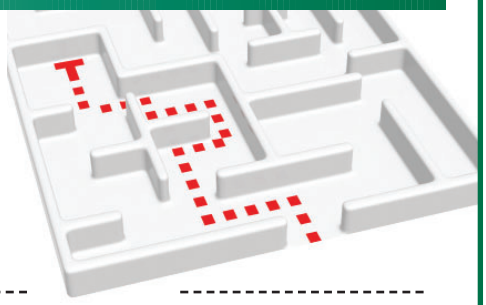

Discounting Dilemmas

TIPS ON AVOIDING VIOLATIONS OF FEDERAL STATUTES

By Amy K. Fehn and Andrew B. Wachler

In most industries, professionals do not think twice about extending courtesies to colleagues, referral sources, or needy clients. For healthcare providers, however, these types of seemingly innocent and even generous practices can create civil and criminal liability.

Professional Courtesy

The term "professional courtesy" can have many meanings, but most often it refers to the provision of free or discounted services to professional colleagues. Sometimes professional courtesy will also be extended to a colleague's family member or office staff. Professional courtesy may include waiving the entire cost of services or waiving cost-sharing amounts, such as co-payments or deductibles.

When professional courtesy is extended to a physician or the family of a physician who is or may become a referral source, this conduct can violate the federal anti-kickback statute, which generally prohibits paying or receiving any remuneration for patient referrals payable by the Medicare program or other federal health programs. The anti-kickback statute is intent-based and is involved even if one purpose of an arrangement is to induce referrals. Violation of the anti-kickback statute is a criminal offense and can lead to imprisonment of up to five years, fines of up to $25,000, and mandatory exclusion from the Medicare program. Most states have equivalent statutes that extend this prohibition to referrals for services covered by private insurance.

The Office of the Inspector General (OIG) addressed the issue of professional courtesy when it published the *OIG Compliance Program Guidance for Individual and Small Group Physician Practices*. Specifically, the OIG discussed the fact that the extension of professional courtesy would engage the anti-kickback statute if the beneficiaries were selected in a manner that takes into account the volume or value of past referrals or the ability to generate future referrals.

Triggering the Stark Law

Professional courtesy, when extended to a physician or entity that refers "designated health services" can also activate the Stark Law. The Stark Law is a strict liability statute and the penalties for violating the statute can include denial of payment, refund demands, civil monetary penalties, and exclusion from the Medicare program.

The Stark ban on physician self-referral generally makes it unlawful for a physician to refer Medicare or Medicaid patients for radiology tests, clinical laboratory tests, physical or occupational therapy, home health care, or other such "designated health services" to an entity with which the physician has a "financial relationship." A financial relationship can be an ownership or a compensation arrangement with an entity. A compensation arrangement is defined to include any arrangement involving any remuneration between a physician and an entity, including remuneration that is "in cash or kind." The provision of free or discounted services to a provider of "designated health services" or the provider's family would be such prohibited remuneration.

There is, however, an exception to the Stark regulations to allow for certain extensions of professional courtesy. In order to fall within the Stark exception, all of the following elements must be 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 must be of 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 boards.
4. The professional courtesy must not be extended to Medicare or other federal health program beneficiaries unless there is a showing of financial need.
5. The arrangement cannot violate the anti-kickback statute or any state law.

Waiver of Co-Payments

Professional courtesy or other practices that involve waiving co-payments or other cost-sharing *(continued on next page)*

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amounts raise additional concerns. When the recipients of such waivers are Medicare beneficiaries, the waiver of co-payments and deductibles can be viewed as a violation of the Federal False Claims Act. This is because Medicare regulations require providers to bill Medicare no more than the "actual charge" for the service rendered. When a provider waives the Medicare copayment, he or she is actually providing the service for a lower cost than what is being reported to Medicare.

For example, if the actual charge of the service is reported as $100 and the co-payment is $20, then waiving the co-payment will result in an actual charge of only $80. A provider who misrepresents the actual charge as $100 could be charged with violating the False Claims Act.

Because the Health Insurance Portability and Accountability Act (HIPAA) extends the reach of the Federal False Claims Act to claims submitted to all payors, the practice of waiving co-payments could also result in violations for non-Medicare patients when a private health plan places the same type of "actual charge" limitation on payment. State laws and private insurance contracts may also prohibit waiver of co-payments for private pay patients.

In addition, a waiver of co-payments, especially to the extent it is advertised to beneficiaries, potentially violates the prohibition on providing inducements to a patient to generate business payable by a federal healthcare program and can subject a provider to civil monetary penalties.

Usual and Customary Charges

Providers can be excluded from the Medicare program for submitting claims for services that are "substantially in excess" of the entity's "usual charges." Routinely waiving co-payments and providing other forms of discounts can decrease a provider's "usual charges" to the point where the Medicare fee schedule is "substantially in excess" of these usual charges. Similarly, many private payors require providers to limit charges to those that are "usual customary and reasonable." Routine waivers and discounts could impact this value as well.

Financially Needy Patients

The OIG has recognized exceptions to the prohibition on waiving co-payments when patients have demonstrated financial need. In a 2004 letter to hospital providers, the OIG stated that waiver of fees for financially needy patients would not be considered when calculating the providers' usual charges and would not be considered to be a violation of the anti-kickback statute. Although the guidance was directed specifically to hospital providers, the OIG's advisory opinions have increasingly been favorable toward the waiver of cost-sharing amounts for patients with demonstrated financial need. Providers who waive patient obligations based on financial need should only do so when the patient has produced documented evidence of financial need.

Compliance

As part of their billing and regulatory compliance plan, providers should have policies in place that address the waiver of co-payments and the extension of professional courtesy. According to a recent report from the AMA, there have been no reported instances of prosecution by the OIG or the Department of Justice (DOJ) for fraud and abuse related to the extension of professional courtesy. However, providers should not take this as a pass to ignore the law, as violations can also be used against a provider in audits and other investigations to increase the government's bargaining position. ▲

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