

Advance Beneficiary Notices, Administrative Fees, and Dual Eligibles

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Federal law prohibits charging Qualified Medicare Beneficiaries (QMBs) with Medicare cost-sharing for covered services. Depending on state law, other beneficiaries who are fully eligible for both Medicare and Medicaid—full benefit dual eligibles—may also be protected from being billed for co-payments or other forms of cost sharing. However, QMBs and other dual eligibles may still be responsible for certain charges or fees. Take, for example, Mr. Jones, who is a dual eligible and enrolled in the QMB program. On a recent doctor's visit, he was billed for a number of charges. He knows he usually does not have to pay for services; however, he is confused about what he must pay. This Justice in Aging Issue Brief describes two situations where fees may be incurred:

1. When a service may not be covered by Medicare (and therefore the beneficiary receives an Advanced Beneficiary Notice, or ABN), and;
2. When a practice charges administrative fees.

In the sections below, we explain what protections QMBs have and what charges they have to pay.

What is an Advance Beneficiary Notice (ABN)?

When a Medicare provider believes that Medicare may not pay for a particular item or service, even though the item or service is generally covered, the provider must provide a notice to the beneficiary.¹ This notice is called an Advance Beneficiary Notice of Noncoverage (ABN), and it must be given to a beneficiary before services are provided. The ABN gives the beneficiary an opportunity to make an informed choice about whether to get a particular service or item. The ABN gives the beneficiary an opportunity to make an informed choice about whether to get a particular service or item.²

ABNs must identify three things:

1. The item or service that the provider expects Medicare will not pay for;
2. An estimate of costs; and
3. The reasons Medicare may not pay.

A standard ABN will also contain three options for a beneficiary to select:

- Option 1: Beneficiary wants the service and asks Medicare to be billed. The provider can seek payment now.
- Option 2: Beneficiary wants the service and asks Medicare not to be billed. The provider can seek payment now.
- Option 3: After learning of potential non-coverage, beneficiary no longer wants the service and is not responsible for payment. Medicare will not be billed.

If Medicare determines the service was covered, Medicare will pay, even if the beneficiary signs and agrees to the costs of the service. If Medicare does cover the service and the beneficiary has already paid, the provider must issue a refund to the beneficiary within 30 days after receiving the remittance advice from Medicare or 15 days after a determination is made on an appeal.³

If Medicare does not cover the service and Medicare denies the claim, the beneficiary can still appeal to Medicare as long as Medicare was billed. There are no appeal rights if Medicare was not billed.

If an ABN should have been issued and was not, the beneficiary does not bear any financial responsibility if Medicare does not pay. Note that CMS does not require providers to issue an ABN if a service is NEVER covered by Medicare, e.g., routine eye examinations to determine an eyeglass prescription. Providers may choose to do so, however, to avoid beneficiary confusion or surprise.

Subject to a few exceptions, providers must only issue ABNs when the particular circumstances warrant it and may not routinely issue ABNs to every Medicare patient, nor can they use them to shift liability to a beneficiary when Medicare would otherwise pay. Providers should give beneficiaries ample time to read and understand the ABN and answer any questions they may have. They also cannot issue them in a medical emergency or under great duress.⁴ Note that failure to comply with these rules gives advocates grounds to challenge the underlying validity of the ABN itself.

What Are the Implications of ABNs for Dual Eligibles and QMBs?

- An ABN puts the beneficiary on notice that Medicare might not cover the service. If a QMB decides to use the service anyway, the beneficiary may be liable if, in fact, Medicare does not provide coverage. QMB protections from improper billing only apply to *Medicare-covered* services.
- If the beneficiary is also a full benefit dual eligible, Medicaid might cover the service even if Medicare does not. However, Medicaid coverage generally will only be available if the provider accepts Medicaid.

- ABNs are different from private pay agreements, which seek to make a beneficiary financially liable for covered services despite legal protections to the contrary. QMBs cannot waive their improper billing protections for covered services by signing private pay agreements.

Ms. Lee is a dual eligible and a QMB. When she went for blood tests prescribed by her doctor, the lab gave her an ABN saying that one of the tests would likely not be covered by Medicare for someone with her diagnosis. She asked the lab whether Medicaid would cover the test but the person she asked didn't know. Mrs. Lee decided not to have the one test done that day. She plans to talk with her doctor about her options. She also plans to talk with her Medicaid managed care plan to find out whether Medicaid will cover the test.

How Does Medicare Treat Administrative Fees?

Many providers charge “administrative fees” for completing a form, a missed appointment, or general fees to run the office. Some providers also charge concierge fees or boutique fees for access to services. These fees can generate confusion among low income older adults. They raise questions of whether the fees are permissible under Medicare and how they are treated by the improper billing rules.

The first step in navigating an administrative fee is determining whether the fee is for something that is already included in the Medicare payment. If the Medicare payment includes the service for which the provider is now charging the QMB an additional fee, this violates the provider's agreement with Medicare.⁵

If the fee covers services that are distinct from what Medicare covers, then it is permissible for the provider to charge, but Medicare will not pay. The payment responsibility will lie entirely with the beneficiary. Because the services are not covered by Medicare, QMB protections will not apply.

There is only limited guidance from CMS on which administrative fees are permissible and which are not.

CMS has been explicit in one case: missed appointments. Medicare providers can charge a beneficiary for a missed appointment, but the charge must be the same as that assessed for non-Medicare patients. In other words, the provider's missed appointment policy must apply equally to all patients regardless of the kind of insurance they have.⁶

CMS also has said that concierge fees are never covered by Medicare.⁷ In addition, the agency has warned that concierge fees must be limited to services that would not otherwise be covered by Medicare. In one case, action was taken against a physician because his concierge contract included some services that the Office of the Inspector General alleged were Medicare-covered services.⁸ The agency did not, however, provide bright lines or detailed guidance.

Certain types of fees may be impermissible on their face, even if the service is not covered by Medicare, because the service should be covered by Medicaid. For example, a doctor contracted with Medicaid charging Medicaid beneficiaries, including dual eligibles, to complete an assessment for home and community based services (HCBS) violates federal rules.⁹

What Are the Implications of Administrative Fees for Dual Eligibles and QMBs?

- QMBs must pay missed appointment charges. They are not considered cost-sharing and are not part of the QMB protections. If the beneficiary, however, is a full benefit dual eligible and the provider also is enrolled in Medicaid, there may be some Medicaid protections against these charges. Advocates should look into their state's rules.
- When in doubt, dual eligibles, QMBs, and their advocates should ask providers to clearly explain what the administrative fees are being charged for. In addition, advocates may consider challenging questionable fees charged by Medicaid providers under the Medicaid payment in full provision; however, the law in this area is not completely settled.¹⁰

Mrs. Lopez's primary care physician has an office policy of charging \$50 for missed appointments and there is a notice at the reception desk telling all patients about the policy. Mrs. Lopez, who is a QMB and does not have full Medicaid, missed her last appointment because she mistakenly marked the wrong date on her calendar. Her doctor's office billed her for \$50. Mrs. Lopez is liable for the charges. She can request that the office waive or reduce the bill because she has been a patient for many years and has never before missed an appointment and because of her low income, but the office is not required to grant her request.

Conclusion

QMBs have broad protections from medical billing, but those protections are limited to services covered by Medicare. QMBs and dual eligible should familiarize themselves with the notices that they may receive about non-covered services and understand when they might be charged. Those who also have full Medicaid benefits may have additional protections. Advocacy tools and additional information on QMB billing protections are available at the Justice in Aging website¹¹ and at the CMS QMB program page.¹²

Endnotes

- 1 CMS Medicare Claims Processing Manual, Ch. 30, “Financial Liability Protections,” available at: www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf. The standard ABN form is available here: www.cms.gov/medicare/medicare-general-information/bni/abn.html.
- 2 CMS has released additional guidance for providers seeking information pertaining to ABNs and the QMB billing protection at www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf, starting on page six.
- 3 CMS Medicare Learning Network, Medicare Advance Beneficiary Notices, p. 6, available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf.
- 4 *Id.* at 4-5.
- 5 For additional guidance, see CMS Medicare Learning Network, MLN Matters, Charging Extra for Covered Services (“Charging Extra”), available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0421.pdf.
- 6 For additional guidance, see CMS Medicare Learning Network, MLN Matters, Charges for Missed Appointments, available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5613.pdf.
- 7 www.medicare.gov/coverage/concierge-care.html.
- 8 See Charging Extra, *supra* note 5.
- 9 42 USC § 1396t(c)(2)(A).
- 10 42 C.F.R. § 447.15.
- 11 www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/.
- 12 www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html.