JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

FACT SHEET

What Should California Advocates Do If Their Clients are Improperly Billed?

Improper billing, sometimes referred to as a form of "balance billing," is the practice in which providers, particularly physicians, seek to bill (1) dual eligible beneficiaries (those with both Medicare and Medi-Cal) for charges not covered by either Medicare or Medi-Cal; or (2) Medi-Cal only seniors and persons with disabilities any amount for a Medi-Cal covered service.

Improper billing violates both federal and state law.[1] State law protects any Medi-Cal beneficiary against improper billing.[2] A provider must accept as payment in full whatever amount the provider receives from Medicare, other insurance (if any), and Medi-Cal. Private pay agreements or other waivers of the improper billing protection are unlawful. Furthermore, federal law protects all dual eligibles – regardless of whether they are QMB – who are enrolled in Medicare Advantage and Cal MediConnect plans from paying co-pays.[3]

Note that the state law improper billing protection applies to Medi-Cal share of cost beneficiaries when the share of cost has been met for the month during which services were rendered.

Providers, however, are often confused about their obligations under law, and billing systems are not foolproof. The result is that both dual eligibles and SPDs can be improperly billed.

Case Example #1

Ms. Jones is a dual eligible who resides in a CCI county. She has Original Medicare and recently joined a Medi-Cal plan, and she visits her Medicare doctor for a regularly scheduled office visit. Although the doctor has not billed her for previous visits, he does not have a contract with Ms. Jones's new Medi-Cal plan so he instead sends her a bill for the charges that Medicare did not pay.

RULE: Under no circumstances may the doctor bill Ms. Jones. Even if he does not have a contract with Ms. Jones's Medi-Cal plan, the doctor can still bill her plan for the Medicare coinsurance.

Case Example #2

Ms. Garcia is a dual eligible with a Medi-Cal share of cost of $100 and lives in a CCI county. In February, she sees her Medicare fee-for-service doctor, and she receives a bill from him for $50, which is 20 percent of the Medicare-approved amount for the service.

RULE: If Ms. Garcia has not yet met her share of cost for February, she can pay the $50 bill and have it count toward her share of cost. If she has already met her share of cost for February prior to this visit, improper billing protections are in effect, and she should not pay the bill.

[1]Federal law provides that all Medicare providers who serve qualified Medicare beneficiaries ("QMBs") cannot bill them for Medicare cost-sharing. 42 U.S.C. Sec. 1396a(n)(3)(B) (Sec. 1902(n)(3)(B) of the Social Security Act). The state law covers all Medi-Cal beneficiaries, whether or not they are QMBs. Cal. Welf. & Inst. Code § 14019.4.

[2] Cal. Welf. & Inst. Code § 14019.4. See also the All Plan Letter on Coordination of Benefits: Medicare and Medi-Cal guidance (supersedes APL 13-001) (February 8, 2013), available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf.

[3] 42 C.F.R. sec. 422.504(g)(1)(iii)

Providers who improperly bill beneficiaries are subject to penalties under both federal and state law, but advocates may find some providers who either do not understand the protections or refuse to bill properly. If a provider has erroneously billed a beneficiary, upon proof of Medi-Cal enrollment, the provider must call off any collection efforts that have begun, and if the bill has been sent a debt collection agency, the agency also must correct any erroneous information sent to credit reporting agencies.[4]

Case Example #3

Ms. Allen lives in California and has both Medicare and Medi-Cal. She is also a member of a Your Care Medicare Advantage plan. Upon visiting her in-network knee surgeon prior to a scheduled knee surgery, she is told by the billing staff that she owes a co-pay and has to pay as a condition to getting the surgery.

RULE: Under no circumstances may the knee surgeon bill Ms. Allen. As a dual eligible in Your Care Medicare Advantage plan, Ms. Allen is protected from paying any co-pays.

What Should Advocates Do If Their Clients are Improperly Billed?

- Advocates should work with beneficiaries to make sure their improper billing provider knows of the beneficiary's MediCal enrollment, should inform beneficiaries of their legal rights, and should encourage them not to pay the bill. Justice in Aging's improper billing toolkit includes model California-specific letters to providers.
- Beneficiaries can also be instructed to contact the local Health Insurance Counseling and Advocacy Program (HICAP) agency (1-800-434-0222) to report the issue. The Health Consumer Alliance (1-888-804-3536) can also assist clients on improper billing issues.
- Advocates can call 1-800-MEDICARE to report Original Medicare providers who have been improperly billing QMB clients.
- If beneficiaries are enrolled in a Medicare managed care plan (Medicare Advantage), advocates should reach out to the plan and alert them about the improper bills. The plans have a responsibility to assist in correcting improper charges.
- Please tell Justice in Aging if you see improper billing issues so we can monitor the issue. Justice in Aging also is available to provide technical assistance to advocates.
- For advocates looking to challenge administrative fees, including charges for In-Home Supportive Services (IHSS) certification paperwork, refer to Justice in Aging's issue brief on the topic.

[4] Cal. Welf. & Inst. Code § 14019.4(d).