WAIVER OF CO-PAY

According to the Department of Health and Human Services (HHS), Office of Inspector General (OIG), "It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments." *(67 Fed. Reg. 72,896 (Dec. 9, 2002))*. This applies to health care and services paid by Medicare and any other program paid partially or in full with federal funds. The OIG issued a Special Fraud Alert warning about this specific practice that year. *OIG Special Fraud Alert (1994) "Routine Waiver of Medicare Part B Copayments and Deductibles*":

> What Are Medicare Deductible and Copayment Charges?
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> The Medicare ``deductible" is the amount that must be paid by a Medicare beneficiary before Medicare will pay for any items or services for that individual. Currently, the Medicare Part B deductible is $100 per year.
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> ``Copayment" (``coinsurance") is the portion of the cost of an item or service which the Medicare beneficiary must pay. Currently, the Medicare Part B coinsurance is generally 20 percent of the reasonable charge for the item or service. Typically, if the
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> Medicare reasonable charge for a Part B item or service is $100, the Medicare beneficiary (who has met his [or her] deductible) must pay $20 of the physician's bill, and Medicare will pay $80.
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> Why Is it Illegal for ``Charged-Based" Providers, Practitioners and Suppliers to Routinely Waive Medicare Copayment and Deductibles?
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> Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.
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> A ``charge-based" provider, practitioner or supplier is one who is paid by Medicare on the basis of the ``reasonable charge" for the item or service provided. 42 U.S.C. 1395u(b)(3); 42 CFR 405.501.
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> Medicare typically pays 80 percent of the reasonable charge. 42 U.S.C. 1395l(a)(1). …
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> A provider, practitioner or supplier who routinely waives Medicare Co-payments or deductibles is misstating its actual

> charge. For example, if a supplier claims that its charge for a piece of equipment is $100, but routinely waives the copayment, the actual charge is $80. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the supplier's misrepresentation, the Medicare program is paying $16 more than it should for this item.
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> In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them….
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> One important exception to the prohibition against waiving Co-payments and deductibles is that providers, practitioners or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This 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 copayments must be made….

As far back as 1991, the Office of Inspector General ("OIG") issued a Special Fraud Alert entitled "Routine Waiver of Copayments or Deductibles":

> To help reduce fraud in the Medicare program, the Office of Inspector General is actively investigating health care providers, practitioners and suppliers of health care items and services who (1) are paid on the basis of charges and (2) routinely waive (do not bill) Medicare deductible and copayment charges to beneficiaries for items and services covered by the Medicare program.

Under certain circumstances, such as the indigency or financial hardship of the patient, co-pays and deductibles may be legally waived. However, it is crucial that the physician, practice or facility document the circumstances. In order to qualify for hardship status and waiver of co-pay, Medicare regulations require that a "Financial Hardship Application" be filled out by the patient

and approved. This can't be a matter of routine, however, and should only be done when actual financial hardship and inability to pay are documented.

Blow the Whistle on Waiver of Co-Pay Fraud

Individuals with knowledge of fraud committed by companies or health care providers waiving co-pays may be able to blow the whistle on this kind of fraud using the FCA, the TMFPA and other whistleblower reward programs. Whistleblowers play a critical role in bringing this type of fraud to light and holding wrongdoers accountable when they try to cheat the system.

To talk with me about your waiver of co-pay fraud case, call my Dallas law offices at 214-505-0097 or contact me online. Consultations with a Dallas County Waiver of Co-Pay Fraud attorney are free and confidential. I handle these types of cases on a contingent fee basis, meaning you owe me no legal fees or expenses unless I obtain a recovery for you.

EXAMPLE OF WHISTLEBLOWER/RELATOR FEES AWARDED AND SETTLEMENTS IN WAIVER OF CO-PAY CASES

In November of 2019, the **whistleblower received $1.9 Million** as her share of the government's recovery when a hospital pharmacy agreed to pay **$10 million** to the federal government to settle claims that it violated the FCA by submitting false claims to Medicare for prescription drugs that did not meet Medicare coverage requirements. The settlement also resolved allegations that the company submitted claims to Medicare that resulted from improper remuneration provided to Medicare beneficiaries in the form of free blood glucose testing supplies and waiver of co-payments and deductibles for insulin, in violation of the AKS. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Kentucky Hospital to Pay over $10 Million to Resolve False Claims Act Allegations (Nov. 20, 2019), https://www.justice.gov/opa/pr/kentucky-hospital-pay-over-10-million-resolve-false-claims-act-allegations.