

User Fees in Health Care: Physician Charges for Administrative Services

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Introduction

There has been a trend during the past few years of an increasing number of physicians charging patients direct fees for services not generally covered by their health insurance plan. Although some of the services may contain a direct clinical component (e.g., telephone consultation with a physician on a patient's medical condition), these services are generally considered "administrative" in nature and may include other phone consultations, faxes, calling in prescription refills, completing forms for schools, sports or camp, forms for life insurance and documents which have legal uses such as Family and Medical Leave Act and disability coverage applications and certifications, e-mail, copies for medical records and charging patients for missed appointments. The nature of the service performed, the amount of time it takes to complete the service and what the physician's time is worth on an hourly basis influence the amount charged for these administrative services, which generally run between \$5 and \$50. The idea of charging patients for certain non-clinical administrative costs, such as providing photocopies of medical records, is not new and a number of states, including Maryland, directly regulate the amounts that physicians and other providers can charge for such services. Maryland Health General §4-304(c).

Some national professional organizations have officially endorsed the propriety of physicians charging for certain administrative fees, particularly where the provision of the administrative service is necessary because of a health plan or regulatory requirement. The Board of the American Academy of Family Physicians formally adopted the statement that “[t]he Academy believes that physicians should be able to charge and receive payment for administrative requirements imposed by any public or private health plan, or any regulatory authority, unless such charges are prohibited by contract or regulation. This would include, but not be limited to, the costs associated with changes of individual prescriptions made solely for formulary compliance.” www.aafp.org/x21353.xml. Other physicians are reportedly reluctant to charge for such services for a variety of reasons: (1) it may deter economically disadvantaged patients from calling with serious problems, (2) it may create a negative image of physicians, (3) some physicians may be tempted to overuse or abuse these charges, and (4) patients who do not want to pay the charges may switch physician practices. *See* Braithwaite SS, Unferth NO, “Phone Fees: A Justification for Physician Charges”. *J. Clinical Ethics*. 1993; 4: 219-224[Medline]. Some physicians may also have liability concerns about making a diagnosis or treatment recommendations without seeing the patient in person.

As a response to the sustained and rapidly escalating cost of professional liability coverage, some physicians are also asking patients to bear the cost of annual increases in the cost of their malpractice insurance. However, the Maryland Attorney General has recently declared that charging a patient such a “malpractice surcharge” is not legally permissible and violates the Maryland HMO Act’s statutory “hold harmless” provision,

which contains a prohibition against “balance billing” -- charging patients for services that should be covered by and paid for by their health maintenance organization (HMO) – even if the HMO itself fails to make the required payments to the physician. 90 Op. Att’y Gen. 29. Although some medical practices phrase the request for malpractice subsidies as a voluntary contribution, the Attorney General has opined that the request for such payments would nevertheless violate Maryland’s HMO statute. This Opinion only applies to patients who are covered by a licensed HMO and the Attorney General has not yet opined on whether charging for other types of administrative services would also run afoul of the ban on balance billing. However, the rationale for banning malpractice surcharges, that the cost should already be included in the physician’s professional charges, might also apply to charges for other services.

The Impact of the “Hold Harmless” Statute.

The Maryland HMO Act, Health General §19-701 *et seq.*, contains a statutory “hold harmless”, a consumer protection provision that generally prohibits health care providers, including physicians, from billing any patient for services covered under the terms of their HMO policy, unless the services are contractually permitted (copayments, deductibles, coinsurance charges, etc.) or are specifically excluded from coverage under the terms of the plan (e.g., cosmetic and experimental procedures, etc.). Maryland’s hold harmless statute is relatively unique in that it even applies to non-contracted providers, those who have not entered into a services agreement with the HMO for the provision of covered services to its enrolled members. Health General § 19-710(i). The hold harmless

requirement has been routinely enforced in Maryland and the Attorney General has previously elaborated on various aspects of the balance billing prohibition. 83 Op. Att’y Gen. 128 (1998); 85 Op. Att’y Gen. ___ (2000) [Opinion No. 03-005 (March 13, 2003)]; 89 Op. Att’y Gen. 53 (2004).

In the case of the malpractice surcharge, the Attorney General reasoned that the costs of a physician’s overhead, including liability premiums, should ordinarily be included in the physician’s professional fees. “Malpractice insurance is, of course, one element of the overhead involved in operating a medical practice. These expenses are typically encompassed within the professional service charge of the provider.” 90 Op. Att’y Gen. 29. Since the HMO Act contains no specific provision that would permit a physician to charge a malpractice surcharge, and patients are not otherwise legally required to pay any elements of a physician’s overhead (*See also, Patel v. Health Plus, Inc.*, 112 Md. App. 251, 266, 684 A.2d 904 (1996)), the Attorney General viewed the surcharge as tantamount to billing a patient for the costs of the covered services that are the HMO’s sole liability under the terms of the statute. A related legal issue for physicians is whether such malpractice surcharges are contractually included in the definition of the “net collections” on which an outside billing agency’s fee is calculated and payable under the terms of any billing and collection agreement that the practice may have with a third party billing vendor.

When a medical practice does implement charges for administrative services, it may be prudent to check their terms of their Professional Services Agreement with the

payor. That agreement may require the physician to obtain a written acknowledgement from the patient that (1) the patient understands that the health plan will not pay for the service, (2) the patient is assuming financial responsibility for payment, and (3) the patient agrees not to submit a bill to the health plan. The physician may also want to reserve the right to change the applicable fees periodically.

Recent Developments

What has caused the issue of physician charges for administrative services to become the subject of recent industry discussion and regulatory action? At a time when patients are requesting these services with increasing frequency and reporting a high satisfaction rate with telephone and other value added physician office services, many health plans refuse to make payment for these services, either because they consider them services that are not covered under the terms of the policy, or, like the Maryland Attorney General, they view the services as already included in the professional charges that they are paying to the physicians.

Some patients may welcome a schedule of charges for these services since this may help to ensure that the services will be regularly and routinely available and not provided only at the discretion of the physician. If physicians cannot charge the patients for the costs of administrative services, some would likely decline to offer the services at all. Even in circumstances where phone calls and other administrative services are covered by the payor or paid for by the patient, the remuneration is often not generous

and may not be worth the effort necessary to document the time, duration and subject matter of the calls. A survey of telephone triage and call centers sponsored by pediatric facilities revealed that the mean charge for a physician phone call was \$3.50, with the second most common charge per call being \$5.90. Melzer, S, Poole, SR. *See*, “Automated Telephone Triage and Advice Programs at Children’s Hospitals: Operating Characteristics, Financial Performance and Perceived Value”. *Arch Pediatr Adolesc Med* 1999; 153: 858-863 [Medline].

Offering these services is also viewed as convenient and efficient for patients. If a physician will not consult with the patient over the phone, the patient may have to make an appointment for an office visit. Consider the parent who has school or camp forms to fill out for a child. In lieu of coming into the physician office and using up not only the parent’s time but also the physician or physician’s staff time to fill out such forms, it may be much more efficient for the patient to fax in the form, have the doctor complete it and then send it back, only charging a nominal fee to cover the time of completing the form. If the physician had to schedule time to have the patient come in and then complete the form, and was unable to bill for that time, there would be little or no incentive for the physician to perform such services.

Not surprisingly, charging administrative fees to patients who are not accustomed to pay for these services has the potential to strain the doctor-patient relationship. The American Academy of Family Physicians reports that its membership has expressed a concern that, if they were to start charging patients for these services, the patient may

make life even more difficult for their staff, leave the practice or complain to their health plans. However, physicians who charge their patients for these services claim that nearly all of their patients pay these fees. *See* “Should You Charge Your Patients for “Free” Services?”, July/August 2004, American Academy of Family Physicians, Leigh Ann Backer.

The Government Accountability Office released a report entitled “PHYSICIAN SERVICES: Concierge Care Characteristics and Considerations for Medicare”, which found that charging patients administrative fees did not appear to present a significant obstacle to access for Medicare patients because the number of doctors charging the fees was small. *See* GAO-05-929. However, charging administrative fees under certain circumstances may put some doctors on shaky ground with private insurance companies and the federal government. For example, by law Medicare patients cannot be charged extra for services already covered under Medicare or the terms of their health plan.

Ethical Issues

The American Medical Association (AMA) is conscious of the time and effort physicians expend in performing administrative duties, and has issued a policy proclaiming that the Current Procedural Terminology (CPT) Editorial Panel should develop CPT codes for physicians to charge third party payors for complex administrative duties that they perform. CPT codes are used to categorize the professional services provided by physicians for reimbursement purposes and define what services are included in each code. *See AMA Policy D 285-989*. The AMA has also

issued ethical guidelines in dealing with “concierge” medical practice (see additional discussion below) which can be instructive when exploring the ethical dilemmas of charging patients administrative fees for certain non-clinical services. These policies should be read together in order to determine the overall view of the AMA regarding physicians charging patients for various categories of administrative fees. Of the four ethical guidelines outlined in *AMA Policy E-8.055 Retainer Practices*, one of the most applicable policies states “[p]hysicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care.” Physicians who charge administrative fees should be careful not to allow the non-payment of such fees to prevent patients from accessing medical care and attention required under the terms of fiduciary obligations established by the doctor-patient relationship in order to avoid claims of patient abandonment or other patient harm. The AMA has also issued a guideline with regard to charging the patient a fee for coordinating admission into a hospital, which states “[c]harging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is unethical. Physicians should derive their income from medical services rendered, in keeping with the traditions of the American Medical Association.” See *AMA Code of Ethics E-4.01 Admission Fee*. The AMA has also issued a policy which “opposes managed care contract provisions that prohibit physician payment for the provision of administrative services.” This provision could encourage physicians to charge their patients for administrative services, or it may also have the effect of encouraging physicians and third party payors to create a fee

schedule for these services which reimburses physicians at negotiated rates for performing specified administrative duties. *See AMA Policy H 285-943.*

AMA policy H-385.984 states an “attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs.” This policy encourages physicians and payors to determine which administrative costs are “complex” and which are “simple,” so that physicians are reimbursed either by the payor or the patient. This policy does not make clear whether “without charge” means the physician should not charge the patient for “simple” administrative services, but may charge the payor, or whether the physician should not be reimbursed at all for any “simple” administrative services. Again, these policies must be read closely and collectively, since AMA policy H-435.955 does support “the ability of physicians to institute an ‘administrative surcharge’ and/or a ‘liability surcharge’”, which would seem to include the imposition of a surcharge for medical malpractice insurance on patients.

Finally, the AMA does support reimbursement of physicians’ time consulting with patients over the telephone and through electronic mail and acknowledges that the federal Centers for Medicare and Medicaid Services (CMS) and other third party payors should not consider these communications as services that are already “bundled” into the CPT codes for other evaluation and management (E&M) services. Furthermore, AMA

encourages third party payors to allow physicians to charge their patients for these services, and not be confined by the Medicare regulations. *AMA H 390-859* provides that:

“(1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other form of communication. (2) Our AMA presses CMS and other payers for separate recognition of such supplemental communication work, not as bundled into existing service codes, or have such services recognized as not covered by Medicare and therefore chargeable as a patient convenience service outside the benefit package of Medicare.”

Some of the most important legal and ethical issues to consider when evaluating or implementing these surcharges, in the form of a malpractice surcharge, completing a form to establish disability, etc. have the potential to prevent patient access to physicians’ services. If administrative charges are implemented in such a way as to deny treatment or coverage to patients, the practice could contravene the ethical policies of the AMA and negatively impact patients’ trust in the physician-patient relationship. *See AMA Board of Trustees Report 20 - I-04.*

Distinguishing “Concierge” Medicine

There is a difference between charging patients administrative fees and the recent trend of “concierge” medical practice. “Concierge” medicine, variously known as “boutique,” “retainer,” or “VIP” medicine, usually involves a payment of an annual fee (ranging from \$1,500 to \$4,000 per year for an individual) in exchange for a limited

number of patients that physicians accept in their practice so that they may offer more personalized services to their patients, including annual physicals or wellness exams, same or next day appointment, telephone physician advice, including review of test labs and tests, preventive services and counseling, house calls, guaranteed response time on patient call backs, referral and prescription requests, access by e-mail, completion of medical history and referral forms, scheduling with referral providers, publication of a patient newsletter, and availability during non-business hours. *See Doherty, J., Freed, S., Legal Implications of Concierge Practice for Health Plan Providers and Enrollees, HMOs & Health Plans, Winter 2005 (February) Volume 8, Issue 1.* While concierge medicine does offer administrative services and other enhanced services in exchange for a fee, this fee is typically paid on an annual basis and the patient is charged the fee regardless of whether they actually utilize any of the services. However, charging for administrative services in most physician offices is typically done on a fee-for-service basis at the time of service. There are also practices which charge a much lower annual “subscription” fee for a monthly newsletter, lecture series and e-mail access.

“Bundled” Services

Many payors are opposed to physicians charging administrative fees since many of the services for which doctors charge are regarded by the payors as already “bundled” into the CPT codes for payment of other services rendered to the patient, such as an office visit. However, it may be difficult for physicians to discern which services are bundled and which are legitimately billable, and they should contact their payors to

confirm which services are being denied payment as non-covered, and which are considered by the payor to be “bundled” into other CPT codes. Non-covered administrative services may be billable to the patient without implicating the hold harmless clause, whereas billing for “bundled” services might be considered by some payors to constitute fraudulent “double billing” for the service.

Experiment

BlueCross BlueShield of Tennessee has initiated a pilot program, paying \$25 to physicians for each phone call or e-mail consult and \$20 for each chronic-disease patient who participates in a group visit. While the program is limited in the patients who qualify with specific chronic diseases and in the parameters to which the doctors must adhere, BCBS Tennessee believes that it can save money by reducing ER visits and hospital admissions.

Conclusion

Physicians and other health care providers may have the ability to charge patients directly for certain administrative services not otherwise covered or reimbursable under the terms of the patient’s health plan. Medical practices in Maryland that are considering implementing such a policy should be mindful of the current ban on charging malpractice surcharges to HMO patients and the other potential impacts of the existing statutory ban on balance billing. Physicians may want to document their compliance with the terms of their Professional Services Agreements by obtaining the patient’s written consent to pay

for such services. The implementation of administrative charges should never act as an impediment to the provision of necessary care and any amounts billed to a third party payor should be consistent with the policies and procedures established by the payor for claims involving those types of services.