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No-Charge Pre-Authorizations: Good Business or Legal Minefield?

By: Stuart J. Vogelsmeier, J.D.

Introduction: Some hospitals and freestanding imaging centers have provided no-charge pre-authorization services for physicians and patients for years. Other hospitals and freestanding imaging centers have been advised by counsel that such a practice would be risky because such services may be viewed as an inducement to the referring physicians. Recently, the Office of Inspector General of the Department of Health and Human Services (the "OIG") issued two Advisory Opinions, which provide significant guidance for hospitals and freestanding imaging centers that have considered this practice.

Factual Background: Advisory Opinion 10-13 (August 31, 2010) and Advisory Opinion 10-20 (September 28, 2010) describe plans by a nonprofit hospital and a radiology group, respectively, to provide free pre-authorization services[i] for all patients referred to the hospital or the radiology group for imaging services. The proposed arrangements in the two Advisory Opinions were very similar. When the patient's imaging procedure required pre-authorization, the imaging provider (in these examples, either the hospital or the radiology group) personnel would contact the patient's insurer and provide it with the information necessary to obtain pre-authorization. The pre-authorization service would be at no charge, and made available on an equal basis to all patients and referring physicians without regard to any physician's overall volume or value of expected or past referrals. The imaging provider would obtain from physicians the documentation required by insurers. The imaging provider would identify itself to insurers as the imaging provider, and would disclose the nature of the arrangement. A record would be sent back to physicians containing relevant information such as the pre-authorization cost, the test ordered and date the tests would be performed. The imaging providers in the Advisory Opinions stated that they commonly receive incorrect pre-authorization information from referring physicians, but that the referring physicians did not have a motivation to ensure accurate information, because the referring physicians were not being paid for the imaging services.

Legal Analysis: The OIG position on the provision of free or below-market goods or services to actual or potential referral sources has been that such arrangements are suspect, and may, depending upon the circumstances, violate the Anti-Kickback statute. In Advisory Opinions 10-13 and 10-20, the OIG acknowledges that obtaining pre-authorization from insurers is an administrative service with independent value to a physician. When the referring physician's contract with an insurer specifically allocates responsibility for obtaining pre-authorization to the physician, an imaging provider's free pre-authorization services could relieve that physician of

having to perform those services. In cases where a physician's contract with an insurer allocates responsibility for obtaining pre-authorization services to imaging providers or patients, an imaging provider is not relieving an express financial obligation that the physician would otherwise incur, but it may still relieve staff that is devoting considerable time to pre-authorizations. The same is true for physician-insurer contracts which do not allocate responsibility to any party.

In both Advisory Opinions, the OIG states that there was a low level of risk, and would not pursue administrative sanctions against the parties involved because of the following reasons:

1. The proposed pre-authorizations would not target any particular referring physicians. The OIG stated that given the multitude of insurance plans and plan requirements, the imaging providers were unlikely to know physicians' obligations with respect to an order for a particular patient. Thus, any relief to the physicians of pre-authorization obligations would occur by chance, not by design. Given that the pre-authorization service would be made available on an equal basis to all patients and physicians, without regard to any physician's volume or value of expected or past referrals, the risk that the imaging providers were rewarding referrals was minimized.

2. The imaging providers were not making payments to physicians to reward referrals. Moreover, the imaging providers made no assurances to physicians or patients that their pre-authorization service would result in pre-authorization being approved.

3. The arrangements were transparent. The imaging providers would identify themselves to insurers as representatives of the imaging provider, disclose the nature of the program, and provide each physician with a copy of all the information they submit to insurers. The imaging providers would have little opportunity to influence referrals because the patients would have already selected the imaging providers. The OIG contrasted this type of program with relationships in which the ability to influence referrals exists, such as discharge planners or home care coordinators.

4. The imaging providers had a legitimate business interest in offering uniform pre-authorization services. Only the imaging providers' reimbursements are at stake. An imaging provider's financial interest in ensuring that pre-authorization is diligently pursued provides a business rationale that is wholly distinct from a scheme to curry favor with referral sources.

Conclusions: Although Advisory Opinions may not be relied upon by providers who are not parties to the specific Advisory Opinion request, Advisory Opinions do shed valuable light on the OIG's enforcement position. The factors cited by the OIG in approving the pre-authorization services provide a starting point for analysis of a proposed pre-authorization program.

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[i] Pre-Authorization generally refers to the process in which the payor provides an authorization code or confirmation number for the imaging service. The Centers for Medicare and Medicare Services ("CMS") confirmed to the OIG that Medicare generally does not require pre-authorization for imaging services. However, some Medicare and Medicaid HMOs do require pre-authorization for some diagnostic imaging services.