Marketing Basics for Medical Practices:

Focus on the Three P's

By: Dave Anderson

Medical practices are faced with many challenges in today's competitive marketplace. Questions remain on the effect that pending healthcare reform efforts will have on physician reimbursement, practices are scrambling to meet ARRA-imposed deadlines for transitioning to electronic medical records, and our nation's economy has led to a an environment highlighted by corporate mergers and acquisitions.

Because of these obstacles and the referral-based nature of managed care, the answer to attracting and retaining a steady base of patients has become far more complicated than the development of a glossy brochure. This gets compounded further in today's marketing circles, with emerging trends like viral marketing, stealth marketing and guerilla marketing taking center stage. It's easy to get lost in buzzwords and lose sight of the fundamentals of marketing – focused and strategic communication.

Regardless of the marketing methods you choose, your communications efforts should always be constructed on a foundation of The Three C's Model, as originated by business and corporate consultant, Kenichi Ohmae. While Ohmae was referring to your Corporation, your Customer, and your Competition, in the realm of medical practices, we can call it the Three P's: your Practice, your Patients, and other Providers.

Everything Begins and Ends with Your Practice

It may seem obvious that the marketing process begins with your practice. After all, it's you and your staff that come up with ways to respond to patient needs through the services that you provide. Yet practices often lose sight of their significance within the marketing mix equation.

Perhaps at an even more fundamental level, a practice needs to be able to identify the values that underscore its own identity, and the value proposition of its services for patients and payers. It's a truly important exercise for a practice to go through the process of asking itself, "Who are we? When people see our name or our logo, what do we want them to think, or how should they feel?" and "What should patients experience when they visit?"

For physicians, the answer to these questions may well be in the very nature of what you do: consulting. There is a term in marketing called "consultative selling," which means that through on-going dialog in multiple forms, you get to know all about the customer- or patient-base you serve, and use this knowledge to better respond to their needs. This may be via suggestion boxes at your office locations, staff recognition opportunities, in-person customer surveys, or online feedback and contact us forms. Once you gathered, your staff can use this information to improve the services that you offer and enhance the way that you communicate with your patients.

It's not unlike looking in a mirror and trying to sum up your life in a few descriptive words. Marketing and communications experts work with practices to unpack the unique essence of the organization's identity, and then figure out how this identity should translate into every unit of the practice's communication. That may mean reviewing and redeveloping logos, stationery, business cards, Web sites, newsletters, brochures, regional advertisements and even customer service interfaces like patient scheduling calls and other forms of outreach.

Cozying up to the Patient

Since patients are the basis for the practice's existence, it stands to reason that being patient-focused is extremely important. Yet, there are numerous studies that point to major patient dissatisfaction with practices, including communication about delayed appointments and the manner of communicating medical results.

The simple truth to remember is that your medical practice should operate to serve the patient. In marketing terms, that means being aware of, and understanding the different ways that different patients use your services. Perhaps most of your practice's patients visit your practice for preventive care, for example. Or it may be that you've come to realize that very few of the patients who visit your office come from outside of a 10-mile radius. How does this knowledge affect how you serve your patients or how you communicate with them?

The medical practice also needs to think about how it can satisfy existing patient needs, at the same time anticipating new ones. Perhaps your practice already has an online New Patient Form that patients can print out, complete and bring with them to their appointment to save time. Is this feature being communicated to your prospective patient base through promotional outreach? What other methods are you using to better serve your patients, and how have those benefits been communicated?

The Competitive Provider

This last area of focus is routinely the one most neglected by medical practices. Your practice needs to communicate its competitive advantages by differentiating itself against other providers in your area. Given a choice, what are the reasons that people should choose your practice and its services? How can you encourage people to choose you for the first time, and to continue choosing you for future visits?

Every practice should be able to identify its own strengths and weaknesses, or assets and liabilities. There may be one area in which your practice excels in relation to other providers, and this unique strength can be leveraged in retaining existing patients and attracting new ones. If your practice has gained a reputation for shorter wait times, then existing patients could be informed of this simply by posting such a statement on a wall near the reception desk, and potential patients should be able to easily find this information, for example, on the practice's Web site.

There will, of course, be other areas where a practice falls short of what its competition offers. Perhaps your practice has fewer physicians or physicians' assistants than the practice across town. This simply means you have to figure out how you can turn this into an asset: there are many patients who prefer smaller practices, but you need to get this information to this audience in order to attract them.

The most important thing to remember in understanding how marketing can help physician practices is the fact that the three P's need constant focus. Your practice should engage in quarterly reviews of each of the three areas to examine recent progress and chart future directions, asking:

- How are we doing as a **practice**? Are we meeting our objectives? Are we successful in building on our strengths while minimizing our weaknesses?
- How can we better serve our **patients**? Do we need to evolve our services? How can we improve our communication with our patients?
- What are we doing to surpass **other providers** in our field or within our region? How can we stay ahead of the market?

Through a keen focus on these three areas, the marketing efforts of a medical practice can ultimately allow it to reach its full potential by supporting not only communication, but quality patient service as well.

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What Can Brown Do for You?

Washington Report

Bill Finerfrock, David Connolly, Carolyn Abdenour, Zhaneta Mansaku

In an election heard "round the world" Scott Brown (R-MA), a little known state Senator, captured the seat formerly held by Senator Ted Kennedy (D-MA) in a special election. Beyond the immediate symbolism of electing a Republican to a seat held by a Kennedy for more than 60 years; the election of Brown dramatically changed the voting dynamics of the United States Senate and sent a chill down the spines of those advocating for major changes in our nation's healthcare system.

With the seating of Senator Brown, the political alignment in the U.S. Senate will be as follows:

Democrats – 57

Independents – 2

Republicans – 41

The two Independents – Lieberman of Connecticut and Sanders of Vermont – caucus with the Democrats.

Under the rules of the Senate, it takes 60 votes to end debate on most bills or amendments. Prior to Brown's election, the Democrats enjoyed a "filibuster proof" majority. Ironically, while the White House and the popular media have often characterized the Healthcare Reform debate in the Senate as being stymied due to Republican filibusters, the fact is that until now, Republicans alone could not sustain a filibuster on any legislation. To the extent there was a filibuster and the Senate rejected an attempt to end a filibuster, it would take at least one Democrat to vote with the Republicans to sustain a filibuster.

Discerning the meaning of the Brown election will be the subject of months of debate. Was Brown just the beneficiary of a poorly run campaign by Massachusetts Attorney General Martha Coakley (D-MA)? Or, were the people of Massachusetts collectively sending a message to the rest of the nation regarding one-party rule in Washington, DC? Was the election about healthcare reform or something else altogether?

Like most elections, there were a multitude of issues that ultimately led to the outcome. For some, it was healthcare for others, it was the quality of the candidate.

Opponents of healthcare reform point to the clear distinction between the two candidates regarding HCR – Brown opposed the plan before the Congress, Coakley supported it. Similarly, supporters of HCR note that as a state Senator, Brown voted for comprehensive healthcare reform and that because the voters of Massachusetts already have near "universal coverage" the Massachusetts election had little to do with healthcare reform.

We know that Scott Brown is the new Senator from Massachusetts and that is all we know. Whether his election has any effect on the ultimate success or failure of Healthcare Reform or whether his presence in the Senate changes the type of healthcare reform being considered remains to be seen.

Washington Report December 2009

Ms. Louie and Mr. Burleigh Go to Washington

Bill Finerfrock, David Connolly, Jordan Robbins, Matt Dwyer

Ms. Louie and Mr. Burleigh Go to Washington

Holly Louie, HBMA Board Member and Co-Chair of the HBMA ICD-10 Task Force and Bob Burleigh, Co-Chair of the ICD-10 Task Force, spent three fun-filled days in Washington DC recently talking about electronic transaction code set standards and the conversion from ICD-9 to ICD-10. In addition, Louie and Burleigh spent a day walking around Capitol Hill meeting with Congressional staff, Senate staff and a U.S. Senator to talk about these issues.

Holly and Bob were in Washington to represent HBMA at two very significant events.

On December 8th, Louie and Burleigh participated in an all-day "Listening Session" conducted by CMS to talk about the upcoming adoption of both the 5010 Transaction Code Set Standards and the subsequent conversion from the use of ICD-9 Codes to ICD-10 Codes. Participating with the Task Force Co-Chairs were representatives of the AMA, AHA, MGMA, the Blue Cross/Blue Shield Association, AHIP (the association of health insurance plans), AHIMA, AAPC and various staff from CMS. This listening session was an opportunity for informal discussion among the various entities involved in the creation, transmittal and payment of medical claims about the common problems, concerns and issues each segment of the health care delivery system was encountering as it prepared for both 5010 and ICD-10.

On Wednesday, December 9th, Louie and Burleigh ventured to Capitol Hill to meet with 7 different Congressional offices to talk about both ICD-10 and 5010 as well as efforts to achieve the Administrative Simplification goals promised by HIPAA. Although neither Louie nor Burleigh appears ready to make Washington a full-time place of residence, their contributions to the policy making process almost guarantee a return visit.

Finally, on Thursday, December 10th, Holly testified before the National Committee on Vital and Health Statistics (NCVHS). NCVHS is the advisory committee charged with making recommendations to the Secretary of Health and Human Services on matters related to HIPAA transaction standards and enforcement. Similar to the "Listening Session" each witness was asked to testify about various issues surrounding both the 5010 implementation and the use of the ICD-10 codes.

HBMA was joined at the witness table by representatives from the AMA, AHA and AHIP. One of the more striking developments from the hearing was the near unanimous question each of the witnesses asked of the NCVHS Committee members: Why? Why are physicians, hospitals, health plans and billing companies and others being asked to undertake such a massive change at a critical point in our nation's fiscal, economic and healthcare history?

As Louie noted in her testimony, *"…even in the best of times, the transition to 5010 and ICD-10 would be both a functional and economic challenge. Undertaking this transition at a time when the economy is in the worst shape in several decades, new federal incentives for EHR and mandates for "meaningful*

use" are pending, and the fact that Congress is considering major changes to our nation's healthcare delivery system could amount to the "perfect storm" in American healthcare."

The NCVHS is expected to make several recommendations to the Secretary with regard to the transition to 5010 and ICD-10. If you would like to learn more about the testimony Holly presented to the NCVHS, look for her article in the January issue of **"Billing."**

Where Have All the Leaders Gone?

And What You Can Do to Become One

By Robert E. Mittelstaedt, Jr.

I'm old enough to remember the Pete Seeger ballad “Where have all the flowers gone?” recorded by a number of different groups in the 1960s. I had short hair then, wore a uniform, and drove nuclear submarines, so don’t read an anti-war message into my fondness for the song’s lyrics. But it’s one of those songs that sticks in your head. And in recent years it has stuck in my head in a new version: “Where have all the leaders gone?”

As kids growing up in the 1950s and 60s we heard about leaders from World War II and had a couple of them as presidents (Eisenhower and Kennedy). But I cannot remember any time in my life like the present, when we hear so much about leadership in such a negative context.

Every day we wake up to headlines that trumpet the lack of leadership around us—a narrowly focused partisan Congress; Bernard Madoff stealing and regulators who couldn’t catch him; public officials trying to sell their influence; athletes taking banned substances; business people taking fees to sell mortgages to people who could not afford them; and people rationalizing their actions in some way or another as not their fault.

Leadership was a subject of constant discussion during the seemingly endless presidential campaign of 2006-2008, and while all the candidates talked about it, few had any actual experience as leaders. It was all theoretical—their view of what a leader might be, but without the visceral feel of what a leader must do based on gut-wrenching experiences in making decisions that affect people and having to live with the consequences.

How do we change this? How do we get leaders who think broadly and understand they have a responsibility to look out for the best interests of those they serve and not just themselves?

WHAT MAKES A LEADER?

Believe it or not, leadership starts with each one of us as individuals. A society with good leaders has good followers, each of whom practices leadership, but at different levels. One doesn’t have to be the CEO to take a leadership role in an organization. Here are a few leadership characteristics that everyone can demonstrate:

Willingness to take responsibility. First and foremost, leaders are people who take responsibility. This must happen at every level in an organization. Do you believe it is your job to get things done in a high-quality fashion that advances your organization? Do you believe it is your responsibility to make sure important things are done, even if it is not in your job description or assigned responsibilities?

Most leaders have followers, but we can lead as individuals even without followers. Each of us has the power to impact others through personal example, such as excellent customer service, unquestionable ethics, teaching and mentoring colleagues, helping those in need, or suggesting ways to improve operations. We can serve as leaders by having the courage to say, when necessary, that “the emperor has no clothes.”

A bias for action. Leaders do not delay dealing with problems, be they personnel matters or the challenges of starting new businesses. They do not act hastily, but once they have gathered and analyzed facts and options, they make decisions, communicate them, and hold themselves and other accountable for action.

A broad perspective. Leaders train themselves to synthesize information from a variety of sources and to discern patterns or hidden meaning from seemingly disparate pieces of data. By cultivating a focused, but broad perspective on issues and situations, leaders help others “see the forest for the trees.”

Creativity. Leaders must find creativity in themselves and/or cultivate it in others to ensure that a broad range of options is considered. They have to be fair, consistent, tough, and be trusted straight talkers. Being “nice” rarely comes up in conversation about great leaders.

Readiness to admit mistakes. Leaders can make mistakes, but they admit them—publicly if necessary. They learn from their mistakes and move on. Leaders do not rebuke others for their mistakes in public; but they do not miss learning opportunities with subordinates in private.

Ability to get results. Leaders don’t have all the answers. They do not all look or act alike, but the most common characteristic is that they get results. They know how to mobilize and incentivize their team. The goal is to have people look at what happened, and although they may not know how it happened or who was specifically responsible, they do know that leadership had something to do with the outcome.

That is what the best leaders seek —a world class result, based not on individual performance, but based on the entire team doing an amazing job. That is when the leader can step back and say, “It is time for me to lead by not leading. My team has learned what needs to be done and reacts instinctively.”

Every one of us can be a leader at some level and must be a leader in order for our organization to succeed. You will know you have succeeded as a leader when you see folks doing things they never thought they could do. Or when you see the organization achieving goals it never imagined. Or when problems are being handled effectively without people having to ask you what actions they should take.

The potential is there, the journey is sometimes painful, and no one waves a checkered flag to tell you that the race has been won. But you will feel it when the time comes—and it will feel good. As a mature leader, you will know you had something to do with the result. It may now be out of your hands; the team has grown up and needs you as an advisor and mentor but not as the only decision maker. You will feel it. And you will know when you have succeeded.

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Who's Being Stimulated?

How Federal Dollars Will Be Deployed for Healthcare

By Mark R. Anderson, FHIMSS, CPHIMS

On February 17, 2009, President Obama signed into law the American Recovery & Reinvestment Act (ARRA) designed to stimulate the lagging U.S. economy. For the healthcare sector, ARRA included a health IT component labeled the HITECH Act. The 267 pages outline a plan for spending approximately $19.2 billion dollars to encourage healthcare organizations to adopt and effectively utilize electronic health records (EHR) and to establish health information exchange (HIE) networks at regional and local levels. The act also is designed to ensure that the systems deployed protect and safeguard critical patient data at the core of the system.

The opportunity presented by the bill is enormous, but is there any real stimulus in the stimulus plan? Before we talk about the details of the HITECH Act, readers should understand that stimulus funding does not start until 2011 and only if the healthcare organization can prove "meaningful use" and "interoperatability" with other care providers in the local region. The majority of the funds are not for the purchase of technology, but rather, for the proven utilization of technology based on reporting capabilities.

The real question: will a physician spend upwards to $45K over the next two years in hopes that he or she will receive funding over a five-year period starting in 2011? The answer is still unknown, but every physician and every HBMA member must understand the requirements and processes to meet the government's goal of allowing every patient to access his or her medical records by 2014.

So what's in the stimulus bill?

$19 Billion—in Detail

There are two portions of the HITECH Act. One provides $2 billion immediately to the Department of Health & Human Services (HHS) and its sub-agency, the Office of the National Coordinator for Health IT (ONCHIT), and directs the creation of standards and policy committees. The second sets aside $17.2 billion that will eventually be paid to those healthcare physicians and hospitals that can demonstrate their use of electronic health records.

$2 Billion to HHS/ONC

The Secretary of HHS is directed to spend $300 million of the $2 billion fund to establish more health information exchange (HIE) initiatives in regions and towns across the country, as well as to help existing HIEs to progress in connecting providers. Local community HIEs are extremely important, since without a community, physicians will not qualify for any of the $17.2B in EHR funding.

$17.2 Billion in Incentive Payments to Physicians and Hospitals

When the bill was first announced, many organizations were excited to hear that the government was going to help fund EHR adoption. At first glance, most healthcare providers believed they were going to receive funding to purchase an EHR. They were wrong. Physicians who had already adopted EHRs thought that they were going to receive funding to help reimburse them for their EHR. They, too, were wrong.

Funding is going to providers who meet "meaningful use" criteria, can report quality indicators to the government, and most importantly, can exchange patient-specific clinical data with other providers in the community. Funding will not go to providers who have pre-existing EHRs unless they are connecting to a community HIE. One of the government's primary goals is to eliminate the silos of patient information within an individual provider organization.

"Meaningful use" has not yet been defined by the government. The Office of the National Coordinator for Health Information Technology (ONCHIT) office is supposed to publish the requirements by Dec 31, 2009. Same for the Quality reporting. This is our prediction of what both terms might mean.

Meaningful use criteria:

- Include a clinical data repository and Computerized Provider Order Entry (CPOE) supported by clinical decision support.
- Use ePrescribing technology to electronically transmit prescriptions to pharmacies.
- Exchange health information electronically with external entities.
- Use E-submission of claims complying with HIPAA Claims Attachment regulations
- Use quality reporting metrics.

Quality Reporting includes:

- Baseline reporting of percentage of medical orders entered electronically into the EHR by physicians
- Baseline electronic reporting of Joint Commission core measures
- Baseline reporting of the Agency for Healthcare Research and Quality (AHRQ) quality outcomes
- Baseline reporting of National Priorities Partnership goals, convened by National Quality Forum
- Baseline reporting of all adverse (drug) events
- Baseline reporting of percentage of prescriptions sent to the pharmacy electronically upon a patient's visit

The vast majority of the funds within the HITECH Act are assigned to payments that will reward physicians for effectively using a robust, connected EHR system to exchange patient data. In order to qualify for the incentive payments, both physicians and hospitals have to prove three things:

1. Use of a certified EHR product with ePrescribing capability that meets current HHS standards
2. Connectivity to other providers to improve access to the full view of a patient's health history
3. Ability to report on their use of the technology to HHS

Additionally, because the government wants to spur quick movement in this area, all of the incentives include payments for up to five years but provide the largest payments early in the program. Those who don't adopt EHR will eventually be penalized through lower payments. The incentive payments begin in 2011 to ensure that providers have time to adopt and learn to use the EHR; penalties begin in 2015.

Specifics of the Physician Opportunity

There are two incentive programs: one for those physicians who see large volumes of Medicaid patients and one for those who accept Medicare. Physicians will choose program participation.

- **Medicaid:** Physicians who see more than 30% of patients paying with Medicaid (20% for pediatricians) are eligible for payments of up to $64,000 over five years.
- **Medicare:** Physicians who do not have a large Medicaid volume but do accept Medicare can receive up to $44,000 over the five years.

Fee Reductions: Providers who do not demonstrate meaningful use in 2014 will see, in their 2015 fee schedules from Medicare, a decrease of 1%. An additional decrease will be affected in 2016 and 2017 down to a total of 97% of the regular fee schedule. Fee schedules can be further reduced to 95% if the Secretary determines that total adoption is below 75% in 2018.

Action for HBMA Members

All HBMA members should become educated on the ARRA Bill and the HITECH Act. As the provider's trusted advisor, HBMA members should provide knowledge to their clients and should help to eliminate the confusion in the marketplace. To qualify, HBMA physician clients must implement certified EHRs, must meet the "meaningful use" criteria, and physicians must be connected via a local HIE. To enhance community exchanges, HBMA members should consider developing their own HIE or joining one of the local pre-establish HIEs.

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Discounting Dilemmas

Tips on Avoiding Violations of Federal Statues

By Amy K. Fehn and Andrew B. Wachler

In most industries, professionals do not think twice about extending courtesies to colleagues, referral sources, or needy clients. For healthcare providers, however, these types of seemingly innocent and even generous practices can create civil and criminal liability.

Professional Courtesy

The term "professional courtesy" can have many meanings, but most often refers to the provision of free or discounted services to professional colleagues. Sometimes professional courtesy will also be extended to a colleague's family member or office staff. Professional courtesy may include waiving the entire cost of services or waiving cost-sharing amounts, such as co-payments or deductibles.

When professional courtesy is extended to a physician or the family of a physician who is or may become a referral source, this conduct can violate the federal anti-kickback statute, which generally prohibits paying or receiving any remuneration for patient referrals payable by the Medicare program or other federal health programs. The anti-kickback statute is intent-based and is implicated if even one purpose of an arrangement is for the purpose of inducing referrals. Violation of the anti-kickback statute is a criminal offense and can lead to

imprisonment of up to five years, fines of up to $25,000, and mandatory exclusion from the Medicare program. Most states have equivalent statutes that extend this prohibition to referrals for services covered by private insurance.

The Office of the Inspector General (OIG) addressed the issue of professional courtesy when it published the *OIG Compliance Program Guidance for Individual and Small Group Physician Practices*. Specifically, the OIG discussed the fact that the extension of professional courtesy would implicate the anti-kickback statute if the beneficiaries were selected in a manner that takes into account the volume or value of past referrals or the ability to generate future referrals.

Triggering the Stark Law

Professional courtesy, when extended to a physician or entity who refers “designated health services” can also implicate the Stark law. The Stark law is a strict liability statute and the penalties for violating the statute can include denial of payment, refund demands, civil monetary penalties, and exclusion from the Medicare program.

The Stark ban on physician self-referral generally makes it unlawful for a physician to refer Medicare or Medicaid patients for radiology tests, clinical laboratory tests, physical or occupational therapy, home health care, or other such “designated health services” to an entity with which the physician has a “financial relationship.” A financial relationship can be an ownership or a compensation arrangement with an entity. A compensation arrangement is defined to include any arrangement involving any remuneration between a physician and an entity, including remuneration that is “in cash or kind.” The provision of free or discounted services to a provider of “designated health services” or the provider’s family would be such prohibited remuneration.

There is, however, an exception to the Stark regulations to allow for certain extensions of professional courtesy. In order to fall within the Stark exception, all of the following elements must be met: (1) the professional courtesy must be extended to all members of the entity’s medical staff in the case of a hospital, or all members of the local community or service area, in the case of a physician practice; (2) the health care items and services are of a type routinely provided by the entity or practice; (3) the professional courtesy policy must be set forth in writing and approved in advance by the entity’s governing boards; (4) the professional courtesy must not be extended to Medicare or other federal health program beneficiaries unless there is a showing of financial need; and (5) the arrangement cannot violate the anti-kickback statute or any state law.

Waiver of Co-Payments

Professional courtesy or other practices that involve waiving co-payments or other cost-sharing amounts raise additional concerns. Where the recipients of such waivers are Medicare beneficiaries, the waiver of co-payments and deductibles can be viewed as a violation of the Federal False Claims Act. This is because Medicare regulations require providers to bill Medicare no more than the "actual charge" for the service rendered. When a provider waives the Medicare copayment, he or she is actually providing the service for a lower cost than what is being reported to Medicare. For example, if the actual charge of the service is reported as $100 and the co-payment is $20, then waiving the co-payment will result in an actual charge of only $80. A provider who misrepresents the actual charge as $100 could be charged with violating the False Claims Act.

Because the Health Insurance Portability and Accountability Act (HIPAA) extends the reach of the Federal False Claims Act to claims submitted to all payors, the practice of waiving co-payments could also result in violations for non-Medicare patients where a private health plan places the same type of "actual charge" limitation on payment. State laws and private insurance contracts may also prohibit waiver of co-payments for private pay patients.

In addition, waiver of co-payments, especially to the extent it is advertised to beneficiaries, potentially violates the prohibition on providing inducements to a patient to generate business payable by a federal health care program and can subject a provider to civil monetary penalties.

Usual and Customary Charges

Providers can be excluded from the Medicare program for submitting claims for services that are "substantially in excess" of the entity's "usual charges." Routinely waiving co-payments and providing other forms of discounts can decrease a provider's "usual charges" to the point where the Medicare fee schedule is "substantially in excess" of these usual charges. Similarly, many private payors require providers to limit charges to those that are "usual customary and reasonable." Routine waivers and discounts could impact this value as well.

Financially Needy Patients

The OIG has recognized exceptions to the prohibition on waiving co-payments where patients have demonstrated financial need. In a 2004 letter to hospital providers, the OIG stated that waiver of fees for financially needy patients would not be considered when calculating the providers' usual charges and would not be considered to be a violation of the anti-kickback statute. Although the guidance was directed specifically to hospital providers, the OIG's advisory opinions have increasingly been favorable toward the waiver of cost-sharing amounts for patients with demonstrated financial need. Providers who waive patient obligations based on financial need should only do so when the patient has produced documented evidence of financial need.

Compliance

As part of their billing and regulatory compliance plan, providers should have policies in place addressing the waiver of co-payments and the extension of professional courtesy. According to a recent report from the AMA, there have been no reported instances of prosecution by the OIG or the Department of Justice (DOJ) for fraud and abuse related to the extension of professional courtesy. However, providers should not take this as a pass to ignore the law, as violations can also be used against a provider in audits and other investigations to increase the government's bargaining position.

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