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BILLING / FEES / INSURANCE

# Your Billing Questions Answered

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I hear a lot of the following questions: I am afraid I may doing something illegal. I have heard I cannot have different fees for the same service. I have several different fees for many types of patients, as I do belong to a lot of plans, and I am concerned that I can 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 very large deductibles and co-pays.

In reality, what you are experiencing and questioning is common in today's health care environment. Due to the myriad of health care plans including, PPO's, HMO's, EPO's, Medicaid, workers' compensation et al, there are fees or allowances that are agreed or mandated based on contracts between the provider and the insurance or are mandated by law.

In fact, there is one "insurance" fee but that would be 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 lesser than your regular fee. This would include contracts with Blue Cross Blue Shield, American Specialty Health, Optum Health (United Health Care), Aetna, CIGNA, etc. As I am sure you are aware and likely experienced with, your regular fee is often reduced for the patient where 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 then your regular fee. The trade-off of this lesser amount is a likely an anticipated increase in the 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, your regular fee is $50 for a particular service and your contracted or allowed rate with plan one is $25, plan two $42 and workers' compensation is $47.75. These different allowances or fees does not violate or create an illegal fee schedule but simply contracted fees between the provider and the plan. These allowances will vary between plans and are independent, with one not affecting the other.

It would be a sound business practice and a potential marketing tool to be sure patients are aware when seeking care with you, and you are part of these plans, that 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 t necessary care when they are aware of the value and affordability when seeking services with you.

However, non contracted fees would or should be the same for all and 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 would be an exception.

I must also address, though not directly inquired about "prompt pay" or cash and whether there can be any discounts. States like California has a law that allows a discounted rate for those patients who are not insured or have no insurance reimbursement for a service. This fee can be discounted and that 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 this California law, Washington state law states the following: WAC 246-808-545, Improper billing practices. 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 or attorney about the legality of offering such discounts. But there is direction from the Office of Inspector General (OIG) that has made an opinion on the offering of discounts for prompt pay. In the OIG Advisory Opinion No. 08-03 it states that a 5% to 15% reduced rate, from prompt payment, is reasonable. This, in my opinion, is fair and reasonable, considering the actual bookkeeping savings by 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 you state laws however and each provider is responsible to be within the laws of their state and should take the time to verify what is allowed and understand any specific regulations unique to your practice area.

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 that 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 and the regular fee should not be reflected on the billing but simply the amount charged. Do not allow the patient to have a billing whether 1500, superbill or some other receipt that reflects an amount higher than what they paid. They should not receive any benefits (deductibles) or payments from an insurance above an amount they have actually paid or are expected to pay.

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%. Not understanding this 80% is not always (nor often) 80% of what was billed but 80% of what the plan allows and they owe any and all amounts not covered.

For example, you are not contracted and billed $100 for services. The plan "states" they pay 80% but it was not clarified as to 80% of what. This "what" is their allowed amount not necessarily your billed amount. In this example, the billed amount is $100 but the plan allows only $50 and pays $40 which is 80%. When you are not contracted with this plan your obligation is to collect $60 as that is the amount not paid and the liability, of the patient. Hence 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 kick back as the 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 accept the insurance payment as payment in full or simply waiving 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 may more likely seek care with you. Do not place yourself in a situation wherein you mistakenly put yourself in an illegal situation with the intent or belief that the benefit to the patient supersedes the law.

For this reason, never set your regular fee based on the 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 less likely to continue or seek care. Hence why some are enticed to waive or forgive fees on those lower allowed plans but still collect the higher on others. That method of collection however would be the illegal factor you intimated.

NOVEMBER 2015