COURTESY DISCOUNTS FOR PHYSICIANS AND GOVERNING BOARD MEMBERS

FREQUENTLY ASKED QUESTIONS
January 10, 2005
Updated:
March 1, 2007, June 13, 2011
Effective September 21, 2012

1. **Question**: Is the Tenet provider required to adopt the Law Department Policy on Courtesy Discounts For Physicians and Governing Board Members (the "Policy")?

   Answer: No. Each Tenet provider may elect whether or not to adopt this Policy. The Policy sets forth the minimum standards that must be adhered to should the Tenet provider elect to adopt the Policy. In order to adopt the Policy, the Policy must be in writing, submitted to and approved by the provider's Governing Board for approval, and reflected in the minutes. It is recommended that each Tenet provider copy the Policy onto its letterhead prior to implementation and designate the date of approval in the header of the Policy.

2. **Question**: What kind of discounts are covered by the Policy?

   Answer: If the individual receiving the discount is covered by insurance, the Tenet provider may waive all co-payments, deductibles and other patient cost-sharing items requested to be paid by the individual under his or her insurance plan except that the total discounts provided to the individual and his or her spouse, dependent children, or parents (including mothers- and fathers-in-law) shall not exceed an aggregate amount of $5,000 per calendar year per family. If the individual receiving the discount is uninsured, discounts may be offered and provided to eligible individuals only as set forth in Tenet's Compact with Uninsured Patients (see *Regulatory Compliance policy COMP-RCC 4.56 Implementation of Tenet's Compact With Uninsured Patients).*

3. **Question**: Can the Tenet provider limit who it offers professional courtesy discounts to?

   Answer: If the Tenet provider elects to adopt the Policy, then the Tenet provider is required to offer discounts to all of the following individuals without regard to the volume or value of referrals or other business generated between the parties:

   (i) all current members of its medical staff;
   (ii) all physicians who practice within the Tenet provider's service area;[1]
   (iii) all current members of its Governing Board; and
   (iv) the spouses, dependent children, and parents (including mothers- and fathers-in-law) of (i)-(iii) above.

[1] Service Area means the lowest number of contiguous postal zip codes from which the Tenet provider draws at least 75 percent of its inpatient discharges during the most recent calendar year for which data is available. If the Tenet provider does not provide inpatient services, substitute outpatient services for inpatient discharges.

Allied health professional (*e.g.*, nurse practitioners, surgical techs, physician assistants, etc.,) are not eligible for this discount except as family members of an eligible physician or governing board member.

Notwithstanding the above, the Stark II Phase II regulations and the Policy prohibit the Tenet provider from offering a professional courtesy discount to any of the above individuals if they are a federal health care program beneficiary unless there is a good faith showing of financial need. In order to demonstrate a good faith showing of financial need, the beneficiary will need to meet all of the requirements set forth in Tenet's Policy on Waivers and Discounts of Patients Accounts.

4. **Question**: Does the Policy extend to common law husbands or wives or domestic partners of physicians or members of the Governing Board?

   Answer: Maybe. A common law husband or wife or a domestic partner is covered by the policy if the relationship is recognized under applicable state or local law. Contact your Regional Counsel for assistance in making the determination as to whether an individual is a "spouse" under the Policy.

5. **Question**: Are dependent children over the age of 18 covered by the Policy?

   Answer: Maybe. A dependent child must be the natural or adopted child or stepchild of the physician or governing board member and meet the following conditions to be covered by the Policy: (i) age 26 or less; (ii) unmarried; (iii) live with the physician or governing board member (when not attending school if a student); and (iv) the physician or governing board member provides more than ½ of the child's financial support; or of any age who are permanently disabled and reliant upon the financial support of the physician or governing board member.

6. **Question**: Can a treating hospital offer a professional courtesy discount to a physician on another Tenet hospital's medical staff who practices outside the hospital's service area?

   Answer: No. The Stark II Phase II regulations permit a hospital to offer a professional courtesy discount to a physician who practices in the local community or service area of the hospital. Thus, even though a physician may be on another Tenet provider's medical staff, if the physician does not practice in the treating provider's service area, then a professional courtesy discount may not be offered to that physician or his or her family.

7. **Question**: How does the Tenet provider notify its medical staff of the professional courtesy discount Policy?

   Answer: The Tenet provider may communicate the availability and limitations of a professional courtesy discount either in person, in writing or through other private forms of communication. It is recommended the Tenet provider submit a general notification letter to its Regional Counsel for review and approval prior to dissemination to the

medical staff and Governing Board. Also, the Tenet provider may not advertise the availability of professional courtesy discounts.

8. **Question**: Is the professional courtesy discount offered on all items and services the Tenet provider furnishes?

   Answer: No. The Stark II Phase II regulations and the Policy limit the discount to those health care items and services that are of a type routinely provided by the Tenet provider. Thus, if a hospital does not routinely provide an item or service and it has to purchase the item or service for this particular patient, then a professional courtesy discount may not be offered for that item or service.

9. **Question**: Is there a limit on the amount of the discount a Tenet provider can offer?

   Answer: Yes. If the individual receiving the discount is covered by insurance, then the maximum discount that can be offered to the individual and his or her spouse, dependent children, and parents (including mother- and father-in-law) shall not exceed an aggregate amount of $5,000 per calendar year per family. The Tenet provider will need to document the dates, recipients and amounts of discounts provided each year. If desired, the Tenet provider can choose to set a lower dollar limit.

10. **Question**: If a physician or his or her family member received medical services prior to the date the Tenet provider's Governing Board approves the Policy, can a discount be offered to this individual?

    Answer: No. Discounts may only be offered for items and services furnished after the date the Governing Board approves the Policy.

11. **Question**: Can a Tenet provider offer a professional courtesy discount under the Policy to an uninsured individual?

    Answer: No. If the individual is uninsured, Tenet's senior management has determined that discounts may only be offered and provided to eligible individuals as set forth in Tenet's Compact With Uninsured Patients policy (see *Regulatory Compliance policy COMP-RCC 4.56 Implementation of Tenet's Compact With Uninsured Patients*).

12. **Question**: Can the Tenet provider waive all or a portion of the deductible, co-payment or other cost-sharing amount?

    Answer: Yes. The Tenet provider can waive all or a portion of the deductible, co-payment or other cost-sharing amount provided the total discount does not exceed $5,000 per calendar year per family. For example, a Tenet provider's Policy may limit the waiver to 25% of the co-payment obligation up to a maximum of $5,000 per calendar year per family, or it can waive 100% of the co-payment obligation up to $5,000 per calendar year per family. The waiver of all or a portion of the deductible, co-payment or

cost-sharing amount needs to be reflected in the Policy. Please contact your Regional Counsel to modify the Policy accordingly.

13. **Question**: Is the Tenet provider required to notify the insurer or third party payor of the discount?

Answer: Yes. If required by state law or contract with the insurer, the Tenet provider's business office must notify the insurer or other third party payor in writing of the discount provided pursuant to the Policy. The Tenet provider should either: (i) attach a copy of the discount to the bill, (ii) stamp it on the bill when submitted, or (iii) submit the attached letter to the insurer on or after the date on which the health care services were provided to an individual eligible under the Policy. If the Tenet provider fails to notify the payor of the discount, then the Tenet provider shall not provide professional courtesy discounts.

14. **Question**: Will the insurer discount its payment to the Tenet provider when it receives notice that the Tenet provider waived all or a portion of the patient's deductible, co-payment or other cost sharing amount?

Answer: Maybe. Payors require individuals to pay deductibles, co-payments and other cost sharing amounts to ensure appropriate utilization of medical services. When deductibles and co-payments are waived, payors will often reduce the amount of payment for medical services rendered on the theory the provider did not actually intend to collect the usual and customary charge reflected on the bill. Depending on state law, some courts have held when a provider waives all or a portion of a patient's co-payment or deductible amount, that the provider did not intend to actually collect the entire amount of the bill submitted. In such cases, the courts have held the payor is only obligated to pay its portion of the bill based on the actual amount expected to be received by the provider, or no amount at all. For example, if a patient's co-payment obligation is 20%, the provider's invoice is $100, and the provider waives the patient's co-payment obligation of $20, some courts have held the provider's usual charge is not actually $100, but only $80, since this is the amount the provider actually intended to collect. Since the payor's obligation is 80% in this example, the payment due by the payor is $64, or 80% of $80. Some courts have also held the amount due by the payor is zero, since if the patient's 20% co-payment obligation is $0.00, then correspondingly, the payor's 80% payment obligation must also be $0.00 (e.g., 80% of $0.00 = $0.00). If a Tenet provider experiences denials, it will either have to accept a reduced or no payment, or it may need to amend its Policy to provide that the physician will not be granted a discount if his or her insurer denies or reduces its payment to the Tenet provider.

15**. Question:** Can the Tenet provider exclude non-covered services, such as elective cosmetic surgery, from its Policy?

Answer: Yes. The Tenet provider will need to either modify the Policy to exclude non-covered services from those services subject to the discount or limit the amount of discount. For instance, the Tenet provider may exclude non-covered services from those

services that are subject to the discount under the Policy or it may limit the waiver to a percentage of the charges, such as 25%, up to a maximum of $5,000 per calendar year per family. The Tenet provider should contact its Regional Counsel to modify its Policy if it desires to exclude or limit the amount of the discount for non-covered services.

16. **Question:** Is the $5,000 limit based on the date of service or when the discount is offered/written off?

Answer: For purposes of tracking the professional courtesy discount, the hospital should generally use the date the health care services were provided to the patient. In recognition of the fact that previous guidance called for use of the date that the payor was notified of a discount, a Tenet provider may elect to use either the date of service or the date that the payor was notified of the discount for services rendered in 2010 where the discount was applied in 2011. For example, if a patient received services on November 15, 2010 and his payor was notified of a $2,000 discount on January 15, 2011, the discount may be claimed for either 2010 or 2011. The discount will apply against the maximum permitted discount for the year for which it is claimed. If the patient is a self-pay patient, then the hospital should use the date it offers the discount to the patient**.**

17**.** **Question:** In a two physician family, does each physician get a $5,000 discount or is it limited to $5,000 per family?

Answer: The Policy limits the discount to $5,000 per family per calendar year.

18**.** **Question:** If a Tenet hospital has a cash rate of $4,000 for a non-covered procedure such as cosmetic surgery but its gross charges are $20,000 for the procedure, is the discount available to the cash rate or is it applied against the gross charges?

Answer: The discount should be applied only against the hospital's gross charges. Applying the discount against the cash rate would have the effect of providing the procedure for free which is clearly not the intention of the Policy.

19. **Question:** May a physician employed by the Tenet provider or an affiliate of the provider be offered discounts under this Policy?

Answer: Maybe. A physician employed by the Tenet provider or an affiliate of the provider may be offered discounts consistent with this Policy, provided such discount is consistent with the physician's benefit plan. If the physician is covered under a high deductible health plan/health savings account, IRS rules prohibit the waiver of deductible amounts. Therefore, the physician would not be entitled to the discounts under this Policy until the deductible is met. After the deductible is met, co-insurance/co-pays can be waived.

Sample Letter to Insurer

Instructions for Use:

- **This letter is to be used for the sole purpose of notifying the insurer of a courtesy discount provided in accordance with Law Department Policy L-13 "Courtesy Discounts for Physicians and Governing Board Members." Before sending the letter, ensure that the discount provided meets all of the requirements of this Policy. See Law Department Policy L-13. Do not use this letter if the patient is a federal health care program beneficiary. See L-13, Section III. B.**
- **Before using this form, obtain the approval of this form from Regional Counsel as the discounts contemplated in this letter may not be permitted under state law. Regional Counsel is not required to approve each individual discount but the CEO or CFO is required to approve each individual discount. See L-13 SectionV.G.**
- **This letter must be sent to the insurer on or after the date on which the health care services were provided to an individual eligible under the Policy.**
- **This letter must be directed to the claims processing unit that will process the electronic claim submitted to the insurer.**
- **A copy of this letter must be retained in the Patient Account files retained in the business office and by the CFO. Copies of these letters must be readily available for review during internal and other audits.**
- **If you have any questions about the use of this letter or desire to modify it in any way, contact your Regional Counsel.**

[Date]

[Contact Person for Processing of Claims]
[Name of Insurance Company]
[Address]
[Address]
Attention: Claims Processing Unit

Re: Patient Name: _____
Date(s) of Service: _____
Insured: _____
SSN: _____
Claim Number: _____
Total Charges: _____

Dear Sir or Madam:

The patient referenced above received services at our hospital on the date(s) of service referenced above. Under the hospital's Courtesy Discount Policy, this patient was eligible to receive a discount on the claim referenced above as the patient is a:

- ☐ physician
- ☐ spouse, dependent child, or parent of a physician
- ☐ current member of the hospital's Governing Board
- ☐ spouse, dependent child, or parent of a current member of the hospital's Governing Board

In accordance with our Courtesy Discount Policy, the hospital has waived $_____, which had the effect of forgiving all [part] of the patient's otherwise applicable patient cost sharing amount.

If you have any questions about our Courtesy Discount Policy or this claim, please contact me at [phone number or email address].

Sincerely,

[Business Office Manager/Regional Business Office Director]

cc: Chief Financial Officer
Patient Account File