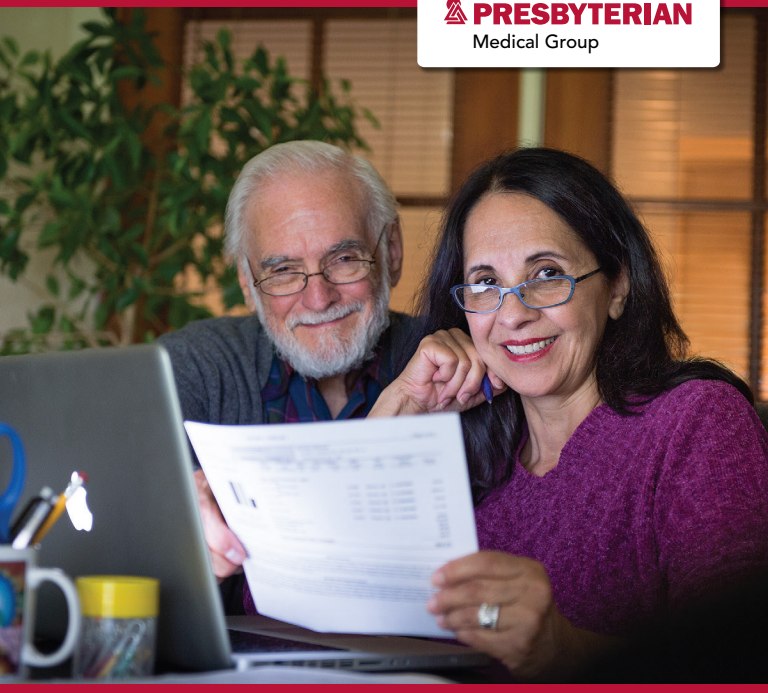
Hospital-Based Billing

A guide for Medicare Recipients

PRESBYTERIAN
Medical Group



Hospital-Based Billing

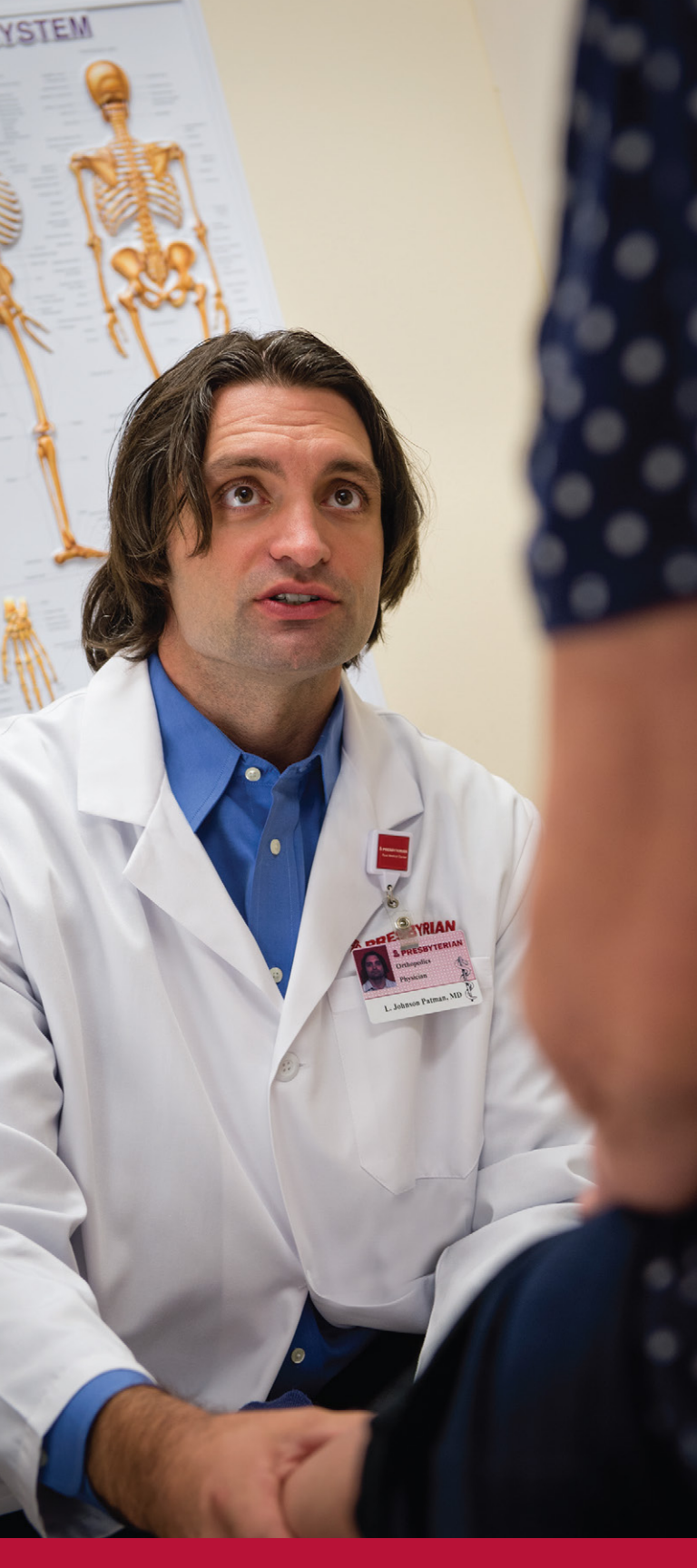
Medicare reimburses Presbyterian Medical Group (PMG) clinics as "hospital-based" facilities. The clinics function as departments of Presbyterian Hospital and provide care that is integrated with the Presbyterian Hospital delivery system. This designation by Medicare affects the way you are billed.

Hospital-Based Status

What does it mean?
Medicare recognizes all integrated healthcare systems in a distinct way. According to Medicare rules, if a clinic is owned by a hospital and integrated into the operation of the hospital, then it is designated as hospital-based. With this designation, the clinic is paid under hospital department rates. Medicare recognizes PMG clinics as departments of Presbyterian Hospital, thus the term hospital-based.

How does it affect Medicare recipients?
When seeing a PMG provider, Medicare patients will only see a difference in the way they are billed. Under this designation, Medicare requires that all hospital-based clinic services be billed in two parts:

- A provider (usually a physician) fee billed by the clinic
- An outpatient facility services fee billed by the hospital


YSTEM
& PRESBYTERIAN
Orthopedics
Physician
L. Johnson Patman, MD

Upon completion of medical services, two claim forms will be submitted to Medicare for clinic services. Medicare patients will receive two Explanation of Benefits (EOB) statements from Medicare.

Once Medicare has paid its portion of the charges, in many cases, a secondary payor will pay the remaining balance. If there is no secondary insurance, the Medicare patient will then receive two bills: a bill from the clinic for the provider charge and one from the hospital for the clinic facility charge.

Please note: Your copayment, coinsurance, or deductible may vary depending on your individual insurance benefit plan. If a balance remains after insurance pays, you will receive a monthly statement and payment is due within 30 days following the date of billing. If you are in need of financial assistance, please call (505) 923-6400 or 1-800-251-9292.

What is the process for PMG to submit a Medicare claim?

All hospitals and clinics are required to screen Medicare patients according to Medicare secondary payor rules. At each visit to the clinic, Medicare patients will be asked to complete or update a Medicare secondary payor questionnaire. The answers to these questions confirm that Medicare is the primary payor or that another payor is primary.

The process for submitting PMG claims to Medicare includes:

- The physician (provider) component of the claim will be billed on one claim form and sent to Medicare.
- A second claim form for the facility services fee will be created and sent to Medicare.
- All ancillary services, such as laboratory and radiology services, will be billed separately.

What are typical or average out-of-pocket expenses for visits to a PMG clinic?

The typical or average additional out-of-pocket expenses for visiting a hospital-based PMG clinic are:

- New patient visit – $31
- Established patient visit – $23
- Nurse visit – $13

Please note: Your specific charges will depend upon the actual services you receive. Your physician may elect to perform additional procedures/tests which will affect your out-of-pocket expense. Keep in mind this is an **estimated** amount only. PMG adjusts its fee schedules annually to stay relative to Medicare reimbursement rates.

Presbyterian Medical Group

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For additional information about hospital-based billing, please call (505) 923-6400 or 1-800-251-9292.

Presbyterian exists to improve the health of the patients, members and communities we serve.

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A department of Presbyterian Hospital

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