Certify Financial Need Before You Waive Copayments or Deductibles

Radiology practices sometimes choose not to collect patient copayments and deductibles. The patient may claim poverty. Or the amount (for example, $5 or $10) may not seem worth pursuing. Or the practice may view waiving these payments as a way to increase business. But waiving copayments or deductibles is tricky business. Legal experts tell the Insider that the law allows you to waive these payments only in certain situations. If your policy is to waive these payments routinely, you may be violating the federal False Claims Act, as well as the federal antikickback law and similar state laws. And you risk fines of up to $25,000 and possible exclusion from federal insurance programs for violating the federal antikickback law alone. If the patient has private insurance, you could be giving the patient’s insurer an opening to escape paying its share of your bill.

Smart practices waive copayments and deductibles only after determining that paying them would impose a financial hardship on the patient. We’ll explain how they make this decision. And we’ll give you a Model Policy (see p. 3) and a Model Form (see p. 4) that you can adapt and distribute to your staff to help you avoid this health care fraud trap.

How Waiver of Copayments and Deductibles Can Lead to Legal Penalties

Waiving copayments or deductibles can get you into three types of legal trouble.

**False Claims Act violation.** Medicare usually pays 80 percent of the “reasonable charge.” To calculate reasonable charges, Medicare looks at actual charges. By waiving copayments and deductibles, you’re misstating your actual charge. So you’re overbilling Medicare.

*Example:* If you tell Medicare that your charge for a procedure is $500, but you routinely waive a 20 percent copayment, you’re really charging $400 (80 percent of $500). If Medicare pays you 80 percent of $500, you’ve overbilled them by $80. That’s because your actual charge is really $400, so Medicare should pay you 80 percent of that, which is $320.
CERTIFY FINANCIAL NEED (continued from p. 1)

Antikickback law violation. Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) says that “routine” waivers of copayments and deductibles violate the federal antikickback law, according to Scott Becker, a health care attorney with Chicago-based Ross & Hardies. That’s because routine waivers can be an incentive to patients to bring you their Medicare- or Medicaid-reimbursable business—which could lead to abuse of Medicare or Medicaid resources. Even if you’re not offering the waiver for the purpose of luring Medicare patients, you risk a costly and time-consuming OIG investigation, says Becker.

Failure to comply with obligations under managed care agreements. Most managed care agreements require practices to collect copayments and deductibles from patients, says Becker, before they collect from the managed care plan. Based on this clause (which you may find in the “coordination of benefits” section of your agreement), the managed care plan may choose not to pay you if you waive copayments and deductibles, says Becker. And courts may agree with the insurer’s position. Result? You get paid nothing for your services.

Insider Says: Waiving copayments and deductibles may also permit your malpractice carrier to argue that it’s not liable for claims filed by the patients from whom you didn’t collect.

Base Decision to Waive on Financial Need

Fortunately, says Becker, you can reduce your risk of violating the law and not getting paid by instituting a simple policy: waiving copayments or deductibles only in cases of documented financial hardship. Setting and following such a policy helps prove to CMS that you don’t waive these payments routinely, Becker explains.

After drafting your policy, give a copy to all billing staff and post the policy in patient registration areas. Explain to your staff that the policy isn’t intended to attract patients; rather, it’s to be used as a way to handle requests from patients who can’t afford the copayment or deductible.

Your policy, like our Model Policy, should do the following.

State general rule against offering kickbacks. Begin your policy with the general rule that you don’t offer any kinds of incentives, such as kickbacks, bribes, rebates, or waiver of copayments or deductibles, to anyone for bringing health care business to your practice, says Becker [Policy, par. 1].

State exception for financial hardship. Next, set out the exception: that billing staff of your practice may waive copayments or deductibles on request—but only if the patient offers specific proof of financial hardship, says Becker [Policy, par. 2].

Define financial hardship. While there’s no set definition of financial hardship, prudent practices base their definitions on an impartial third-party standard. Becker advises using the federal poverty guidelines as a starting point. For example, you may choose to waive copayments and deductibles for patients whose gross family income is at or below, say, 200 percent of the current federal poverty guidelines [Policy, par. 3]. Our Model Policy lists the year 2001 guidelines, which were published in the Federal Register in February. Update your policy every year to reflect the most recent guidelines.
Require proof. Your policy should require the patient requesting the waiver to submit reliable written proof of income, says Becker. Examples of acceptable proof are: W-2 forms; pay stubs; tax returns; forms approving or denying unemployment compensation, Medicaid eligibility, or other state-funded assistance; or statements from employers or welfare agencies [Policy, par. 4].

Insider Says: Be sure to keep all documents the patient submits confidential.

Assign decision-maker. Your policy should say who will decide whether to grant patients’ requests for waivers. Because the decision to grant waivers involves serious state and federal antifraud laws, it’s best if the

(continued on p. 4)

**Waive Copayments or Deductibles Only After Patients Prove Financial Need**

Here’s a policy to help your staff decide whether to waive patient copayments or deductibles. The policy says you won’t waive copayments or deductibles unless the patient shows a “financial hardship.” In so doing, the policy helps you avoid violating state and federal antikickback laws. Talk to your attorney about adapting the policy to fit your particular needs. Give a copy of the policy to staff members who handle patient billing, and consider posting a copy of the policy in your patient registration area. The policy was drafted with help from attorney Scott Becker of Ross & Hardies.

### WAIVER OF PATIENT COPAYMENTS OR DEDUCTIBLES

**1. GENERAL RULE**

In general, no employee or member of ABC Radiology shall offer any kind of payment, including any kickback, bribe, or rebate, whether in cash or in kind, in any manner or form, including waiver of copayments or deductibles, to any physician, patient, or other party to induce the referral of any health care business, patient, or other item of service to ABC Radiology.

**2. EXCEPTION FOR FINANCIAL HARDSHIP**

Notwithstanding the general rule, billing staff of ABC Radiology may, on receipt of a request from a patient, waive copayments or deductibles, provided that such waivers shall be made only in documented cases of financial hardship. If a patient’s parent asks about waiver of copayments or deductibles, staff should give the parent a Request to Waive Copayment or Deductible Form and ask the parent to fill it out.

**3. ELIGIBILITY CRITERIA**

A patient is eligible for a waiver of the copayment or deductible under this policy if the patient’s gross family income for the 12 months before the date of the request is at or below 200 percent of the current federal poverty guidelines (as listed in the Federal Register for the current year—see box at right).

For patients getting ongoing treatment or returning for other reasons, we will reevaluate eligibility every four months.

**4. PROOF**

We will base our decision whether to grant a request to waive copayments or deductibles on written documentation provided by the patient. ABC Radiology shall require the patient to submit one or more of the following documents:

- W-2 withholding statements;
- Pay stubs;
- An income tax return;
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
- Forms approving or denying unemployment compensation; or
- Written statements from employers or welfare agencies.

We will keep all information relating to the request confidential, except as needed to comply with a court order or other legal requirement. If we deny a request to waive copayments or deductibles and later receive additional documentation of financial hardship, we will reconsider the request based on the new documentation.

**5. DECISION**

The chief compliance officer or administrator must approve any waivers of deductibles or copayments.

### POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES & THE DISTRICT OF COLUMBIA (2001)

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>Poverty Guideline</th>
<th>200% of Poverty Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$8,590</td>
<td>$17,180</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>8</td>
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<td>$59,460</td>
</tr>
</tbody>
</table>

For families with more than 8 members, add $3,020 for each additional member to determine the poverty guideline ($6,040 to determine 200 percent of the poverty guideline).

[Source: Federal Register, Feb. 16, 2001, pp. 10895–10897]
compliance officer or administrator makes the decision [Policy, par. 5].

**Insider Says:** To avoid allegations of discrimination, be sure to apply your policy to all patient requests equally, regardless of whether patients have public or private insurance.

Get patient to sign financial hardship statement. To set your policy on firmer legal ground, have patients fill out a form, like our Model Form, swearing that they meet the test for hardship set out in your policy, says Becker. This form should say that the patient will agree to make copayments or pay the deductibles for future services if the patient becomes financially able to do so.

**Insider Says:** Don’t advertise that you waive copayments or deductibles. Advertising could lead to a deluge of requests for waivers. And, if you grant a large number of waivers, says Becker, you may appear to be waiving the payments routinely—a red flag to the OIG. Plus many state licensing boards frown on this kind of advertising.

To get the full picture on the risks involved in waiving copayments and deductibles, consult your attorney. The attorney can check your state law to see what’s barred and whether there are exceptions. You’ll also have to decide how to handle the bookkeeping and accounting for waivers of copayments and deductibles—we’ll show you how in a later issue of the Insider.

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**CERTIFY FINANCIAL NEED**
(continued from p. 3)

**Use Form to Get Waiver Request**

Here’s a form you can use when patients request waivers of their copayments or deductibles. In signing this form, patients declare, under penalty of perjury, that they meet the test for financial hardship set out in the Model Policy (see p. 3). Talk to your attorney about adapting this form to your practice’s needs. The form was drafted with help from attorney Scott Becker of Ross & Hardies.

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**CMS Issues New Instructions on Diagnostic Tests**

On Sept. 26, 2001, CMS published long-awaited instructions to carriers and intermediaries amending section 2070-2070.1 of the Medicare Carriers Manual relating to ordering diagnostic tests. The instructions are good news and bad news for radiology practices, says Virginia health care attorney Thomas W. Greeson. We’ll explain what the instructions say and why they’re important to your practice.

**What Instructions Say**

The instructions to carriers and intermediaries clarify who can order diagnostic tests and in what circumstances. The instructions also establish guidelines for handling various situations radiologists commonly face.

The instructions apply only to diagnostic tests performed by a “testing facility” that the instructions define as “a physician or group of physicians (for example, radiologist, pathologist), a laboratory, or an independent diagnostic and treatment facility (IDTF)” furnished to “a beneficiary who is not an institutional inpatient or outpatient.” CMS
deferred to JCAHO requirements and internal hospital policies regarding who can order tests—which means the instructions don’t apply to diagnostic tests for hospital inpatients or outpatients, Greeson explains.

You should get familiar with the new carrier manual instructions on ordering diagnostic tests, says Greeson, because they may change the way you handle certain patients.

“Treating physician,” “treating practitioner” defined. The instructions reiterate Medicare rules that only a “treating physician” or “treating practitioner” may order a diagnostic test. A treating physician is a physician who furnishes a consultation or treats a beneficiary for a specific medical condition. A treating practitioner is a nurse practitioner, clinical nurse specialist, or physician assistant, acting within his or her scope of practice under state law, who furnishes a consultation or treats a beneficiary for a specific medical condition.

The instructions clarify that an interventional radiologist performing a therapeutic interventional procedure is considered a treating physician, Greeson notes. But the instructions say that a radiologist performing a diagnostic interventional procedure isn’t considered a treating physician, he says.

Order explained. According to the instructions, the order for a diagnostic test needn’t be written, says Greeson. But keep in mind that other federal regulations require that at least the initial order for a test performed at an IDTF be in writing, and the instructions don’t trump those regulations, Greeson asserts. In a physician office or other non-IDTF testing facility, instead of writing out the order, the treating physician can communicate with the testing facility by e-mail or telephone. But the instructions say that if the treating physician orders the test over the telephone, both the treating physician and the testing facility must document the phone call and the test order in the patient’s record.

Insider Says: The instructions also note that test orders can be conditional—that is, the order can specify that an additional test should be performed if the initial test yields a specified result. So a treating physician can make a conditional order and eliminate the need for the radiologist to contact him when an initial test result indicates that an additional test should be performed, Greeson says.

Radiologist may not correct clinically inappropriate test order. The instructions say that a radiologist may not correct a clinically inappropriate or suboptimal test order without the treating physician’s prior approval, Greeson explains. So, for example, if the treating physician ordered a CT scan when the clinical indications support an MRI, the radiologist can’t perform an MRI until she has gotten the treating physician’s approval to do so. In the past, some radiologists corrected inappropriate test orders on their own and simply notified the treating physician of the changed order. This change may inconvenience both testing facilities and patients if treating physicians are unavailable, Greeson remarks.

Unordered diagnostic tests barred except in special circumstances. The instructions say that testing facilities may not perform additional diagnostic tests without the treating physician’s order. But, if a patient requires an additional test and the treating physician can’t be reached, the radiologist may perform the additional test if:

- The test the treating physician ordered was performed;
- The radiologist determines and documents that because of the results of the initial test an additional unordered test should be performed;
- A delay in performing the additional test could have an adverse impact on the patient’s care and treatment;
- The result of the additional test is communicated to the treating physician and used in the patient’s treatment; and
- The radiologist documents why he performed the additional test.

Limited radiologist exception. According to the instructions, unless the radiologist first notifies the treating physician of any changes, the radiologist must carry out the treating physician’s orders as presented, with very few exceptions, Greeson says. Those exceptions include:

- A radiologist may determine the design of the test (for example, the number of views required, whether or not to use contrast media) unless the treating physician has specified test design in the order.
- A radiologist may correct a clear error that would be obvious to a lay person. For example, say a patient has a swollen and painful left arm but the order is for an x-ray of the right arm. The radiologist may x-ray the patient’s left arm without getting the treating physician’s prior approval.
- A radiologist may cancel a test without the treating physician’s prior notification or approval if the patient’s physical condition warrants cancellation of the test.


Insider Source
Thomas W. Greeson, Esq.: Reed Smith Hazel & Thomas, 3110 Fairview Park Dr., Ste. 1400, Falls Church, VA 22042.
CMS Transmittal on ICD-9 Coding

On Sept. 26, CMS published a program memorandum on diagnosis coding. This program memorandum is a boon to radiology practices because it finally sets forth CMS policy on the correct way to assign ICD-9-CM codes for diagnostic tests, explains Atlanta health care consultant Jackie Miller. Before this memorandum, carriers had been setting their own rules about whether to code the radiologist’s findings or the patient’s symptoms—and that led to widespread confusion, says Miller. Here are the main points the program memorandum covers:

**Test yields confirmed diagnosis.**
If an exam is ordered for signs and symptoms, but the radiologist’s interpretation yields a confirmed diagnosis, then the radiologist should code that diagnosis. The radiologist may also code the patient’s signs and symptoms as a secondary diagnosis, if he chooses to do so.

*Example:* A patient with a cough is referred to a radiologist for a chest X-ray. The X-ray reveals a pulmonary nodule. The radiologist should code a diagnosis of “pulmonary nodule” and may include an additional code for a diagnosis of “cough.”

**Test is normal or inconclusive.**
If the results of a diagnostic test are normal or didn’t yield a diagnosis, the radiologist should code based on the patient’s signs or symptoms.

*Example:* A patient complaining of back pain is referred for a spinal X-ray. The radiologist interprets the X-ray as normal. The X-ray should be coded with a diagnosis of “back pain.”

**Test is inconclusive or normal, and treating physician’s diagnosis is uncertain.** If the treating physician’s order indicates uncertainty in the diagnosis (for example, “rule out,” “question of,” “possible”) and the radiologist’s interpretation is inconclusive or normal, the treating physician’s diagnosis should not be coded. Rather, says Miller, the patient’s signs or symptoms should be reported.

The program memorandum explicitly indicates that if the treating physician’s order doesn’t indicate the reason for the exam, and the radiologist is unable to obtain that information from the treating physician, the radiologist may obtain the information directly from the patient or the patient’s medical record, says Miller. Although several Medicare carriers have indicated that questioning the patient about the reason for the exam is acceptable under certain circumstances, this is the first time the issue has been addressed in national CMS policy.

*Example:* The treating physician orders a chest X-ray to rule out pneumonia. The radiologist’s interpretation is normal. The X-ray should be coded using the patient’s symptoms (for example, cough), which may be obtained from the treating physician or from the patient.

**Test yields incidental findings.**
If a radiologist documents findings that aren’t related to the reason for the exam, those incidental findings shouldn’t be reported as the primary diagnosis, Miller reports. This is true even if the radiologist can’t make a definitive diagnosis, she emphasizes.

*Example:* A wheezing patient is referred for a chest X-ray. The chest X-ray shows normal lungs and heart and degenerative joint disease in the patient’s spine. Because the spinal disease isn’t causing the wheezing, it shouldn’t be reported as the primary diagnosis—instead, the diagnosis should be coded as “wheezing.” The degenerative joint disease may be coded as a secondary diagnosis, Miller explains.

**Insider Says:** Unrelated and coexisting conditions may also be reported as secondary diagnoses.

**Test is for screening purposes.**
The radiologist must code a test that’s ordered in the absence of signs or symptoms of illness as a screening test. If the test yields positive findings, the radiologist may code the findings as a secondary diagnosis. Miller notes that reporting the positive finding as the primary diagnosis would be incorrect and could appear to be an attempt to circumvent payor restrictions on coverage of screening exams.

*Example:* A nonsmoking patient with a family history of lung cancer gets a screening chest X-ray, which reveals a lung lesion. The test must be coded as a screening test, and the lung lesion may be reported as a secondary diagnosis.

**Insider Says:** You can see the memo by going to www.hcfa.gov/pubforms/transmit/AB01144.pdf.

**Insider Source**
Jackie Miller: Per-Se Consulting Services, 2840 Mt. Wilkinson Pkwy., Atlanta GA 30339.
Start Compliance Tasks Now Without Wasting Effort on HIPAA Privacy Regs that May Change

Now that the HIPAA privacy regulations are final, the compliance clock is ticking and you’ll need to complete dozens of tasks by the compliance date. But because some changes to the regulations are still likely to be made, you may be wondering whether starting your HIPAA compliance efforts now makes sense.

For instance, the final HIPAA privacy regulations require you to sign detailed contracts with each of your business associates. To complete that task, you’ll have to identify your business associates and create, negotiate, and sign a contract with each one by the compliance date. That will require a lot of time, effort, and legal input. Should you start that process now or wait because the Department of Health and Human Services (HHS) may change the privacy regulations? If you wait to start any compliance, you risk missing the HIPAA compliance deadlines.

With the help of data security officer Chris Apgar, and health care attorney Jackie Huchenski, we’ll tell you what changes to the HIPAA privacy regulations are likely, and, with that information in mind, which privacy compliance tasks are safe to start now.

What Changes Are Likely?
HHS has indicated that it will make changes to the HIPAA privacy regulations in two ways, Huchenski says.

First, HHS issued guidance to help health care organizations interpret and implement the privacy regulations, she explains.

Then, HHS will issue modifications to the regulations, which will be published in the Federal Register and will be open to public comment. HHS has indicated that it may issue such modifications later this year.

According to Huchenski, HHS is likely to address at least five areas of the privacy regulations through either guidance or modifications:

1) The consent requirements, which will be simplified so as not to hamper or unnecessarily delay the delivery of patient care;
2) The minimum necessary disclosure requirements, which will be addressed to ensure that health care providers have access to protected health information (PHI) needed to treat their patients and that parents have access to minors’ PHI;
3) The complex requirements related to uses and disclosures for research purposes;
4) Preemption of contrary state law requirements by the regulations; and
5) The requirement to contract with business associates.

Which Privacy Tasks Are Safe to Start Now?
Because many requirements of the privacy regulations seem sure to remain unchanged, you can undertake many compliance tasks now with little or no risk of being affected by later changes, Apgar points out. For instance, you can:

- Appoint a privacy official;
- Conduct a risk assessment and gap analysis for privacy;
- Inventory your PHI;
- Inventory your business associates (for example, attorneys, accountants, consultants, data processing, practice management, and billing and repricing companies);
- Conduct a legal assessment of the state and federal laws, regulations, and accreditation standards that apply to your practice relating to health information privacy, and analyze where you have gaps;
- Gather and compare existing confidentiality agreements for employees, volunteers, vendors, and others;
- Coordinate employee education efforts and begin privacy awareness training; and
- Gather and compare your existing privacy policies and procedures.

Since the compliance date is less than two years away (for all except small health plans, which have almost three years), get started on these tasks now and await clarification on the more controversial areas of the privacy regulations, suggests Huchenski.

Where Can You Get Help with HIPAA Compliance?
Here are a few ways to get help with your compliance efforts:

- Become involved with local, state, and national cross-disciplinary groups that are developing industry standards or best practices for providers, payors, clearinghouses, and third-party organizations, suggests Apgar. You may already be a member of, or at least familiar with, these organizations, such as the American Hospital Association, the American Medical Association, the Health Insurance Association of America, the American Association of Health Plans, or the American Health Information Management Association. This will help you find out what industry standards are being

(continued on p. 8)
Voluntarily Disclosing Provider Fraud to Plan

Q I suspect that another provider in the network I belong to is fraudulently billing plans we contract with. I don’t want to end up liable for or connected to this other provider’s activities. Should I tell the plans what I suspect?

A Tread carefully and talk to an attorney who’s knowledgeable about insurance fraud before contacting any plan. Most plan contracts don’t require providers to report suspected fraudulent billing—even their own. The risks of voluntarily reporting another provider’s fraud may outweigh any potential benefits, warns Chicago attorney Philip L. Pomerance. “If you can’t substantiate your hunch that the provider is fraudulently billing the plan, the other provider can sue you for libel,” he explains. And if you would benefit financially by the other provider’s expulsion from the plan—say, if it competes with you for business—you’re odds of losing such a suit increase, he says.

The other risk of reporting your suspicions is that it may cause the plan to audit your network. The plan may also report the accused provider to your state’s licensing board, the Centers for Medicare and Medicaid Services (CMS), or other government agencies, which can trigger further investigations of the network. And even if you reported the fraud to the plan anonymously, you would be caught up in any audit or investigation because you’re part of the network.

You probably don’t have any obligation to report the billing to the plans even if your network is participating in a Medicare HMO, says Pomerance. CMS requires providers who participate in the Medicare program to report inappropriate billing that affects Medicare funds, and even operates a program encouraging providers to voluntarily disclose such fraud. But these required reports relate only to disclosures of your own fraudulent billing, not the alleged fraud of others, Pomerance notes.

If you have a direct contract with a plan, check to see if it imposes any duty on you to disclose any suspicions you may have. You probably don’t have any duty to report the billing even if your network is participating in a Medicare HMO, says Pomerance. CMS requires providers who participate in the Medicare program to report inappropriate billing that affects Medicare funds, and even operates a program encouraging providers to voluntarily disclose such fraud. But these required reports relate only to disclosures of your own fraudulent billing, not the alleged fraud of others, Pomerance notes.

Supervising Physician Need Not Be Radiologist

Q Our radiology practice has a satellite office located in the same building as an internal medicine practice. The office is staffed with an ultrasound tech,
an X-ray tech, and a radiologist who comes in part time to interpret tests. The radiologist told us that CMS’s new physician supervision memorandum requires that he be present in the office to supervise the tests that require direct supervision—in our case, ultrasounds. Currently, we pay a physician from the internal medicine group to supervise the ultrasounds. Are we doing something wrong?

A No, as long as the satellite office isn’t an independent diagnostic and treatment facility (IDTF), says Maryland health care consultant Claudia Murray. The supervision memorandum requires that a licensed physician provide direct supervision for certain tests—including ultrasounds—but there’s no requirement that the physician be a radiologist. Keep in mind, however, that the physician you hire to supervise the ultrasounds must physically be in your office when the ultrasounds are performed—being in the same building isn’t good enough for tests that require direct supervision, Murray notes.

But for an IDTF, the rules are a little different. They say that the supervising physician must have demonstrated proficiency in the interpretation of the test he or she is supervising. This generally means that a radiologist must supervise radiological tests, although a nonradiologist who can “demonstrate proficiency” should be acceptable under a plain reading of the rule, Murray remarks. Check with your carrier for its requirements, she advises. ■

Insider Sources
Philip L. Pomerance, Esq.: Hinshaw & Culbertson, 222 N. LaSalle St., Ste. 300, Chicago, IL 60601.

Don’t Let Hold Harmless Clause Bar You from Legitimately Billing Plan Members

Managed care contracts typically have what’s called a hold harmless clause, which says that you can bill only the plan for any covered services you provide to plan members. You can’t bill or collect from members for these services, even if the plan refuses to pay you or goes bankrupt. Plans may tell you that the clause isn’t negotiable because state law (or federal law, in the case of Medicare or Medicaid managed care plans) requires the contract to have the clause. But you can’t take the plan’s word that the hold harmless clause is nonnegotiable, warns Florida billing consultant Martin Gotlieb. Plans often draft much more restrictive hold harmless clauses than the law requires. They bar you from billing members at all—even for services not covered by the plan—or allow it only under very limited circumstances.

If you agree to a contract without reviewing the hold harmless clause and comparing it to the law, you may unnecessarily be giving up the right to bill members. The result: You’ll collect much less than you’re entitled to.

How Hold Harmless Clause Can Hurt Physicians

State hold harmless laws typically bar physicians from trying to collect from members what the plans are supposed to pay on members’ behalf, says New Hampshire attorney Robin Fisk. Plans often use the law as an excuse to impose additional restrictions on a physician’s ability to bill and collect fees from members, notes Dr. Robert Barber, head of contract performance management for a North Carolina integrated delivery system.

For instance, some plan contracts say that physicians can’t bill members for any services, even those not covered by the plan, such as copayments, deductibles, or services originally preauthorized but later denied by the plan. Or they draft the clause in such a general way that it confuses physicians into thinking that the clause bars it from billing members at all. “Physicians should always be entitled to bill members for noncovered services, and the contract should be clear about that,” Barber says. Other contracts bar physicians from billing members for the difference between the negotiated contract amount and the physician’s usual and customary charges, even though some states allow physicians to bill for that amount.

Many plans take further advantage of physicians by inserting a hold

(continued on p. 10)
GETTING PAID (continued from p. 9)

harmless clause into a contract in states where it isn’t required. Not all states require plan contracts to have a hold harmless clause. And even in the states that have some sort of hold harmless requirement, it’s usually limited only to HMO members. “The clause may not be required in PPO contracts,” says Barber.

Three Steps to Deal with Problem

To help you avoid unnecessary or overly restrictive hold harmless clauses, take three simple steps.

Step #1: Review the law. Check with your attorney to see if or how your state restricts your right to bill plan members for services. Hold harmless laws vary widely. Some states may apply the hold harmless law even to noncontracted physicians. If you participate in any federally funded managed care program, have your attorney check federal law also.

Step #2: Compare law to contract clause. Compare the law to the hold harmless clause in your contract, looking for discrepancies. You may want to get your attorney’s help to do this.

Step #3: Contact plan about discrepancies. If the contract language matches the law, you’ve got no grounds to argue with the plan about it. But if you discover a discrepancy between the law and the clause, point that out to the plan. Anything not required by law is negotiable, says Barber.

What Plans Negotiate

Usually a plan caught overreaching will back down or compromise with you. Many plans will delete the clause if it’s not required at all.

Plans will also clarify in the contract when you can bill members directly. For instance, they’ll usually add a sentence to the hold harmless clause that says that you can bill members for copayments, deductibles, noncovered services, and claims that the plan retroactively denies, says Gottlieb, who frequently adds such clarifications to contracts he negotiates on behalf of physicians. Here is language he recommends adding to the clause:

Model Contract Language

In no event shall said clause bar, limit, or restrict Physician from billing or collecting from Members’ copayments, deductibles, noncovered services, retroactively denied claims, or any other related charges not otherwise prohibited by law.

If your state law also allows you to bill members for the difference between your negotiated discount and your usual and customary fee, or to bill members if the plan goes bankrupt or insolvent, make sure your contract says that.

If Plan Hesitates

If the plan is hesitant about adding language stating when and how you can bill members directly, try a different approach. Ask the plan to add to the beginning of the hold harmless clause the phrase “to the extent required by law,” suggests Barber. This makes the contract conform to the law, and lets you bill members directly where the law allows you to, he says, regardless of what the rest of the clause says. Just make sure that language elsewhere in the contract doesn’t conflict with your compromise.

Insider Sources

Robert Barber, DHA: Director of Contract Performance Management, Carolinas HealthCare System, PO Box 32861, Charlotte, NC 28232.

Robin Fisk, Esq.: Law Offices of Robin Fisk, 85 Main St., Plymouth, NH 03264.