



CALIFORNIA HEALTH ADVOCATES

Medicare Assignment and Costs

Original Medicare

If you have Medicare, you have either Original fee-for-service Medicare (Parts A and B) or a Medicare Advantage (MA) plan (Part C), which must provide Medicare Parts A and B benefits. This fact sheet is for people with Original Medicare. It discusses providers who accept Medicare assignment, those who do not, and how that affects your costs. If you are in a Medicare Advantage plan, please consult the plan materials about which providers are in your plan and copayments for services. **Note:** There are different types of Medicare Advantage plans. For more information on all the types of MA plans and how they work, see our fact sheet, "Medicare Advantage Plans: An Overview."

Assignment

When a doctor, other health care provider, or supplier accepts assignment in Original Medicare, they agree to accept the Medicare-approved amount as the total payment for the service or item. They also agree to bill Medicare, as you have "assigned" Medicare to pay the doctor, other provider, or supplier directly for your care.

Example: A doctor charges \$120 for a service. Medicare's approved amount for the service is \$100. A doctor who accepts assignment agrees to the \$100 as full payment for that service. The doctor bills Medicare who pays him or her 80% or \$80, and you are responsible for the 20% coinsurance (after you have paid the Part B annual deductible of \$155 in 2010).

Note: For more info about your out-of-pocket costs, please see our fact sheet "2010 Premiums, Coinsurance and Deductibles (Original Fee-for-Service Medicare)."

Who accepts assignment?

Doctors and other providers who participate in Medicare accept assignment for all their Medicare patients. Doctors and other providers who do NOT participate in Medicare CAN also accept assignment. They may accept assignment for some Medicare patients on a case-by-case basis, but not all their Medicare patients. Always ask your doctor in advance if he or she accepts Medicare assignment.

For a list of doctors and suppliers who participate in Medicare, call 1-800-Medicare (1-800-633-4227), or look up this information on the Medicare's website: Medicare.gov.

Providers who do not accept assignment

Doctors and other providers who do not accept assignment can charge you more than the Medicare-approved amount, but they cannot charge you more than 115% of Medicare's approved amount. The additional 15% is called an excess charge or limiting charge. The limiting charge applies only to certain services and does not apply to supplies or durable medical equipment.

Example: A doctor charges \$120 for a service. Medicare's approved amount for the service is \$100. A doctor who does not accept assignment can charge you more than \$100, but not more than \$115 for that service. The doctor may ask you to pay the \$115 at the time you receive the service.

Even though the doctor does not accept assignment, he or she is required by law to file a claim to Medicare. After Medicare processes the claim, Medicare reimburses you 80% of the Medicare-approved amount, and you are responsible for the 20% coinsurance and limiting charge, assuming you have met the Part B deductible.

Because of the excess or limiting charge, you often save money by going to a provider who accepts assignment, as illustrated below.

Example of What You Could Save by Going to a Provider Who Accepts Assignment

	With Assignment	Without Assignment
Actual Doctor's Bill	\$115.00	\$115.00
Amount Medicare Approves	\$100.00	\$100.00
Medicare Pays 80%	\$80.00	\$80.00
You pay 20% Co-Insurance	\$20.00	\$20.00
Excess Charge	\$0.00	\$15.00
Total You Pay	\$20.00	\$35.00

Your Medicare Summary Notice (MSN) will indicate:

- a) the amount charged by the provider;
- b) the amount approved by Medicare;
- c) whether the physician accepted assignment; and
- d) the amount for which you may be responsible.

The amount for which you may be responsible is a combination of deductibles, coinsurance, and any non-covered charges. Thus, if you go to a doctor who does not accept assignment, the MSN shows if the doctor charged you more than 15% above the approved amount for the service. If he or she overcharged you, you are entitled to a reduction in the charge or a refund.

Before making any payment, it is advisable to wait for the MSN to find out what Medicare covered, what service(s) Medicare did not cover and why, and what you are responsible to pay.

Private Contracting Physicians

Doctors and some other providers may "opt out" of Medicare, which means they cannot bill Medicare for any Medicare-covered services or items for 2 years. If a Medicare beneficiary wants to see a doctor who has opted out and the doctor agrees to treat him or her, the doctor

and Medicare beneficiary must enter into a private contract for services normally covered by Medicare. The contract must be in writing and signed by the beneficiary, who acknowledges that the doctor has opted out and accepts full responsibility for all charges for the doctor's services.

Doctors who have opted out may set their own rates; the limiting charge does not apply to them. If you enter into a private contract with a doctor who has opted out, you cannot get reimbursed from Medicare. Call Medicare (1-800-MEDICARE) to find out if your doctor has opted out of Medicare.

Advance Beneficiary Notice

Medicare covers only those services and items that it considers "reasonable and medically necessary." If your doctor (one that has NOT opted out of Medicare) believes that Medicare will deny payment for a particular service, he or she is required to tell you before providing the service and present an Advance Beneficiary Notice (ABN.) The doctor must use an approved ABN form (Form CMS-R-131) and on the form identify the service; state that he or she expects Medicare may not pay for the service; give his or her reason(s) for believing why Medicare may deny payment; and state the estimated cost.

The purpose of the ABN is to help you make an informed decision about the service or item. If you sign, you agree to pay the doctor for the service if Medicare denies payment. If you do not sign, the service will not be provided. Other providers, such as labs and suppliers may also use the ABN.

If a doctor does not notify you, and does not present the ABN, the doctor can be required to absorb the cost of procedures that Medicare deemed "not reasonable and medically necessary." You aren't required to pay for the service(s) if you were not informed in advance that the service(s) might not be covered by Medicare, or if you did not sign an ABN. However, under some circumstances, if you were aware, or should have been aware, that the services are not covered, you are responsible for payment. For example, services generally known to be excluded from Medicare

coverage include routine physicals, dental care, and hearing aids.

If you cannot resolve a financial issue with your provider or supplier, please contact the Health Insurance Counseling and Advocacy Program (HICAP) — see below.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call HICAP. HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.