THE OFFICE

To Discount or Not to Discount

As the "Great Recession" continues, there is much discussion on medical forums about how to increase cash flow, decrease administrative expenses, and deal with ever-increasing numbers of unemployed and uninsured patients.

Extending discounts to patients who pay at the time of service or pay out of pocket is one effective way of addressing all three of these issues. Exercise caution, because discounts can run afoul of federal and state laws. These include state antikickback statutes, the anti-inducement provision of the Health Insurance Portability and Accountability Act, the Medicare exclusion provision, and state insurance antidiscrimination provisions.

BY JOSEPH S. EASTERN, M.D.

From a legal standpoint, any discount is a kickback of sorts—you are returning part of your fee to the patient—and many laws designed to thwart real kickbacks can apply in such situations.

Take the straightforward case of time-of-service discounts for cosmetic procedures and other services not covered by insurance. You would think such transactions are just between you and your patients, but you need to avoid the appearance of using these discounts as marketing incentives (inducements to attract patients).

Also, a shrewd third-party payer could try to pull a fast one on you. Many provider agreements contain what are often called "most favored nation" clauses, which require you to automatically give that provider the lowest price you offer to anyone else, regardless of what they would otherwise pay. In other words, they could demand that you give them the same discount.

My response in that situation would be that a time-of-service discount is exactly that: It is offered only when payment is made immediately. Third parties never pay at the time of service and are not entitled to it.

Things get complicated if you also want to extend discounts for covered services. Be sure that the discounted fee you charge the patient is also reflected on the claim submitted to the insurer. Billing the insurer more than you charged the patient invites a charge of fraud. Avoid discounting so regularly that the discounted fee becomes your new usual and customary rate.

Waiving coinsurance and deductibles can be trouble, too, particularly with Medicare and Medicaid. You might intend it as a good deed, but the Centers for Medicare and Medicaid Services may see it as an inducement or kickback, especially if you do it routinely. The CMS has no problem with an occasional waiver, especially "after determining in good faith that the individual is in financial need" (according to the Office of Inspector General), but thorough documentation is in order in such cases.

Waiving copays for privately insured patients can be equally problematic. Nearly all insurers impose a contractual duty on providers to make a reasonable effort to collect applicable copays and/or deductibles. They view the routine waiver of patient payments as a breach of contract, and there has been litigation against providers who flout this requirement. As with the CMS, accommodating patients with individually documented financial limitations is acceptable, but when there is a pattern of routine waivers and no documentation, you will have difficulty defending it.

In addition to antikickback laws, some states have antidiscrimination laws that forbid either lower charges to any subset of insurance payers or any noninsurance payer than to any insurance payer. Some states make specific exceptions for legitimate discounts—as in cases of financial hardship, or when you are just trying to pass along your lower billing and collections costs—but others do not. Check your state's laws and run everything past your attorney.

As for how much of a discount you can give, I cannot suggest an amount, but if it is completely out of proportion to the administrative costs of submitting paperwork and the hassles associated with waiting for your money, you could, once again, be accused of offering a discount that is a de facto increase to insurance carriers, and that could result in charges of fraud.

In cases of legitimate financial hardship, the most effective and least problematic strategy may be to offer a sliding scale. Many large clinics and community agencies and all hospitals have a written policy for this, often based on federal poverty guidelines. Do a little homework: Contact local social service agencies and welfare clinics, learn the community standard in your area, and formulate a written policy with guidelines for determining a patient's indigence. Once again, consistency of administration, objectivity in policies, and documentation of individual eligibility are essential. ■

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LAW & MEDICINE

Expert Medical Testimony

Question: A witness may be qualified as an expert based on:

A. Knowledge or education, but not experience alone.

B. Skill, but not training alone.

C. Knowledge, skill, experience, training, or education.

D. Whether a witness qualifies as an expert is determined by the judge and jury.

E. A nurse may equally offer expert testimony in a medical malpractice case.

BY S.Y. TAN, M.D., J.D.

Answer: C. In a malpractice trial, the plaintiff has to show via expert medical testimony that the defendant doctor has breached the standard of care. Court rules of evidence dictate that the expert must possess "the knowledge, skill, experience, training, or education" necessary for establishing that standard. These qualification criteria are not overly restrictive, and evidence is admissible so long as it is relevant and reliable. However, lay testimony usually is insufficient to define the standard of care, unless it falls under the "common knowledge" exception (*res ipsa loquitur*). The judge, not the jury, makes these determinations.

The expert's proffered standard must take into account the circumstances of the case and the qualifications of the defendant-doctor. For example, in litigated cases involving diabetic complications, the courts have disallowed using an internist's standard for a general practitioner, or an endocrinologist's standard for an internist.

A qualified doctor rather than a nurse or an allied health professional usually will serve as the expert, although doctors have been allowed to testify outside their specialty, for example, an internist with subspecialty training in infectious diseases was qualified as a plaintiff expert in a stroke case. However, Arizona has a recent statute, ARS §12-2604 (A), which requires a medical expert to be a specialist who is actively practicing or teaching in that area of medicine. The state Court of Appeals held that this violated the separation of powers doctrine (conflicting with Arizona Rule of Evidence 702), but the Supreme Court of Arizona subsequently reversed and reinstated the law, which makes it more difficult to qualify as a medical expert in an Arizona courtroom.

Most malpractice lawyers have a listing of available experts, derived from past experiences, contacts, or word-of-mouth recommendations. Some plaintiff organizations have access to willing medical experts, and ads in the media and legal journals identify doctors wishing to act as experts. Attorneys generally seek experts who communicate well. How the jury perceives the expert is crucial. Qualifications might be what are initially assessed, but communication skills, credibility, and demeanor can matter more.

Can a physician be forced to testify as an expert?

The Wisconsin Supreme Court has held that whereas a treating physician might be required to provide expert testimony regarding the care of his/her own patient, he/she cannot be forced to give expert testimony regarding the standard of care of another physician's patient unless the judge has determined that there are compelling circumstances. Additionally, there must be reasonable compensation and no requirement to do additional preparation in order to provide expert testimony.

The reimbursement rate for an expert varies widely, usually in the range of $200-$500/hour for review work. These figures are of course higher for depositions and live testimony in open court. A Colorado court has held that a deposition fee of $2,000/hour was grossly excessive, and a New Jersey federal magistrate judge characterized a neurosurgeon's charge of $7,000 for two hours of deposition as "near to being extortionate." In Europe, expert witnesses are appointed by the courts, and are compensated according to a standard fee schedule.

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In 1995, the American College of Cardiology put forth seven criteria for expert witnesses. Of particular import is criterion seven, which states: "Expert witness testimony should be fair, thorough, and objective. It should not exclude any relevant information that has a bearing on the case." Various other medical associations and malpractice insurers have published similar guidelines for those asked to testify as experts.

The American Medical Association considers providing expert medical testimony to be analogous to the practice of medicine. It has this to say about the ethical responsibilities of medical experts: " … they should have recent and substantive experience or knowledge in the area in which they testify, and be committed to evaluating cases objectively and to providing an independent opinion. … Physician testimony must not be influenced by financial compensation; for example, it is unethical for a physician to accept compensation that is contingent upon the outcome of litigation."

Finally, in *Austin vs. American Association of Neurological Surgeons*, the seventh U.S. Circuit Court of Appeals reaffirmed an association's right to discipline a physician for improper medical testimony. The case involved a Detroit neurosurgeon who testified for the plaintiff against a fellow association member who allegedly caused permanent recurrent laryngeal nerve damage following an anterior cervical fusion. The court wrote, "There is a great deal of skepticism about expert evidence. It is well known that expert witnesses are often paid very handsome fees, and common sense suggests that a financial stake can influence an expert's testimony, especially when the testimony is technical and esoteric and hence difficult to refute in terms intelligible to judges and jurors. More policing of expert witnessing is required, not less." ■

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