

Proposed Rule On Discounting

By David M. Werfel, Esq. - Wednesday, October 29, 2003

On September 15, 2003, the Inspector General published a Proposed Rule (68 Federal Register 53939) to amend the IG's exclusion authority and to define the terms "substantially in excess", "usual charges" and "good cause".

The Proposed Rule defines when Medicare is billed substantially in excess (i.e. 120%) of "usual charges"(defined as an average of certain charges). As a result, the IG is also defining how much the ambulance industry can discount when it bills hospitals and other non-government payors. If you can not bill Medicare more than 120% of usual charges, then, by definition, you can not discount more than 16.67% off of your Medicare allowables when billing hospitals, SNFs, etc. However, this does not limit the discount to all contracts as "usual charge" is defined based on an average of all non-excluded charges, as defined below.

It is important to note that the Proposed Rule does not affect the anti-kickback provision. The Proposed Rule affects the statute under which the IG may exclude an individual or entity. The current statute [Social Security Act Section 1128(b)(6)(A)] allows the IG to exclude an individual or entity from participation in any federal health care program if the individual or entity:

"has submitted or caused to be submitted bills or requests for payment...under subchapter XVIII... for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs..."

"Substantially in Excess"

The IG has proposed defining "substantially in excess" as:

"any charge or cost submitted for a furnished item or service that is more than 120 percent of the individual's or entity's usual charge or cost for that item or service; provided, however, that for items and services whose reimbursement is subject to a payment cap, including without limitation, a payment cap in the form of a fee schedule amount, the charge or cost for that item or service will be deemed to be the lower of the submitted charge or cost or the payment cap".

"Usual Charge"

The proposed definition for "usual charge" is an average of non-excluded charges, as follows:

"an amount that is determined by –

(1) Arraying for the most recent calendar or

rolling 1-year period all charges for an item or service offered or contracted for by the individual or entity

(and its affiliated entities), including duplicate charges; provided, however, that an affiliated entity means any entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the individual or entity;

- (2) Excluding certain unusual charges described in Paragraph (a)(3)(ii)(B) of this section; and
- (3) Dividing the sum of the remaining charges by the number of remaining charges.

Please note, while the IG's Proposed Rule defines "usual charge" as an average of non-excluded charges, the IG is also considering using the 50th percentile, i.e. the median.

"Usual charge" includes:

- amounts billed directly to patients.
- amounts billed to patients covered by insurance, with which there is no contractual agreement.
- any fee-for-service rates contractually agreed to, with any payor, including discounts with managed care plans.

"Usual charge" does not include (i.e. the paragraph (a)(3)(ii)(B) exclusions noted above):

- charges to uninsured patients, free or at substantially reduced rates.
- capitated rates.
- rates offered under contracted fee-for-service arrangements where more than 10% of the maximum potential compensation could be paid in the form of a bonus or a return of all or part of certain funds previously deducted from the individual's or entity's compensation.
- fees set by Medicare.
- fees set by other federal health care programs.
- fees set by state health care programs.

NOTE: Rates negotiated with TriCare and Dept. of Defense and rates negotiated with M + C Plans, state and federal managed care plans are not excluded from "usual charge", unless noted above.

"Good Cause"

An individual or entity will not be excluded for submitting claims substantially in excess of usual charges or costs when there are unusual circumstances or medical complications requiring additional time, increased costs associated with serving Medicare or Medicaid beneficiaries or other "good cause". "Good cause" is determined in the discretion of the Inspector General and is not subject to administrative or judicial review.

This is only a Proposed Rule, at this time. Comments can be submitted by November 14, 2003 to: Office of Inspector General, Department of Health and Human Services, Attention: OIG-53-P, Room 5246, Cohen Building, 330 Independence Avenue, S.W., Washington, DC 20201. The AAA will submit comments. Thus, you might want to wait to see what comments are submitted by the AAA before determining whether to submit your own comments.

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