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Meet the Presenter…

Heidi Kocher
JD, MBA, CHC

On the topic:
Discount & Waivers – Do It Right and Stay Out of Trouble
Waivers and Discounts

Presented by:
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Counsel

Discount vs. Waiver

Discount – reduction in amount owed
• Contractual – usually negotiated in advance in exchange for other benefit. If part of plan design are acceptable, provided have been disclosed to patients, third-party payers, and providers.
  – Example: in-network status with private payer
• Non-contractual - individualized

Waiver – intentional relinquishment of right to collect
• Usually non-contractual
Deductibles and Co-payments

- Deductible – amount payable by patient before insurance company or payer will pay the claim.

- Co-payment – amount that the patient must pay for each service to provider as share of total payment for services.

Objective – make patients bear some financial cost for health care services, in order to encourage beneficiary involvement in decision-making and discourage unnecessary services.

Differing percentages and amounts depending on payer and program.

- 2015 Medicare Part A deductible = $1,260 per benefit period; Part B deductible = $147.
- Traditional Medicare copay = 20%

Exception to Deductible Requirements

Certain services – example: wellness visits, pneumococcal and influenza vaccinations, Pap tests and pelvic exams

Provider liability – when care is found to be not medically necessary or when care is custodial
Anti-kickback Statute
(42 U.S.C. §1320a-7(b))

Prohibits remuneration of any kind in exchange for referral of patient for any service reimbursable under Medicare, Medicaid or other federal health care program.

Not collecting or forgiving patient deductibles and co-pays can be viewed as unlawful inducement, ESPECIALLY if it is “routine”

Safe Harbor

• Waiver of beneficiary copayments and deductibles for hospital inpatients (Part A), provided following conditions are met:
  • Medicare pays for services under PPS
  • Hospital does not claim reduced or waived amount as bad debt on its cost report
  • Reason for admission, length of stay or diagnosis related group are not considered when discount or waiver is offered or when claim is filed
  • Not part of an agreement between hospital and any third-party payer regarding price reductions, unless it is part of a Medicare SELECT supplemental policy or contract.

• Waiver of beneficiary copayments and deductibles for patients treated at Federally Qualified Health Center (FQHC) or any other facility under Public Health Services Grant
  • Mostly indigent care
  • Approximately 1,200 in US
Stark Law

Remember prohibits referral of Medicare/Medicaid patients where physician for “designated health services” where physician or his/her immediate family members have “financial relationship”

Financial relationship =
  • indirect or direct ownership or investment interest in entity providing item or service
  • any “compensation arrangement”

Exceptions to prohibition: professional courtesy, community-wide health information systems, e-prescribing items and services, electronic health records items and services, medical staff incidental benefits, non-monetary compensation,

Other Safe Harbors / Exceptions

• Subsidy for implementing electronic health records
• Compliance training and education
• Ambulance restocking

• BEWARE – All Safe Harbors (AKS) or Exceptions (Stark) have specific conditions that must be met
OIG Guidance

Special Fraud Alert, December 19, 1994

“Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.”

Results in misstatement of actual charge (and cost) of service.

Indicators of Improper Waivers

- Advertisements stating ``Medicare Accepted As Payment in Full,'', "Insurance Accepted As Payment in Full," or "No Out-Of- Pocket Expense."

- Advertisements stating ``discounts'' will be given to Medicare beneficiaries.

- Routine use of ``Financial hardship'' forms which state that the beneficiary is unable to pay the coinsurance/deductible (i.e., no good faith attempt to determine the beneficiary's actual financial condition).

- Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (``Medigap'') coverage (i.e., the items or services are ``free'' to the beneficiary).
Indicators of Improper Waivers (cont.)

• Charges to Medicare beneficiaries which are higher than those made to other persons for similar services and items (the higher charges offset the waiver of coinsurance.)

• Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigency (e.g., a supplier waives coinsurance or deductible for all patients from a particular hospital, in order to get referrals).

• ``Insurance programs'' which cover copayments or deductibles only for items or services provided by the entity offering the insurance, where``premium'' insignificant and can be as low as $1 a month or even $1 a year. These premiums are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles.

Potential Penalties

• False statements and/or false claims (18 U.S.C. § 287 and 1001)
• Antikickback Statute
  • Civil damages & forfeiture
  • Civil monetary penalties
  • Imprisonment
  • Criminal fines
  • Exclusion
OIG Advisory Opinions

• AO 97-4 – ASC’s policy of seeking reimbursement only from employer-sponsored Medicare complementary coverage for retirees’ Medicare copays for professional fee and not collecting copays for facility fee from retiree patients potentially violates AKS

ZPIC Actions

Even ZPICs may address issue. Sample of SafeGuard Services (Zone 7) letter:

FINDINGS

The purpose of this letter is to educate and inform you that on June 4, 2011, our office received a complaint alleging that an ASC knewingly process Medicare claims as if the patient is paying their co-payments but the patients are not although Medicare shows the patients have paid their percentage and pays the remainder.

Please be advised that the Office of Inspector General released an alert regarding the issue on routinely waving copayments for Medicare patients. Here is what it says, “In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.” Ref: http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.
ZPIC Actions (cont.)

Please be advised, this letter is intended to be educational in regards to the appropriate submission of Medicare claims. You may be subject to a follow-up review of your billing practice in the future to ensure compliance with the information and recommendations in this letter. Additionally, continuation of identified problems can result in exclusion from the Medicare Program in accordance with Section 1128(b) of the Social Security Act; Civil Monetary Penalties; and/or suspension of Medicare payments under Title 42 of the C.F.R., Section 405.370 et seq.

Private Payers

• Usually explicit requirement to collect deductibles and copays

How should providers handle deductibles and coinsurance?
Each of the Aetna Medicare Open Plans may impose different member cost sharing amounts. In almost all of the plans, the cost sharing amount is lower than Original Medicare. In each situation, providers should collect the applicable deductibles and/or coinsurance from patients enrolled in the Aetna Medicare Open Plan.

• Often compliance requirements as well

Sample:

2.4.3.1 Medicare Compliance Program Requirements.

(a) Physician agrees to comply with all applicable requirements set forth in the CMS Compliance Program Guidelines (“Compliance Program Guidelines”) that apply to “first tier entities” and/or “downstream entities,” as those terms are defined by CMS. In accordance with the Compliance Program Guidelines,
Prompt Pay Discounts

• OIG will permit if:
  – Amount of discount relates to cost to collect
  – Offered to all patients for all services/items, regardless of diagnosis, length of stay/treatment, etc.
  – Not advertised
  – Costs are not shifted to Medicare, Medicaid or other government programs
  – Private payers are notified

Advisory Opinion 08-03; 56 Fed Reg 35952 (AKS Safe Harbors regulation)

• BUT may affect “usual and customary charges” under private payer contracts

Free tests or services

• Example: health fairs
• OIG permits if:
  – Free test or service is not conditioned on use of services or items from any particular provider
  – Patient not directed to or referred to any particular provider
  – Patient not offered any special discounts or follow-up services
  – If results are abnormal, patient is directed to follow-up with his/her own physician/health care professional

Advisory Opinion 09-11
Free transportation for patients

OIG has approved provided:

• Program is open to all eligible patients, not limited to special populations or groups
• Transportation type is reasonable (e.g., no limo)
• Travel is to local physician offices
• Public transportation and parking is limited or difficult
• Cost of program not claimed on cost report or otherwise shifted to federal program

*Advisory Opinion 11-02*

Non-routine waiver of deductibles & co-pays

• MUST be documented
• MUST NOT be “routine”
• Develop a policy & procedure for determining patient financial situation and STICK TO IT.
• Conduct periodic audits of patient accounts to verify that policy & procedure is followed.
• NEVER, EVER allow sales & marketing personnel to discuss this policy with referral sources or patients
Suggested Elements of Financial Hardship Waiver Policy

• Clearly identify who has responsibility for making waiver decisions
  • Should NEVER be somebody with sales or marketing responsibilities
  • Recommend a financial person
• Clearly outline steps in process
• Develop criteria for waiver
  • Income and expenses
  • Large or unusual bills
  • Catastrophic or Disaster situation – sudden major illness, death, divorce, etc.
  • Assets
  • Bankruptcy
  • Other objective criteria

Suggested Elements (cont.)
• Federal Poverty Guidelines
• [http://aspe.hhs.gov/poverty/15poverty.cfm](http://aspe.hhs.gov/poverty/15poverty.cfm)
Suggested Elements (cont.)

• Documentation – pay stubs, tax returns, unemployment benefits notices, Medicaid card
• Have patient sign statement that all information is truthful
• Special write-off code in billing/accounting system for these waivers
• Periodic audit of waivers
  • Including supporting documentation
• Discipline for policy – especially for sales & marketing personnel discussing with patients
• Update annually with new federal poverty guidelines

Considerations / Options in Financial Waiver Policy

• Offer of prompt pay discount
• Stepped discount based on percentage income is above federal poverty guidelines.
  • Example

<table>
<thead>
<tr>
<th>When Family Income is:</th>
<th>Discount off Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0 – 0.99 x poverty level</td>
<td>100%</td>
</tr>
<tr>
<td>1.0 – 1.75 x poverty level</td>
<td>75%</td>
</tr>
<tr>
<td>1.76 – 2.25 x poverty level</td>
<td>50%</td>
</tr>
<tr>
<td>2.26 – 3.00 x poverty level</td>
<td>25%</td>
</tr>
<tr>
<td>Over 3.00 x poverty level</td>
<td>No discount</td>
</tr>
</tbody>
</table>
Inability to collect deductibles and copayments

- Improper remuneration does not include inability to collect deductibles and copayments after reasonable efforts. (42 CFR 1003.101)
- Again, MUST have policy & procedure
- Key issue is what is “reasonable efforts to collect”?
  - Attempt to obtain deductibles and copayments prior to or at time service is rendered.
  - If did not collect deductible or co-payment at time of service, send statements.
    - Amount of copayment
    - Number of statements

Inability to collect (cont.)

- Again, do NOT ever permit sales personnel to discuss billing and collection processes with patients or referral sources
- Common problem: “Oh, they’ll send you X number of statements. Just ignore them. If you don’t answer or pay, the company will write-off the remaining balance due.”
- Warning sign of problems – increasing or large amounts of bad debt
- Consider sending to outside collection agency
Professional Courtesy

• Providing care or services to another health care provider or his/her family members for free or at a reduced rate.
• May be a violation of False Claims Act because the subsequent claim misstates the actual charge for the service and may be a false claim
• OIG believes that professional courtesy may be violation of AKS, especially if there is intent to induce referrals

OIG Compliance Program for Individual and Small Group Physician Practices:

“Whether a professional courtesy arrangement runs afoul of the fraud and abuse laws is determined by two factors: (i) How the recipients of the professional courtesy are selected; and (ii) how the professional courtesy is extended.”

A physician’s regular and consistent practice of extending professional courtesy by waiving the entire fee or otherwise applicable copayments for services rendered to a group of persons (including employees, physicians, and/or their family members) may not implicate any of the OIG’s fraud and abuse authorities so long as membership in the group receiving the courtesy is determined in a manner that does not take into account directly or indirectly any group member’s ability to refer to, or otherwise generate Federal health care program business for, the physician.
Professional Courtesy

OIG Compliance Program for Individual and Small Group Physician Practices (cont.)

Any waiver of copayment practice, including that described in the preceding bullet, does implicate [the Civil Monetary Penalties provisions] of the [Social Security] Act if the patient for whom the copayment is waived is a Federal health care program beneficiary who is not financially needy.

Professional Courtesy

**Stark Law Exception** – Professional Courtesy permitted if conditions met:

1. The professional courtesy must be extended to all members of the entity's medical staff in the case of a hospital, or all members of the local community or service area, in the case of a physician practice;

2. The healthcare items and services are a type routinely provided by the entity or practice;

3. The professional courtesy policy must be set forth in writing and approved in advance by the entity's governing board(s);

4. The professional courtesy must not be extended to Medicare or other federal health program beneficiaries unless there is a showing of financial need, and;

5. The arrangement cannot violate the anti-kickback statute or any state law or regulation.
Professional Courtesy

AMA Ethical Opinion 6.13 – Professional Courtesy

While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient copayments may violate Opinion 6.12, "Forgiveness or Waiver of Insurance Copayments."

Professional Courtesy

American Medical Association Ethical Opinion 6.12 – Forgiveness or Waiver of Insurance Copayments

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.
Professional Courtesy

Medicare Benefit Policy Manual, Chapter 13, Section 160, bars Medicare payment for “items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge.”

Immediate relative:
- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

Training on Waivers and Discounts

- MUST train staff on these matters
- Must address key elements of policies
- Should be refreshed annually when updated federal poverty guidelines are published
- May need tailored training for sales and marketing personnel and finance / customer service personnel
- Adapt training based on periodic audits
Compliance Tips

- Implement and FOLLOW written policy defining when discounts and waivers will apply
- Train personnel, including sales and marketing personnel, about the policy and the Do’s and Don’t’s
- Document the decision to waive or reduce patient responsibilities through written hardship application, with supporting documents
- Monitor your write-offs and bad debts
- Periodically audit write-offs and bad debts
- Periodically audit financial hardship waiver files
- Consider using outside collection agency

Compliance Tips

- Writing off entire bill is less risky than waiving or writing off only deductibles or copays
- Consider that physician may be recipient of improper waiver / discount, not just offeror
- Beware of deals too good to be true – for example, reduction in rental payments of MOB space, or “something for nothing”
- There is no stupid question – contact somebody who has experience
Contact Information

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