

HEALTH LAW MONITOR

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No More Dr. Nice Guy Waiving Patient Fees and Co-Pays

You operate a medical, dental, chiropractic, or other clinic providing health care services. For a variety of reasons, you want to occasionally or regularly waive patients' fees or co-pays. Can you do so? As with many questions relating to health care clinic operations, the answer is - yes and no. The answer to the question depends largely on whether the patient is insured, what kind of insurance the patient has, and your purpose in waiving the fee or co-pay.

Patients Insured By Federally Funded Health Care Programs

Federal law prohibits anyone from offering or providing any "remuneration" to a Medicare, Medicaid, or other federally insured patient, if you know that the remuneration is likely to influence the patient to

receive items or services from a particular provider. This law specifically defines "remuneration" as including the waiver of coinsurance and deductible amounts (unless the waiver is made because you've determined in good faith that the patient has a documented financial hardship and is unable to pay.) The feds believe that providers who routinely waive patient co-pays for Medicare patients do so to influence the patient to continue seeing a particular provider - them. That type of waiver would violate federal law and subject the provider to civil monetary penalties.

This law was amended within the last few years to allow providers to give Medicare and other federally insured patients certain incentives (including waiver of co-payments) to promote the delivery of preventive care. To meet this new exception, however, the preventive care must be listed in the current U.S. Preventive Services Task Force's Guide

to Clinical Preventive Services, and the provision of the incentive can't be linked to an attempt to induce the patient to receive non-preventive care from the provider.

Certain types of patient discounts may run afoul of federal anti-kickback prohibitions as well. If a health care provider waives all or part of its fee, and the selection of patients to whom the provider extends this courtesy is determined in a manner which takes into account the patient's (or patient's spouse's or other family member's) ability to refer or generate federal health care program business for the provider, then this practice will violate the federal anti-kickback law. As an example, assume Dr. Smith extends "professional courtesy" to Dr. Jones, and never charges Dr. Jones, Dr. Jones' husband, or any of Dr. Jones' family members a fee for Dr. Smith's services. If he extends this courtesy because Dr. Jones refers a lot of Medicare and Medicaid patients to Dr. Smith, then both Dr. Smith AND Dr. Jones have violated the federal anti-kickback statute, and face up to five years in federal prison and a \$250,000 fine.

In general, clinic providers shouldn't waive patient co-pays for federally insured patients unless the patient has a documented financial hardship that makes them unable to pay. Additionally, providers should never waive fees or co-pays for patients in a position to refer federally insured patients to them.

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Felhaber Larson Fenlon & Vogt

Under The Microscope: Jan D. Halverson, J.D.

Jan D. Halverson, born and raised in Duluth, Minnesota, has been with the Felhaber firm since 1989. A 1973 graduate of the University of Michigan Law School, he joined the firm after serving for several years as the General Counsel for the University of Minnesota Hospital and Clinic here in the Twin Cities.

Jan represents clients in the areas of both health law and labor and employment law. He recently defended a hospital against allegations of racial discrimination, and spent many, many hours representing hospital clients in collective bargaining with the Minnesota Nurses Association earlier this year. He also recently provided legal counsel to a hospital in a disciplinary matter involving a physician. His years of experience as General Counsel at the University of Minnesota Hospital and Clinic, coupled with his earlier experience as an attorney for the National Labor Relations Board, make him well-suited to meeting the legal needs of Felhaber's many health care clients.

Jan is married, and his wife is an attorney for a large, multi-national medical device manufacturer. They have two daughters. Their oldest daughter works as a counselor at PS-97 in Manhattan and their youngest is a junior at New

York University. Thankfully, Jan's daughters remain alive and healthy after the tragic events of September 11.

Jan had an interesting experience soliciting clients early in his career. Not long after graduation from law school, Jan served as a VISTA attorney in Cook County, Illinois. He was assigned to provide legal services to residents of a locked mental health ward at Chicago Reed Hospital in Chicago, IL. Jan arrived on the locked ward, and hollered, "Does anyone want to see a lawyer?" According to Jan, the ensuing scene was like something out of *One Flew Over The Cuckoo's Nest*, and convinced Jan to significantly alter his marketing technique.

Jan's philosophy for the practice of law? Honesty and integrity are the hallmarks of a successful legal career. We at Felhaber are delighted to have Jan both as a partner and a friend!



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This article represents the first in a series showcasing our attorneys who serve health care clients.

NEWS: STAT!

TAP Pharmaceutical Products paid \$875 million to settle criminal and civil health care fraud allegations levied against it by the Department of Justice. The settlement, following allegations that TAP conspired with physicians to overbill federal healthcare programs for Lupron, a cancer drug, is the largest health care fraud settlement in the United States to date. The case represents a continuation of the U.S. government's heightened scrutiny of relationships between pharmaceutical manufacturers and physicians.

The Office of Inspector General released its Fiscal Year 2002 work plan in October 2001. To review this document summarizing the OIG's coming investigative and audit initiatives, go to http://www.hhs.gov/oig/wrkpln/2002/Work_Plan_2002.htm.

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Patients With Private Insurance

What about patients with private insurance? Can a clinic provider waive fees or co-pays for them?

Generally, yes - as long as the patient's insurance carrier knows that the provider is waiving the fee or co-pay, and agrees with the practice.

Here's why. Most insurance carriers will object to so-called "insurance only" billing, where a provider bills the insurance carrier for a service, but then doesn't collect the required co-payment from the patient. Most private insurance carriers pay a certain percentage of the amount billed by the provider (generally around 80%), and expect the patient to pay the provider the remainder as a copayment. If the provider waives the co-pay and does not tell the private insurance carrier that the co-pay was waived, the insurance carrier may rightfully claim that it has been defrauded. For example, if a doctor submits a bill for \$100 to a carrier with a policy requiring the carrier to pay 80%, the carrier will pay \$80, expecting that the doctor will bill the patient for the remaining \$20. If the doctor doesn't collect the co-pay from the patient, however, the carrier will probably take the position that the doctor's total charge was actually \$80, and not \$100. Then, under the terms of the policy, the carrier would only be required to pay 80% of \$80, or \$64. If the doctor didn't tell the carrier that it waived the co-pay, the carrier could easily take the position that it had been defrauded out of \$16.

Once again, providers can certainly waive co-pays where the privately insured patient has a documented financial hardship and cannot pay.

Finally, some health care clinics are self-insured, and contract with insurance companies solely to provide claims administration services. These clinics can provide their own employees with health care services and, as an employee benefit, waive

any out-of-pocket financial responsibility the employees would otherwise have for those services.

Patient Discounts and Medicare and Medicaid Charges

Although the federal government doesn't directly regulate what a provider can charge its private pay patients, it can and does regulate what charges may be submitted to Medicare and Medicaid. These regulations do impact, to some extent, what charges a provider may make to its private pay patients.

One federal law says that a provider may be excluded from participation in Medicare and Medicaid if the provider submits charges for items or services furnished that are "substantially in excess" of the provider's "usual charge". In order to determine a provider's usual, or customary, charge, Medicare arrays each charge the provider has made for a service in a particular year in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charged data is then selected as the provider's customary charge for the service. A provider can certainly charge a private pay patient less than what it charges Medicare for the same service. Grounds for exclusion will arise, however, if most of the charges the provider makes to patients or payers other than Medicare are less than what the provider charges to Medicare. The Office of Inspector General reiterated in April of 2000 that providers don't have to worry about the possibility of exclusion unless it is discounting close to half of its non-Medicare/Medicaid business.

The Minnesota Medical Assistance (Medicaid) program has similar charge restrictions. Minnesota Medicaid regulations state that a provider must bill its "usual and customary" fee for services rendered. A "usual and customary" fee for a service is the charge of the provider to the type of payer that constitutes the largest share of the provider's business. Under these regulations, if private pay patients constitute the

largest share of a clinic's business, and the clinic elects to offer discounted fees to all of its private pay patients, then it must extend the same discount to Medicaid.

Therefore, clinics should be careful not to be TOO generous in agreeing to waive patient fees or co-pays. If the percentage of patients who receive waivers climbs too high, it could affect the legal amount the clinic can charge Medicare and Medicaid for the same services.

Discounts and "Most Favored Nations" Clauses

Finally, clinics should be aware of charge restrictions that might be included in the clinics' contracts with insurance carriers. Some insurers have contract clauses requiring providers to charge them no more than what they charge any other payer. Although these contract clauses typically are limited to charges made to other insurance carriers, clinics should carefully review contract language to see if any clauses require the clinic to charge the insurer no more than what the clinic charges anybody else. If a clinic routinely waives co-pays or charges for patients, it may be required under the terms of these types of contracts to extend the same discounts to the insurance carrier.

So, no more Dr. Nice Guy?

So, have we seen the end of Dr. Nice Guy? No. Clinics can still occasionally waive fees and co-pays as long as they comply with the rules summarized above. Just make sure that you do it with the right patients, the right insurers, and for the right reasons.



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When Is A Nurse A Supervisor?

The U.S. Supreme Court decided a case on May 29, 2001 which helps define when some employees will be viewed as supervisors for purposes of enforcing the National Labor Relations Act.

Kentucky River Community Care, Inc. in Pippa Passes, Kentucky, operated a care facility for residents who suffered from mental retardation and mental illness. The facility employed approximately 110 professional and nonprofessional employees. Included in that group of employees were six registered nurses.

In 1997, a labor union petitioned the National Labor Relations Board (the "NLRB") to represent a single bargaining unit of all 110 potentially eligible employees at Kentucky River. Kentucky River objected to inclusion of the six registered nurses in the bargaining unit, arguing that they were "supervisors" under the National Labor Relations Act (the "NLRA"), and therefore excluded from the class of employees subject to the Act's protection. The NLRB disagreed, and the case began winding its way up through the federal court system.

The United States Supreme Court reviewed the actions of the NLRB and, in a decision released May 29, 2001, found that the Kentucky River registered nurses were supervisors, despite the fact that none of them had traditional "hiring" or "firing" authority over others.

How can a nurse be a "supervisor" if she can't hire, fire, promote or discipline employees? The answer is found in the broad definition of the term "supervisor" found in the National Labor Relations Act:

The term 'supervisor' means any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

Here, the registered nurses provided care to Kentucky River residents along with other care providers, including nursing assistants. Although the registered nurses weren't so-called "direct line" supervisors of the nursing assistants, they did provide direction to them on how to render care to facility residents. The Supreme Court determined that this direction required the registered nurses to use "independent judgment", and therefore the nurses fell within the statutory definition of "supervisors".

The NLRB asked the Supreme Court to carve out an exception from this broad definition, and determine that the nurses didn't use "independent judgment" when they simply exercised ordinary "professional or technical judgment" in directing less-skilled employees (the nursing

assistants) to deliver services in accordance with standards specified by Kentucky River. Essentially, the NLRB believed that the registered nurses shouldn't meet the statutory definition of a "supervisor" if they were simply providing resident care instructions to the nursing assistants based on the professional and technical training and judgment the nurses obtained in nursing school and beyond.

The Supreme Court found, however, that there was no basis in the NLRA at all to restrict the definition of "independent judgment" to exclude professional or technical judgment. Indeed, the Court determined, if you applied this proposed exception to every possible exercise of a supervisory function (such as decisions to hire, fire, promote or discipline an employee), it would virtually eliminate "supervisors" from the NLRA.

The Court noted that Congress certainly intended to include professional employees within the broad category of employees covered by the NLRA, and that many professional employees (such as lawyers, doctors and nurses) customarily give judgment-based direction to less-skilled employees with whom they work. The Court suggested that the NLRB could in the future offer a limiting interpretation of who qualifies as a "supervisor" by virtue of exercising independent judgment in the direction of others, by distinguishing employees who direct the manner of others' performance of discrete tasks from employees who direct other employees. However, in the Kentucky River case, the Court was limited to responding to the NLRB's broad contention that the NLRA categorically excludes professional judgments from the term "independent judgment". Finding absolutely no justification in the Act itself for this conclusion, the Supreme Court found for Kentucky River.

Unless and until the NLRB narrows its interpretation of who qualifies as a "supervisor", or Congress changes the definition of a "supervisor" found in the NLRA, this decision can and will affect who is a proper member of a bargaining unit.



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NEWS: STAT! ■ *Continued from page 2*

KPMG Peat Marwick, LLP agreed to pay the government \$9 million to settle allegations that it defrauded federal health care programs by preparing false hospital cost reports for HCA, Inc. At issue was the preparation of "reserve" cost reports to estimate the potential impact on hospital reimbursement if federal auditors detected certain non-allowable expenses in the filed reports.

The Centers for Medicare and Medicaid Services (formerly HCFA) announced three national coverage decisions on October 19, 2001. Medicare and Medicaid will now cover:

1. Ocular photodynamic therapy with verteporfin for the treatment of age-related macular degeneration
2. Ambulatory blood pressure monitoring for patients with suspected "white coat" hypertension (blood pressure increases triggered by being in a doctor's office)
3. Twice a year foot exams for patients with diabetic peripheral neuropathy with loss of protective sensation

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The *Health Law Monitor* is a report on legal developments. It is not intended to be legal advice and should not be relied on without consulting counsel.

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