

# G2 Compliance Report



For Hospitals, Laboratories and Physician Practices

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## COMPLIANCE PERSPECTIVES



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### Labs Beware: Business and Legal Challenge Presented By Out-of-Network Billing

Managing out-of-network status is one of the many challenges facing health care providers, including independent laboratories. Out-of-network status can present even greater complications for laboratories than for most other types of providers because the patient's treating physician, rather than the patient, typically chooses the laboratory that performs the testing ordered for the patient. Even though the patient did not make a conscious decision to utilize a particular laboratory, the patient may experience financial consequences if the laboratory is not in-network.

In such situations, the patient often does not understand why money is owed to the out-of-network laboratory and may become upset with the laboratory and the treating physician upon learning the reason for the charges. Laboratories understandably wonder what steps they can take to avoid this situation while limiting legal and business risks.

Even though government enforcement activity in this area is rare, this issue takes on new importance in light of the increasingly aggressive steps being taken by private insurers to ensure that members use in-network providers and to limit the amounts paid to out-of-network providers. Private insurers want to discourage the use of out-of-network laboratories because the negotiated rates paid to in-network laboratories often are lower than the amounts paid to out-of-network laboratories.

To incentivize patients to stay in-network, private insurers impose financial consequences on patients who use out-of-network laboratories, and such insurers expect those laboratories to collect copayments, coinsurance, deductibles, and other amounts owed by patients for their services.

Actions being taken by private insurers to protect their networks include but are not limited to (1) threatening to revoke the in-network status of physicians who order from out-of-network laboratories, (2) disregarding the assignment of payment by patients to out-of-network laboratories and then paying patients directly, and (3) capping out-of-network benefits payable to patients.

Another timely example is a new Blue Cross and Blue Shield (BCBS) Association policy that changes how regional BCBS plans reimburse for laboratory testing performed for patients who access services outside their home state or region.<sup>1</sup> Before implementation of this policy, a laboratory could contract with and bill the local BCBS plan in its region for services rendered to patients covered by other BCBS plans.<sup>2</sup> The local BCBS plan would then determine reimbursement at the in-network rate.<sup>3</sup>

<sup>1</sup> *New BlueCard Policies Affect Lab Test Claims*, The Dark Report, Jul. 16, 2012, at 3.

<sup>2</sup> *Id.* at 5.

<sup>3</sup> *Id.*

Under the new policy, a laboratory must bill the BCBS plan where the specimen was drawn, and that plan will reimburse the laboratory at the out-of-network rate unless the laboratory is in-network with that plan.<sup>4</sup> The BCBS Association's change in policy undoubtedly will result in many patients being billed for out-of-network services for the first time.

In addition, some private insurers have recently initiated litigation against out-of-network providers based in part on allegations regarding unconscionable out-of-network charges and the routine waiver of amounts owed by patients. For example, in February 2012, Aetna Life Insurance Co. filed a lawsuit in California state court against several ambulatory surgery centers (ASCs) claiming in part that the ASCs induced Aetna's members to utilize their services by waiving coinsurance, deductibles, and other amounts owed (cost-sharing amounts).<sup>5</sup>

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According to Aetna, because the ASCs did not intend to collect the patients' cost-sharing amounts—which are part of the aggregate charges billed to Aetna—the ASCs inflated their charges on claims submitted to Aetna and thus violated California's insurance fraud statute,<sup>6</sup> its prohibition on unfair competition,<sup>7</sup> and other California laws.<sup>8</sup> Aetna also contended that the ASCs' out-of-network billing practices amounted to tortious interference with Aetna's member and provider contracts.<sup>9</sup> United Healthcare Services Inc. filed a similar complaint in the same court a few months later.<sup>10</sup>

Given these activities, laboratories should carefully consider legal risks when formulating an out-of-network billing strategy. Discounting or waiving cost-sharing amounts owed by private-pay patients could implicate certain state laws. While a small number of states have enacted specific prohibitions against a provider's waiver of all or part of cost-sharing amounts owed by patients, most states have not expressly addressed the issue. A few highlights of relevant state laws are discussed below.<sup>11</sup>

### Insurance Fraud

As demonstrated by the cases filed by Aetna and United, waiving all or part of cost-sharing amounts could give rise to claims under state insurance fraud statutes. Virtually all states have an insurance fraud statute, and, generally, these laws prohibit the presentation of a false or fraudulent claim for payment under an insurance policy. Some state insurance fraud statutes allow only the Attorney General's Office or another state agency to enforce the law, while others permit private parties (which could include private insurers, competitors, or others) to bring suit.

<sup>4</sup> *Id.*

<sup>5</sup> *Complaint, Aetna Life Insurance Company v. Bay Area Surgical Management, LLC, et al.* (Cal. Super. Ct. of Santa Clara County, filed Feb. 2, 2012, No. 112CV217943).

<sup>6</sup> Cal. Penal Code § 550(a)(6). California's insurance fraud statute prohibits the knowing submission of any false or fraudulent claim for payment of a health care benefit.

<sup>7</sup> Cal. Bus. & Prof. Code § 17200 et seq. Under this law, "unfair competition" includes any unlawful, unfair, or fraudulent business act or practice and unfair, deceptive, untrue, or misleading advertising.

<sup>8</sup> *Complaint, Aetna Life Insurance Company v. Bay Area Surgical Management, LLC, et al.* (Cal. Super. Ct. of Santa Clara County, filed Feb. 2, 2012, No. 112CV217943, at 15-16).

<sup>9</sup> *Id.* at 24-25.

<sup>10</sup> *Complaint, United Healthcare Services, Inc. v. Bay Area Surgical Management, LLC, et al.* (Cal. Super. Ct. of Santa Clara County, filed Jun. 18, 2012, No. 112CV226686).

<sup>11</sup> This article does not address all possible state laws implicated by waiving all or part of cost-sharing amounts owed by patients, or all theories that could be alleged under the laws highlighted. In addition, potential implications under federal law are beyond the scope of this discussion.

Regardless, the theory in such cases is typically that because a laboratory routinely waived cost-sharing amounts and never intended to collect the full charge for services provided, the laboratory filed false or fraudulent claims because the charges stated on the claims do not represent the actual charges for the services.

For example, if a laboratory's charge for a service is \$100, and it routinely waives the patient's out-of-network coinsurance obligation of 20 percent (or \$20), the enforcing party could argue that the laboratory's charge for the service is actually \$80 because the laboratory never intended to collect the full \$100 charge.

To mitigate risk, a laboratory should consider disclosing its out-of-network billing practices to private insurers. If the laboratory makes such a disclosure, the enforcing party may have difficulty demonstrating that the laboratory intended to commit fraud.

Florida is one state that specifically addresses waiver of amounts owed by patients. Florida's insurance fraud statute prohibits any service provider, other than a hospital, from billing amounts as the provider's usual and customary charge if the provider has agreed with the insured or intends to waive deductibles or copayments, or if the provider does not intend to collect the total amount of the

usual and customary charge.<sup>12</sup> In determining whether a violation has occurred, the statute allows consideration of evidence of whether the service provider has made a good-faith attempt to collect the deductible or copayment.<sup>13</sup>

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#### Patient Inducement

A laboratory's waiver of all or part of cost-sharing amounts could also give rise to claims of patient inducement. Unlike the federal government—which prohibits giving something of value (including the waiver of copayments, coinsurance, or deductibles) to induce a Medicaid or Medicare beneficiary to use a particular provider<sup>14</sup>—most states do not have a specific ban on such conduct. However, some states do have an anti-kickback statute that could be read broadly to extend to patient inducement.

#### Physician Inducement

All laboratories accepting specimens from New York must hold a license issued by the New York State Department of Health (NYS DOH) and should therefore take notice of a New York state regulation establishing that a laboratory's routine waiver of copayments, coinsurance, or deductibles for services performed for patients of a referring "health services purveyor"<sup>15</sup> is deemed consideration given for the referral of specimens and is therefore prohibited.<sup>16</sup>

In addition, the New York regulation prohibits the waiver of fees owed by health maintenance organization (HMO) patients to an out-of-network laboratory where such waiver results in consideration being received by the referring health services purveyor.<sup>17</sup> The regulation does, however, permit a clinical laboratory to waive copayments, coinsurance, deductibles, or fees if the patient cannot afford to pay, or if the cost of collection is greater than the amount owed.<sup>18</sup>

<sup>12</sup> Fla. Stat. Ann. § 817.234(7)(a).

<sup>13</sup> *Id.*

<sup>14</sup> 42 U.S.C. 1320a-7a(a)(5).

<sup>15</sup> A health services purveyor includes any entity that provides health-related services. N.Y. Comp. Codes R. & Regs. tit. 10, § 34-2.2.

<sup>16</sup> N.Y. Comp. Codes R. & Regs. tit. 10, § 34-2.12.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

In a 2010 advisory letter to licensed laboratories, the NYS DOH noted a “troubling increase in the number of complaints alleging laboratories are offering inducements” and reminded laboratories that the routine waiver of copayments, deductibles, or coinsurance amounts that would otherwise be out-of-pocket expenses for patients and their families is prohibited.<sup>19</sup> The letter noted, however, that “laboratories must engage in balance billing to the extent costs of collection do not exceed the amount to be collected, the patient is not medically indigent, and the patient is not a member of an HMO.”<sup>20</sup>

The NYS DOH expects laboratories to train their sales representatives on these requirements, to document this training, and to monitor communications between sales representatives and new accounts.<sup>21</sup> Licensed laboratories should take steps to ensure compliance with this regulation because the NYS DOH does engage in enforcement activities, particularly when it receives competitor complaints.

### Recommendations

The state laws discussed above represent only a few examples of statutes that laboratories should take into account when formulating an out-of-network billing strategy. If a laboratory waives all or part of cost-sharing amounts owed by patients who are financially needy or medically indigent, or offers discounts to patients for prompt payment, it should document and closely follow those policies, implement eligibility standards that are consistent with industry standards, and keep eligibility documentation and proof of attempts to collect on file. Any laboratory that decides to waive all or part of cost-sharing amounts owed by other out-of-network patients should consider applicable legal and business risks and implement compliance safeguards, such as disclosure to private insurers.

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<sup>19</sup> Letter from the Betty Kusel, director, regulatory affairs program, the New York State Department of Health to Regulated Laboratories (May 11, 2010).

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

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