

NEW YORK'S BALANCE BILLING LAW

The amount a person with Medicare owes their doctor may be less than they expect. A New York law limits the amount that Medicare non-participating doctors (doctors who do not accept Medicare assignment) may charge no more than 5% above Medicare's approved amount. This limit applies to all services except certain home and office visits for basic medical examinations, (those with procedure codes of 99201 to 99215 and 99341 to 99353). For services with these code numbers, the federal limit of 15% above Medicare's approved amount applies. Medicare's approved amount for health care services and supplies is shown on the beneficiary's MSN.

Medicare participating doctors (those who do accept Medicare assignment) have already agreed to collect no more than Medicare's approved amount.

The following refers to non-participating doctors only:

Ask a non-participating doctor if he or she will be willing to accept Medicare's approved amount as the total due. Non-participating doctors may accept assignment on a case-by-case basis.

If a beneficiary's doctor will not accept Medicare assignment...

A beneficiary should ask their doctor if they might pay their bill after they receive their MSN. A person with Medicare will then be sure that their doctor's bill conforms to the new New York State limit.

If a beneficiary's doctor charges more than 5% above Medicare's approved charge...

Contact their doctor. The law requires that the doctor make an adjustment or refund the person with Medicare if they are overcharged.

If a beneficiary's doctor believes that Medicare's approved amount is incorrect...

The person with Medicare may request a review of their claim. Send a copy (not the original) of the Medicare Summary Notice (MSN) form with a note to please review and provide their signature. Mail to the address shown on the front of their MSN.

If a beneficiary's call to the doctor does not resolve the bill...

The New York State Department of Health is designated by law to investigate possible overcharges. The beneficiary's complaint, a brief description of the problem, and photocopies, not originals, of the MSN and other documentation, including their Medicare appeal decision, may be sent to:

*Medicare Balance Billing
New York State Department of Health
Albany, New York 12237*

A person with Medicare may call their local Health Insurance Information, Counseling and Assistance Program, or the HIICAP Hotline, 1-800-333-4114, for help with this and other health insurance concerns.

The Medicare Summary Notice (MSN) will tell the person with Medicare whether or not a doctor accepted assignment. If assignment was accepted, the person with Medicare generally owes 20% of the approved amount shown on the MSN. If the doctor did not accept assignment, the person with Medicare will be responsible for an additional 5% of the approved amount for most services in New York, or in the case of specific procedures not covered by New York state law, an additional 15%, the federal limit.

Note: The limiting charge does not apply to Durable Medical Equipment (DME)

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Caution: A person with Medicare will need to do his or her own computation for New York State services. The Medicare Part B carrier is a federal contractor and shows only the federal limiting charge of 15% above Medicare's approved amount. However, the MSN will include a separate message about New York's balance billing limit. Let the person with Medicare know they shouldn't risk paying too much for a service or supply. Encourage them to ask their doctor or other provider if they may pay after receipt of the MSN. The MSN will give the approved charge on which to calculate what is actually owed to the non-assigned doctor. If the code number of the service the doctor provided is 99201 through 99215, or 99341 through 99353, the federal limit applies. Multiply the Medicare approved amount by 1.15 to determine the maximum the doctor may charge. For all other code numbers, the New York State limit applies. Multiply the Medicare approved amount by 1.05 to determine the maximum the doctor may charge.

ADVANCE BENEFICIARY NOTICE (ABN) AND SPECIAL AGREEMENTS: ARE THEY LEGAL?

Right: A beneficiary has the right to understand why Medicare will not pay for a service or supply in certain circumstances, and the reason why. The health care provider must give them, in writing, before the service is rendered, the reason why they believe Medicare will not pay for the service in a specific case. This is called an Advance Beneficiary Notice.

It must contain four parts:

1. The service in question
2. The date of the service
3. A specific reason why they believe the coverable service may not be paid.
4. A beneficiary's signature indicating they understand and agree to accept responsibility to pay for the service.

Effective October 1, 2002, CMS has instructed providers to use one of two standard ABN forms. Form CMS R-131-G is for general use. CMS-R-131-L is specific for lab services. Sample copies of the two forms can be found at the end of this module.

"Blanket Waivers," which are not specific, are not binding. Doctors are not permitted to ask a person with Medicare to sign a statement guaranteeing that they will pay any and all charges that Medicare does not pay. These blanket coverage waivers are not legal and one is not bound by them. If a doctor asks a person with Medicare to sign this type of waiver, it should be reported to the Medicare carrier.

Only when the doctor has informed the person with Medicare that Medicare does not cover a particular service and they had signed a statement agreeing to accept responsibility for a particular bill is a waiver legally binding. A small number of doctors attempt to avoid the limiting charge laws set by state and federal government. The Centers for Medicare & Medicaid Services (CMS) has released its position on such inappropriate physician tactics for collecting more than the law allows. A person with Medicare should be on guard if a doctor suggests any of the following:

- that they sign a blanket waiver ("pay for everything Medicare doesn't") like the one described above
- that they pay the full charge in excess of Medicare's approved amount
- that they pay for services such as telephone calls or prescription refills that are normally considered to be part of the charge of a visit.

This doctor may be attempting to avoid Medicare regulations. Doctors are legally obligated to charge no more than what federal and state laws permit. They are not permitted to bill separately for each individual part of a visit. Call the Medicare carrier to report all such cases.