

Fraud and Abuse and Other Risks Related to “Bundling” of Services and Supplies

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Under the Medicare Prospective Payment System (PPS), therapy services are “bundled.” That is, Medicare certified home health agencies caring for patients under an episode of care are required to pay for therapy services for patients whether or not they are provided directly by agencies.

Agencies, for example, may pay for whirlpool therapy rendered at locations other than patients’ homes because it is extremely difficult to provide this type of therapy in patients’ homes.

The obligation of agencies to pay for such services is, however, limited. Specifically, agencies are required to pay for these services only if they have a contract with providers at the time they are rendered.

Despite the fact that the PPS System is well established and has been fully implemented for some time, there are some therapists who still do not understand the criteria described in general terms above. Agencies are, therefore, still receiving requests from therapists for payment for services rendered to Medicare patients under home health episodes of care without a contractual relationship with agencies caring for patients.

Although agencies are under no legal obligation to pay for therapy services under these circumstances, they should carefully consider fraud and abuse implications and other risks associated with decisions about whether to pay “after the fact” for such services.

Such considerations include:

1. When agencies pay for therapy services rendered without a contract, they have had no opportunity to approve them before they were provided or to monitor the quality of services while they were rendered. Whether services were medically necessary and reasonable, therefore, remains an open question from agencies’ points of view. Nonetheless, if agencies pay for these services, they are then vouching for their necessity and reasonableness. If it is later determined that they were fraudulent or abusive because they were not appropriate, agencies will undoubtedly share liability for them.

Agencies will also certainly share in other types of liability associated with the services, such as liability for negligence.

Agencies may effectively manage these risks by reviewing records of care provided by therapists before making a decision about whether to pay for them. If the reasonableness, necessity or quality of care is in doubt, agencies may decline to pay for these services.

2. When considering requests for payment from therapists for services rendered without a contract, agencies may discover that patients had a need for therapy services, but their own staff members failed to identify them. Agencies may, for example, encounter these situations in assisted living facilities (ALF's).

The fraud and abuse implications are also significant in these situations. Agencies are required to provide all reasonable and necessary care to patients they serve, whether such services are provided directly or under arrangement. If therapists identify the need for and provide services that agencies should have provided, agencies may have engaged in a type of fraud called underutilization of services.

Agencies may actually receive more reimbursement when patients receive therapy services. The PPS system creates incentives to over-utilize therapy services, as opposed to under-utilize them. Nonetheless, the failure to provide appropriate services regardless of reimbursement implications certainly raises questions about the potential for fraudulent or abusive activities.

Agencies' dilemmas are even more difficult to resolve when it was reasonable and necessary to provide the services, but the quality of care rendered did not meet applicable national standards of care.

3. When agencies refuse to pay therapists for services rendered without a contract, they may encounter therapists who indicate that they are going to continue to provide services to patients free of charge. Therapists may be tempted to provide free services to agencies' patients in order to maintain preferred or exclusive relationships with ALF's or specialty physicians, such as orthopedists.

Under these circumstances, agencies should educate therapists about a Special Fraud Alert published by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services regarding the provision of free services. This Special Fraud Alert makes it clear that providers may not give beneficiaries goods and/or services valued at greater than \$50.00 during a calendar year. The cost of one (1) therapy visit will undoubtedly exceed this limit.

Consequently, it is impermissible for therapists to continue to render free services to beneficiaries.

Agencies must carefully consider the fraud and abuse issues and other potential risks when they receive requests for payments for services from therapists who did not have contracts with agencies when they provided services. Agencies that fail to do so could be drawn into situations of potential fraud and abuse that they could otherwise avoid.

(To learn more about these issues in a book entitled Medicare/Medicaid Fraud and Abuse: A Practical Guide for Providers, send a check to the above address in the amount of \$30.00, including shipping and handling, made out to Elizabeth E. Hogue, Esq.)

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