STRATEGIC MANAGEMENT SERVICES

Rapid Increases in Home Health Agency Fraud

Richard P. Kusserow | March 2024

Key Points:

- **Among the fastest growing healthcare sectors, as well as for fraud**
- **Long been recognized as vulnerable to fraud, waste, and abuse**
- **HHA M&As should include regulatory due diligence with legal and financial**
- **Common fraud schemes and "Red Flags"**
- **Physician gatekeepers are often the source of fraud**

Home Healthcare Agencies (HHAs) continue to be among the fastest-growing sectors in healthcare, as well as among the top areas for enforcement actions. Home Health Care represented in 2023 about a 3% share of health expenditure. The spending for services provided by freestanding HHAs increased 6.0% in 2022 to $132.9 billion, accelerating from growth of 0.3% in 2021. This sector is expanding so rapidly it has created new opportunities for those seeking to exploit HHA services through fraudulent means. Many schemes are being used, but among the most common are billing for services that were not provided or billing for services that were not medically necessary. For M&As involving HHAs, it is critical that due diligence reviews be legal, financial, and regulatory. The "gatekeepers" CMS relies upon to prevent fraud and abuse are physicians who certify that the services ordered are medically necessary and manage beneficiaries' care plans. However, it is common for physicians to be a principal party to fraud schemes by approving medically unnecessary home health care services in exchange for kickbacks (e.g., cash, free trips, and products). The following are common types of fraud issues encountered among HHAs:

1. Upcoding the types of services provided to receive higher payment
2. Submitting bills for patients who are not homebound
3. Visits by home health staff that are not medically necessary
4. Home health visits that a doctor ordered but did not render
5. Billing for equipment a patient never received

6. Fake signatures on medical forms or equipment orders
7. Pressure to accept unneeded items and services
8. Providing services not ordered by a physician
9. Offering free goods or services in exchange for Medicare numbers
10. Billing for medically unnecessary services
11. Paying kickbacks to physicians to sign plans of care or to patients for their participation
12. Forging physician signatures to bill Medicare, billing for unqualified patients
13. Fabricating or altering visit notes relating to ordered services and products
14. Billing for housekeeping and unskilled services as skilled nursing care

The OIG has also reported common "Red Flags" identifying potential fraud cases include (a) beneficiaries with no recent visits with a physician to certify care ordered is medically necessary; (b) where home health care services were not provided following a hospital or nursing home stay; and (c) where the primary diagnosis is diabetes or hypertension, which typically do not justify home health care services; and (d) beneficiaries with multiple home health readmissions in a short period.

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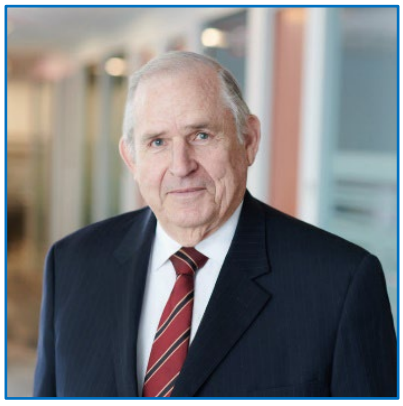

About the Author

Richard P. Kusserow established Strategic Management Services, LLC, after retiring from being the DHHS Inspector General, and has assisted over 2,000 health care organizations and entities in developing, implementing and assessing compliance programs.