

Fraud Alert: Overutilization of Therapy Services

Elizabeth E. Hogue, Esq.

Office: 877-871-4062

Fax: 877-871-9739

E-mail: ElizabethHogue@ElizabethHogue.net

It is especially important for management to guard against the use of tools that may support a conclusion that the agency encourages therapists to make decisions regarding the number of visits provided to patients based on enhanced reimbursement as opposed to clinical condition. There is a fine line to walk between educating therapists about how Medicare reimburses agencies so that staff members can be fiscally responsible and providing tools and reports to staff that spell out the financial implications of decisions regarding utilization. The latter is certainly to be avoided.

Specifically, the use of any OASIS edit software for the sole purpose of identifying revenue opportunities that are not supported by medical necessity should be strongly discouraged.

Recent changes in Medicare reimbursement with regard to therapy services have significantly enhanced the risk that providers who over-utilize therapy services in order to increase reimbursement will be targeted.

At the same time, these recent changes create powerful incentives to over-utilize services. Providers should build checks and balances into their systems of retrospective audits, pre-billing reviews and quality assurance activities to offset these powerful incentives.

Pre-billing reviews should, for example, address the following questions:

- The patient required skilled therapy services that were reasonable and necessary to the treatment of the patient's unique medical condition;
- The patient demonstrated rehabilitation potential or need for establishment of a safe and effective maintenance program;
- Therapists' opinions were based on sound clinical judgment;
- Documentation in the clinical record supported patient need or status;
- Therapists had options to object to, and remedy, potentially inappropriate utilization determinations;
- The diagnostic code accurately reflects the medical condition and severity of the patient without inappropriate input by agency management;

Copyright, 2008.

Elizabeth E. Hogue, Esq.

All rights reserved.

No portion of these materials may be reproduced by any means without the advance written permission of the author.

- Documentation of the patient's condition was not manipulated so OASIS responses created a profile to validate therapy services for financial gain

Enforcement efforts are likely to be based on the federal False Claims Act that makes it clear that providers who submit information that is not true on claims submitted to the government in order to get paid have submitted false claims. The statute provides, in part, as follows:

“Whoever—

- (1) knowingly and willfully makes or causes to be made any false statement or a representation of a material fact in any application for any benefit or payment under this subchapter,
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,
- (3) having knowledge of the occurrence of any event affecting
 - (A) the initial or continued right to any payment or
 - (B) the initial or continued right to any such benefit or payment of any other individual on whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willingly converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall
 - (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) or items or services for which payment is or may be made under this subchapter, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years, or both, or
 - (ii) in the failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.”

Copyright, 2008.

Elizabeth E. Hogue, Esq.

All rights reserved.

No portion of these materials may be reproduced by any means without the advance written permission of the author.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has consistently stated that claims based on over- or underutilization of services are also false claims. The OIG's position is that when providers submit claims for payment, they are promising that care provided was reasonable and necessary and did not involve any overutilization of services.

Although fraud and abuse enforcement has been ongoing for a number of years, providers cannot afford to become complacent. Agencies remain especially vulnerable to enforcement actions for overutilization of therapy services.

Copyright, 2008.

Elizabeth E. Hogue, Esq.

All rights reserved.

No portion of these materials may be reproduced by any means
without the advance written permission of the author.