Providers Risk Serious Liability by Failing to Collect Co-Payments and Deductibles

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by Len Tamburello, Esq.

Third-party payers, primarily insurance companies, are spearheading tough new penalties against physicians and other providers who waive co-payments and deductibles. Both in-network ("preferred") and out-of-network providers who fail to properly charge and collect co-payments and deductibles may expose themselves to civil suit for insurance fraud which can have far-reaching consequences, up to and including potential loss of licensure from the State.

I. In-Network Provider Common Law Liability

An in-network provider who regularly neglects to collect co-payments or deductibles breaches their provider agreement, and may also be committing fraud.[1] For example, a dentist who routinely waived his patient's co-payments once he received reimbursement from the carrier, usually around 80 percent of his billed amount, was found to be perpetrating civil fraud. In that case, the dentist "intend[ed] to forgive co-payment in all cases in which he submits to a carrier (whose agreement provides for percentage co-payment) a statement of patient charges."[2] Because of this, his "usual customary and reasonable" (UCR) charges, as represented to the insurance company, were rarely collected, if at all. This was found to be problematic because "if [the dentist] tells the insurance carrier he charges $100 and then collects $80 from the carrier, and by prearrangement, forgives his patient's co-payment [of $20] he has lied to the carrier."[3] Under this reasoning, the dentist's actual UCR should have been submitted as $80 (based on the amount he usually collected from the insurance companies), for which 80 percent reimbursement would have been $64.

Although the court then held a plenary hearing on the remaining elements of common law fraud to determine whether there was actual deception and reasonable reliance on the billing statements, such proofs would not be needed today to sustain a violation under the Insurance Fraud Protection Act,[4] (the "Act"), which became law the same year as Feiler was decided.

II. Modern Liability under the Insurance Fraud Prevention Act

Unlike a private action for common law fraud which exposes a practitioner to damages in the form of repayment of amounts collected in excess of the actual UCR rate, the Act opens the door to treble damages, an award of counsel fees incurred by the insurer, disgorgement of all payments received from the payer, and possibly adversary proceedings before the practitioner's licensing board.

Additionally, unlike common law fraud which must be established by clear and convincing evidence, a violation of the Act may be sustained by a mere preponderance of the evidence.[5]

The Act is violated where a person or practitioner

> [p]resents or causes to be presented any written or oral statement as part, or in support to, a claim for payment or other benefit pursuant to an insurance policy. . . knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim.[6]

Under the Act, a successful plaintiff may be awarded compensatory damages, costs of investigation, costs of suit and counsel fees.[7] Compensatory damages under the Act include *all payments previously made to the provider.*[8] Treble damages are available if there is a "pattern" of violations.[9] A "pattern" is defined as "five or more related violations under [the Act.]

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Violations are related if they involve either the same victim or the same or similar actions on the part of the person or practitioner charged with violating [the Act.]"[10] Had Feiler been sued under the Act, it is very likely that his actions as described by the Chancery Division would have exposed him to treble damages and other penalties.

Such adverse findings of fact may be viewed by the Attorney General as "false promise," "false pretense" or professional misconduct which could lead to disciplinary proceedings before the appropriate licensing board.[11] Although the severity of sanctions depend on the facts and circumstances of each case, the licensing body may impose the ultimate sanction – permanent loss of license in such cases, notwithstanding any lack of patient harm.[12]

Defense before the licensing board can be complicated and almost impossible if the board accepts the findings of fact made in the earlier civil suit under the Act as true. This acceptance of the earlier findings of fact is based upon a legal doctrine known as "collateral estoppel" which precludes relitigation of facts "actually litigated" at an earlier proceeding involving the same parties.[13]

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III. Out-of-Network Provider Liability

Out-of-network providers are not beyond the reach of payer-initiated litigation under the Act. Recently, an unpublished Appellate Division opinion held that an out-of-network provider who fails to collect required co-payments and deductibles from patients may be liable to the carrier for tortious interference[14] with the carrier-payer contract.[15]

In that case, defendants Dr. Carabasi and Carabasi Chiropractic Center were non-participating chiropractic providers who saw Aetna-insured patients but did not collect co-payment or deductibles, but when billing Aetna would leave blank the area of the form for "Amount Paid" and "Balance Due." Aetna claimed that this practice constituted insurance fraud, common-law fraud, negligent misrepresentation, unjust enrichment and tortious interference with subscriber contracts.[16] The Law Division dismissed the complaint for failure to state a claim and other grounds. The Appellate Division reversed and reinstated the fraud and tortious interference claims, but affirmed the dismissal of the unjust enrichment claim.[17]

Aetna alleged that leaving the invoice spaces blank for "Amount Paid" and "Balance Due" was tantamount to a failure to disclose waiver of the co-payment or deductible from the patient which resulted in overstatements of the total charge for the services provided.[18] In contrast, the Law Division concluded that the blank spaces made no representation whatsoever to Aetna (let alone a false one) regarding defendants' collection or waiver of co-payments, and that in light of Aetna's failure to request additional information on these claims before paying them, it could not have relied on the blank spaces. The Appellate Division called these conclusions "premature" and remarked that: "[i]f Aetna's allegations prove true, Carabasi failed to disclose a fact material to his right to receive reimbursement and if done knowingly, could certainly give rise to a claim of fraud."[19]

Aetna's tortious interference claim was based upon Carabasi's knowledge of Aetna's subscriber contracts which obligated it to pay only a fixed percentage of the cost of services with the balance paid by subscribers. In support of this theory, the complaint alleged that Carabasi waived the co-payments by members "in order to access insurance information, to encourage over utilization of services by the insureds and to bill [Aetna] for amounts in excess of those actually charged to the patient."[20]

Aetna argued Carabasi's non-disclosure of the co-payment waivers have "resulted in... overstating the total charge for the services provided"[21] and that defendants interfered with contract provisions designed to deter patients from: (1) using non-participating providers; (2) receiving unnecessary or excessive treatment; or (3) over-utilizing Carabasi's services in particular. The Appellate Division found these facts to "clearly set forth a claim for tortious interference." It reinstated this claim along with Aetna's fraud theories, and remanded to the Law Division.[22]

In the Appellate Division's view, a provider who leaves blank spaces on claims forms and does not collect a co-payment or deductible has failed to disclose a material fact, which, if relied upon, is actionable under the Act. Although this is an unreport-

ed decision, and therefore not technically binding on lower courts, it nonetheless sends a strong signal to practitioners and provides a strong disincentive to follow similar practices.

IV. What's Next for Providers

In sum, although New Jersey has not explicitly outlawed the waiver of co-payments and deductibles by a specific statute, regulation[23] or court decision,[24] insurers can effectively enforce such a ban through aggressive use of the Act. Assisted by a lower threshold of proof[25] and enticed by the prospect of disgorgement of all payments (not just those in question) along with the prospect of recovering attorney fees, and costs of investigation and treble damages,[26] increased use of the Act against practitioners who may not always collect co-payments or deductibles is foreseeable, if not expected. A provider who is accused of such practices would be well counseled to defend these claims vigorously and at all costs attempt to avoid any findings of fact that could later be used in a disciplinary matter against them by the State.[27]

A final, perhaps confusing, twist in this area of the law is occasioned by the fact that New York, where many New Jersey providers are also licensed, takes a completely different approach by specifically allowing doctors to advertise that they will accept any insurance payments as "payment in full."[28]

About the Author

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References

1 *Feiler v. New Jersey Dental Association,* 191 *N.J. Super.* 426 (Ch. Div. 1983), *aff'd o.b.,* 199 *N.J. Super. 363* (App. Div. 1984).
2 *Id.* at 436, 447.
3 *Id.* at 436.
4 *N.J.S.A.* 17:33A-1 to -30.
5 *Liberty Mutual v. Land,* 186 *N.J.* 163, 177 (2006).
6 *N.J.S.A.* 17:33A-4(a)(1).
7 *N.J.S.A.* 17:33A-7(a).
8 *Material Damage Adjustment Corporation v. Open MRI of Fairview, 352 N.J. Super.* 216, 232 (Law Div. 2002).
9 *N.J.S.A.* 17:33A-7(b).
10 *N.J.S.A.*17:33A-3.
11 *N.J.S.A.* 45:1-21(b) (false promise, false pretense); *N.J.S.A.* 45:1-21(e) (professional misconduct).
12 *See In re Zahl* 186 *N.J.* 341, 355-56 (2006).
13 *Zoneraich v. Overlook Hosp.,* 212 *N.J. Super.* 83, 98-99 (App. Div. 1986), *certif. denied,* 107 N.J. 32 (1986).
14 The elements of a cause of action for tortious interference are: (1) plaintiff must have a reasonable expectation of economic advantage; (2) the interference and harm inflicted must be done intentionally and with "malice," not necessarily in the sense of ill will, but in the sense of conduct that is wrongful and without justification or excuse under all the circumstances; (3) the interference must have caused a lost prospective gain; and (4) the loss or injury caused damage. *Printing Mart-Morristown v. Sharp Elec. Corp.,* 116 *N.J.* 739, 751 (1989).
15 *Aetna Health, Inc. v. Carabasi Chiropractic Center, Inc.,* (App. Div., A-3185-04T1) (decided January 13, 2006).
16 *Id. at 2.* The complaint also alleged that defendants billed and received payment for services which were actually performed, were not medically necessary and/or were not sufficiently documented; and submitted bills and received payment for multiple charges for the same services, misrepresented the amounts actually changed and received double-payment.
17 *Id.* at 11.
18 *Id.* at 7.
19 *Id.* at 8.
20 *Id.* at 10.
21 *Id.* at 7.
22 *Id.* at 10-11.
23 A non-exhaustive list of states taking this approach include California, Colorado, Ohio, Connecticut, and Florida. *See Cal. Admin Code § 28 CCR* 1300.71(p) (West 2006) (providing that a health service plan or the plan's capitated provider shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed upon the plan relating to claims processing or payment); *Colo. Rev. Stat. Ann.* § 18-13-119 (West 2006) (making the "regular business practice" of waiving copayments or deductibles an illegal an abuse of health insurance. Such activity is considered a "regular business practice" if a provider waives more than 25% of co-payments or deductibles during any calendar year, or advertises its intent to do so); *Ohio Rev. Code* § 4731.22(B)(28) and -(N) (West 2006) (prohibiting physicians from waiving deductibles or co-payments if waiver is used to entice patient to receive services from the physician, unless health benefit plan allows such a practice and waiver is done with the plan's full knowledge and consent); *Conn. Gen. Stat.* § 53-442 (West 2006) (stating that waiver of a patient's co-pay or deductible may qualify as fraud under Connecticut's Health Insurance Fraud Act); *Fla. Stat. Ann.* § 817.234(7)(a) (West 2006) (stating that a non-hospital provider's "general business practice" of waiving co-payments and deductibles "is a material omission and insurance fraud... if such provider has agreed with the patient or intends to waive deductibles or co-payments, or does not for any other reason intend to collect the total amount of such charge").
24 Federal decisions which have disapproved of waivers of co-payments and deductibles on contract or tort grounds include *Kennedy v. Connecticut Gen. Life. Ins. Co.,* 924 F.2d 698, 699 (7th Cir. 1991) and *Tom v. Hawaii Dental Service,* 606 F. Supp. 584, 586-87 (D. Haw. 1985).
25 *Land, supra,* 186 *N.J.* at 177.
26 *N.J.S.A.* 17:33A-3 and -4(a)(1); -7(a); -7(b).
27 *Zoneraich, supra,* 212 *N.J. Super.* at 98-99.
28 *Cohen v. Fromovitz,* 1995 *WL* 478859 (N.Y. City Civ. Ct. 1995) at *1, *4.