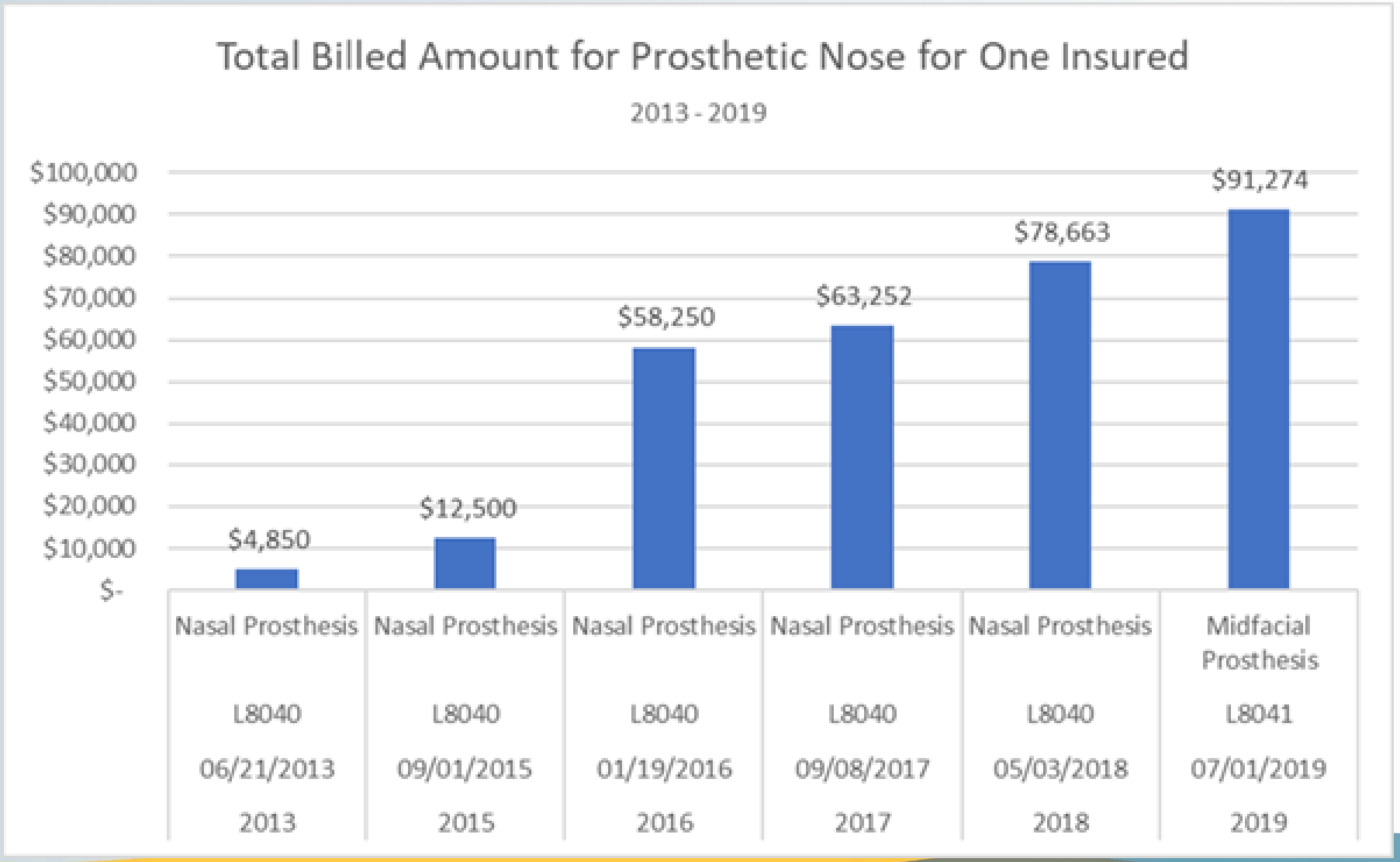
NEBRASKA DEPARTMENT OF INSURANCE

The DME Issue

SITF November 30, 2021

NEBRASKA

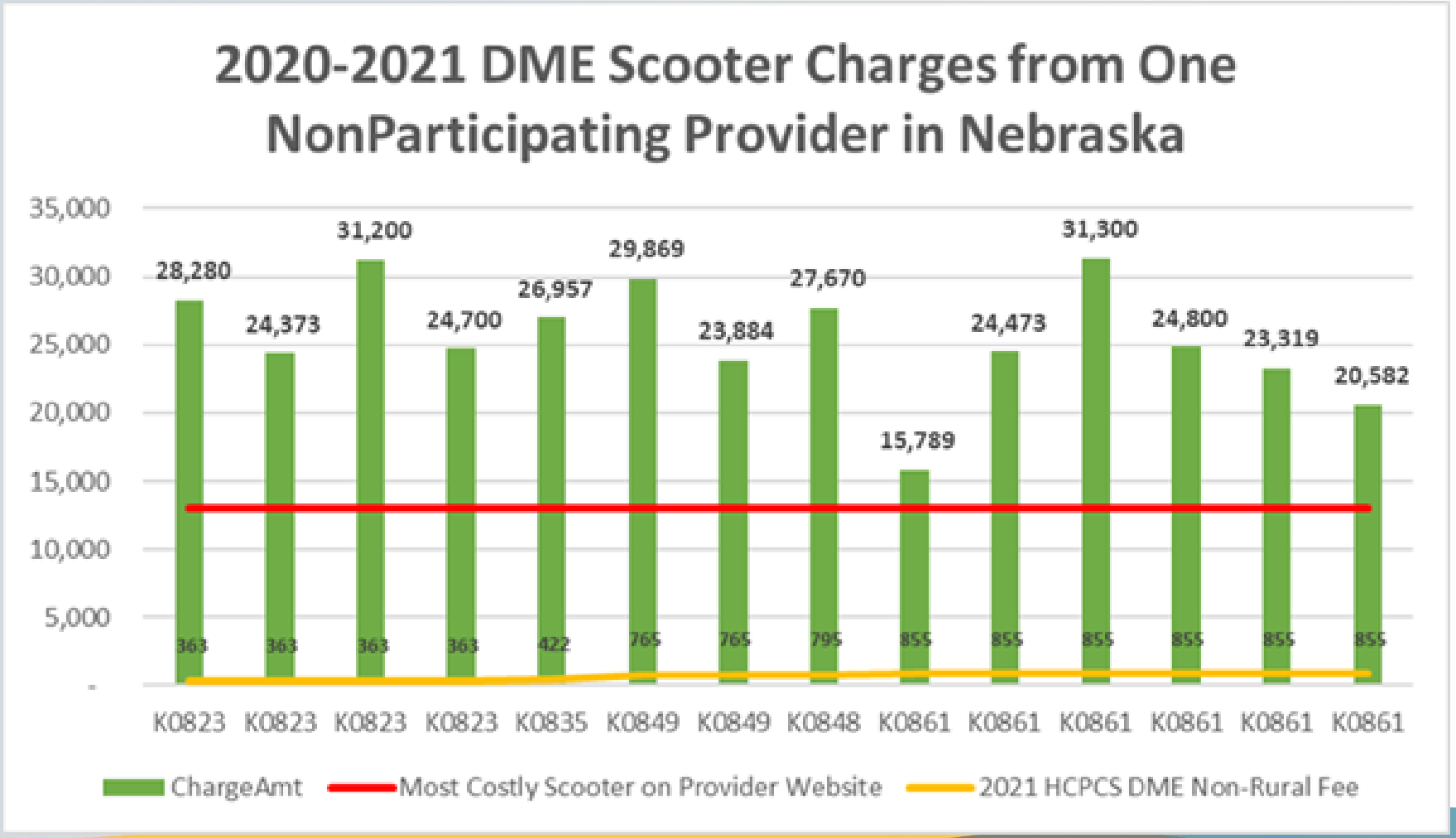
EXAMPLE ONE: THE PROSTHETIC NOSE



EXAMPLE TWO: SCOOTER STORE

- 2019
  - Medicare was billed $43,485.10 for a **power wheelchair**. Medicare approved $4,702 leaving the insurer to pay the balance of $38,783.10.
  - Medicare was billed $44,422.83 for a **power wheelchair**. Medicare approved $4,706.58, leaving the insurer to pay the balance of $39,716.25.
  - Medicare was billed $37,281.84 for a **hospital bed**. Medicare approved a monthly rental only which left the insurer to pay the balance after the approved charges of $16,383.14. The scooter store was called on this one and was told this was the cost of the hospital bed and they billed it as not assigned to Medicare and they will bill Medicare a monthly rental of the bed. The insurer pointed out the rental rate of the bed and the scooter store explained that he billed for the cost of the bed up front as he is allowed and will bill Medicare the monthly rental only.
- 2020
  - Medicare was billed $28,323.44 for a **power wheelchair and special cushion**. Medicare approved $11,486.15, leaving the insurer to pay the balance of $20,869.08.
- 2021
  - Medicare was billed $10,841.04 for a **hospital bed**. Medicare approved a monthly rental charge only which left the insurer to pay the balance after the approved charge of $10,767.18. A call was made on this claim and the insurer was told that the scooter store billed for the cost of the bed and they billed it again as not assigned. They will bill Medicare the monthly rental of the bed.

COMPARING POSTED PRICES AND (MUCH HIGHER) AMOUNT CHARGED



NAIC MODEL 651, "EXCESS CHARGES"

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

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NAIC MODEL 651, "EXCESS CHARGES"

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

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NAIC MODEL 651, "EXCESS CHARGES"

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

LIMIT FOR PHYSICIAN'S SERVICES

- 42 U.S. Code § 1395w–4 - Payment for physicians' services (SSA § 1848)

(g) LIMITATION ON BENEFICIARY LIABILITY

(1) LIMITATION ON ACTUAL CHARGES

(A) In general

In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) Application of limiting charge

No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) No liability for excess charges

No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

LIMITING CHARGE IS 115%

(2) "LIMITING CHARGE" DEFINED

(C) After 1992

For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) Recognized payment amount

In this section, the term "recognized payment amount" means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1395u(b)(4)(A)(iv) of this title) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

COULD THIS BE FIXED BY INTERPRETATION?

- It is reasonable that the term "physicians service" in § 1848 could be read to include writing the prescription for a scooter or other DME item, which the supplier then fills.
- This would make the "limiting charge" language make more sense because it includes both nonparticipating physicians and "nonparticipating suppliers or other persons."

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