

Why Discharge Planners/Case Managers Need to Know About Legal Implications of Provision of Free Services to Patients

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Based upon their overriding commitment to patients, case managers or discharge planners may be tempted to “take up the slack” by urging post-acute providers to render free or voluntary services to patients. Case managers/discharge planners may state to post-acute providers that they will not receive additional referrals unless they agree to provide services to so-called “indigent patients,” some of whom may not have a payor source for their care.

Staff members who provide free services and organizations that allow staff members to do so run the risk of engaging in fraudulent conduct. Specifically; to the extent that free or voluntary services are perceived as an inducement to patients to initiate, continue, or re-initiate services with particular providers; organizations and practitioners may run the risk of violation of Medicare/Medicaid fraud and abuse prohibitions, especially the federal anti-kickback statute. Violations may also occur if provision of free services is an inducement for additional referrals, as described above. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (DHHS), a primary source of enforcement activity, has clearly stated that the provision of free services to beneficiaries may constitute a violation of these prohibitions.

The OIG has also clearly delineated limits on free items and services that may be provided to patients. Providers may give patients only non-cash items of nominal value. Non-cash items, including free services, may not exceed \$10.00 in value at a time and \$50.00 in value during a calendar year. Most post-acute services, including even one visit to a patient’s home, clearly exceed these limits.

This position may strike discharge planners/case managers as confusing and perhaps contradictory. Since the point of enforcement is to prevent unnecessary costs, shouldn’t the government welcome the provision of free services to beneficiaries by providers that save money, since they are free? Nonetheless, the government’s point of view is that, when free services result in additional utilization of services, there is a potential fraud problem.

The question of whether free services induce beneficiaries to utilize services paid for by the Medicare/Medicaid and other federal and state healthcare programs that they otherwise would not have utilized is certainly a tricky one to answer. In the current environment of hypersensitivity to fraud and abuse, the best course of action for post-acute providers is likely to completely avoid the provision of free services to patients.

In response to these concerns, providers may wish to develop and implement a policy that permits provision of so-called “charity care” *after* the requirements of the policy have been met. At a minimum, such policies should require providers to bill patients three times before writing off the services as “charity care.” This practice is likely to help “shield” providers from allegations of fraud.

The good intentions and fine motivations of case managers/discharge planners must be acknowledged. The “bottom line,” however, is that the provision of free services is problematic in today’s healthcare environment and should be avoided for all of the above reasons.