used compliance component for reporting violations is a dedicated hotline that allows staff, contractors, residents, family members, visitors, and others with concerns to report suspicions. Regardless of the reporting vehicle, ideally coverage for reporting and addressing resident safety issues would be on a constant basis (*i.e.*, 24 hours per day/7 days per week). Moreover, nursing facilities should make clear to caregivers, facility staff, and residents that the facility is committed to protecting those who make reports from retaliation.

Facilities may also want to consider a program to engage everyone who comes in contact with nursing facility residents—whether health care professionals, administrative and custodial staff, family and friends, visiting therapists, or community members—in the mission of protecting residents. Such a program could include specialized training for everyone who interacts on a regular basis with residents on recognizing warning signs of neglect or abuse and on effective methods to communicate with potentially fearful residents in a way likely to induce candid self-reporting of neglect or abuse.[67]

(b) Resident Interactions

The nursing facility industry, resident advocacy groups, and law enforcement are becoming increasingly concerned about resident abuse committed by fellow residents. Abuse can occur as a result of the failure to properly screen and assess, or the failure of staff to monitor, residents at risk for aggressive behavior. Such failures can jeopardize both the resident with aggressive behaviors and the victimized resident.

Heightened awareness and monitoring for abuse are crucial to eradicating resident-on-resident abuse. Nursing facilities can advance their mission to provide a safe environment for residents through targeted education relating to resident-on-resident abuse (particularly for staff with responsibilities for admission evaluations). Thorough resident assessments, comprehensive care plans, periodic resident assessments, and proper staffing assignments would also assist nursing facilities in their mission to provide a safe environment for residents.

(c) Staff Screening

Nursing facilities cannot employ individuals ''[f]ound guilty of abusing, neglecting, or mistreating residents,'' or individuals with ''a finding entered into [a] State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.'' [68] Effective recruitment, screening, and training of care providers are essential to ensure a viable workforce. Although no pre-employment background screening can provide nursing facilities with absolute assurance that a job applicant will not commit a crime in the future, nursing facilities must make reasonable efforts to ensure that they have a workforce that will maintain the safety of their residents.

Commonly, nursing facilities screen potential employees against criminal record databases. OIG is aware that there is a ''great diversity in the way States systematically identify, report, and investigate suspected abuse.'' [69] Nonetheless, a comprehensive examination of a prospective employee's criminal record in all States in which the person has worked or resided may provide a greater degree of protection for residents.[70]

Verification of education, licensing, certifications, and training for care providers can also assist nursing facilities in their efforts to ensure they provide patients with qualified and skilled caregivers. Many States have requirements that nursing facilities conduct these checks for all professional care providers, such as therapists, medical directors, and nurses. Federal regulations require a nursing facility to check its State nurse aide registry to ensure that potential hires for nurse aide positions have met competency evaluation requirements or are otherwise exempted from registration requirements.[71] In addition, the facility must also check every State nurse aide registry it ''believes will include information'' on the individual.[72] To ensure compliance with this requirement, facilities should have mechanisms in place to identify which State registries they must examine.

B. Submission of Accurate Claims

Nursing facilities must submit accurate claims to Federal health care programs. Examples of false or fraudulent claims include claims for items not provided or not provided as claimed, claims for services that are not medically necessary, and claims when there has been a failure of care. Submitting a false claim, or causing a false claim to be submitted, to a Federal health care program may subject the individual, the entity, or both to criminal prosecution, civil liability (including treble damages and penalties) under the False Claims Act, and exclusion from participation in Federal health care programs.

Common and longstanding risks associated with claim preparation and submission include duplicate billing, insufficient documentation, and false or fraudulent cost reports. While nursing facilities should continue to be vigilant with respect to these important risk areas, we believe these risk areas are relatively well understood in the industry, and therefore they are not specifically addressed in this section.

As reimbursement systems have evolved, OIG has uncovered other types of fraudulent transactions related to the provision of health care services to residents of nursing facilities reimbursed by Medicare and Medicaid. In this section, we will discuss some of these risk areas. This list is not exhaustive. It is intended to assist facilities in evaluating their own risk areas. In addition, section III.A. above outlines other regulatory requirements that, if not met, may subject nursing facilities to potential liability for submission of false or fraudulent claims.

1. Proper Reporting of Resident Case-Mix by SNFs

We are aware of instances in which SNFs have improperly upcoded resident RUG assignments.[73] Classifying a resident into the correct RUG, through resident assessments, requires accurate and comprehensive reporting about the resident's conditions and needs. Inaccurate reporting of data could result in the misrepresentation of the resident's status, the submission of false claims, and potential enforcement actions. Therefore, we have identified

[67] Facilities could explore partnering with the ombudsmen and other consumer advocates in sponsoring or participating in special training programs designed to prevent abuse. *See* ''Elder Justice: Protecting Seniors from Abuse and Neglect: Hearing Before the Senate Committee on Finance,'' 107th Congress (2002) (testimony of Catherine Hawes, Ph.D., titled ''Elder Abuse in Residential Long-Term Care Facilities: What is Known About the Prevalence, Causes, and Prevention''), available at *http://finance.senate.gov/hearings/testimony/061802chtest.pdf.*

[68] 42 CFR 483.13(c)(1)(ii).

[69] OIG, Audit Report A–12–12–97–0003, ''Safeguarding Long-Term Care Residents,'' September 1998, available on our Web site at *http://oig.hhs.gov/oas/reports/aoa/d9700003.pdf.*

[70] Because there is no one central repository for criminal records, there is a significant limitation to searching the criminal record databases only for the State in which the facility is located. A better practice may be to search databases for all States in which the applicant resided or was employed.

[71] 42 CFR 483.75(e)(5).

[72] 42 CFR 483.75(e)(6).

[73] A 2006 OIG report found that 22 percent of claims were upcoded, representing $542 million in potential overpayments for FY 2002. OIG, OEI Report OEI–02–02–00830, ''A Review of Nursing Facility Resource Utilization Groups,'' February 2006, available on our Web site at *http://oig.hhs.gov/oei/reports/oei-02-02-00830.pdf.*

the assessment, reporting, and evaluation of resident case-mix data as a significant risk area for SNFs.[74]

Because of the critical role resident case-mix data play in resident care planning and reimbursement, training on the collection and use of case-mix data is important. An effective compliance program will include training of responsible staff to ensure that persons collecting the data and those charged with analyzing and responding to the data are knowledgeable about the purpose and utility of the data. Facilities must also ensure that data reported to the Federal Government are accurate. Both internal and external periodic validation of data may prove useful. Moreover, as authorities continue to scrutinize quality-reporting data,[75] nursing facilities are well-advised to review such data regularly to ensure their accuracy and to identify and address potential quality of care issues.[76]

2. Therapy Services

The provision of physical, occupational, and speech therapy services continues to be a risk area for nursing facilities. Potential problems include: (i) Improper utilization of therapy services to inflate the severity of RUG classifications and obtain additional reimbursement; (ii) overutilization of therapy services billed on a fee-for-service basis to Part B under consolidated billing; and (iii) stinting on therapy services provided to patients covered by the Part A PPS payment.[77] These practices may result in the submission of false claims.[78]

In addition, unnecessary therapy services may place frail but otherwise functioning residents at risk for physical injury, such as muscle fatigue and broken bones, and may obscure a resident's true condition, leading to inadequate care plans and inaccurate RUG classifications.[79] Too few therapy services may expose residents to risk of physical injury or decline in condition, resulting in potential failure of care problems.

OIG strongly advises nursing facilities to develop policies, procedures, and measures to ensure that residents are receiving medically appropriate therapy services.[80] Some practices that may be beneficial include: Requirements that therapy contractors provide complete and contemporaneous documentation of each resident's services; regular and periodic reconciliation of the physician's orders and the services actually provided; interviews with the residents and family members to be sure services are delivered; and assessments of the continued medical necessity for services during resident care planning meetings at which the attending physician attends.

3. Screening for Excluded Individuals and Entities

No Federal health care program payment may be made for items or services furnished by an excluded individual or entity.[81] This payment ban applies to all methods of Federal health care program reimbursement. Civil monetary penalties (CMP) may be imposed against any person who arranges or contracts (by employment or otherwise) with an individual or entity for the provision of items or services for which payment may be made under a Federal health care program,[82] if the person knows or should know that the employee or contractor is excluded from participation in a Federal health care program.[83]

To prevent hiring or contracting with an excluded person, OIG strongly advises nursing facilities to screen all prospective owners, officers, directors, employees, contractors,[84] and agents prior to engaging their services against OIG's List of Excluded Individuals/Entities (LEIE) on OIG's Web site,[85] as well as the U.S. General Services Administration's Excluded Parties List System.[86] In addition, facilities should consider implementing a process that requires job applicants to disclose, during the pre-employment process (or, for vendors, during the request for proposal process), whether they are excluded. Facilities should strongly consider periodically screening their current owners, officers, directors, employees, contractors, and agents to ensure that they have not been excluded since the initial screening.

Facilities should also take steps to ensure that they have policies and procedures that require removal of any owner, officer, director, employee, contractor, or agent from responsibility for, or involvement with, a facility's business operations related to the Federal health care programs if the facility has actual notice that such a person is excluded. Facilities may also wish to consider appropriate training for human resources personnel on the effects of exclusion. Exclusion continues to apply to an individual even if he or she changes from one health care profession to another while excluded. That exclusion remains in effect until OIG has reinstated the individual, which is not automatic.[87] A useful tool for the training is OIG's Special Advisory Bulletin, titled ''The Effect of Exclusion From Participation in Federal Health Care Programs.''[88]

4. Restorative and Personal Care Services

Facilities must ensure that residents receive appropriate restorative and

[74] To the extent a State Medicaid program relies upon RUG classification, or a variation of this system, to calculate its reimbursement rate, nursing facilities, as defined in section 1919 of the Act (42 U.S.C. 1396r), should be aware of this risk area as well.

[75] *See, e.g.*, CMS, ''2007 Action Plan for (Further Improvement of) Nursing Home Quality,'' September 2006, available on CMS's Web site at *http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/2007ActionPlan.pdf.*

[76] In addition to assisting facilities with ensuring that claims data are accurate, monitoring MDS data may assist facilities in recognizing common warning signs of a systemic care problem (*e.g.*, increase in or excessive pressure ulcers or falls).

[77] There may be additional risk areas for outside therapy suppliers.

[78] Additional risks related to the anti-kickback statute are discussed below in section III.C.

[79] *See* 42 CFR 483.20(b) and (k).

[80] *See* OIG, OEI Report OEI–09–99–00563, ''Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients: Medical Necessity and Quality of Care Based on Treatment Diagnosis,'' August 2001, available on our Web site at *http://oig.hhs.gov/oei/reports/oei-09–99–00563.pdf.*

[81] 42 CFR 1001.1901. Exclusions imposed prior to August 5, 1997, cover Medicare and all State health care programs (including Medicaid), but not other Federal health care programs. *See* The Balanced Budget Act of 1997 (Pub. L. 105–33) (amending section 1128 of the Act (42 U.S.C. 1320a–7) to expand the scope of exclusions imposed by OIG).

[82] Such items or services could include administrative, clerical, and other activities that do not directly involve patient care. *See* section 1128A(a)(6) of the Act (42 U.S.C. 1320a–7a(a)(6)).

[83] *Id.*

[84] A nursing facility that relies upon third-party agencies to provide temporary or contract staffing should consider including provisions in its contracts that require the vendors to screen staff against OIG's List of Excluded Individuals/Entities before determining that they are eligible to work at the nursing facility. Although a nursing facility would not avoid liability for violating Medicare's prohibition on payment for services rendered by the excluded staff person merely by including such a provision, requiring the vendors to screen staff may help a nursing facility avoid engaging the services of excluded persons, and could be taken into account in the event of a Government enforcement action.

[85] Available on our Web site at *http://oig.hhs.gov/fraud/exclusions/listofexcluded.html.*

[86] Available at *http://www.epls.gov/.*

[87] Reinstatement of excluded entities and individuals is not automatic. Those wishing to again participate in the Medicare, Medicaid, and all Federal health care programs must apply for reinstatement and receive authorized notice from OIG that reinstatement has been granted. Obtaining a provider number from a Medicare contractor, a State agency, or a Federal health care program does not reinstate eligibility to participate in those programs. There are no provisions for retroactive reinstatement. *See* 42 CFR 1001.1901.

[88] OIG, ''The Effect of Exclusion From Participation in Federal Health Care Programs,'' September 1999, available on our Web site at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.*