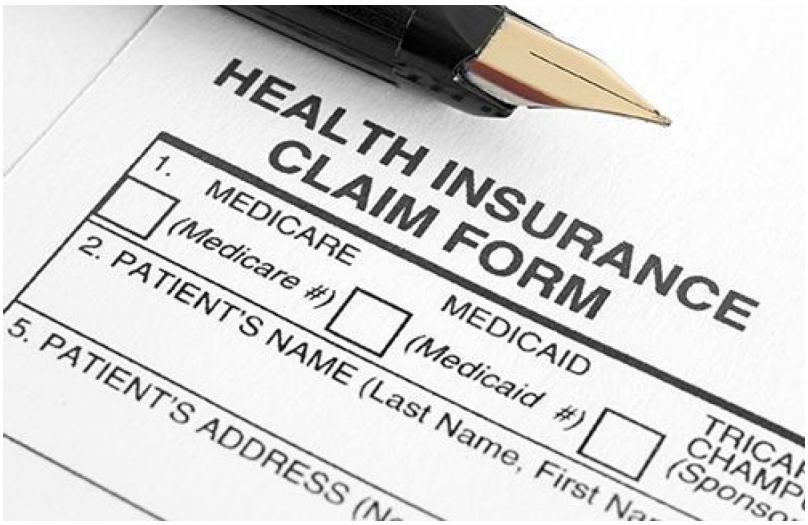
Dynamic Chiropractic



BILLING / FEES / INSURANCE

Troubleshooting: Billing Multiple Fees for the Same Service

Samuel A. Collins

Q: I am afraid I may doing something illegal. I have heard I cannot bill different fees for the same service. I charge several different fees for many types of patients, as I do belong to a number of plans, and I am concerned I could be audited for illegal practices by having dual or actually multiple fees for the same code. Is what I am doing correct or against the rules? I also want to understand my rights and whether it is legal to waive co-pays and deductibles. I have so many patients now who have plans with extremely large deductibles and co-pays.

A: In reality, what you experiencing and questioning is common in today's health care environment. Due to myriad health care plans including, PPOs, HMOs, EPOs, Medicare, Medicaid, worker's compensation, etc., fees or allowances are agreed upon or mandated based on contracts between the provider and insurance companies, or are mandated by law.

There is one "insurance" fee, but that is the fee for plans to which you are not contracted with and is likely your highest fee. However, the fee for plans you *are* contracted with will be different and less than your regular fee. This includes contracts with Blue Cross Blue Shield, American Specialty Health, Optum Health (UnitedHealthcare), Aetna, CIGNA, etc.

"Managed Cost" Discounts

As I am sure you are aware and likely have experienced, your regular fee is often reduced for the patient when you are a member of their insurance plan. This reduced fee is an agreement between the insurance and you, as a member provider, to accept and collect a lesser amount than your regular fee. The trade-off for this lesser amount is a likely or anticipated increase in your volume of patients. This managed care contract is what legally allows you to have differing fees from your "regular" or "non-contracted" rate. I believe these plans are better understood when we call them "managed cost" instead of managed care.

For example, consider that your regular fee is $50 for a particular service and your contracted or allowed rate with plan #1 is $26, plan #2 $41.50 and Medicare $34.90. These different allowances or fees do not violate or create an illegal fee schedule; they are simply contracted fees between the provider and the plan. These allowances will vary between plans and are independent, with one not affecting the other. This also applies to mandated fees such as Medicare, Medicaid and worker's compensation.

It would be a sound business practice and a potential marketing tool to ensure patients are aware that because you participate in these plans, they are receiving a discount or reduced fee by using a contracted provider. Patients do choose care based on their expenses and are more likely to seek necessary care when they are aware of the value and affordability of seeking services with you.

However, non-contracted fees are or should be the same for all and should not vary, as there is no contract or mandated fees. If you were to have varied fees for non-contracted insurance plans from patient to patient or insurance to insurance, this would constitute a dual fee and is an improper billing practice. (*Note:* Case-by-case hardships are the exception.)

Other Discount Considerations

I also must address, although not directly inquired about, the issue of "prompt pay" or cash and

whether there can be any discounts. California allows a discounted rate for patients who are not insured or have no insurance reimbursement for a service. This fee can be discounted and the rate does not affect the regular or insurance rate. Specifically, this law is Business and Professions Code 657, and only applies in California.

But in deference to California law, Washington state law (WAC 246-808-545: Improper Billing Practices) states, "The following acts shall constitute grounds for which disciplinary action may be taken":

(1) Rebating or offering to rebate to an insured any payment to the licensee by the third-party payor of the insured for services or treatments rendered under the insured's policy.

(2) Submitting to any third-party payor a claim for a service or treatment at a greater or an inflated fee or charge than the usual fee the licensee charges for that service or treatment when rendered without third-party reimbursement.

Before offering any discounts for cash or prompt pay, providers should inquire with their state licensing board, department of insurance and/or attorney about the legality of offering such discounts.

The Office of Inspector General (OIG) has issued an opinion with regard to offering discounts for prompt pay. OIG Advisory Opinion No. 08-03 states that a 5-15 percent reduced rate from prompt payment is reasonable. This, in my opinion, is indeed fair and reasonable, considering the actual bookkeeping savings from eliminating the administrative and clerical work associated with billing insurance, not to mention the waiting period for payments.

The OIG opinion, while valid, does not supersede your state laws, however. Take the time to verify what is allowed and understand any specific regulations unique to your practice area.

Waiving Co-Pays & Deductibles

As far as the waiving of co-pays and deductibles, there is no vagueness here. If a physician's office routinely fails to collect the patient's portion of the care, it is considered a violation of both the Anti-Kickback Statute (AKS) and the False Claims Act. OIG and the Department of Justice recognize there are cases of financial hardship and make allowances for those unable to pay. They also recognize when a physician makes a reasonable effort to collect from a patient, but does not receive payment. It is the *routine* waiver of the patient responsibility that can cause serious consequences.

If you are providing any discount for services, be sure the receipt or billing reflects this lesser amount. The regular fee should not be reflected on the billing; only the amount charged. Do not allow the patient's billing, whether 1500, a superbill or some other receipt, to reflect an amount higher than what they paid. They should not receive any benefits (deductibles) or payments from an insurance above the amount they have actually paid or are expected to pay.

Educating Your Patients

Patients must be made acutely aware of their personal responsibility for their services via a financial agreement. This includes deductibles (even when large) and all non-paid amounts when not contracted. When you are not a contracted provider, the patient is liable for all fees not paid by the plan. This often may be confusing to the patient, as they believe their plan will pay 80 percent. Make certain they understand this does not always mean 80 percent of what was billed, but 80 percent of what *their plan allows*. They will owe any and all amounts not covered.

For instance, consider a scenario in which you are not contracted and bill $100 for services. The plan "states" that it pays 80 percent ... but 80 percent of what? This "what" is the plan's allowed amount, not necessarily your billed amount. In this example, the billed amount is $100, but the plan only allows $50 and pays $40 (80 percent). When you are not contracted with this plan, your obligation is to collect $60, as that is the amount not paid and thus the liability of the patient. (This explains why many patients seek care from "in-network" providers to avoid paying above the allowed amount for services.)

The waiving of or non-collection of this amount would be considered a kickback, since insurance was billed and made payments or allowances based on a billed amount of $100; and when there was no intent to collect the billed amount, but rather to accept the insurance payment as payment in full or simply waive collecting the full amount.

My guidance to offices who do this routinely is to join these plans and avoid any legal issues, as you are giving the PPO discount anyway and might as well also get the benefit of having your name available to all plan members, who subsequently may be more likely to seek your care. Do not place yourself in a situation wherein you mistakenly participate in an illegal action with the intent or belief that the benefit to the patient supersedes the law.

For this reason, never set your regular fee based on your highest allowed plan, as patients who do not have plans with as high an allowance will have to pay much more out of pocket and be less likely to continue or seek care. Some are enticed to waive or forgive fees on those lower allowed plans, but still collect the higher on others. This method of collection constitutes the illegality you intimated.

Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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