C. § 1395f(a)(7)(C); 42 C.F.R. § 418.56. Clinical records for each hospice patient must be maintained by the hospice, including plan of care, assessments, clinical notes, signed notice of election, patient responses to medication and therapy, physician certifications and re-certifications, outcome data, advance directives and physician orders. 42 C.F.R. § 418.104.

The hospice must obtain a written notice of election from the patient to elect to receive Medicare hospice benefits. 42 C.F.R. § 418.24. Importantly, once a patient has elected to receive hospice care benefits, the patient waives Medicare benefits for curative treatment for the terminal disease upon which is the admitting diagnosis. 42 C.F.R. § 418.24(d).

The hospice must designate an Interdisciplinary Group (IDG) or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. 42 C.F.R. § 418.56. The IDG members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. A registered nurse that is a member of the IDG must be designated to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, the following qualified and competent professionals: (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice); (ii) A registered nurse; (iii) A social worker; and, (iv) A pastoral or other counselor. 42 C.F.R. § 418.56.

The Medicare hospice regulations, at 42 C.F.R. § 418.200, summarize the requirements for hospice coverage in pertinent part as follows:

To be covered, hospice services must meet the following requirements. They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with §418.24. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in §418.56. That plan of care must be established before hospice care is provided. The services provided must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in section §418.22.

The Social Security Act, at 42 U.S.C. § 1395y(a), limits Medicare hospice benefits, providing in pertinent part as follows: "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services-... (C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness...." 42 C.F.R. § 418.50 (hospice care must be "reasonable and necessary for the palliation and management of terminal illness"). Palliative care is defined in the regulations as "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." 42 C.F.R. § 418.3.

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit and receives hospice care. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in the patient's plan of care. There are four levels of payments which are made based on the amount of care required to meet beneficiary and family needs. 42 C.F.R. § 418.302; CMS Hospice Fact Sheet, November 2009. These four levels, and the

corresponding 2010 daily rates, are as follows: routine home care (\$142.91); continuous home care (\$834.10); inpatient respite care (\$147.83); and, general inpatient care (\$635.74).

The aggregate annual cap per patient in 2009 was \$23,014.50. This cap is determined by adjusting the original hospice patient cap of \$6,500, set in 1984, by the Consumer Price Index. See CMS Internet-Only Manual 100-04, chapter 11, section 80.2; 42 U.S.C. § 1395f(i); 42 C.F.R. § 418.309. The Medicare Claims Processing Manual, at Chapter 11 - Processing Hospice Claims, in Section 80.2, entitled "Cap on Overall Hospice Reimbursement," provides in pertinent part as follows: "Any payments in excess of the cap must be refunded by the hospice."

Hospice patients are responsible for Medicare co-insurance payments for drugs and respite care, and the hospice may charge the patient for these co-insurance payments. However, the co-insurance payments for drugs are limited to the lesser of \$5 or 5% of the cost of the drugs to the hospice, and the co-insurance payments for respite care are generally 5% of the payment made by Medicare for such services. 42 C.F.R. § 418.400.

The Medicare and Medicaid programs require institutional health care providers, including hospice organizations, to file an enrollment application in order to qualify to receive the programs' benefits. As part of these enrollment applications, the hospice providers certify that they will comply with Medicare and Medicaid laws, regulations, and program instructions, and further certify that they understand that payment of a claim by Medicare and Medicaid is conditioned upon the claim and underlying transaction complying with such program laws and requirements. The Medicare Enrollment Application which hospice providers must execute, Form CMS-855A, states in part as follows: "I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal AKS and Stark laws), and on the provider's compliance with all applicable conditions of participation in Medicare."

Hospices are generally required to bill Medicare on a monthly basis. See the Medicare Claims Processing Manual, at Chapter 11 - Processing Hospice Claims, in Section 90 - Frequency of Billing. Hospices generally file their hospice Medicare claims with their Fiscal Intermediary or Medicare Carrier pursuant to the CMS Claims Manual Form CMS 1450 (sometime also called a Form UB-04 or Form UB-92), either in paper or electronic form. These claim forms contain representations and certifications which state in pertinent part that: (1) misrepresentations or falsifications of essential information may serve as the basis for civil monetary penalties and criminal convictions; (2) submission of the claim constitutes certification that the billing information is true, accurate and complete; (3) the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts; (4) all required physician certifications and re-certifications are on file; (5) all required patient signatures are on file; and, (6) for Medicaid purposes, the submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

Hospices must also file with CMS an annual cost and data report of Medicare payments received. 42 U.S.C. § 1395f(i)(3); 42 U.S.C. § 1395x(d)(4). The annual hospice cost and data reports, Form CMS 1984-99, contain representations and certifications which state in pertinent part that: (1) misrepresentations or falsifications of information contained in the cost report may be punishable by criminal, civil and administrative actions, including fines and/or imprisonment; (2) if any services identified in the report were the product of a direct or indirect kickback or were otherwise illegal, then criminal, civil and administrative actions may result, including fines and/or imprisonment; (3) the report is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted; and, (4) the signing officer is familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

Hospice Anti-Fraud Enforcement Statutes

There are a number of federal criminal, civil and administrative enforcement provisions set forth in the Medicare statutes which are aimed at preventing fraudulent conduct, including hospice fraud, and which help maintain program integrity and compliance. Some of the more prominent enforcement provisions of the Medicare statutes include the following: 42 U.S.C. § 1320a-7b (Criminal fraud and anti-kickback penalties); 42 U.S.C. § 1320a-7a and 42 U.S.C. § 1320a-8 (Civil monetary penalties for fraud); 42 U.S.C. § 1320a-7 (Administrative exclusions from participation in Medicare/Medicaid programs for fraud); 42 U.S.C. § 1320a-4 (Administrative subpoena power for the Comptroller General).

Other criminal enforcement provisions which are used to combat Medicare and Medicaid fraud, including hospice fraud, include the following: 18 U.S.C. § 1347 (General health care fraud criminal statute); 21 U.S.C. §§ 353, 333 (Prescription Drug Marketing Act); 18 U.S.C. § 669 (Theft or Embezzlement in Connection with Health Care); 18 U.S.C. § 1035 (False statements relating to Health Care); 18 U.S.C. § 2 (Aiding and Abetting); 18 U.S.C. § 3 (Accessory after the Fact); 18 U.S.C. § 4 (Misprision of a Felony); 18 U.S.C. § 286 (Conspiracy to defraud the Government with respect to Claims); 18 U.S.C. § 287 (False, Fictitious or Fraudulent Claims); 18 U.S.C. § 371 (Criminal Conspiracy); 18 U.S.C. § 1001 (False Statements); 18 U.S.C. § 1341 (Mail Fraud); 18 U.S.C. § 1343 (Wire Fraud); 18 U.S.C. § 1956 (Money Laundering); 18 U.S.C. § 1957 (Money Laundering); and, 18 U.S.C. § 1964 (Racketeer Influenced and Corrupt Organizations ("RICO")).

The False Claims Act (FCA)

Hospice fraud whistleblowers may benefit financially under the reward provisions of the federal False Claims Act, 31 U.S.C. §§ 3729-3732, by bringing false claims suits, also known as qui tam or whistleblower suits, against their employers on behalf of the United States. The plaintiff in a hospice fraud whistleblower suit is also known as a relator. The most common FCA provisions upon which hospice fraud qui tam or whistleblower relators rely are found in 31 U.S.C. § 3729: (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A),

(B), (D), (E), (F), or (G);..., and, (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.... There is no requirement to prove specific intent to defraud. Rather, it is only necessary to prove actual knowledge of the false claims, false statements, or false records, or the defendant's deliberate indifference or reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b).

The FCA anti-retaliation provision protects the hospice whistleblower from retaliation from the hospice when the employee (or a contractor) "is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment" for taking action to try to stop the fraudulent activity. 31 U.S.C. § 3730(h). A hospice employee's relief includes reinstatement, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination or retaliation, including litigation costs and reasonable attorneys' fees.

A SC hospice fraud FCA whistleblower would initially file a disclosure statement, complaint and supporting documents with the U.S. Attorney's Office in Columbia, South Carolina, and the US Attorney General. After the disclosures are filed, a federal court complaint can be filed. The SC division where the frauds occurred, the relator's residence, and the defendant residence, will determine which division the case will be assigned. There are eleven federal court divisions in South Carolina. Once the case has been filed, the government has 60 days to decide whether or not to intervene. During this time, federal government investigators located in South Carolina will investigate the claims. If the case involved Medicaid, SC Medicaid fraud unit investigators will likely become involved as well. If the government intervenes in the case, the U.S. Attorney for South Carolina is usually the lead attorney. If the government does not intervene, the relator's SC attorney will prosecute the case. In South Carolina, expect a qui tam case to take one to two years to get to trial.

Tips on Recognizing Hospice Fraud Schemes

The HHS Office of Inspector General (OIG) has issued Special Fraud Alerts for fraudulent and abusive practices of hospices. U.S. and South Carolina hospices, patients, hospice employees and whistleblowers, their attorneys and lawyers, should be familiar with these hospice fraud practices. Tips on recognizing hospice frauds in South Carolina and the U.S. are:

- A hospice offering free goods or goods at below market value to induce a nursing home to refer patients to the hospice.
- False representations in a hospice's Medicare/Medicaid enrollment form.
- A hospice paying "room and board" payments to the nursing home in amounts in excess of what the nursing home would have received directly from Medicaid had the patient not been enrolled in the hospice.
- False statements in a hospice's claim form (CMS Forms 1450, UB-04 or UB-92).
- A hospice falsely billing for services that were not reasonable or necessary for the palliation of the symptoms of a terminally ill patient.
- A hospice paying amounts to the nursing home for "additional" services that Medicaid

considered included in its room and board payment to the hospice.

- A hospice paying above fair market value for "additional" non-core services which Medicaid does not consider to be included in its room and board payments to the nursing home.
- A hospice referring patients to a nursing home to induce the nursing home to refer its patients to the hospice.
- A hospice providing free (or below fair market value) care to nursing home patients, for whom the nursing home is receiving Medicare payment under the skilled nursing facility benefit, with the expectation that after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from that hospice.
- A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.
- Incomplete or no written Plan of Care was established or reviewed at specific intervals.
- Plan of Care did not include an assessment of needs.
- Fraudulent statements in a hospice's cost report to the government.
- Notice of Election was not obtained or was fraudulently obtained.
- RN supervisory visits were not made for home health aide services.
- Certification or Re-certification of terminal illness was not obtained or was fraudulently obtained.
- No Plan of care was included for bereavement services.
- Fraudulent billing for upcoded levels of hospice care.
- Hospice did not conduct a self-assessment of quality and care provided.
- Clinical records were not maintained for every patient.
- Interdisciplinary group did not review and update the plan of care for each patient.

Recent Hospice Fraud Enforcement Cases

The DOJ and U.S. Attorney's Offices have been active in enforcing hospice fraud cases.

In November 2009, Kaiser Foundation Hospitals - Kaiser Sunnyside Medical Center, Kaiser Foundation Health Plan of the Northwest and Northwest Permanente P.C., Physicians & Surgeons (collectively, "Kaiser"), agreed to pay \$1.83 million to settle FCA claims concerning the hospice's Medicare billing practices between 2000 and 2004. The government contended that the Oregon hospice failed to have the necessary written certifications of terminal illness from both the hospice director and the beneficiary's primary physician prior to billing Medicare.

In May 2009, Southern Care, Inc., an Alabama health care company, and several of its affiliates, paid \$26.7 million to resolve claims from two *qui tam* FCA suits. The company allegedly submitted fraudulent claims to federal health care programs for hospice patients. Many of the patients were enrolled for Medicare hospice benefits when they did not meet Medicare's hospice care requirements in that they were not terminally ill. Other fraud allegations were that the defendant lacked documentation of terminal illnesses and that the company illegally marketed to potential patients with the promise of free medications, supplies, and the provision of home health aides. The defendant operated hospices in 15 states, including South Carolina. Southern Care also entered into a 5-year Corporate Integrity Agreement with the OIG as part of the settlement. The *qui tam* relators received almost \$5 million. Nancy Romeo ex rel. United States of America v. Southerncare, Inc., Civil Action No. 2:07-cv-2325-IPJ (N.D.A1).

In 2008, S-Hospice Group, Inc. d/b/a Home Hospice of North Texas, and its principal owners, Andrew P. Milligan and Neil F. Livingston, settled an FCA claim for \$500,000 regarding allegations of fraudulently billing Medicare regarding hospice services. The U.S. alleged Home Hospice: (1) was paid for claims for unallowable hospice items and services; (2) misrepresented to Medicare the medical conditions of patients to ensure such patients would be or continue to be patients; (3) misrepresented to physicians the medical conditions of patients to ensure they would certify or continue to certify that patients were appropriate for admission; and (4) misrepresented the purpose of and coverage criteria of Medicare's hospice benefit to ensure patients were or continued to be admitted for hospice care. The defendants cooperated with the government during its investigation, and, due to their demonstrated financial problems, the amount of the settlement was substantially reduced and they were allowed to make settlement payments over a several-year time period. The defendants also entered into a five-year Corporate Integrity Agreement with OIG to ensure compliance with applicable Medicare hospice statutes and regulations.

In 2006, Odyssey Healthcare, Inc., a national hospice provider based in Dallas, Texas, paid \$12.9 million to settle a qui tam suit for false claims under the FCA. The hospice fraud allegations were generally that Odyssey billed Medicare for providing hospice care to patients when they were not terminally ill and thus ineligible for Medicare hospice benefits. A Corporate Integrity Agreement was also a part of the settlement. The hospice fraud relator, a former regional vice president of Odyssey, received about \$2.3 million for her qui tam suit against the defendant. United States ex rel. JoAnne Russell v. Odyssey Healthcare, Inc., Civil Action No. 2:03-cv-00865-AEG (E.D.Wis.).

In 2005, Faith Hospice, Inc., settled claims regarding an FCA action for almost \$600,000. The hospice fraud allegations were generally that Faith Hospice billed Medicare for providing hospice care to patients more than half of whom were not terminally ill and thus not eligible for hospice Medicare and Medicaid benefits.

In 2000, Michigan osteopath Donald S. Dreyfuss, who earlier pleaded guilty to several health care fraud charges, including violation of the AKS, 42 U.S.C. § 1320a-7b(b)(1)(B), for receiving illegal kickbacks from a hospice for recommending the hospice to the staff of the osteopath's nursing home staff, settled civil FCA claims for \$2 million. The defendant was sentenced in the criminal case to two years of home confinement and five years probation, and ordered to pay a criminal fine of \$213,030.80 and restitution in the amount of \$522,225.00. In addition to the kickbacks, the defendant knowingly billed Medicare and Medicaid for providing physician services to nursing home patients when he had never actually provided such services, the services were not medically necessary, or the complexity of the services was exaggerated. The government also alleged that, in connection with a hospice, Dr. Dreyfuss knowingly certified that patients were eligible for Medicare or Medicaid services when, in fact, they were not. United States v. Dreyfuss, Criminal No. 2:98-cr-80617-JCO (E.D.Mich.).

Conclusion

Hospice fraud is a growing problem in South Carolina and throughout the United States. South Carolina hospice patients, hospice employees, and their SC lawyers and attorneys, should be familiar with the basics of the hospice care industry, hospice eligibility under the Medicare and Medicaid programs, and typical hospice fraud schemes. Hospice organizations should take steps to ensure full compliance with Medicare/Medicaid hospice billing requirements to avoid hospice fraud allegations and FCA litigation.

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