Fraud, Waste & Abuse Role-Based Training- Kindred Therapy Department

Help Section

Welcome to Kindred's Fraud, Waste & Abuse training. If this is your first time taking a module on this website, please take a moment to learn how to navigate through this course and gain the most from this learning experience.

Introduction

Our Kindred facilities operate under federal, state and local laws and regulations. These regulations govern not only the delivery of care to patients, but also a wide range of other vital facility functions, such as the documentation and retention of records and the billing process.

In addition to providing Kindred's patients the level of care that is medically necessary to meet their needs, the federal government, through a law called the False Claims Act, requires that facilities bill the federal government appropriately. Kindred's Compliance Program is the guidepost for the company and its employees to follow. The goal is for Kindred's employees to act with honesty and integrity and provide the highest quality care to patients.

Much of the care and services Kindred provides to patients is paid for by the federal government through Medicare, or by the state through Medicaid. Because Kindred facilities accept these payments, we must follow specific rules the government has put in place. These rules describe not only how patients are cared for, but also how to bill for services and maintain clinical and other records.

Kindred is committed to identifying and preventing fraud, waste and abuse. Kindred has developed and implemented policies and procedures to ensure compliance with the laws and to govern our operations as a healthcare provider. These policies include requirements for criminal background checks to ensure quality hiring; clinical policies to ensure quality of care; financial policies to ensure accurate billing; business policies to discourage fraud, waste and abuse; and conflicts of interest policies in an effort to ensure that Kindred's patients receive uncompromised service.

Kindred addresses and prevents fraudulent activity by having an effective Compliance Program. As a Kindred employee or contractor, you have the responsibility to act in a way that is ethical and complies with the law and Kindred's Policies and Procedures. Further, if you observe something you believe is improper or potentially illegal, you are required to report this behavior so that it can be addressed in a timely manner.

It is important for you to understand the legal and ethical standards required of you and to recognize your responsibility to make sure the Kindred's Compliance Program is effective and successful. This course has been prepared with those objectives in mind. Click the **Next** button to continue.

Course Objectives

At the end of this module, you will be able to:

- List the legal and ethical principles included in Kindred's Code of Conduct
- Describe the requirements of the Deficit Reduction Act of 2005 as it applies to false claims
- Describe fraud, waste & abuse
- Explain how to report suspected fraudulent behavior

Click the **Next** button to continue.

Corporate Compliance Program

Kindred's Corporate Compliance Program has policies and procedures designed to prevent and detect fraudulent conduct. This ensures that we are providing the highest quality of care to our patients while maintaining compliance with all applicable laws and regulations. An effective compliance program can help a facility detect and prevent misconduct by staff.

Every Board Member, officer, employee and contractor plays a role in ensuring the Compliance Program is successful. Training and properly educating employees, management and even contractors is essential to preventing fraud in addition to ensuring patients medically necessary services.

Code of Conduct

Kindred recognizes that as a healthcare organization we must comply with the laws and regulations which govern the provision of healthcare services. The foundation of Kindred's Compliance Program and the guiding principles of working for Kindred are the Code of Conduct and the company's policies and procedures. The Code of Conduct describes Kindred's values, standards and expectations that apply to all parts of its operations. The Code promotes both ethical and legal principles as well as transparency across all aspects of the organization.

Adhering to **Legal Principles** simply means that you must follow the law. Illegal activities may include actions such as abuse and neglect of patients or inaccurate completion of corporate or payroll taxes. Employees cannot engage in any activity or scheme intended to defraud anyone of money, property, or medically necessary items and services.

Applicable laws also prohibit engaging in fraudulent behavior. **Fraudulent Behavior** is when someone knowingly violates the law. For example, this may occur if someone lies or tricks an individual into committing fraud for personal gains.

The Federal False Claims Act prohibits fraudulent billing. For the False Claims Act, "knowing" means not only actual knowledge or involvement, but also ignoring fraudulent acts. Looking the other way and acting as if you "don't want to know" or as if "it is someone else's problem," is considered "knowing" under the False Claims Act. The continued submission of claims for payment when a facility knowingly is not meeting the needs of its patients may constitute fraudulent conduct.

Another example of fraudulent behavior is billing for services not actually provided. Facilities receive government funds to provide quality care to patients. For example, if a facility bills for therapy services, but the patient never received those therapy services or the services were not provided as billed, then the submission of that bill to the government would be a false claim.

A pattern of inaccurate clinical records could also be considered fraudulent behavior. An example of this might be routinely signing off that a restorative program was completed before it was actually done or completing an input/output record from memory rather than accurate measurement. Click the **Next** button to continue.

Scenario 1

LeeAnn (Rehab Program Director): While discussing Ms. Ashby in today's Medicare meeting, I noticed that the therapists recorded a total of 718 minutes for Ms. Ashby's 30-day assessment reference date. If we had provided 720 minutes of therapy during this period, we would have a higher Resource Utilization Group score for this assessment period. That would be an increase of $150/day from the current RUG.

After the meeting, I went to the therapy department to talk to the treating therapist. I explained to her the difference between the current RUG score and the potential RUG score, and I asked her if she was sure those minutes were accurate. Before she could answer me, I got called away to the Administrator's office to meet with a disgruntled family member.

Therapist: Wow!!! $150 a day. That is a big difference. I wonder what LeeAnn meant when she asked if I was sure those minutes were accurate? Did she mean that I should just go ahead and change the minutes to get the higher RUG score? What should I do? I want to ensure that my facility gets the most money possible. I guess I'll just add some time to show that Ms. Ashby received 721 minutes of therapy. It's just a couple of minutes. What's the big deal?

Narrator: Changing the therapy minutes from 718 minutes to 721 is fraudulent. Because Medicare billing is based on a RUG category, the therapist's "simple" change will lead to a higher RUG category and therefore a higher reimbursement rate.

How could this situation have been prevented? In this situation, LeeAnn led the therapist to think that she wanted her to change the therapy logs in order to obtain a higher RUG score.

Rather than asking the therapist if she was sure the minutes were accurate, the therapist should have realized that by changing the therapy logs she was committing fraud. If a direct supervisor asks you to change documentation or billing without appropriate reasons, you must refuse to do so. If in fact, the minutes that were entered into the therapy system were incorrect, the therapist should have followed the policy and procedure for correcting their daily records of treatment. Click the Next button to continue.

The DRA

Under the Deficit Reduction Act of 2005, also known as the DRA, Kindred must provide detailed information, in the form of written policies on the False Claims Act and any state laws that pertain to making false claims to the government and its agencies. These policies apply to employees, contractors, and agents.

The DRA also offers financial incentives for states to enact their own False Claims Acts that mirror the federal False Claims Act, and many states have done so. The DRA requires facilities to educate their staff on the federal False Claims Act, as well as any state false claims act or similar statute.

Under the DRA, facilities must have written policies in place which:

1. Provide detailed information about the False Claims Act. This includes criminal, civil and administrative remedies for false claims. Remember that you have an obligation to be proactive about any incorrect billing and repay the state or federal government any overpayment, even if the government is unaware of the overpayment. You have the obligation to notify and ask for instructions to carry out the reimbursement.
2. Include whistleblower protections to prevent and detect fraud.
3. Incorporate policies and procedures for reporting potential wrongdoing and fraudulent activity, and clearly assert that your facility or company will not tolerate wrongdoing. The employee handbook contains DRA and state specific False Claims Act information.

In order for the policies to be effective, staff must to be educated on them. In addition to having these written policies, one of the ways to do this is to teach your staff, agents and contractors about the False Claims Act and how it applies to them.

Waste & Abuse

"Abuse" refers to provider, contractor, or member practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to programs such as Medicare or Medicaid. It may also mean reimbursement for services that are not medically necessary or services that fail to meet professionally recognized standards for health care. Additionally, it includes practices that result in unnecessary cost. An example of abuse would be a physician performing laboratory tests on a large number of patients when the provider knows only a few tests needed to be performed.

"Waste" generally means the overuse of services or other practices that result in unnecessary costs. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. Waste also includes the government incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls.

Health care abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. The

distinction between "fraud," "waste" and "abuse" depends on specific facts and circumstances such as the available evidence, the intent and the prior knowledge of the individuals involved, among other factors. Click the **Next** button to continue.

Scenario 2
Mr. Winston was admitted to Kindred Rehab Center under Medicare Part A, for rehab after having a stroke that affected his left side. In addition, while he was in the hospital, he developed pneumonia and received IV antibiotics. Mr. Winston's physician ordered physical and occupational therapy five times a week.

Mr. Winston was participating well with therapy for the first week, but towards the end of his second week of therapy, Mr. Winston began having loose stools and was not feeling well enough to participate for the entire therapy session. On Friday, the therapist realized that he did not complete enough minutes to get the anticipated RUG score, so the therapist came into the facility to work with Mr. Winston on Saturday and Sunday to obtain the required number of therapy minutes.

What is wrong in this situation? Since the therapy orders specified five times a week, by providing therapy on Saturday and Sunday, the therapist did not follow the physician orders or the plan of care. Adding additional therapy days to obtain additional therapy minutes could be perceived as fraud to obtain more revenue. In addition, this could also be perceived as waste, since the patient only had orders for five days of therapy but received seven. If it was truly clinically appropriate to add the services for Saturday and Sunday, the therapist and/or nurse should verify the increased days with the physician. Click the Next button to continue.

Kickbacks and Inducements

The Code of Conduct and Kindred policies require all employees to accurately and honestly perform all responsibilities related to their job. In the Code of Conduct and Kindred policies you will find rules about business transactions, gifts, conflicts of interest, and record keeping and documentation. Facilities must carefully examine their relationships with hospitals, hospices, physicians, and vendors. Since facilities have control over whom they contract with for many services, the facility must be certain there are no kickbacks.

A kickback is defined as the offering or accepting of cash or anything of value in exchange for influencing the referral of federally-funded business. For example, your cousin, who sells coffee products to nursing homes, offers to give you a cut of the deal for getting him the account.

Another example would be if a durable medical equipment company representative called and asked if the therapy department would be interested in a new model of wheelchair they are now carrying. He stated he knew that the therapy staff members were extremely busy so he offered to provide lunch at no cost to the facility, while he demonstrated the new line of wheel chairs. After the lunch and demonstration, he stated that he would leave the wheelchairs for the therapists to try for their patients and the therapy department accepted. What is wrong in this scenario?

The appearance of an inappropriate or improper business transaction or activity can damage Kindred's reputation. There are very specific rules about when staff members may accept or offer gifts to existing or potential vendors. Kindred prohibits its employees from accepting any gift, gratuity or business courtesy from its vendors and contractors or potential business affiliates if the value is more than nominal and it is intended to or could be construed to influence business opportunities awarded to any such vendor or contractor.

Likewise, Kindred prohibits the giving of gifts of more than nominal value to persons or businesses in a position to influence the referral of business, including patients and other customers, to Kindred. Please consult with the Law Department for specific questions regarding gifts.

You should never accept gifts, favors, services, entertainment, money, or other items of value that are intended to influence or affect your decision-making, judgment, or actions, especially if your decisions or actions will affect the facility. You should never offer or give money, gifts, favors, services, or other items of value that are intended to influence a vendor's decision or actions. Further, you should not accept or offer patients or families tips, gratuities, or gifts.

Policies and Procedures and Medical Records

Kindred facilities provide our patients with a safe environment where they can achieve the highest possible quality of life. The quality of care for a patient can be significantly improved by addressing several areas through the development of policies and procedures and ensuring that staff are trained on and follow these policies.

One of these areas is addressed through the requirement that every facility must maintain thorough, accurate and appropriate records for each patient. Evaluations, progress notes, care plans, medication administration records and treatment records are examples of documents that must contain truthful information about the patient or patient's care and condition. The falsification of these records constitutes a federal and state crime. If you witness conduct that you believe does not follow Kindred's patient care policies and procedures, you must report it to your immediate supervisor, administrator, the Corporate Compliance Officer or the Compliance Hotline at 1-800-359-7412. You cannot be punished or retaliated against for telling a supervisor or the compliance officer about improper behavior. Click the **next** button to continue.

Billing and Cost-Reporting

Billing practices within the billing departments may pose a risk for improper and fraudulent billing. The following practices are considered fraudulent:

- Billing for items or services not rendered
- Submitting claims for equipment, medical supplies and services that are medically unnecessary
- Upcoding to increase reimbursement if not clinically supported
- Duplicate billing
- Failing to identify and refund credit balances
- Billing for patients covered by a third party payer
- Forging physician or beneficiary signatures
- Filing false cost reports

It is important to keep in mind that your actions support Kindred's ability to submit claims for payment to the government. If you document something that you did not do, then the bill that was submitted for care that was not rendered is fraudulent. Kindred is committed to accurate billing and the prevention of submitting false claims to the government. If you believe fraudulent behavior has occurred, you must report it to your immediate supervisor, administrator, the Corporate Compliance Officer or the Compliance Hotline at 1-800-359-7412. You may not be punished or retaliated against for telling a supervisor or the compliance officer about improper behavior. Click the **Next** button to continue.

Scenario 3

Therapist: My name is Jonathan, I am a Physical Therapist at Kindred Rehab. I was completing an evaluation on Mr. Taylor who was admitted due to a fractured left ankle that resulted in a slight contracture of the ankle. I determined that he needed a brace for his left ankle to aid with ambulation.

I asked the nurse to order the brace for Mr. Taylor. She informed me that Mr. Taylor did not have Medicare part B and that she would have to contact the family to see if they would pay for the brace. She told me not to hold my breath because she didn't think they would pay for the brace

since it's hard to get money out of them even for his blood pressure medication. She was sure they would see the ankle brace as just something he should be able to manage without.

I asked the nurse if she would check with the family and that I would see if I could come up with another recommendation if they refused. While I was in the nurse's office, a package was delivered to the therapy department.

When I got back to the therapy office, I unpacked the box. Imagine my surprise when I pulled out the left ankle leg brace that had been ordered for another patient, Mr. Brooks, last week. When I went to give it to his nurse so he could wear it right away, she informed me that he had discharged that morning.

Then, I had a great idea. Why don't I use this brace for Mr. Taylor? There is no reason for it to go to waste. Mr. Taylor really needs it, and who knows when his family might get around to paying for one, if at all. So, I checked to see if it fit, and it did, perfectly. I let the nurse know that I had found a brace for Mr. Taylor and there was no need to contact the family. I was really lucky with how everything worked out.

Narrator: Even though the therapist had good intentions, patient equipment or medication can only be used for the patient for whom it was ordered. Equipment or medication should never be shared or "borrowed" among patients. Medicare was billed for a brace for Mr. Brooks, therefore, giving it to another patient is considered fraud.

What should the therapist have done? The therapist should have waited for the nruse to contact Mr. Taylor's family to see if they could assist in the cost of the brace. In addition, the therapist should inform the facility administrator of the situation. If Mr. Taylor's family was unwilling to assist with the cost of the brace, the facility may have to purchase one. Also, the brace that was ordered for Mr. Brooks should be returned to the supplier so that Medicare is credited and there is no overpayment.

Scenario 4

Chris Johnson, PT, was carrying an extremely high caseload and was feeling stressed-out. His supervisor has been unable to hire an additional therapist to pick up the extra patient treatments. When Chris walked into the therapy gym this morning and checked the schedule board, he noted that today was the Assessment Reference Date, ARD, for two of his Medicare Part A patients and that he needed to treat each of them for 55 minutes. In addition, he realized he had orders to evaluate two new Medicare Part A patients today, and needed to treat each of them for 30 minutes. Plus, he still had to see the rest of his patients.

In order to provide treatment to all of his patients, Chris decided to group the four Medicare Part A patients. Since these 4 patients had already received 25% of their allowable group treatment this week, he decided to bill the patients for individual treatments instead of group. He made an effort to provide extra attention to each of the patients so that they would receive good quality care almost as if he *had* seen them individually.

What could Chris have done differently? Chris should have discussed the situation with his supervisor. If appropriate, he may have been able to group other patients or perhaps another therapist could have provided additional treatment time. Or perhaps his supervisor could have checked to see if a grace day could be used and still capture the appropriate minutes. Billing for services not provided is fraud. Medicare reimbursement is based on the RUG category. By billing individual treatment instead of group, the RUG minutes were not subjected to the grouper calculation which resulted in a higher RUG category and therefore a higher reimbursement rate. Billing for individual therapy when group therapy was provided is a fraudulent activity.

Scenario 5

Joan Mitchell, OT, just received a call from her daughter's school. The school nurse indicated that her daughter had a fever and that Joanie needed to come pick her up. This was the third time this month that Joan had to leave work early, and she was afraid that her supervisor would reprimand her.

So that she wouldn't get in trouble, Joanie decided to leave without telling her supervisor. She had one Medicare Part A patient left on her caseload today, but because the ARD for that patient was today, she decided to bill for the services today and make up the extra treatment time tomorrow. After all, she was still going to provide the same amount of services in the end.

What should Joan have done? Joan should have discussed the situation with her supervisor. She may have been able to pick up her daughter and return to work later that day to finish her patient care, request another therapist to provide the services, if appropriate, or perhaps her supervisor could have checked to see if the ARD could be changed to use a grace day and still capture the appropriate minutes. Billing for services not provided is fraud. Medicare reimbursement is based on the RUG category and Joanie's billing for services not provided that day will result in a higher RUG category and therefore a higher reimbursement rate.

Fraudulent billing practices may lead to disciplinary action up to and including termination. In addition, fraudulent billing may lead to a complaint filed with the state licensing board that could result in loss of your professional license. Click the Next button to continue.

Employee Screening

Employee screening is another important part of Kindred's Compliance Program. Kindred must ensure that services are delivered to patients by qualified individuals who have not been convicted of a crime or who were debarred, excluded, or otherwise have become ineligible for participation in federal healthcare programs. Pre-employment screening is critical to ensuring the integrity of the work force.

Screens of all current officers, employees and contracted physicians and entities are completed monthly by the Support Center staff in the Risk Management and Compliance Department. As an employee, Kindred requires you to certify that you have not been convicted of an offense that would preclude employment and that you have not been excluded from participation in the federal healthcare programs. As a staff member at Kindred, you are required to notify your supervisor if your status changes at any time during employment. Click the **Next** button to continue.

Consequences for Non-compliance

It is critical for all members of the team to be an active part of Kindred's Compliance Program. In fact, a component of your yearly evaluation will include how well you have followed the company's Compliance Program. The consequences of not following the corporate compliance program can be very serious. Anyone failing to participate in compliance training or failing to follow Kindred's Code of Conduct will be subject to disciplinary actions.

Key Points to Remember

Now, let's review the key points in this course. Kindred's Compliance Program is a system of policies and procedures designed to prevent and detect fraudulent behavior in an effort to ensure Kindred's patients receive the highest quality of care in compliance and accordance with all applicable required laws and regulations.

Kindred's Risk Management and Compliance Department oversees the components of the Compliance Program. If you have any concerns about potential unethical or fraudulent activity, you should contact the Support Center at 1-800-545-0749 or the Compliance Hotline at 1-800-359-7412 so that the issue can be investigated and addressed.

Remember, you are a vital part of Kindred's compliance efforts. It is important for you to understand the legal and ethical standards you are required to follow and recognize your responsibility in making sure Kindred's Compliance Program is successful. Compliance is everyone's responsibility. If you see something that is not right, report it to the appropriate person.

If you have any questions regarding any information you learned in this module, please contact the Risk Management and Compliance Department or the facility administrator for clarification. Thank you for completing this training module.