

Risk Management Issues of Fee Adjustments and Sliding Fee Scales

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The following article is for informational purposes and should not be construed as constituting legal advice. A psychologist concerned about the use of fee adjustments and sliding fee scales is advised to consult with an attorney familiar with the psychological practice and fee arrangements.

Many psychologists are concerned about the legal, ethical and risk management issues involved in fee adjustments and the use of sliding fee scales. This is a simple question, but unfortunately the answer is complicated and unclear.

To understand the reasons for this, we have to look back in history to the late 1970's when psychology, through passage of freedom of choice and mandated mental health benefits legislation, first entered the insurance reimbursement system. At that time almost all insurers were indemnity insurance companies. Fees were based on the "usual and customary" system that had been developed by Blue Cross/Blue Shield (which was, one should remember, a physician-created reimbursement system). Under that system a provider was paid the lowest of what they charged for a particular session or their usual and customary (average) fee. In order to work, this system depended on the honesty of providers. When a health care provider purposely distorted the information he or she sent to the insurance company in order to maximize reimbursement, he or she could be prosecuted for insurance fraud.

The mental health benefit at that time was limited; the most common model for delivering psychotherapy was generally long term psychodynamic therapy, frequently lasting in excess of 52 sessions per year. Under this model many patients exhausted their insurance benefit prior to the end of the year but wanted their treatment to continue. Since many of the psychologists in private practice were veterans of the community mental health system, they were accustomed to using sliding fee scales to help those who could not afford to pay full fee for the services they received. This was consistent with the philosophy and ethics of psychology, whose ethics code was patient-centered and at that time even mandated a certain percentage of services be provided on a pro bono basis.

What is Considered Fraud?

According to the law, fraud is the intentional misrepresentation of fact with intent to deceive. In order to qualify as fraud, the psychologist must know that his or her statement (i.e., fee) is false and the victim must rely on the information and be damaged financially

by that reliance. Fraud can be prosecuted criminally or it can be addressed civilly in a suit for damages. In criminal fraud cases, all of the elements of the crime must be proven beyond a reasonable doubt. However, in civil cases, the elements are proven by a preponderance of the evidence (generally thought to be 51%). In civil cases, the standard is that the person making the statement must know, or should know, with reasonable prudence, that the statement is false. The majority of fraud cases reviewed involved clearly intentional schemes.

For example, a provider might bill an insurance company \$150.00 per session, but actually charge his or her patients less if the insurance company had a 25% co-payment or when the insurance benefits were exhausted. When the insurance no longer supported the full fee, the provider might adjust the charges to \$100 and forgo the co-payment to the client.

Fee adjustments were quite common during the early days. As long as the benefit was not exhausted, the provider would bill the full fee to the insurance company. Once exhausted, however, the fee could be adjusted downward so the patient could remain in treatment. Many health care providers felt that such manipulations of insurance reimbursement were in the best interest of getting needed services to their patients. They often felt strongly that helping people secure affordable mental health care created a higher ethical responsibility than abiding by rules of insurance companies. The chances of discovery were very small and therefore the risk level of these kinds of arrangements was considered worthwhile. Many health care providers argued that their patients expected this kind of arrangement based on past professional relationships with other health care providers. There were very few instances where providers suffered severe repercussions as a result of fee adjustments, although there were a number of cases in which patients, angry about some other dispute with the provider, filed a complaint with the authorities and these practices were discovered. However, usually the only consequence was recoupment of fees.

When this issue began to be discussed in various publications and in conferences, some individuals took the position that any fee or co-payment adjustment was potentially dangerous and arguably unethical. Others took the position that fee adjustments were permissible as long as they were based on a real assessment of financial necessity and were not done so frequently as to constitute a pattern. The major insurers, including Blue Cross/Blue Shield and several major managed care players, basically agreed with this policy. However, it was difficult to assess how many fee adjustments constituted a pattern. One suggestion was that a provider should set his or her fees in a manner so that 85-90% of patients could afford to pay it without insurance reimbursement.

With the passage of time and as managed insurance benefits took over from the “usual and customary” system, the issue of fee adjustments became more obscure. Managed care companies that paid a fixed fee per unit of service, regardless of provider charges, could

hardly object to private fee arrangements when insurance benefits were exhausted or services were deemed not medically necessary. Further, insurance company benefit packages became so complicated that it was hard to distinguish a modified “usual and customary” from a fixed fee system. Historically, fee adjustments have very rarely created disciplinary or financial recoupment problems for practitioners who are reasonable about their utilization.

Psychologists’ successful efforts to secure inclusion in the Medicare system as independent providers raised the issue of fee adjustments in a different guise. The question was—could the provider adjust patient “co-payments” to account for financial need? Many years ago a major Rand study (Robert H. Brook, John E. Ware, William H. Rogers, Emmett, B. Keeler, Allyson Ross Davies, Cathy Donald Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patti Camp, and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment*. Santa Monica, Calif.: RAND Corporation, R-3055-HHS, December 1984.) demonstrated an almost one-to-one correlation between co-payments and reduced utilization; Medicare, as well as private insurers and managed care companies have adopted the co-payment strategy to control costs. Medicare has been very clear that it considers routine adjustment of co-payments to constitute fraud or abuse and has proceeded aggressively against individuals it feels are engaging in this practice. This has been a particular problem for psychologists due to the disparity between the Part B 50% co-pay for mental health services compared to 20% for Part B medical services (fortunately, legislation passed in 2008 corrected that inequity although it will take 6 years to fully implement the equalization). Since many Medicare recipients have limited resources without a supplemental policy, 50% co-pays were difficult to afford. This was particularly true for those who qualified for Medicare benefits under Social Security Disability Insurance.

Medicare policy regarding fee adjustments is clearly stated; however, it does not provide clear guidance to practitioners about how the rules are implemented. This is particularly problematic given the aggressive audit policy that Medicare is currently pursuing. Here is how the Center for Medicare Services discusses the problem (retrieved from www.wpsmedicare.com):

A provider, practitioner, or supplier who routinely waives Medicare co-payments or deductibles for the majority of Medicare patients may be misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is \$100, but routinely waives the co-payment, the actual charge is \$80. Medicare should be paying 80 percent of \$80 (\$64), rather than 80 percent of \$100 (\$80). As a result of the supplier's misrepresentation, the Medicare program is paying \$16 more than it should be on this item.

One important exception to the prohibition against waiving co-payments and deductibles is that providers, practitioners, or suppliers may forgive the co-payment in consideration of a particular patient's financial hardship. The hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and co-payments must be made.

Mental Health Parity legislation, the reduction of Medicare mental health co-payments from 50% to 20% over the next six years, and the coming of major health care reform that the Obama administration has promised to prioritize makes the situation both more fluid and more confusing. The psychologist might consider the following advice when dealing with this situation:

1. The regular use of sliding fee scales is by its very nature deceptive and thus dangerous to the current reimbursement system unless the provider bills the insurance company the same amount that the patient would be billed under the fee schedule. However, implementation of a sliding fee scale could create problems in other ways. Medicare requires that it not be billed a higher rate than the provider bills to any other payer and some private companies have a version of this policy in place. We recommend against the use of sliding scales and we further recommend that providers not describe their policies as "sliding fee scales" unless their practices are entirely outside third party reimbursed systems.
2. While the risk of being "caught" for these practices outside of the Medicare system is very low, the consequences of being caught can be quite expensive. The potential always exists for disgruntled patients to file complaints or innocently communicate these practices to a third-party payer. Remember the old adage: No good deed goes unpunished.
3. Providers should look at their fee structure in terms of what their patients can actually afford to pay. If the fee charged to insurance companies is in excess of what most of one's patients can afford to pay without insurance, then one is at risk as being seen as abusing the system.
4. Medicare policy on the appropriateness of non-routine fee adjustments in cases where there is real financial need, is supported by most major insurers (although not all). Providers contemplating such adjustments should have a direct conversation with each patient requesting adjustment according to their individual financial situation and this should be carefully noted in the patient's chart. Bills should reflect the provider's customary fee, list the adjustment to the fee and conclude with the amount

due from each patient. This transparency will be helpful if there are problems. But remember, these adjustments should not be something that is frequently a part of the psychologist's practice!

5. Without any certainty about the difference between "necessary" and "routine" fee adjustments, it is recommended that adjustments be given to no more than 10-15% of one's patients. There is no magic about this number. Whatever the percentage, it must be reasonable.
6. Since the greatest risk for problems in this area is participation in the Medicare system and since participation is mandatory for all providers who do not officially "opt out" of the system and who treat Medicare eligible individuals, opting out of the system should be carefully considered.
7. Small adjustments for cash payment may be acceptable, but they should be close to the actual cost of using insurance.
8. Payment plans are acceptable providing that they bear some semblance to reality and that you and the patient are serious about the patient taking responsibility for paying you. This does not mean that you have to take patients who don't comply with collection actions or small claims court. Regardless of the above, keep in mind that collection actions create an unacceptable level of risk of licensing board complaints. We generally recommend against these types of fee collection strategies. However, payment plans that are not seriously administered are like routine fee adjustments — abusive and potentially fraudulent.