

PROFESSIONAL COURTESY: A TRADITION UNDER ATTACK

What is Professional Courtesy?

While the term “profession courtesy” can refer to a wide variety of practices, most commonly, it refers to the provision of free or discounted medical care to medical professionals and / or their families. Notably, the term has also become associated with the practice of waiving coinsurance or other out-of-pocket expenses for certain patients. Over the years, the tradition of providing a “professional courtesy” discount has become deeply ingrained in many physician practices.

Why Provide Professional Courtesy?

There are a number of reasons why a physician might choose to provide medical services for free or at a reduced rate. In some cases, the provision of professional courtesy is meant as a reflection of the close personal and professional relationships that have been built among medical professionals. Some physicians believe that this time-tested practice serves to build professional bonds between physicians. It also provides an incentive for physicians to send members of their immediate family to another physician. A perhaps more compelling reason for waiving or eliminating co-payments is that such a practice can better ensure that economically disadvantaged patients will more readily have access to medical care.

Statutory Problems With Providing Professional Courtesy

As many third-party billing companies will attest, a number of physicians still offer some form of professional courtesy to family members, physicians, the indigent and others. Despite the fact that both Federal and private payors have made it increasingly clear that such conduct could constitute a crime and / or may represent a breach of contract, many providers have continued to extend waivers and discounts to their patients. Such conduct may represent violations of the Federal False Claims Act (FCA).

I. Federal False Claims Act (31 U.S.C. § 3729)

Generally, the FCA provides that anyone who knowingly submits a false or fraudulent claim for payment to the government can be fined \$5,500 to \$11,000 per false claim, plus treble damages.

The federal government has argued that should a physician or other health care provider waive the cost-sharing amount due from a Medicare beneficiary, such an act may constitute the submission of a false claim to the government. Essentially, the government believes that such a waiver results in the “real”



amount of the charges being misstated to Medicare. Since Medicare is only supposed to pay a certain percentage of the allowable amount, it ends up paying more than it should. Notably, this concern has been publicized by HHS-OIG for many years.

As early as 1991, HHS-OIG issued a “Special Fraud Alert” emphasizing that the “routine” waiver of co-payments and / or deductibles is equivalent to misstating the actual charges submitted to Medicare for payment. As a result, such conduct may result in FCA liability. Moreover, should a case proceed to trial where a judgment and finding of liability is made, a provider may be excluded from participation in Federal health care benefits programs.

While fines and penalties under the FCA can be extraordinarily high, the remedies sought are still civil in nature. Depending on the facts, the conduct may constitute a criminal violation of the Federal Anti-Kickback Statute.

II. Federal Anti-Kickback Statute (42 U.S.C. §1320a-7b)

Under the Federal Anti-Kickback Statute, it is a crime to engage in the knowing and willful solicitation, receipt, offer or payment of anything of value in exchange for, or to induce, the referral of business for which payment may be made by Medicare, Medicaid or another Federally-funded health care program.

Violations of the statute can result in fines of up to \$25,000, five years imprisonment or both. Notably, HHS-OIG has specifically warned physicians that the forgiveness of

financial obligations for reasons other than true financial hardship, where inadequate attempts have been made to collect the monies owed may constitute a violation of the Anti-Kickback Statute. Essentially, the government is concerned that unjustified waivers may serve as an inducement for Medicare patients to obtain goods and services from a provider who will not seek to collect the required co-payments, cost-sharing amounts or deductibles.

In assessing cases, it is important to remember that it isn't necessary that a patient be a Medicare beneficiary in order to implicate the Anti-Kickback Statute. For instance, suppose you are approached by a patient seeking care whose parents both qualify for Medicare. Should you waive the non-beneficiary's co-payment in order to induce the patient to refer her Medicare-eligible parents to your practice, the government may allege that you have violated the law. Further, suppose you are approached by a Medicare patient seeking to have a procedure that is not covered by Medicare (e.g. cosmetic surgery).

Should you offer to provide these non-covered services at a discounted rate, the government may seek to determine whether the offer of a discount was an attempt to gain favor with the patient so he / she would be more likely to seek care from you in connection with Medicare-covered services. In large part due to the uncertainties of the law, most providers generally fall into one of two camps. While a significant number of providers continue to permit waivers (often based on traditional "professional courtesy" bases), a second group of providers is extraordinarily reluctant to waive co-payments or cost-sharing amounts, regardless of the circumstances.

HHS Clarifies its Position

In an effort to address growing provider criticism and to dispel unwarranted concerns that all discounts are improper, HHS-OIG issued guidance addressing the views of HHS-OIG regarding (1) discounts provided by hospitals for uninsured patients who cannot afford their bills and (2) the reduction or waiver of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. Although specifically addressing "hospitals" the concepts articulated are generally helpful in assessing how HHS-OIG views these issues.

As the guidance reflects, "No [HHS-OIG] authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills." Rather, as HHS states ". . . Discounts may not be linked in any manner to the generation of business payable by a Federal health care program.

Discounts offered to underinsured patients potentially raise a more significant concern and under the Anti-Kickback Statute hospitals "should exercise care to ensure that such discounts are not tied directly to or indirectly to the furnishing of items or services payable by a Federal health care program." Importantly, HHS-OIG also pointed out that they have "never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients."

While the routine waiver of Medicare co-insurance and deductibles can violate the Federal Anti-Kickback Statute, there are important exceptions to the general prohibition against these waivers. Providers, may forgive a Medicare coinsurance or deductible in consideration of a patient's financial condition.

Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived as long as;

- The waiver is not offered as part of any advertisement or solicitation.
- The party offering the waiver does not routinely waive coinsurance or deductible amounts.
- The party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.

HHS-OIG recognizes that what constitutes a "good faith" determination of "financial need" may vary depending on the each individual's circumstances. Some factors to consider may include:

- The local cost of living.
- A patient's income, assets, and expenses.
- A patient's family size.
- The scope and extent of a patient's medical bills.

In summary, providers do exercise the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nevertheless, it is imperative that providers fully document the steps taken and the processes utilized prior to waivers or discounts any amounts due from patients.

Private Payor Concerns

As a final point, it is important to remember that the waiver of co-payments is likely a breach of a participating provider's contract with the payor. Such conduct could be the basis for a breach of contract claim. Moreover, depending on the facts, this type of conduct could constitute common law fraud or even mail fraud based on the provider's misrepresentation of the true amount of the claim and the payor's financial responsibility.

Should you have questions regarding this AMBA Special Advisory, please feel free to contact:

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The information discussed in this advisory does not constitute legal advice. Readers with questions may contact Liles Parker, PLLC or contact the attorney with whom they normally consult.

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