Usual, Customary & Reasonable Charges (UCR) Defined
Patient Advocate Foundation
Mission Statement

The Patient Advocate Foundation is a national, non-profit organization that serves as an active liaison between the patient and their insurer, employer, and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis through case managers and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

***************

Editor's Note

This is the first in a series of brochures developed by the Patient Advocate Foundation, Inc. The information herein is in response to frequently asked questions (FAQ's) by patients. The brochure is intended to provide general but informative responses to these inquiries. Any incident, inquiry or issue may vary according to these specific facts and circumstances relating to the individual.
Usual, Customary and Reasonable Charges (UCR) Defined

Usual, Customary and Reasonable Charges (UCR) are a calculation by a managed care plan of what it believes is the appropriate fee to pay for a specific health care product or service in the geographic area in which the plan operates.

Neither State nor Federal governments regulate UCR charges. Medicare is one entity that publishes their UCR charges.

Providers of care may have different UCR Charges (Actual Charges) from the UCR Charges (Allowable Charges) of the insurance carriers. When an insurance carrier has a UCR Charge (Allowable Charge) that is below that of a provider of care’s UCR Charge (Actual Charge), then the patient may be responsible for the difference. This is called **Balance Billing**.

The type of plan that the patient has selected (PPO, POS, EPO, PHO, IPA, Managed Indemnity Program, and HMO), determines Balance Billing and financial responsibility of the patient. Patients should know what type of plan they have and what their financial responsibility will be with regard to Balance Billing. This information should be addressed in the Summary Plan Description (SPD).

When care is to be rendered outside of an insurance carrier’s network of providers, the patient should always approach their insurance carrier to request that they contact the provider of care to arrange for a reduction in the UCR Charge (Actual Charge) for the patient or that they accept the UCR Charge (Allowable Charge) of the insurance carrier as payment in full to alleviate the risk of Balance Billing.
If a provider of care agrees to accept the UCR Charge (Allowable Charge) of the insurance carrier as a payment in full, which is called **accepting assignment**, then the patient should not be responsible for Balance Billing. Providers of care can accept assignment (Allowable Charges) on a case-by-case basis.

If a provider of care notifies a patient, either verbally or provides written notification when the patient signs a waiver of financial responsibility, he/she is advising the patient that they could be subjected to Balance Billing. The provider of care can then take legal action to collect the Balance Bill from the patient after their insurance carrier has paid their UCR (Allowable Charge).

Medicare and TRICARE health plans both have a legal limit of 15% above the UCR Charge (Allowable Charge) that a provider of care can collect from a patient for services rendered. The provider of service must write-off the remaining balance. Other health plans generally do not provide this protection from excessive Balance Billing to the patient.

When Balance Billing occurs due to a difference in UCR Charges between the insurance carrier and the provider of care, the patient's first recourse is to Appeal the UCR Charge (Allowable Charge) of their insurance carrier to their insurance carrier. The patient should seek the assistance of their provider of care in gathering information to include in their Appeal to justify why their provider of care has a higher UCR (Actual Charge) than their insurance carrier (Allowable Charge). The objective of an Appeal is to have the insurance carrier reimburse the provider of care at a higher rate, allowing a reduction in the financial responsibility (Balance Billing) of the patient.

After the Appeals process has been exhausted, the patient may take their case to the Insurance Commissioner of their state for an investigation of the insurance carrier's UCR
Charges (Allowable Charges), if their plan is not covered under ERISA. If the Insurance Commissioner determines that a case exists, he/she may require the insurance carrier to justify their UCR Charges (Allowable Charges). It is possible that with the assistance of the Insurance Commissioner that a patient may get their insurance carrier to increase the reimbursement (Allowable Charge) to the provider of care, thereby reducing the patient's financial possibility.

An example of UCR (Actual Charges) from the provider of care and UCR Charges (Allowable Charges) of the insurance carrier and the patient's financial responsibility after his/her deductible has been met.

| Bill from Dr. Bob Smith to Insurance Carrier | $125.00 (Actual Charge) |
| Insurance Payment to Dr. Bob Smith | $ 90.00 (Allowable Charge) |
| Patients Co-Insurance at 20% of Allowable Charge | $ 18.00 (Co-Insurance) |
| Balance Bill due to Dr. Bob Smith from Patient | $ 17.00 (Balance Bill) |
| Total Amount Due from Patient to Dr. Bob Smith | $ 35.00 (Co-Insurance + Balance Bill) |
Patient Advocate Foundation
Publications

- The Managed Care Answer Guide
  (available in English & Spanish)

- The Patient Pal (available in English & Spanish)

- Your Guide to the Appeals Process

- First My Illness…Now Job
  Discrimination: Steps to Resolution

- The National Financial Resource Guide
  for Patients: A State-by-State Directory

- Chelsey’s Story: One Patient’s Search to
  Solve Insurance Problems Including a
  Legislative Visit to Washington

If you would like further information about any of these publications, please contact our office.
Give “A Promise of Hope”

Light “A Promise of Hope”
Patient Advocate Foundation National Luminary Campaign is a national fundraising campaign in support of access to health care for uninsured Americans.

Donate a Clever “Promise of Hope’
- Appreciated stock that you owned for at least a year
- Frequent-flier miles and similar perks from credit card or other rebate programs
- A gift for a child from a child—Help your children or grandchildren pick out a stuffed animal or toy to give to a child in the hospital.
- Time—Volunteer for the Patient Advocate Foundation

Become a Partner in Progress with a Monetary “Promise of Hope”
- Donate a tax-deductible contribution In Memory or In Honor of someone special
- Encourage the company or organization with which you are employed to match your contribution
- Consider making a donation even if you don’t have cash using your credit card
- Remember Patient Advocate Foundation in your estate