

## ANSWERS TO COMMON QUESTIONS ASKED BY OUR MEDICARE PATIENTS

**What is the difference between the terms “accepting assignment” and “not accepting assignment” and “PAR Provider” versus “Non-PAR Provider”?**

A “**Par**” provider is also referred to as a provider who “**accepts assignment**”.

A “**Non-Par**” provider is also referred to as a provider who “**does not accept assignment**”.

The primary **differences** are, 1) the fee that is charged, 2) the amount paid by Medicare and the patient, and 3) where Medicare sends the payment.

The primary **similarities** are, 1) the provider must bill Medicare directly, 2) there is the same annual deductible, and 3) a 20% co-insurance is applied to the charge.

### **FEE AMOUNT:**

The following assumes the annual nominal deductible has been met.

A “**Par**” provider bills Medicare directly an amount equal to the Medicare “**Par Fee**”. Medicare pays the **provider** directly for 80% of the “**Par Fee**”. The patient is then responsible for paying the provider the 20% co-insurance amount (which may be covered by a secondary policy if the patient purchased such coverage).

A “**Non-Par**” provider bills Medicare directly an amount called the Medicare “**Limiting Charge**”. The “**Limiting Charge**” is set at 15% higher than the “**Non-Par Fee**”. The “**Non-Par Fee**” is 5% less than the “**Par Fee**”. Medicare pays the **patient** directly for 80% the “**Non-Par Fee**”. The patient is then responsible for passing on the Medicare payment to the provider, plus pay for the 20% co-insurance on the “**Non-Par Fee**” as well as the 15% difference between the “**Non-Par Fee**” and the “**Limiting Charge**”. (portions or all of which may be covered by a secondary policy if the patient purchased such coverage).

There are a few exceptions such as in-office lab charges, Ambulatory Surgical Unit Facility Fees and some physician assistant fees which are always treated as “Par Fee” scenarios.

**Are Boulder Medical Center providers “par providers (accept assignment)” or “non-par providers (do not accept assignment)”?**

Boulder Medical Center physicians have chosen, as a group, to be non-par providers (do not accept assignment) based on their assessment of Boulder community needs and the health care market.

**Following is an example:** Assumes a "Par Fee" of \$100 & the annual deductible has been met.

### Par Provider

Medicare Charge Amount	\$100.00	(Par Fee)
Patient Co-Insurance	\$20.00	(20% of Par Fee)
Medicare Pays	\$80.00	(80% of Par Fee)
<b>Total Patient Share</b>	<b>\$20.00 * (20%)</b>	
<b>Total Medicare Paid</b>	<b>\$80.00 (80%)</b>	

### Non-Par Provider

Medicare Charge Amount	\$109.26	(Limiting Charge)
Patient share	<u>\$14.26</u>	
Subtotal	\$95.00	(also called Non-Par Fee)
Patient Co-Insurance	\$19.00	(20% of Non-Par Fee)
Medicare Pays	\$76.00	(80% of Non-Par Fee)
<b>Total Patient Share</b>	<b>\$33.26 * (30.4%)</b>	
<b>Total Medicare Paid</b>	<b>\$76.00 (69.6%)</b>	

\* all or portions of which may be covered by secondary insurance if the patient has purchased such coverage.

### **When am I expected to pay my bill?**

We ask that you pay for all office charges at the time the services are rendered. We will provide you with an office encounter form, which you can take to the cashier in the lobby to make your payment. A copy of this encounter form will be provided to you so you can bill your Medigap carrier once Medicare has paid you their share. (If your bill exceeds \$75 you may ask the cashier to let you meet with an account representative to work out a payment plan on the amount exceeding \$75.00, i.e. delay payment until you have been paid by Medicare.)

(over)

## **What if Medicare denies a charge?**

If you receive an explanation of benefits from Medicare that denies a charge, please send or bring a copy of the explanation of benefits to our business office. Include a note requesting that the charge be reviewed and why. Our office will review the charge. If we conclude that the charge should have been covered we will appeal to Medicare on your behalf. If the charge is ultimately determined to be for a service that Medicare does not cover, then you will be responsible for the charge.

## **Why are some of my claims paid directly to Boulder Medical Center?**

Medicare requires that every provider process certain services as 'assigned' claims regardless of whether the provider is non-participating. Examples are in-office lab charges, Ambulatory Surgical Unit room fees and some physician assistant charges. You will be billed for coinsurance (the portion of the bill that Medicare does not pay) for any Ambulatory Surgical Unit room fees and psychological counseling charges incurred. Also, Medicare does not cover routine exams & any lab services connected with such an exam.

## **Why doesn't the Boulder Medical Center file claims with my secondary insurance?**

As non-par providers who do not contract directly with Medicare, our physicians do not receive payments or explanations of benefit information from Medicare. Instead, Medicare sends the payment and the explanations of benefits directly to you. Medicare will not furnish the non-par physicians with explanations of benefit information. Therefore, you are responsible for filing with any secondary insurance carrier in what is the most efficient and timely manner. NOTE: Per Medicare, automatic crossover of your claims to your secondary is determined on an individual basis. To pursue this you would contact your supplemental carrier. If your supplemental carrier has the computer capability, the crossover will be initiated. Many of the BCBS and AARP plans will automatically crossover but the patient should still contact Medicare to make sure they are set up.

## **Is there somewhere I can find help with filing my secondary claims?**

Yes, there are organizations established to assist you with all aspects of handling your medical bills. You can find out where these organizations are by contacting the Division of Insurance at 303-443-1933.

## **MEDICARE ELIGIBLE PATIENTS**

1. Medicare patients will not have to stop at the cashiers, once they have checked in at the registration desk, filled out the registration form, and had their Medicare card copied.
2. Boulder Medical Center requests that you pay on your way out if your provider gives you the charges for your visit.
3. If you have a primary insurance other than Medicare, you will be required to stop at the cashiers before every visit to Boulder Medical Center. Examples are Kaiser, HMO insurances and those patients that have Part A only and do not have Part B. This also includes those patients that have Medicare as primary, but their secondary insurance requires that they make a copay.