Pass Through Billing: Risky Business

by: Tim Gary

The ever increasing financial pressures on physicians' practices over the last several years have had a varied effect on the business side of the practice of medicine. One result of these pressures has been that physicians in increasing numbers are opting to close down their individual or group practices in favor of other employment options. Another effect is that those physicians that remain in private practices are looking for alternative ways to increase their revenues. In this environment an old business proposition, know alternatively as "Account Billing" or "Pass Through Billing", has recently re-emerged. "Pass Through Billing" occurs when an ordering physician requests and bills for a service while the actual services are not performed by the ordering physician. Instead, another entity–usually a commercial laboratory–performs the test, invoices the physician and forwards the results and billing codes to the ordering physician in order to allow the physician to bill the payor and earn a profit on the transaction.[1] Typical of these marketing schemes is a caveat that services that will be billed to Medicare and Medicaid are specifically excluded from the offering. Research of the applicable regulatory authorities speaks unmistakably to the legally problematic nature of Pass Through Billing.

Applicable Regulatory and Ethical Considerations:

Federal. As discussed above, the proposed arrangements specifically exclude services that will be billed to Medicare or Medicaid. This exception is presumably based upon concerns regarding the Federal Anti-Kickback statute which prohibits "knowingly and willfully offering, paying, soliciting or receiving remuneration to induce referrals . . . of services covered by Medicare, Medicaid or any federally funded program . . . ." *See* 42 U.S.C. § 1320a-7b(b). This prohibition is important to consider in an analysis of the issue, given that the "main purpose [of the Federal Anti-Kickback statute] is to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions."[2]

The laboratory services industry is currently awash in an ever evolving wave of marketing schemes apparently intended to steer physicians offices and pain management clinics to given laboratory companies with offers that are couched in terms of assisting physicians in increasing their earnings. One proposal that is currently making the rounds among physicians practices tracks directly with the definition of Pass Through Billing set forth above. It is logical to assume that the result of steering the laboratory services for patients covered by commercial or third-party payor health plans will likely result in the utilization of services for Medicare and Medicaid patients as well. The exclusion of services that will be billed to Medicare or Medicaid does not cure a Pass Through Billing Scheme of its regulatory and ethical troubles.[3]

The Office of the Inspector General for the Department of Health and Human Services (the "OIG"), the entity charged with enforcement of the Federal Anti-Kickback statute, examined an arrangement virtually identical to the "Pass Through Billing" scenario described above. *See* OIG Advisory Op. No. 99-13 at 4 (Dec. 7, 1999). There, the OIG was asked to consider a scenario where a clinical laboratory directly billed physicians for diagnostic services, accepting payment from the physicians when the patients had private and commercial insurance, and allowing the physician to bill the laboratory services to commercial third-party payors at a marked-up rate. As in the present circumstance, Medicare/Medicaid and patients with federally funded health insurance were excluded from the arrangement. The OIG found that labs engaging in this kind of practice often charged the physicians less for commercially insured diagnostic services than the amounts the laboratories charged to federally funded payors, therefore allowing physicians to profit on the claims submitted to commercial insurers and private payors. This, the OIG concluded, often resulted in the physician referring virtually all of their patients to the laboratory, regardless of the insurance coverage involved.

The resulting inference for these suspect pricing arrangements is that laboratories and physicians may be swapping discounts on "Pass Through Billing" business in exchange for profitable, non-discounted federal health care program business. *Id.* The OIG considers the offering of improper discounts with the intent of inducing referrals of Medicare/Medicaid patients a significant risk under the Federal Anti-Kickback statute. *Id.* Therefore, providers participating in such prohibited steering arrangements may be subject to the penalties and program exclusions that exist under the statute, especially if the charge to Medicare or Medicaid substantially exceeds the amount the laboratory frequently charges for non-Federal payors. *Id.* at 5.

AMA and other ethical guidance. In addition to the federal regulatory issues involved in "Pass Through Billing," the American Medical Association has denounced the practice.
The American Medical Association, in Opinion E-8.09(2), stated "[a] physician should not charge a markup, commission, or profit on the services rendered by others." It further comments that "the physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit, is not acting in the best interests of the patient."[5] (Emphasis added) This stance is strongly echoed by the American Society for Clinical Pathology ("ASCP"). In Policy No. 04-03, Self-Referral, Markups, Fee Splitting, and Related Practices, the ASCP expressly provides that it "strongly supports federal and state . . . measures to prevent clinical providers from profiting on their patient referrals for anatomic pathology and clinical laboratory services."

State Guidance. Various state legislatures, as well as the appropriate licensure agencies in numerous states, have measures that prohibit the practice of "Pass Through Billing" entirely. These prohibitions are also reflected in the provider manuals and policies of many third-party payors.

Tennessee provides an excellent example of how Pass Through Billing schemes have been dealt with at the state level. Tennessee law provides that "it is an offense for any licensed physician or surgeon to divide or to agree to divide any fee or compensation of any sort received or charged in the practice of medicine or surgery with any person without the knowledge and consent of the person paying the fee or compensation or against whom the fee may be charged." Tenn. Code Ann. § 63-6-225(a).[6] As such, absent the expressed permission of the health insurance company that provides payment for the services in question, there is a very real exposure for the licensed physician involved. A close examination of the provider manuals of several health insurance carriers indicates that, to the contrary of having consented to such a fee splitting arrangement, the companies specifically prohibit "Pass Through Billing."[7]

Further guidance on this issue has been provided by the Tennessee Board of Medical Examiners. In interpreting the provisions of Tenn. Code Ann. § 63-6-225, the Board, in Private Advisory Ruling MD-04-01 (March 17, 2004), stated as follows[8]:

> The economics of the practice of "client billing" have given rise to at least two questionable practices which are by implication included in the questions submitted by the petitioner in his request for this Advisory Ruling. They are as follows:
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> 1. The practice of some clinicians billing patients or their third party payors for pathology services in an amount considerably more than that paid by the clinicians to the laboratory or pathologists. In some instances the clinician is billing the total amount of the reimbursement rate authorized for payment for that . . . service by the patient's third party payor even when the amount the clinician actually paid the laboratory . . . is less (sometimes far less) than the third party payor's authorized reimbursement rate.
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> 2. The practice of some laboratories . . . who discount the cost of their . . . services in an effort to induce clinicians to obtain their required services from them. This is perhaps a natural consequence of a free enterprise system and not per se objectionable since federal law has been enacted to prevent flagrant abuse of this practice. However, when this practice is considered in reference to the practice set forth in paragraph 1 it provides an obvious added economic incentive for clinicians to utilize such laboratories . . . and has led some to question whether it creates an incentive to over-utilize such services. In fact, an entire segment of the health care community could be devoted to such agreement between clinicians and laboratories . . . the sole purpose of which would be to institutionalize the combination of these practices for financial gain of all parties to those agreements.

The Tennessee Board of Medical Examiners has also addressed the ethical issues related to the practice of Pass Through Billing in the same Private Advisory Ruling. The Board echoed the position of the American Medical Association as follows:

> The physician's ethical responsibility is to provide patients with high quality services. This includes services that the physician performs personally and those that are delegated to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless she or he has the utmost confidence in the quality of its services. A physician must always assume personal responsibility for the best interest of his or her patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary *criterion or who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit, is not acting in the best interest of the patient. Id.*

In conclusion, when one considers the offer by a provider of laboratory services to provide the means to a physician to engage in "Pass Through Billing" as a marketing strategy that is clearly calculated to serve as an inducement to steer referrals to that laboratory against the regulatory backdrop and authorities outlined above, the dangers associated with the proposed practice become readily apparent. A friend of mine recently observed that health care as a business is a minefield. When considering the "purchase" of laboratory services be resold at a profit, caveat emptor clearly applies.

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[1] The definition of, or transaction structure referred to here as, "Pass Through Billing" is derived from various industry sources. OIG also refers to the practice as "account billing".

[2] Office of Inspector General, Fact Sheet November 1999.

[3] It should be noted that the Federal Anti-Kickback statute contains a safe harbor for "a discount…if the reduction is properly disclosed and… reflected in the charges made by the provider" to a Federal health care program. See Section 1128B(b)(3)(A) of the Act.

[4] The OIG referred to this practice as "account billing."

[5] *See*, Tennessee Board of Medical Examiners; Private Ruling Regarding "Client Billing" (March 17, 2004); (Citing also AMA Opinion E-8.09).

[6] Violations of Tenn. Code Ann. § 63-6-225(a) constitute a Class B misdemeanor.

[7] *See* United Health Care, Physician Administrative Manual, 2009; BlueCross BlueShield of Texas, Blue Review Issue 7, 2010; BlueCross BlueShieldNM Blue Provider Reference Manual, Section 13, January, 2011.

[8] The Tennessee Board of Medical Examiners referred to Pass Through Billing as "Client Billing".

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