

DEDUCTIBLES, COST-SHARING AND ROUTINE WAIVERS

CCM, PFS CPT Code 99490, is subject to patient deductibles and cost-sharing. Must providers charge and collect the patient co-pay for CCM? How much does the provider actually receive?

The Short Answer and Dulcian Recommendations: Providers must collect or demonstrate that they tried to collect. After deductibles are met, for 2015, a successful claim will gross \$32 from the insurer and \$8 from the patient, totaling \$40+ national average, per patient per month, in any calendar month that services are delivered and other requirements of CCM are met. This has the potential to produce, on average up to \$200,000 additional annual revenue for your practice, but you must collect the patient's share of the scheduled reimbursement.

Prior to and including 2015, routine waivers of Medicare deductibles and copayments are prohibited under Federal law. Any waiver policy must be consistently applied across all insured patients of your practice and waivers should be based on justifiable standards with ample documentation of each patient's financial circumstance. See details Page 2.

Dulcian advises providers to follow HHS CMS 2014 Guidance of the Medicare Enrollment and Claims Submission Guidelines (ICN 906764), section titled "DEDUCTIBLES, COINSURANCE, and COPAYMENTS". See details Pages 3 of this paper.

"If a beneficiary is unable to pay these charges (deductibles or co-pays), he or she should:

- Sign a waiver that explains a financial hardship.
- If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off.
- The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries.
- Constantly waiving deductibles, coinsurance, and copayments may be interpreted as abuse.
- On assigned claims, the beneficiary is responsible for:
 - Unmet deductibles;
 - Applicable coinsurance and copayments; and
 - Charges for services and supplies that are not covered under the Medicare Program."

Dulcian recommends documenting billing and collection efforts, documenting practice policy and applying policies across patients of all insurers. Document each patient's file completely if waivers are granted.

For providers, collection of patient co-pays is required by Law and is an audit target "risk" area for payers. Advise your patients to verify expectations with their carriers.

The Discussion: The rules, providers' sincerest intentions and patients' perceptions.

If the qualifying patient hasn't reached the deductible and no supplementary plan is in place, the patient would pay the full reimbursement rate under the Fee Schedule until their deductible is met. In this case, 2015 Medicare patients would pay the full reimbursement rate national average of \$40.39 per patient, per month, when all CCM requirements are met.

Eligible patients meet the criteria for CCM, so perhaps we can assume their Medicare deductible of \$147 for 2015 is met due to face-to-face visits during the month in which the billable minimum threshold for non-face-to-face services is reached. In this case, the allowed reimbursement rate is subject to cost-sharing, better known as the patient's co-pay. Based on the average reimbursement of \$40.39, each month in which qualifying services are provided per patient, Medicare would pay you \$32.31 directly and you must bill and collect the patient co-pay, \$8.08 from the patient or supplementary insurance where applicable.

The Final Rule specifically states that cost-sharing applies to the new CPT Code 99940, CCM.

Commenters were concerned that the \$8 estimated coinsurance amount proposed would hinder beneficiary access. Several commenters believed that CCM is a preventive service that should be exempt from beneficiary cost-sharing.

CMS response and the Final Rule is clear. CCM services do not fall into any of the statutory preventive services benefits that are exempt from cost-sharing categories of the Act. The Rule states specifically that CMS is not empowered to exempt this code from cost-sharing. (42 CFR Parts...410, et.al; Vol. 79 page 67718 / Thursday, November 13, 2014 / Rules and Regulations)

This aspect is a large part of the reasoning, discussed in the Rule, to require patient consent prior to the delivery of CCM services. The Rule requires obtaining a signed "Consent" agreement and proving it by recording its existence, effective date and revocation date in your CERT! This agreement must contain information about the cost-sharing aspect of the service and they (CMS) suggest "Practitioners should explain that a likely benefit of agreeing to receive CCM services is that although cost-sharing applies to these services, CCM services may help them (patients) avoid the need for more costly face-to-face services that entail greater cost-sharing." (42 CFR Parts...410, et.al; Vol. 79 page 67718 / Thursday, November 13, 2014 / Rules and Regulations)

Patients may ask providers not to charge the co-pay and you may want to accommodate them. These are our most ill patients with diseases of severe complexity and they may want to have face-to-face care if they are going to make the sacrifice to pay \$8.00 per calendar month. After all, they realize you, their trusted partner PCP and clinical staff, are already performing most of these services and it doesn't cost them extra money.

The practice reimbursement just may not be a concern of these beneficiaries. They know that if the practice is doing a good job for them, these services are performed anyway. Easing your practice overhead may not be on the minds of your most severely ill patients. They think that the doctor is doing "OK" and that may be true.

Your practice may be faced with patients who need the care, access and services that CCM provides, but who may not elect the service because they lack financial ability to pay or they want to save the co-pay money for "in office" visits. There may be cases where you don't want to subject your patients to this extra out of pocket cost because the patient needs the care and you will be happy with your 80% reimbursement share. Something is better than nothing!

This gives rise to the question: Must providers charge and collect the co-pay for CCM?

The short answer is **YES**. You must make an earnest effort to bill and try to collect. Despite your most sincere intentions, the penalties to routinely waive cost-sharing are harsh and could be ruled a felony under Anti-Kickback law. As of 2015, OIG provides no Safe Harbor for this under applicable law.

The Anti-Kickback Statute (AKS) prohibits the practice of routine waivers of Medicare deductibles and co-pays.

"Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly..., in cash or in kind, to any person to induce such person to refer an individual [for] any item or service for which payment may be made ... under a Federal health care program, ... shall be guilty of a felony." 42 U.S.C. § 1320a-7b(b). There is a safe harbor under the AKS for discounts (i.e, a discount that fits within the regulatory definition is not illegal "remuneration." Routine reductions or waivers of coinsurance or deductibles, however, are specifically excluded from the definition of discount (42 CFR 1001.952(h)(5)(iv).¹

The Civil Monetary Penalties law also bars the practice as illegal remuneration (42 USC 1320a-7a(a)(5); "remuneration" includes waivers of copays and deductibles" (42 USC 1320a-7a(i)). The only exception to the rule is where (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the person does not routinely waive coinsurance or deductible amounts; and (iii) the person (I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or (II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts.(42 USC 1320a-7a(i).¹

“Medicare law frowns on the routine waiver of copayments and coinsurance. Forgiving this amount for some patients, for some services, or even by one provider for all patients, for all services, constitutes an improper “inducement” to patients to obtain the services in question from that provider.”¹

Under August 2014 HHS CMS Medicare Enrollment and Claims Submission Guidelines (ICN 906764)
“DEDUCTIBLES, COINSURANCE, AND COPAYMENTS”:

“You must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year.

Under FFS Medicare and Medicare Advantage Private Fee-For-Service Plans, coinsurance is a percentage of covered charges that the beneficiary may pay after he or she has met the applicable deductible. You should determine whether the beneficiary has supplemental insurance that will pay for the deductible and coinsurance before billing him or her for them. In some Medicare health plans, a copayment is the amount that the beneficiary pays for each medical service.

If a beneficiary is unable to pay these charges, he or she should:

- Sign a waiver that explains a financial hardship.
- If a waiver is not signed, the beneficiary’s medical record should reflect normal and reasonable attempts to collect the charges before they are written off.
- The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries.
- Constantly waiving deductibles, coinsurance, and copayments may be interpreted as abuse.
- On assigned claims, the beneficiary is responsible for:
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As a practical matter, a large proportion of Medicare beneficiaries have secondary insurance, and in practice, a low percentage of beneficiaries fail to pay their coinsurance obligations.

In June 1993, the AMA issued “Opinion 6.12” under Medical Ethics Resources titled “Forgiveness or Waiver of Insurance Copayments”. This opinion to Providers refers to the inclination to forgive the copays and consequences under the law. (See www.ama-assn.org)

“Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer’s payment but waive the copayment for all patients.....

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver.

Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.”

References:

¹ Comment and Legal citations provided by attorney David Harlow in professional correspondence June-July 2015.

42 CFR Parts...410, et.al; Vol. 79 page 67718 /Nov 2014 / Rules and Regulations.....Revisions to Part B for CY 2015; Final Rule

OIG Federal Anti-Kickback Statute; 42 U.S.C. § 1320a-7b(b); (42 CFR 1001.952(h)(5)(iv); (42 USC 1320a-7a(a)(5); (42 USC 1320a-7a(i)

Medicare General Information, Eligibility, and Entitlement Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations (Rev. 89, 11-21-14)

.20.2 - Deductibles

.20.3 - Part B Coinsurance (Rev. 1, 09-11-02)

AMA June 1993 "Opinion 6.12" Medical Ethics Resources "Forgiveness or Waiver of Insurance Copayments".

August 2014 HHS CMS Medicare Enrollment and Claims Submission Guidelines (ICN 906764)
"DEDUCTIBLES, COINSURANCE, AND COPAYMENTS"