

"Usual Charges" for Medicare Patients: OIG Proposed Rule

NOTE: Because of significant interest on the part of hospices, this article is being reprinted. Over two years since the article was written, the OIG proposed rule is "still in the deliberative process."

The Office of the Inspector General has proposed a rule that could have a significant impact on hospices contracting with HMOs and other insurers or offering care to uninsured patients at discounted rates, except when based on financial need. Under this proposed rule, hospices and other providers would be prohibited from charging Medicare patients more than 120% of the charges that the same provider charges for the same service to private pay patients, to patients who are on insurance plans for which the provider is not a "participating provider" and for fee for service rates offered to enrollees of managed care plans. The deadline for comments on this proposed rule was November 14, 2003. While it is expected that there will be changes to the proposed rule, this is a very important signal to hospices and other providers that the government disfavors providing services to patients who are either private pay or covered under commercial insurance unless fees are in line with Medicare rates.

In fact, section 1128(b)(6)(A) of the Social Security Act and the implementing OIG regulations set forth at 42 C.F.R. § 1001.701(a)(1) provide that the OIG may exclude an individual entity that has "[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs containing charges or costs for items or services furnished that are substantially in excess of such individual's or entity's usual charge or costs for such items or services."

Many hospices never charge patients. While caring for patients "regardless of ability to pay" is part of most hospices' missions, never charging, even when patients are financially able to pay, poses a significant risk to the hospice from the standpoint of federal fraud and abuse, as well as state fraud laws. If the hospice never charges a patient, regardless of ability to pay, and likewise provides deep discounts when commercial insurance is involved, the hospice runs the risk of allegations that the "usual and customary charge" is really far less than the Medicare rate. Hospices often express concern that it is difficult to obtain payment from commercial carriers and HMOs. Often, contracts are set far lower

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than Medicare and/or the hospice accepts payment for only the "medical" services such as nursing and CNA visits. Not only do these practices present the risk of fraud allegations; they also imperil the financial solidity of the hospice. In addition to Medicare and Medicaid considerations, donors have the right to expect that a hospice will charge fairly for its services. Hospices are advised to implement a sliding scale system so that no patient is turned away for a lack of ability to pay.

The proposed rule makes it acceptable to charge Medicare patients more if it can be demonstrated that Medicare patients have more medical need or if it can be demonstrated that it costs more to comply with Medicare regulations. However, the burden of proof is on providers to demonstrate either of these exceptions. For now, it is prudent to review private pay and commercial insurance/HMO billing procedures to ensure that charges are similar for similar services and that any discounts are related to differentials in care, administrative costs or ability to pay.

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