Administrator Program
Monday, November 14, 2022
4:15pm-5:30pm

3c. Advanced Concepts in Compliance

Presented by:
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ADVANCED COMPLIANCE TOPICS

Texas Association for Home Care & Hospice (TAHC&H)
Administrator Conference

Monday, November 14, 2022

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Agenda

- HIPAA
  - Privacy
  - Security
  - Breaches
  - Social Media
- Telehealth
- DOJ memos
- Excluded individuals
- Medical Directorships and marketers
- Compliance tips

HIPAA Privacy

- As of January 2022, OCR received over 289,000 complaints of privacy violations
- Patient rights to restrict disclosure of information
  - Sharing information with family members OK, if patient doesn’t object or agrees. 45 CFR164.510(b).
  - Beware of disclosures involving mental health
  - If patient is incapacitated, provider may share information with family members, if, in his/her professional judgment, provider decides that patient would not object and/or in best interest of patient.
  - Remember – only minimum necessary!
- OCR guidance for providers: [https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf)
- Use of social media
  - CMS published memo on long term care staff use of social media, especially photographs. [https://tinyurl.com/mrxwb7c5](https://tinyurl.com/mrxwb7c5)
  - Make sure you have a policy in place.
American Nursing Association Ethics

- Principles for Social Networking and the Nurse: Guidance for the Registered Nurse, 
  https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/social-networking.pdf:
  - Nurses must not transmit or place online individually identifiable patient information.
  - Nurses must observe ethically prescribed professional patient-nurse boundaries.
  - Nurses should understand that patients, colleagues, institutions and employers may view postings.
  - Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
  - Nurses should bring content that could harm a patient’s privacy, rights or welfare to the attention of appropriate authorities.
  - Nurses should participate in developing institutional policies governing online contact.

HIPAA Security and Data Breaches

- Security risk analysis
  - MUST conduct security risk analysis!!!

- Use of personal devices –
  - Patients’ home WiFi = unsecured network!
  - Are devices secure?

- Significant concerns about PHI in employees’ personal possession
  - Lincare, Feb. 2016 – Regional manager of DME provider kept patient files in car and in personal residence.
    August 2008 – Regional manager moved out of residence, leaving her husband. December 2008 – Husband notified OCR he had found files under a bed and in a kitchen drawer. 278 patients’ data disclosed. OCR found Lincare did not have any policies regarding safeguarding PHI taken off work premises. Lincare paid $239,800 in fines.

- Major issues in notifications to patients and reporting of data breaches
  - Time limit to notify patients – 60 days, federal and state
  - HIPAA – notify OCR if 500 or more individuals affected
  - Texas – must report data breach to Texas Attorney General if 250 or more individuals affected.
HIPAA Security and Data Breaches (cont.)

- State attorneys general getting into data security and breach notification prosecutions
  - Aveanna Healthcare, Nov. 2022 – HHA experienced phishing attacks (600+ emails) in July 2019. HHA discovered some employee accounts hacked in August 2019 and notified affected patients in February 2020. PHI of over 4,000 patients and employees exposed. Massachusetts AG stated HHA’s security program did not meet requirements of Massachusetts Data Security Regulations. Aveanna to pay $425,000 settlement and implement “comprehensive” information security program. Corrective action plan = 4 years. Breach ALSO lead to class action lawsuit by affected patients
  - Retrieval-Masters Credit Bureau dba American Medical Collection Agency – AMCA collects small balance medical debts. Aug 2018 – March 2019, had breach of systems and 1.4 million Texans’ data exposed (7 million people total). 41 state attorneys general sued. AMCA agreed to 7 year corrective action plan implementing a information security program, including hiring of CISO, and paying $2.8 million in fines.

Recent HIPAA Resolution Agreements

- Improper disposal of PHI
  - Dermatology practice permitted empty specimen containers with PHI on labels to be placed in garbage bin in parking lot. Containers were treated as regular waste. Practice will pay $300k+ in fines and enter into 2 year corrective action plan. CAP requires updated policies & procedures, training, reporting of certain events, implementation report and annual reports.

- Patients’ Right of Access Initiative
  - HIPAA requires disclosure of PHI within 30 days of request
  - 41 cases investigated and settled where providers failed to promptly provide patients with all records requested. Providers were slow in responding, provided only portions of records, charged copying fees, did not respond to a personal representative, or withheld records due to outstanding balances. Some providers also failed to response to OCR’s multiple data requests and outreach.
  - Don’t forget Texas HB 300 actually requires disclosure within 15 days of written request

- Hacking breach
  - Hacker installed malware on Oklahoma State Univ. server, disclosing PHI of almost 280k patients. Breach was undetected for almost 2 years! OSU fined for failing to conduct security risk analysis, implement security incident reporting system and failure to provide timely breach notification to patients. OSU paid $875k in fines.
### Telehealth

- Telehealth poses risks
  - OCR exercising enforcement discretion during COVID Public Health Emergency
  - COVID PHE renewed October 13, 2022, and will expire January 11, 2023 (but 60 days’ notice not given)
  - Telehealth platforms usable during PHE may not be compliant when PHE expires

- New G codes for home health telehealth claims – usable beginning January 1, 2023, and required July 1, 2023
  - G0320 – real-time, two-way interactions (audio and visual)
  - G0321 – real-time, one-way interaction (audio only)
  - G0321 – remote patient monitoring

### DOJ memos / Individual accountability

- Yates memo, Sept. 2015 – describes steps to be taken in investigations of corporate misconduct and holding individuals accountable for corporate misconduct.
  1. Corporations will not be eligible to earn cooperation credit unless they provide to the DoJ ‘all relevant facts’ relating to the individuals responsible for the misconduct.
  2. Individuals should be a focus of investigations from inception.
  3. DoJ civil attorneys should consider whether suits against individuals for damages are appropriate (the DoJ can prosecute cases civilly as well as criminally).
  4. Criminal and civil attorneys at the DoJ should be in close contact with each other.
  5. The DoJ will not release individuals from liability when settling a matter with their employer.
  6. Investigations of the corporation should not be resolved without a plan to resolve related individual cases.

- Trump administration, Nov. 2018 – limited Yates memo to individuals “substantially involved” in misconduct
DOJ memos / Individual accountability (cont.)

▪ Monaco memo, Oct. 2021
  1. reinstates Yates memo to full force
  2. Creates Corporate Crime Advisory Group – including whether AI can be used to process data for use in investigations. Also incorporating input from business community and defense attorneys.
  3. Orders AUSAs to consider ALL misconduct by a corporation, including regulatory enforcement actions, when making decision about whether to charge criminally and how to resolve
  4. Favors imposition of monitor if company’s compliance program is “untested, ineffective, inadequately resourced, or not fully implemented”

DOJ memos / Individual accountability (cont.)

▪ Monaco memo II, September 2022 - “carrots and sticks”
  1. Timely disclosure of information about individual misconduct
  2. Voluntary self disclosure – all elements of DOJ must permit voluntary self disclosure to avoid guilty plea or indictment
  3. Evaluation of compliance programs – at time of offense and time of charging decision (remediation)
  4. Effective compliance programs must include financial penalties and incentives to further compliance (compensation clawbacks, escrowing compensation), use of compliance metrics in compensation and use of performance reviews to measure and reward compliant behavior
  5. Implement policies on use of personal devices and third-party messaging platforms
  6. Complete investigations into individuals before or simultaneously with resolution of corporate wrongdoing
  7. Prior misconduct resolutions – less weight to criminal conduct more than 10 years old and civil/regulatory conduct more than 5 years old
  8. Documents located overseas – must product ALL documents for cooperation credit
  9. Corporate monitor – voluntary self disclosure + effective compliance program avoids corporate monitor; 10 possible factors to evaluate necessity of a monitor
DOJ memos / Individual accountability (cont.)

- Evaluation of Corporate Compliance Programs, June 2020
  - Three fundamental questions a prosecutor should ask:
    1. Is compliance program well designed?
       a. Was risk assessment performed, and are resources devoted to risk areas?
       b. How are policies written and implemented? Are they comprehensive, accessible to employees?
       c. Do employees receive tailored training based on risks? Is training appropriate to audience? Is it effective? Is it updated? How do employees find out about misconduct?
       d. Is there a confidential reporting mechanism and are reports properly investigated and resolved by qualified personnel?
       e. Are third-party relationships properly evaluated, documented, managed and monitored?
       f. If there is a merger, was appropriate pre-closing due diligence completed and who reviewed it? How was acquired company integrated, including compliance function?

   3. Does program work in practice?

DOJ memos / Individual accountability (cont.)

2. Is program adequately resourced and empowered to function effectively?
   a. What is commitment by senior and middle management?
   b. Is compliance program sufficient autonomous and empowered, and adequately resourced?
   c. Are compliance personnel experienced and qualified?
   d. Are there clear disciplinary procedures for non-compliance, and are they applied consistently?
   e. How do compensation and incentive systems work?
DOJ memos / Individual accountability (cont.)

3. Does the compliance program work in practice?
   a. Is there continuous improvement, periodic testing/auditing, and review of results?
      Are the results used to update risk assessments and policies?
   b. Is the culture of compliance measured?
   c. Are allegations of misconduct independently investigated by qualified personnel?
      What is the response to investigations?
   d. Is a root cause analysis of misconduct conducted? What controls failed? How was
      the misconduct funded? Were there opportunities to discover the malfeasance?
   e. What remediation occurred?
   f. Were responsible individuals held accountable? How?

Excluded Individuals/Entities

- Cannot employ or contract with excluded individual or entity - 42 U.S.C. §1320a-7
  - There are currently 76,785 excluded individuals and entities

- Careco Medical, Inc., April 2021 – home health agency employed a physical therapist who in 2012
  pleaded guilty to obstructing a federal audit, agreed to pay $328,828 in fines, and entered into Integrity
  Agreement. PT defaulted on obligations and was excluded in 2015. Careco hired him as a manager in
  November 2018 and he worked until March 2019. Careco paid $28,246 in fines.

- MUST be checking exclusions databases monthly: https://oig.hhs.gov/exclusions/index.asp and
  https://sam.gov/content/exclusions

- Don’t forget Texas also has an exclusions database! https://oig.hhs.texas.gov/exclusions
  - NOT the same thing as the Texas employability status search
    (https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp) or DPS criminal record check
    (https://securesite.dps.texas.gov/DpsWebsite/CriminalHistory)

- If hiring out-of-state individual, make sure to check that state’s exclusions database too.
**Problematic relationships: Medical directors and marketers**

- Medical directors
  - OIG continues to scrutinize medical directorships
  - Sham medical directorships continue to lead to prosecutions
  - Medical directorships can fit into “personal services and management contracts” exception/safe harbor
    - In writing, for term of at least 1 year
    - Must cover all services to be provided and describe those services
    - Services must be commercially reasonable and do not exceed those reasonably necessary to accomplish business purpose
    - Compensation methodology must be set in advance
    - Compensation must be fair market value and not take into account referrals or other business involving health care programs
  - Keep and review documentation of time logs
  - Only hire number of medical directors needed for legitimate purposes

- Marketers
  - Marketers may be employees or independent contractors
  - Bona fide marketing employees fit into the “employee” safe harbor
    - Employer must exercise proper supervision over employee
    - Bona fide employee can be paid in any manner employer chooses
      - HOWEVER – there are conflicting court cases on whether compensation for pure referrals is illegal.
  - Independent marketing agreements must fit into “personal services and management contracts” safe harbor
    - In writing, for term of at least 1 year
    - Must cover all services to be provided and describe those services
    - Services must be commercially reasonable and do not exceed those reasonably necessary to accomplish business purpose
    - Compensation methodology must be set in advance
    - Compensation must be fair market value and not take into account referrals or other business involving health care programs
    - Keep and review documentation of time logs

- Discusses practices that OIG has found in investigations and studies of home health agencies. [Link to document](https://oig.hhs.gov/compliance/alerts/guidance/HHA_%20Alert2016.pdf)

- Criminal convictions and settlements discussed included:
  - making and accepting payment for patient referrals
  - falsely certifying patients as homebound
  - billing for medically unnecessary services or for services not rendered
  - arrangements involved home health agencies, individual physicians, and heads of home-visiting physician companies

OIG Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians (cont’d)

- Criminal convictions and settlements discussed (cont’d):
  - payments for referring or soliciting Medicare and Medicaid patients sometimes involved payments to physicians disguised as payments for serving as medical director
  - HHAs billing for medically unnecessary nursing services to patients not confined to home
  - home-billing physician companies upcoding patient visits and billing for care plan oversight services not actually rendered
  - physicians falsely certifying patients as homebound

- Discusses settlement reached by OIG with 12 individual physicians
  [link](https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Philysician_Compensation_06092015.pdf)

- Compensation relationships discussed included:
  - Payments taking into account value and volume of referrals and did not reflect fair market value for services performed
  - Non-performance by physicians of services called for under the agreement
  - Payment of salaries of physician office staff

OIG Bulletin, Offering Gifts and Inducements to Beneficiaries – August 2002

- Federal law prohibits offering a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of covered items or services
  - Penalty of up to $10,000 CMP for each wrongful act
  - Section 1128(A)(5) of the Social Security Act

- OIG Bulletin issued in August 2002 states that it “…provides bright-line guidance that will protect [Medicare and Medicaid], encourage compliance, and level the playing field.”

  [link](https://oig.hhs.gov/fraud/docs/alertsandbulletins/sabgiftsandinducements.pdf)
OIG Bulletin, Offering Gifts and Inducements to Beneficiaries (cont.)

- May offer inexpensive gifts (other than cash or cash equivalents) or services of nominal value. Per December 7, 2016 OIG Policy Statement, nominal value is now having retail value of no more than $15 per item or $75 in aggregate annually per patient. [https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf](https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf)

- May offer more expensive gifts in 5 categories that include, among other things:
  - non-routine unadvertised waivers of cost-sharing based on individualized determinations of financial need
  - practices permitted under the safe harbor rules


- Dr. Jacques Roy had 11,000+ patients and was affiliated with 500 HHAs
- Home health agency personnel drove around Dallas homeless shelter, offering food stamps or to buy groceries. One HHA owner paid recruiters $50 and offer to buy homeless patients McDonalds. Other HHAs went door to door looking for Medicare beneficiaries.
Case Study – U.S. v. Miles (Texas, 2004)

- Affiliated Professional Home Health (“APRO”) owned by members of the Miles family. APRO paid a public relations/marketing company $300 per-patient commissions for distributing marketing information and business cards to physicians. The marketers apparently also periodically brought cookies to the doctors. If a physician decided a patient needed home health, the physician would contact either the HHA directly or the marketing company, which would send the patient info to APRO. At trial, the RN owners were convicted of violating the Anti-kickback statute.

- The appeals court overturned conviction, reasoning that the marketer never referred anybody to the HHA, and payments were for ordinary marketing activities. Evidence showed that at least one physician chose from 10 different HHAs.

Case Study – U.S. v. George (Illinois, 2018)

- Marketer signed a “Work for Hire” contract stating she was an independent referral services to organize health fairs and visit referral sources to convince them to refer to Rosner Home Health care. Marketer was paid $500 per patient admitted. At one point, the marketer expressed concern the arrangement might be illegal, but a Rosner employee assured her they payments were acceptable. That Rosner employee recorded their conversations discussing whether the payments were illegal. At her arrest, the marketer stated she knew it was illegal to be paid per patient. Marketer was convicted at trial.

- On appeal, marketer analogized her activities to the marketing activities in Miles. Appeals court disagreed, saying there was clear intent to induce referrals, not legitimately compensate advertisers as in U.S. v. Miles.
Texas laws

- Texas Patient Solicitation Act (Tex. Occupations Code § 102.001 et seq.) – analogous to Anti-kickback statute and permits any arrangement or practice permitted by federal AKS
- Texas Physician Solicitation prohibition (Tex. Occupations Code §165.155 – analogous to Stark law
- Texas Medicaid Fraud Prevention Act (Tex. Human Resources Code § 36.001 et seq.) – analogous to federal False Claims Act
- Texas Commercial Bribery (Texas Penal Code § 32.43) – no federal equivalent. There are no safe harbors. Fiduciary commits offense if, without consent of beneficiary, solicits, accepts, offers or confers or agrees to accept or confer benefit that will influence conduct of fiduciary in relation to beneficiary. Physician is a “fiduciary” under law. Violation = felony.

Why is this important? New tactic – Federal government is now using Travel Act (18 USC § 1952) to enforce state laws. See Forest Park case – kickbacks paid to induce referrals to physician-owned hospital for out-of-network services violate Texas law and because involved use of mail, Internet, computer networks, etc., violate Travel Act.

Texas Guidelines on Marketing

- Texas HHSC issued guidelines for marketing for providers enrolled in Texas Medicaid, CHIP programs:
- Prohibitions:
  - Unsolicited personal contacts such as email or telephone
  - Offering inducements or give-aways of more than $10 value
  - Offering gifts or inducements designed to influence individual’s choice of provider
  - Reading level greater than 6th grade
- Guidelines contain recommended checklist for provider review of marketing materials
- Provider may submit marketing materials to HHSC for review and approval. Decision generally issued within 30 days.
Examples of problematic practices and relationships

- Sham medical directorships – physician is paid to serve as medical director in exchange for patient referrals
- Agreements with nursing homes to send patients to the hospice
- Marketing materials and agreements that fail to discuss “terminal illness” requirement for Medicare hospice coverage
- Free or below market value services provided by hospice to nursing home
- Referring a home health or hospice patient to a nursing home in exchange for nursing home referring hospice patients
- Multiple medical directors with compensation based on number of referrals

Examples of problematic practices – (cont’d)

- Payments to patient recruiters that are based on volume or value of referrals
- Excessive payment for space rentals to ALFs
- Payments by staff of HHA or home care agency to patients or sham patients to bill for services never rendered or for patients/clients who would not be eligible for services based on condition
- Payment to patients who were not homebound to use Medicare number to bill for services never rendered or not covered
- HHA going through medical records of SNF or ALF patients to mine for referrals without specific patient permission
Case study – US v. VITAS Hospice Services (Missouri, 2017)

- VITAS is largest hospice chain in country
- Allegations include that VITAS engaged in marketing campaigns to families that misrepresented the purpose of hospice, promoting “intensive comfort care” as covered even if patient did not have acute symptoms
- VITAS trained marketers on how to “sell hospice” and paid employees bonuses based on number of patients enrolled in program and for patients with longer stays and need for continuous home care services, setting goals for # of crisis care days to be billed. Marketers who did not meet monthly admission goals were disciplined
- VITAS failed to train medical directors on hospice eligibility criteria. One physician said VITAS expected him to certify patients without actually making a determination that patient has 6 months to live. Another physician refused to certify certain patients but was overruled by the medical director. Likewise, another physician was overruled when he attempted to discharge patients
- Several VITAS medical directors conducted their own internal review of San Antonio location and discharged 75-80 patients for failure to meet eligibility criteria. No further action was taken.

Case Study – US v. VITAS Hospice Services (Missouri, 2017) (cont’d)

- One physician informed the VP of Operations that the medical director for the San Antonio location had knowingly admitted and certified ineligible patients. Nothing further was done
- Field nurses who were providing care to NH residents were expected to identify patients and encourage referrals
- Hospice program was also marketed to assisted living facilities as service for individuals who might actually get better
- Audits and reviews demonstrated patients did not meet criteria for crisis care, and comparison to NHPCO benchmark data revealed VITAS billed for twice as many crisis care days as all other hospice providers combined
- VITAS paid $75 million to government plus relators’ fees and expenses (total payout approx. $85 million) and signed 5 year Corporate Integrity Agreement
Case Study – US ex rel Cordingley v. Good Shepherd Hospice (Missouri, 2015)

- Good Shepherd was based in Oklahoma City, providing services in Oklahoma, Texas, Missouri, and Kansas through 15 offices; Whistleblower was executive director of one of the offices for 6 months
- Hospice hired medical directors based on ability to refer patients, focusing on medical directors with ties to nursing homes. Hospice had 4-5 medical directors, who each worked 2 hours per month, and received about $3,000 salary monthly
- Hospice required medical directors to refer one patient per month. One medical director was terminated for failing to bring in referrals; he subsequently expressed concern about the quality of care as reason for not referring patients
- Hospice would keep at least 1 patient in a nursing home as hospice patient, so that they would have access to NH to continue to market hospice services

Case Study – US ex rel Cordingley v. Good Shepherd Hospice (Missouri, 2015) (cont’d)

- Hospice nurses also performed work of NH nurses when in facility treating the hospice patients. “If you give me five patients, I'll put a nurse's aide in your building all day long.” Also provided expensive Broda chairs free of charge
- Hospice also paid for residents’ room and board, even if it did not receive Medicare payment due to faulty paperwork
- “Hospice Consultants” (aka marketers) gave NH staff gift baskets and free lunches, to achieve quota of 5 admissions per month.
- Good Shepherd settled for $4 million and 5 year Corporate Integrity Agreement
Case Study – Serenity Marketing, Inc. (Illinois, 2016)

- Sundae Williams owned a telemarketing company. She and her employees made unsolicited cold-call phone calls to recruit patients, including Medicare and Medicaid beneficiaries, for home health services. The patients were then referred to a number of Chicago-area HHAs.
- The HHA owners paid her for “marketing services”. The HHA owners entered into contracts that said the services were paid for on an hourly rate. However, Serenity Marketing never tracked hours actually worked and billed the HHAs by converting each patient referral into a made-up number of 10 hours worked. Ms. Williams usually received $600 per patient.
- Ms. Williams was convicted at trial and sentenced to a year in federal prison and $599,000 forfeiture, representing her revenues from her scheme.
- In addition, the HHA owner, James Ademiju, RN, a physician who signed the referrals, Alan Newman, MD, and an RN working with the physician, Diana Gumila, were also convicted. Ademiju received a 11 month sentence plus $1.5 million restitution, Dr. Newman a 1 year sentence plus $2.6 million restitution, and Gumila a 6 year sentence plus $15.6 million restitution.

Case study – US v. Mercy Ainabe (Texas, 2018)

- Ms. Ainabe functioned as a patient recruiter for Texas Tender Care, which she owned. She tried to make it look like she was an employee for other home health agencies, being paid a legitimate hourly wage as a marketing representative, but in fact she was being paid for patient referrals.
- Ms. Ainabe was also a “shadow owner”, meaning she received a portion of the Medicare payments after other conspirators were paid for their roles, but she was not listed as an owner of the company in state corporate filings or on other documents.
- In turn, Ms. Ainabe paid doctors kickbacks to authorize the services. She also paid physical therapists and others to complete paperwork.
- After conviction in a jury trial, she was sentenced to 9 years prison.

- Doctor’s Choice Home Care, Inc., (DCHC) a Sarasota, Florida home health agency paid kickbacks to 3 referring physicians in the form of sham medical directorships. The physicians did little or no work. If physicians did not make sufficient referrals, the medical directorships were terminated early. DCHC closely tracked payments to physicians and compared them to referrals to DCHC.

- In addition, DCHC hired the spouses of physicians as employees. The spouses were paid in a manner that accounted for the volume of referrals by their physician spouses.

- Evidence shows employees were given compliance training, including a 2004 presentation discussing compliance issues with medical directors.

- Owner Christensen sent emails to account execs saying “When I see dinners I will expect some business”; “Dr. [G] is not working out as a med director... He has only given us 17 ref in 6 mo...I think we could find someone more productive with his spot. We’ve paid him 6K so far”; “[G] [gets an] F this month”; “Med Directors are not doing good. My suggestion is to have a talk with them and let them know what the expectation is.”


- Relator was an account executives (marketing). She also raised concerns that Dr. S. was not performing the services identified on his invoices.

➢ After relator joined a competitor, DCHC emailed Dr. S. to prevent him from following her to a competitor. “If you are not going to give [us] 50% of the business, we will be forced to do the following:
  - Personally meet with each and every Family/General/Internal Medicine Physician...to explain your financial relationship with [relator]
  - Notify all State and Federal Agencies of [relator’s] illegal activities (medical director invoices, marketing expenses to physicians and their significant others and most importantly signing physician orders) ... Let me know your intentions or we will assume you will be giving [competitor] 100% of your business.”

- DCHC allegedly arranged for and paid for the costs of Dr. S. to give lectures to the public to market himself and his practice. Dr. S. then invoiced DCHC’s sister entity for the time spent giving the lectures.

- Dr. S. also allegedly performed chart reviews, but none of the Chart Review forms reflected meaningful work and most were signed without comment.

- Dr. S. was paid for 7 hours of time learning to use DCHC’s online portal for patients and 8 hours on a handbook to be distributed to his patients.

- Compliance person raised concerns about lack of documentation and also said she did not remember a 3 hour in-service that Dr. S. submitted an invoice for.


- Dr. J signed medical directorship agreement and received his first payment of $4k before doing any work, along with patient charts. Within 1 hour, Dr. J. returned the signed charts and an invoice for 9 hours of review. When account exec challenged him with impossibility of doing 9 hours of work in the space of 1 hour, he insisted he had done the work. Account exec went to CEO, who told her to “leave things alone” and just keep on getting referrals. DCHC then hired Dr. J’s girlfriend (and later wife), offering a “very lucrative” compensation plan.

- Dr. F, an interventional pain physician, was contracted a “consultant” to perform in-service trainings. Staff were sent to Dr. F’s office to watch him perform routine procedures which provided little educational value. Dr. F later became a medical director and submitted invoices charging 1 hour time for each chart reviewed. Chart Review forms were also signed with no comment. The account execs dropped off charts for review often waiting while he signed the Chart Review forms. Dr. F was informed by DCHC personnel that it didn’t matter how much time he actually spent on chart reviews.
Case study – US v. Dubor and Whitaker (Texas, 2018)

- John Dubor, RN, owned Care Committers Health Services, Inc. Dubor and Whitaker paid group home owners for access to and for referring Medicare beneficiaries, up to $500 for an initial certification and $250 for a recertification. Payments were made both in cash and by check.

- Dubor paid marketers and recruiters, including Whitaker, to find beneficiaries. Beneficiaries were paid to sign blank home health forms.

- Dubor was found guilty after 4 day jury trial and sentenced to 9 years prison and $3.5 million restitution.

Acceptable Marketing Activities

- Focus on what differentiates your agency
  - Star ratings?
  - Use of technology?
  - Specialized services?

- Blogging is OK

- Don’t allow comments on website or Facebook
  - Don’t respond to posts/comments

- Beware of incentives to beneficiaries
Acceptable Marketing Activities

- In person activities
  - Lunch and learns are OK
  - Modest meals/lunches are acceptable, provided they are infrequent
    - There should NOT be an expectation from the recipients that they will routinely receive food
  - Only those people who have a need to hear the presentation or material

- Holiday gifts can be acceptable
  - Nominal value
  - Share-able by all in the office – box of chocolates, fruit tray, etc.

Tips and Best Practices

- Understand the AKS and Stark laws
- Ensure that every relationship with a physician is documented
- Ensure that every contract or arrangement with a physician is reviewed by a healthcare attorney
- Document valid business rationale and fair market value of services, items
- If it sounds too good to be true, it probably is
- Ensure that your employees are truly employees
Tips and Best Practices

- Medical directors should be compensated solely for clinical services. There should be no link to referrals or admissions.
- Document time and effort to support medical director services
- Train medical directors on eligibility criteria, Medicare care definitions, and compliance with law
- Monitor relationships with outside referring physicians, their offices, and marketers as part of your compliance program
- Review invoices submitted to ensure that services provided and hours worked are reasonable for particular category of services

Tips and Best Practices

- Carefully evaluate compensation plans for employees
  - Compensation should not be based on number of admissions or lengths of stay.
  - Even though there is bona fide employment safe harbor/exception, note that many of the cases involving employees still were problematic. Remember “one purpose” rule.
  - Incentive payments, if any, should not be based on individual economic production.
- Compensation for marketing by independent contractors should meet the personal services safe harbor.
  - Should be at fair market value and not based on volume or value of referrals.
  - Contracted services should be valid services and not a “cover” for referrals.
Tips and Best Practices

- Separate the marketing function from the intake/admissions function
- Intake/admissions personnel should not receive bonuses based on new patients admitted
- Stay away from quotas for admissions, and don’t fire people for failure to meet “goals”
- Beware of excessive focus on numbers and revenue
- Routinely check your referral patterns. Unless you are in a rural or underserved area, you should not have more than about 20% of your referrals coming from any one physician.
- Train marketers and admissions/recertification personnel on eligibility criteria, Medicare definitions and compliance with the law
- Monitor marketing practices of independent contractors as well as employees, and their relationships with referral sources

Tips and Best Practices

- Carefully evaluate your marketing materials and approach to patients
- Ensure patients and family members understand purpose of home health and hospice
- Avoid giving gifts, freebies to patients or family members. If you must give gifts, in Texas, stay under value of $10 per gift and $50 total per patient per year (federal policy allows $15 per gift and $75 per year)
- Use checklist in Texas Provider Marketing Guidelines
- Avoid offering free or discounted services to other health care providers or facilities in connection with home health or hospice patients
  - Especially important in hospice relationships with nursing facilities
Tips and Best Practices

- Perform a HIPAA security risk analysis
  - Suggestion – outsource this
  - Once SRA is performed, develop a plan to address deficiencies
- Ensure your telehealth platform is sufficient for when PHE ends
  - Pay attention to when PHE may end!
- Mobile devices – have your field staff carry business-only devices OR ensure you can access/lock down/delete potential PHI on personal devices
- Ensure you document monthly sanctions/exclusions screenings
  - Again, a suggestion to outsource this
  - If you discover an excluded individual, promptly engage counsel to do self-disclosure to OIG

Tips and Best Practices

- NOW is the time to evaluate your compliance program and strengthen it
  - Affordable Care Act section 6401 mandates compliance programs as a condition of Medicare/Medicaid enrollment
  - Identify risk areas
  - Assign responsibility for compliance to a specific individual
  - Give that individual sufficient work time to perform compliance activities!!
  - It is OK to outsource some to most compliance functions if you are a small provider
IF IN DOUBT, ASK!

Questions?

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