Dr. Winthrop's Medicare Policies and Billing Procedures

Patients who are insured by Medicare are free to seek treatment from physicians who are "providers" within the Medicare system or from physicians who have opted out of the Medicare system. I am a provider physician.

- Medicare providers like me must abide by Medicare's fee schedule for all covered services. According to Medicare's guidelines we must charge the exact "allowed amount" specified on the Medicare fee schedule.
- Physicians who have opted out of the Medicare system may charge any amount they choose for any and all services.
- Medicare providers must bill Medicare while non-providers may or may not bill Medicare as they see fit.

So, Medicare sets the fee (the "allowed amount") for hundreds of services; but, as you are probably well aware, it pays only 80% of the allowed charge, leaving 20% of the allowed amount to be paid by the patient and/or a secondary insurer. The Medicare "allowed amount" is already a discounted fee and historically there have been continual decreases in what can be charged for any given service.

Some Medicare providers agree to "accept assignment", which means the doctor accepts whatever discounted fee Medicare will pay, along with any secondary insurance, even if it is less than 100% of the allowed amount. I do not accept assignment because I want to provide my patients with the latest technological advances and a very high overall quality of care. Thus, I expect the remaining 20% of the "allowed amount" to be paid either by secondary insurance and/or the patient.

Finally, because I do not accept assignment, Medicare reimbursement checks are sent directly to my patients and not to my office. This is why I ask my patients to pay the allowed amount at the time of service. My billing department bills Medicare and any secondary insurance for the services I provide and insurance payments are sent directly to the patient (with the exception of Anthem Blue Cross, Blue Shield and Healthnet secondary plans.)

In summary, I am a "***non-accept assignment" provider for Medicare***. I ask for payment at the time of service for office visits and office procedures. My billing department then bills Medicare and any secondary insurer on your behalf. You can expect payment from Medicare and any secondary carrier within 2-3 weeks.

For surgical procedures performed at the Santa Barbara Surgery Center and Cottage Hospital, I will provide you with a statement prior to your surgery that itemizes covered charges and elective charges. You will be asked to pay only for elective charges prior to your surgery. Unlike services performed in the office for which payment is due at the time services are rendered, when you are having a surgical procedure at SBSC or Cottage Hospital I do not expect payment for covered charges until after you have received reimbursement from Medicare and your secondary insurer (if you have one.) My billing department will bill Medicare and any secondary carrier after your procedure, and you will receive reimbursement from those insurers within 2-3 weeks following your procedure. The statement you received from me prior to your surgery will specify a due date of 30 days following the date of your procedure. This will ensure that you receive your insurance reimbursement checks before your medical bill from me is due.

As a side note, financial institutions can no longer accept Medicare checks that have been endorsed over from the patient to the physician. This prohibition is intended to prevent fraudulent elder abuse. Thus, we ask you to pay any balance due with your personal check or credit card (Visa, MasterCard or Discover).

I know this issue can be very confusing. Please be assured that maintaining the highest standard of care for my patients is always my primary objective.