Dynamic Chiropractic

PERSONAL INJURY / LEGAL

# The JD and the DC: A Winning Combination

## MEDICARE: A PRIMER

Kenneth Satin, JD

As a personal injury lawyer, I am constantly besieged with questions about whether Medicare will cover chiropractic treatments for my clients who have been injured in accidents.

All too often doctors as well as patients are confused about what Medicare will cover and will not cover and exactly what it will pay toward incurred medical expenses.

This article will attempt to explain and clear up some of those uncertainties.

Definition of Medicare

Medicare is a program established by the federal government. It was originally designed for people 65-years-old or older, or people of any age with permanent kidney failure, and for certain other people who are disabled and under the age of 65. The agency which administers the programs is the Health Care Financing Administration (HCFA) which is a branch of the United States Department of Health and Human Services.

One of the aspects of Medicare (which often makes it confusing and difficult to understand) is that it really has two separate parts which consist of hospital insurance and medical insurance. If a patient obtains medical services from a hospital certified for Medicare, the hospital insurance will assist in payments for those services deemed to be "medically necessary." The same holds true if the services are accomplished not only by a Medicare certified hospital but also by certain nursing facilities, home health agencies, and hospices. The medical insurance portion of Medicare assists in payment of services rendered by doctors and other assorted services and supplies not covered by the hospital portion of Medicare.

As most doctors of chiropractic are already aware, Medicare does not come even close to paying all medical expenses. Either the patient or the patient's private health insurance company must pay the differential referred to in the Medicare act as "deductibles" and "co-insurance." In other words, the patient or the patient's insurance company bears the burden of paying for all of the charges which exceed the limits established by Medicare. Those limits are severe indeed.

Definition of Terms

The approved amount is referred to as the "reasonable" or the "allowable" charge. This is in connection with Part-B claims. For claims submitted under Part-B, the Medicare insurance carrier (these are private insurance companies which are under contract with Medicare to process claims) compares the charges of the particular doctor with the "prevailing charge" in the community. This author is often astounded at how low the prevailing charge is often said to be.

Generally speaking, Medicare will pay 80 percent of the approved amount, and the patient is responsible for the remaining 20 percent.

The patient portion is typically called "co-insurance." The "excess charge" is that portion of the doctor's charges which exceed the Medicare approved amount.

Medicare also has deductibles and Medicare typically requires the payment of the deductible before Medicare begins to pay. For 1991, the Part-A deductible is $628 per benefit period. The Part-B deductible for 1991 is $100 per calendar year. In short, the patient who is admitted to the hospital is required to pay the first $628 for services covered by Medicare, but if the patient visits the doctor, he must only pay the first $100.

Doctors may either "participate in Medicare" or "accept assignments" of Medicare claims.

Those who agree to accept assignments of a Medicare claim agree the Medicare payment as payment in full and are paid directly by the carrier under contract with Medicare (except for the deductible and amount of co-insurance).

Those doctors who agree to participate in Medicare are typically listed in the Medicare participating physician supplier directory distributed through the Social Security Administration.

With respect to payment to hospitals, a different system of payment is utilized. If the patient is hospitalized, Medicare will pay for all "covered" services during the first 60 days of a benefit period except for the deductible. If the stay is longer than 60 days, the patient must pay co-insurance for each additional day of covered care up to a maximum of 150 days per benefit period.

Benefit periods commence the day the patient is hospitalized and end after the patient has been out of the hospital or skilled nursing facility for 60 days in a row.

It is apparent that there are many things that Medicare does not cover. These include the amount of deductible, co-insurance amount, charges which exceed Medicare's approved amounts, and various other medical services and supplies not covered by Medicare.

Patients often turn to private medical insurance to cover these gaps in Medicare coverage. The basic types of insurance policies are typically called "Medi-Gap," "Hospital Indemnity" insurance, "Nursing Home or Long-Term Care" insurance, "Specified Disease" insurance, "Coordinated Care Plans" (HMOs), and "Competitive Medical Plans" (CMPs).

Medi-Gap Insurance: What Is It?

Medi-Gap insurance is simply private health insurance designed to supplement Medicare's benefits by filling in some of the gaps in Medicare coverage. The policies vary widely and the patient should carefully shop the different policies before making a decision.

*Kenneth A. Satin, J.D.*
*Newport Beach, California*

Editor's Note:

Mr. Satin's law firm is located at 4000 McArthur Street, Suite #950, Newport Beach, California 92660

(714) 851-1163. We thank Mr. Satin for providing this series of articles for our readers.

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