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Butler County Mental Health & Addiction Services Board

January 24, 2020 – Q&A from Web Program on Medicare and Incident to

1. Copays for Medicare Part C. cannot be waived for financial hardship as they can for Part B?

Based on the contract the patient/client has with the Medicare Part C program that requires them to pay co-payments as owed, and to follow the prior authorization process except in cases of emergency, from the patient/client perspective no – they must pay the co-payments

The agency contracts also require that in all cases this is part of their contract with each and every managed care plan for Medicare Part C . If any agency does not honor this process the Part C Medicare Advantage plan (Part C) could lower their reimbursement to the agency by this co-pay amount and/or cancel the contract.

2. Is it true in Ohio BH Redesign that all eligible BH providers for Medicaid must enroll with Medicare also?

Medicare requires all eligible providers who are in a participating entity to enroll with Medicare Part B. The BH SUD redesign process also requires all eligible providers (as agencies and their specific providers) to enroll in Medicare Part B as well. Managed Care Plans (Part C) are based on factors the provider/agency would determine as appropriate.

In Ohio there is an additional law in Ohio 4769.01 does not allow any provider to balance bill Medicare patients above the Medicare rate, with the exception of co-payments, amounts applied and amounts applied to deductibles.

Self pay services are exempt from this rule.

3. If a client/patient has Medicare B & C is Medicare C primary? Including related to #2 above?

Patients cannot have Medicare B and C – they can only have B or C.

4. Can you explain what CAQH under eligible provider enrollment means and how does this applies to ADMHAS Boards?

The CAQH is the national provider credentialing process that all providers (independently licensed and dependently licensed based on enrollment with commercial insurance plans (also used for some counselors) where all pertinent information about education, continuing education, mal practice insurance plans, contract status, and employment status are maintained for all insurance plans to access for ongoing credentialing and re-credentialing.

5. Can an LISW do diagnosis and assessment to begin an "incident to" arrangement with a LPCC for billing purposes?

No – the LISW would need to do the complete assessment and identify the complete plan of care at the initial contact and they any follow up services (because this person is independently licensed in Ohio) could be billed incident to the LISW if the documentation supports following

the same plan as the identified IPS and initial DA and there are NO changes in the process, and the LISW is on site.

6. Can dependently licensed staff bill incident to?

No, this process can only be used, based on the attached documentation, with individuals who are, in the state of Ohio, identified as independently licensed

7. Can a psychologist who is enrolled with Medicare Part B have licensed counselor's bill incident to?

Yes, if the psychologist performs the initial DA and the IPS and is present in the office when the services are provided based on the psychologists plan

8. Do the licensed providers have to "agree" to have services billed "incident to? Or can an agency just do this without their approval?

Yes, whoever the services are billed under, has to be involved in this process and agreeable to this process, as their Medicare provider # is their number to monitor and assure is being used in a compliant method.

Attached is a presentation on this issue from 2018 which reviews key issues as well.

Legal brief concerning the law and waiving co-payments:

In a difficult economic environment, many health care providers are actively trying to increase cash flow and reduce administrative expenses. One potential way for providers to accomplish these goals is to discount their usual and customary fees for patients who pay in cash at the time of service. By extending a discount to patients who pay out of pocket at the time of service or seek reimbursement from their insurance company at a later date, a provider can reduce the administrative costs associated with processing insurance claims as well as the uncertainty and delay of billing and collecting for services rendered.

Offering patients a time-of-service discount may be a useful and permissible billing practice under limited circumstances when the discount reflects the administrative savings to the practice. However, providers must exercise caution because offering discounts to patients can implicate various federal and state laws. A provider who routinely discounts or waives a patient's copayment or deductible (collectively referred to as copayment) obligations, for example, can run afoul of the federal antikickback statute, 42 U.S.C. § 1320a-7b, or be accused of false billing by private insurance carriers not receiving the discount. Consequently, a provider must exercise discretion and sound judgment when offering any discount to patients.

Discounts with Respect to Medicare

Although the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General for the Department of Health and Human Services (OIG) are not alarmed by the occasional waiver of copayment obligations – due to financial hardship or uncollectibility – the *routine* waiver of copayment obligations under Medicare is clearly problematic.

The federal antikickback statute prohibits the offering of any remuneration to induce a person to purchase or order any service for which payment may be made under Medicare. The routine waiver of a patient's copayment obligations implicates this prohibition because it reduces the amount that the patient pays for services, and may therefore induce the patient to seek more services that are payable by Medicare. The OIG has promulgated regulations defining and further specifying those payment practices which will not subject providers to penalties under the antikickback statute – so-called safe harbors. When discussing the propriety of discounts, the OIG stated unequivocally that safe harbor protection does not apply to any discount offered to beneficiaries in the form of "a reduction in price offered to a beneficiary (such as a routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary)." 42 C.F.R. § 1001.952(h)(5)(iv).

Another compelling reason to avoid the routine waiver of patients' copayment obligations under Medicare is that the practice can lead to reduced Medicare reimbursement and a potential government investigation. Medicare reimbursement for physician services is based on "the lesser of the actual charge or the applicable fee schedule amount." 42 C.F.R. § 414.21. If a Medicare carrier becomes aware that a provider routinely waives the collection of copayment amounts for Medicare beneficiaries, except for amounts deemed too small to warrant collection efforts or where documentation of hardship and indigence is established, the carrier is instructed to determine whether the waivers constitute a reduction of the provider's actual charges. The Medicare Claims Processing Manual, CMS Pub. 100-04, ch. 23, § 80.8.1, indicates that an amount billed that is not reasonably related to an expectation of payment is not considered to be the "actual" charge for the purpose of processing a Medicare claim. Consequently, if a Medicare carrier determines that a provider discounts copayment responsibilities to zero, the Manual instructs the carrier to take several steps. First, the carrier must process the current claims received on the basis of the actual charges made (i.e., the amounts the provider actually expects to receive in light of the discount). Second, the carrier must reduce the current customary charge screen by 20 percent. Finally, the carrier is instructed to refer these cases to the OIG and Department of Justice for appropriate action, which may include suspension or exclusion from the Medicare program.

Based on these concerns, offering any type of discount to Medicare beneficiaries is inadvisable. The OIG may take the position that the waiver of copayment obligations on the basis of anything other than specific determinations of indigence, hardship or uncollectibility is offered to induce the purchasing or ordering of Medicare reimbursable services, and this can lead to prosecution under the antikickback statute. Alternatively, it risks the determination that your actual charges are less than the Medicare fee schedule and that your reimbursement should be reduced accordingly.

Discounts and the Concerns of Private Insurance Carriers

Waiving copayment obligations for privately insured patients can also be problematic. Like CMS and the OIG, private insurers and the courts are not generally alarmed by occasional accommodations for individual patients with documented financial limitations. However, insurance carriers have successfully challenged the *routine* waiver of copayment obligations in the courts on numerous occasions.

Courts dealing with challenges to discounts of copayment obligations have been concerned with two basic issues. First, a provider who discounts established fees for some patients but not others, without a valid distinction for the differing treatment, can be subject to claims of false billing by a party not receiving the discount or consideration, including claims by insurance carriers. Second, the routine waiver of patient copayment amounts can be viewed as breach of contract. Almost without exception, insurers impose a contractual duty on providers to make a reasonable effort to collect applicable copayment amounts from patients, and benefits are only available when the charge for the service submitted by the provider is the actual, and the usual, reasonable and customary charge (URC). The reasoning in these cases is that the uniform discounting or waiver of patients' copayment portion of a provider's fee evidences that the

provider really only intends to collect that portion of the fee which is not discounted, making it improper to claim that the fee is the full undiscounted fee.

Perhaps the best judicial analysis of the perils and improprieties attendant to discounts, as well as good advice on how to avoid claims of fraud or misrepresentation, is found in *Feiler v. New Jersey Dental Association Ass'n*, 191 NJ Super. 426 (1983), affirmed 199 N.J. 363. In *Feiler*, the New Jersey Dental Association alleged that Dr. Feiler engaged in untruthful and deceptive billing practices that put other dentists at a competitive disadvantage. The deception centered on Feiler's practice of discounting the copayment of all patients having insurance (as well as special discounts for "cash patients") and then submitting bills to various insurance carriers for the full charge. The court indicated that carrier agreements universally called for the dentist to set forth his "actual" charges to the patient and often additionally required him to indicate that the bill represented the dentist's "usual, customary and reasonable fees." The court stated that because Dr. Feiler, in 97 percent of his cases, either provided a prompt payment discount to uninsured patients or copayment discounts to insured patients, his "usual and customary fees apply only to those few [3 percent] of cases that do not qualify for his discount." The court thus reasoned that the fees Feiler submitted to the carriers were therefore "not usual and not customary…, [a]nd they do not represent actual charges to patients." In support of its conclusion that Feiler fraudulently billed the insurance carriers, the court concluded as follows:

The untruth of such a dentist's statement is highlighted by a comparison. If the insurance payment were not assigned to Feiler, the patient would pay him and seek reimbursement from the carrier. If he had paid Feiler an agreed fee of $80 for a dental procedure, he could not truthfully submit to the carrier a statement that the fee was $100 in order to gain reimbursement of $80. There is no relevant difference between that case and the case in which the dentist, to whom benefits are assigned, states his fee to be $100 when he intends to be satisfied with a payment of $80.

A thorough analysis of the relevant case law reveals certain general principles that are applicable to discounts:

1. Bills presented to a patient or directly to an insurance carrier should represent the actual and URC charge for the service.
2. If you do offer a time-of-service discount, the amount of the available discount should be noted on your bills. If you discount the amount of any copayment (for prompt payment), the copayment discount that is available should also be noted on your bill.
3. The amount of any time-of-service discount, whether relating to the copayment or the entire fee for uninsured patients, should be related to your actual savings, including administrative billing expenses, and the benefit to you of the present value of money received at the time of service as opposed to the future value of money collected through billing procedures.
4. To the extent that you have entered into provider agreements that prohibit discounting or waivers of copayments, you will not be able to offer an insured covered by the agreement a discount that violates the agreement.
5. Certain provider agreements may also have a most-favored-nation clause requiring that any fee you submit to the insurance carrier not exceed the fees charged to any other party. Whether a time-of-service or other discount violates such a clause can only be determined by reference to the language in the agreement and discussions with the carrier.

Conclusion

So, providers can, under certain circumstances waive or discount patient co-payments. But remember, from a legal standpoint, routinely offering discounts to patients is a risky venture. It can implicate various state and federal laws, and can attract the scrutiny of government investigators. However, these regulatory risks should not dissuade a provider from offering discounts in individualized circumstances

based on legitimate financial need, hardship, or uncollectibility. Just be sure that your billing practices are consistent, reasonable, and well documented. When in doubt, consult with your attorney to be sure that your arrangements comply with all applicable state and federal laws