Operational Policy Letter #38

Department of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

July 31, 1996

PAYMENTS TO NON-CONTRACTING MEDICARE PARTICIPATING PHYSICIANS BY A RISK CONTRACTING ORGANIZATION

Issue:

A question was raised regarding payment by a health maintenance organization (HMO) to a Medicare participating physician in excess of the Medicare allowed amount for services to an HMO patient. Under section 1876(j)(1) if a non-contracting physician participates in Medicare, his or her Medicare participation agreement is binding for services furnished to a Part B beneficiary enrolled in the HMO for which the HMO is responsible for payment (e.g. emergency services, approved out of network services). Has a physician (with a participating agreement with Medicare) violated his or her participation agreement by accepting payment in excess of the Medicare allowed amount?

Answer:

We believe that the physician has violated his or her participation agreement (and is subject to sanctions for this violation). Moreover, we have to question if the physician may have violated the anti-kickback provisions of the law if he or she knowingly accepted payment as an inducement to continue to see the HMO's patients. Similarly, we question if the HMO may have violated these provisions of the law by paying more than the Medicare allowed amount as an inducement to provide care.

The Medicare participation agreement the physician signed states that "The participant may not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance." This is based upon section 1842(h)(1) of the Social Security Act (the Act), which states that a participating physician has entered into a voluntary agreement with the Secretary "... which provides that such physician or supplier will **accept payment** under this part on an assignment-related basis..." (emphasis added). Section 1842(I)(1) defines "assignment-related basis" as including claims paid on the basis of an assignment described in sections 1842(b)(3)(B)(ii), 1842(b)(6)(B) or 1870(f)(1) of the Act. Section 1842(b)(3)(B)(ii)(II),

which we believe is the applicable section in this case, states that in accepting payment for the service under assignment, "the reasonable charge is the full charge for the service." In this case, the physician has accepted more than the Medicare allowed charge as the full charge for the service and has therefore violated his or her participation agreement, as well as the assignment agreement on the instant claim. We believe that the penalties in section 1128B(e) may apply, particularly if the physician has established a pattern of this practice.

As a practical matter, participating physicians typically bill Medicare their full actual charges when they provide services to Medicare fee for service patients and these actual charges are usually in excess of the Medicare allowed amount. This practice is acceptable as long as the physician doesn't collect more than the deductible or coinsurance from the beneficiary. In the case of an HMO beneficiary member, the HMO pays the physician the Medicare allowed amount, including any deductible and copayment that would be the responsibility of the beneficiary were he or she not an HMO member. As is the case with fee for service Medicare, it is acceptable for the physicians to bill the HMO for full actual charges in excess of the Medicare allowed amount as long as the payment he or she accepts does not exceed the Medicare allowed charge for the service. If the HMO pays in excess of the Medicare allowed amount for the service and the physician keeps the excessive payment, the physician has violated his or her assignment agreement on the claim in the same manner as if he or she had kept excessive payment made in by a carrier for a fee for service Medicare patient.

The amount that the HMO paid in excess of the Medicare allowed amount would be considered to be an overpayment and the HMO may recover it in accord with State law. The Medicare 3 year statute of limitations on recovery of overpayments does not apply since the HMO, rather than Medicare, made the overpayment.

However, the physician is not freed from his or her obligation to accept the Medicare allowed amount as the full charge for the service because the HMO overpaid the claim and the physician did not recognize that an overpayment had occurred. The physician is in violation of the participation agreement if he or she keeps this excess payment and is subject to sanction, notwithstanding the HMO's error in making the overpayment. Of course, if the physician refunds the excess payments to the HMO, he or she would no longer be in violation of the Medicare participation agreement because he or she will have accepted the Medicare allowed amount as payment in full for the services furnished.

If the excess payment was not as the result of an error, a question arises of whether the physician and HMO may have violated certain criminal provisions of the law. If the HMO knowingly paid in excess of the Medicare allowed amount for the services as an inducement to provide care to HMO patients, the HMO may have violated section 1128B(b)(1) of the Act by making the excessive payment and the physician may have violated that provision by accepting the excessive payment.

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