

Medicare Balance Billing and Private-Pay Contracts

Health Care Law

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This material is intended to flesh out casebook's discussion of assignment, balance-billing, and bypassing Medicare altogether with private-pay contracts.

1. Vocabulary:

For Part B services provided to Medicare beneficiaries, physicians may accept **assignment**, which means they can bill the Medicare program directly and they will accept the Medicare Approved Amount as payment in full for Part B covered services. In other words, physicians who accept assignment may not balance-bill the patient (i.e., bill for the difference between what Medicare will pay and what the physician customarily charged).

Physicians may accept assignment on a case-by-case basis. Alternatively, they may become **participating** (or "**par**") **physicians**, in which case they agree to accept assignment for all covered charges for all Medicare patients for a particular calendar year. That means the physicians agree not to balance-bill any Medicare patient for as long as they are participating physicians.

A "**non-par**" **physician** (one who reserves the right to accept assignment or not on a case-by-case basis) is paid by Medicare on the basis of a non-participating physician fee schedule, which is 5% lower than the fee schedule for a participating physician. In addition, as to those services for which the physician does not accept assignment, the physician's ability to balance-bill is subject to a **limiting change**, which is currently 115% above the fee schedule amount for non-par physicians. When you do the math, this caps the non-par physician's charge at 109.25% (e.g., 115% x 95%) of the Medicare Approved Amount.

2. Facts:

- Patient's name: Mr. Jones
- Physician's name: Dr. Smith
- Procedure Code: 15845 (Skin and muscle repair, face)
- Weighting factor: 20 (in real life, it's more)
- Conversion factor: \$50 (in real life, it's less)
- RBRVS payment = \$1,000 (known as the "Medicare Approved Amount") for participating physicians
- Dr. Smith's usual (non-Medicare) fee for skin and muscle repairs to the face: \$1,250

Medicare deductible: Mr. Jones has an annual Part B deductible of \$100/year. Assume that he has already met his deductible for the current year. (If not, the \$100 would have to be paid first and we would do some of our calculations based on a lower reimbursable amount (i.e., \$900).

Medicare co-pay: Mr. Jones's co-pay obligation is 20% of the Medicare Approved Amount after the deductible (since the deductible has already been met for this year, that's 20% of \$1,000).

Questions

1. Can Dr. Smith balance bill?

a. Yes, if she doesn't accept assignment.

b. **What if the physician is a participating physician?** In that case, she cannot balance-bill any of her Medicare patients, because she is accepting assignment as payment in full for services provided to all Medicare patients.

2. Assume Dr. Smith can balance-bill. (I.e., assume she is not a participating physician and that she has not accepted assignment with respect to Mr. Jones.) **How much can she balance-bill Mr. Jones?**

a. First, recognize that, since she is not a participating physician, Dr. Smith's Medicare Approved Amount is 95% of the scheduled amount, or \$950. Five percent off the top is the penalty she pays for not being a participating physician. (There are other penalties and inconveniences that flow from being non-par as well.)

b. Second, her right to balance-bill is subject to the limiting charge, which is 115% of the Medicare Approved Amount of \$950 (equals \$1,092.50). Another way of thinking of this number is that it is 109.25% of the scheduled RBRVS payment (in this case, 109.25% of \$1,000, or \$1,092.50).

c. Medicare's approved amount is \$950. It will pay 80% of that amount, or \$760, leaving a balance of \$332.50 (i.e., \$1,092.50-\$760). This is the amount that the physician may balance-bill the patient.

3. Can Dr. Smith (and Mr. Jones) skip the entire hassle of this system by stepping outside the Medicare system and rendering (and receiving) covered benefits but not submitting any request for reimbursement by Medicare whatsoever? In Medicare terms, the question is whether Smith and Jones can enter into a private-contracting relationship with respect to items and services that are covered by Medicare. The answer is yes, but read the 42 U.S.C. § 1395a(b) handout for today to see what the consequences are for Dr. Smith.

Then consider the extent to which Medicare affects the economics of the practice of a physician who becomes a Medicare provider -- the extent to which, as a practical matter, the physician's rates are controlled by Medicare-imposed limits and the extent to which the physician cannot escape those limits, except to leave the Medicare system altogether.

Is this Clinton-style nationalized health care for the elderly and the disabled? Is it bad? If it works for our parents and grandparents, who are voracious consumers of health care goods and services, why wouldn't it work for everyone?