Cash Discounts

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This publication from the OMA's Medical-Legal Department is intended to inform our membership about recurring legal issues in the day-to-day practice of medicine. If you would like us to address a particular issue in future publications, please contact Gwen Dayton, JD, OMA General Counsel (gwen@theOMA.org) or Annabel Lucas, JD, OMA Health Policy Specialist (annabel@theOMA.org).

Disclaimer: We hope this information is helpful to you, but it does not constitute formal legal advice, nor does it create an attorney/client relationship with the reader.

Cash Discounts

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**Cash Discounts: What You Need to Know in a Nutshell**

- Identify whether the recipient of the discount has insurance and if so, whether the insurance contract limits your ability to allow a cash discount.
- If the recipient is a beneficiary of Medicare, do not discount the service unless the person demonstrates financial need and you document that need.
- Routine discounts, including waiver of co-insurance, co-payments or deductibles, is a dangerous practice.
- Make certain that all discounts are reflected on the billing statements provided to the patient as well as to any insurer.
- Adopt a written discount policy and stick with it.

As health care costs continue to escalate, physicians find themselves under increasing pressure to extend discounts to patients who have become more savvy consumers of health care services. Whether and to what extent a cash discount is permissible is not an easy question to answer. A number of laws apply when a discounted service is offered. In addition, it is possible to run afoul of contractual obligations with commercial insurance companies. Physicians should exercise care when deciding whether to offer a cash discount and should adopt a formal, written policy on cash discounts.

The following is a list of issues you should consider when preparing and adopting a policy and providing cash discounts to your patients:

**Government-Pay Patients**

**Anti-Kickback Concerns:**

If a physician offers a cash discount to a Medicare or other government program beneficiary, the discount may very well be viewed as an illegal kickback under the Anti-Kickback Statute. If the physician actually publicizes discounts (such as "no out-of-network penalty costs", "no out-of-pocket cost", etc.), then a violation is almost certain. Generally speaking, a beneficiary of a federal health care program may be offered a 'cash discount' **only** if there is clearly demonstrated evidence of financial need. The laws provide a 'safe harbor' where such a discount is offered, under the following specific circumstances:

1. The discount is not offered as part of any advertisement or solicitation. Rather, the discount is offered at the time of payment.
2. The practice does not routinely waive coinsurance, deductible or other patient responsibility costs.
3. There has been a good faith determination of financial need, or, after making a reasonable effort to collect the patient responsibility portion, the practice is unable to do so and therefore writes it off.
Routine Discounts (including waiver of co-insurance, co-payments and/or deductibles) may affect "usual and customary charge":

Routine discounting or waiving entirely 'patient responsibility costs' would likely result in, and be viewed by CMS as the receipt of overpayments by the billing physician because of the unintended effect it has on the physician's usual and customary charge. For example, if a physician performs a procedure that has a usual and customary charge of $100, Medicare would typically pay $80 and the patient would be required to pay $20. If the policy is to only accept 'what insurance pays' and discount the remainder, then CMS would likely take the position that $80 is the physician's usual and customary (or actual) charge, in which case Medicare would only be obligated to pay $64. The difference of $16 would be an overpayment subject to refund and possibly worse, deemed a false claim, subjecting the billing physician to stiff civil penalties and potentially, criminal sanctions.

Private Insurance Patients

If the patient seeking the cash discount has insurance, then the discount the patient seeks (or is given) will likely be to either reduce or eliminate the coinsurance or deductible amount, or to reduce or eliminate the 'out-of-network' penalty (where the practice is not on the provider panel of the particular insurer). Or, the patient may request that you not bill their insurance at all and seek to take advantage of the discount you provide to patients who pay cash at the time of service.

Coinsurance/Deductible Discounts:

Most insurers require their contracted physicians to collect co-insurance, co-payments and deductibles at the time of service. Reduction or elimination of co-insurance, co-payments or deductibles may violate the contractual obligations and/or policies of some insurers, so it is important to determine that before a discount is offered. As with federal healthcare beneficiaries, if there is clearly demonstrated financial need, many insurers will allow the discount to be offered in spite of contractual prohibitions to the contrary.

Time of Service Discounts:

There is nothing wrong with providing cash paying customers with a reasonable time-of-service discount that reflects the lower cost of billings and collections. However, the amount of the discount must reasonably reflect this (for example, a 5 - 15% discount probably would; a 50% discount probably would not). A prompt pay discount would not be unreasonable where a patient has a significant out-of-network penalty to pay as well, and that payment is made at or very near the time of service. Be mindful however of the potential effect that routine discounts may have upon the practice's 'usual and customary' fee. Also, review your insurance contract to ensure there is no prohibition on waiving the billing of the insurance company for covered services.

Patient's Billing Statement - Reflect Cash Discount:

Because some patients that pay in cash may still have insurance, in order to discourage the fraudulent submission of an inaccurate statement to a payer, any discount that is provided to a patient should be clearly indicated.

Medicare Advantage - As Promised From Last Briefing

There is no legal difficulty with physicians selectively contracting with Medicare plans. The Balanced Budget Act of 1997 gave Medicare beneficiaries the option to receive their Medicare benefits through private health insurance plans (Part C), instead of through the original Medicare plan (Parts A and B). Physicians not contracted with a given Medicare plan can still see that plan's members but will be paid according to the fees payable by original Medicare.

Providers are considered as "deemed" to participate in a Medicare Advantage Private Fee for Service (PFFS) plan if they render services to a patient and are aware at the time of service that the patient is covered by a Medicare Advantage PFFS plan. The concept of deeming allows a sponsoring plan to treat physicians that provide service to PFFS enrollees as though they have a contract with the plan, even though no document was signed. The physician is deemed separately for each patient encounter, and once deemed, Medicare does not require the physician to treat that patient again or any other PFFS patient in the future.

OMA's Free Member Service: Practice Roundtable June 11

After a successful first meeting of the OMA Practice Roundtable, Gwen Dayton, JD, OMA's General Counsel, will host the next OMA Practice Roundtable on June 11, 2010 from 8:30 to 10:30 am at OMA Headquarters. The primary topic will be care of minors and the consent, disclosure and other issues associated with care for this group. We also will include other timely issues and participants are encouraged to bring their own issues to the group. This is a free event. To register, visit www.theOMA.org/PracticeRoundtable or contact Jenn Webster at jenn@theOMA.org or (503) 619-8000. We hope you can attend!

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