Insights

Payment Matters: To Collect or Not to Collect?

April 25, 2017

By: Meghan M. Linvill McNab and Thomas N. Hutchinson

A frequent question from physicians is: What do I do if I have a patient who does not pay his or her bill? And for those physicians who are thinking ahead: What can I do to avoid having a patient who does not pay his or her bill? This article briefly addresses strategies physicians may try to utilize for these common scenarios, and whether they are permissible.

Can I require patients to pay up front if I know the patient's deductible will not be met?

Depends on the insurer/payor.

Private Pay: For third-party insurance contracts, your provider contract should be reviewed to determine whether the insurer expressly prohibits such method.

Medicare: Medicare-participating providers are authorized to bill the beneficiaries for deductibles.[1] However, collecting deductibles up front from Medicare recipients may not be a good practice, for the following reasons:

- Unless you are collecting the deductible on January 2, it is very difficult to predict whether a deductible will be applicable, especially as days and months go by. Even though a patient may state that he or she has not seen a doctor since January 1, it is possible that the patient received mail order prescriptions that applied to the deductible before the patient's visit to the physician, and therefore you could improperly collect a deductible.
- Oftentimes a secondary payor or Medicaid will be responsible for the deductible and, these days, a secondary payor may pay the deductible before you even receive Medicare B reimbursement.
- If you incorrectly collect a deductible, this is an over-collection and may be deemed program abuse. Therefore, proper record keeping is necessary to ensure all deductibles are recorded and any improper deductibles are refunded.

- If you incorrectly collect a deductible, it can be costly and timely to go back and determine which deductibles later need refunded. In addition, this may cause confusion for the patients.

When making your decision, you should consider your comfort level of: (1) how accurately you are able to assess whether a person has another payor that will cover the deductible; (2) how accurately you are able to determine whether the individual has otherwise met the deductible at the time of service; and (3) the time, expense, and accountability of issuing refunds for over-collected deductibles.

Medicaid: Indiana regulation states that a Medicaid provider shall not collect from a Medicaid member any portion of the charge for a Medicaid covered service which is not reimbursed by Medicaid except for co-payment and any patient liability payment.[2] Therefore, you can likely collect any applicable deductible but, for the same reasons as described above for Medicare, we recommend proceeding with caution and ensuring you have an adequate record keeping and refund process.

Can I require my insured patient to pay up front and then I submit the claim to insurance?

Depends on the insurer/payer and if in-network versus out-of-network.

Private Pay: If you are not a network provider with the patient's insurance, then you likely can bill the patient up front for the service, and then you or the patient can submit the claim to insurance for payment. If the insurance company pays you directly for the service, you will need to return the appropriate amount of duplicate payment to the patient promptly.

If you are an in-network provider with the patient's insurance, this method may be interpreted as a form of "balance billing," if such practice results in the patient paying beyond any co-payments or co-insurance required by the insurance plan. Balance billing may be prohibited under the provider/insurer contract. Therefore, we do not recommend you require insured patients to pay up front and then submit to insurance. Indeed, for third-party insurance contracts, your provider contract should be reviewed to determine whether the insurer allows such approach.

Medicare: No. Medicare-participating providers cannot charge Medicare beneficiaries for any services for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program, except for deductibles, co-insurance, and services that are not Medicare-covered services.[3] Therefore, you should not collect the entire service charge and then subsequently submit the claim to Medicare and refund the patient.

Medicaid: No. Indiana regulation states that a Medicaid provider shall not collect from a Medicaid member any portion of the charge for a Medicaid-covered service which is not reimbursed by Medicaid except for co-payment and any patient liability payment.[4] Therefore, you should not collect the entire service charge and then subsequently submit the claim to Medicaid and refund the patient.

Can I waive a patient's co-pay?

In limited circumstances.

Physicians should not be in the habit of *routinely* waiving deductibles or co-payments. Any waiver of payment or co-pay should be pursuant to the physician or practice's written indigency policy services.

The Centers for Medicare and Medicaid Services ("CMS") and Office of Inspector General ("OIG") have previously clarified that *hospitals* have discretion to discount or waive the costs of care provided to uninsured patients.[5] However, the guidance appears to require that such discounts and waivers be used in accordance with the *hospital* 's indigency policy, and although the *hospital* has discretion in adopting its indigency policy, the same criteria should apply to Medicare and non-Medicare patients uniformly. Note, although the guidance refers to *hospitals*, as demonstrated in a 2013 OIG Advisory Opinion,[6] the same theory can likely be applied to other providers, such as Community Mental Health Centers (CMHCs), and therefore likely physicians and physician practices.

However, physicians should use caution when discounting or waiving charges for underinsured patients and Medicare[7] and Medicaid patients. When discounting or waiving charges for underinsured patients and Medicare and Medicaid patients, a physician shall strictly comply with the physician or practice's indigency or financial hardship policy and ensure discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program, as issues may arise with the private payer contracts and Fraud and Abuse laws.

If you have any questions, please contact Meghan M. Linvill McNab or Thomas N. Hutchinson.

[1] Medicare Claims Processing Manual (Pub. 100-04) Ch. 1, Sec. 30.1.1.

[2] *See* 405 Ind. Admin. Code 1-1-3(i) and 42 C.F.R. 447.15.

[3] Medicare Claims Processing Manual (Pub. 100-04) Ch. 1, Sec. 30.1.1. *See also* Sec. 30.1.2 which requires providers to promptly refund money incorrectly collected from Medicare beneficiaries. Amounts are considered to have been incorrectly collected "because the provider believed the beneficiary was not entitled to Medicare benefits…." This supports that knowingly billing a Medicare beneficiary for the entire service, in an amount exceeding the deductible or coinsurance, would be improper.

[4] 405 Ind. Admin. Code 1-1-3(i) and 42 C.F.R 447.15.

[5] Letter to American Hospital Association from Tommy Thompson, Secretary of HHS (Feb. 19, 2004) *available at:* http://archive.hhs.gov/news/press/2004pres/20040219.html; CMS FAQ *available at:* https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/faq_uninsured.pdf; OIG Alert *available at:* https://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf.

(6) OIG Advisory Opinion (13-13), *available at*: https://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-13.pdf.

(7) Note of Publication of OIG Special Fraud Alerts (Originally Issued: May 1991, Reissued: Dec. 19, 1994), *see section regarding* Routine Waiver of Part B Co-payments/Deductibles.