PUBLICATION

When It Comes to Medicare Payment, Physicians Have Choices [Ober|Kaler]

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Health care providers can choose to enroll in, participate in, or opt out of Medicare, but…

Not everyone can choose equally and their choices will net direct outcomes in their practice income. Medicare jargon can be confusing and is certainly counter-intuitive. Perhaps you knew that chiropractors can't "opt out" of Medicare, but did you also know they don't have to "participate" or even "enroll" in Medicare? The Medicare choices that a physician must make are often bewildering and the consequences of those choices on practice income can be unpredictably perplexing. Even for those providers steeped in Medicare law and lore, and especially for most physicians who are primarily focused on treating patients, a review of Medicare requirements can be helpfully refreshing and perhaps downright instructive. This brief article is intended to do just that; refresh our memories, clear up a few enduring misconceptions and review some reimbursement options and consequences.

Physicians Do Not Have to Enroll

Let's start with the basics. medical doctors and other health care providers can simply choose never to enroll in Medicare (or to disenroll). This is not the same as opting out of Medicare. It's a determination to have nothing to do with Medicare and any Medicare-eligible patient. Given the lack of equality in reimbursement under Medicare, certain providers, such as chiropractors, may choose this alternative.

As an example, chiropractors are included within the definition of *physician* under the Medicare statute, as provided in section 1861(s) of the Social Security Act (the Act). However, the nature of services for which a chiropractor is considered to be a physician and for which there is a covered benefit is restricted to chiropractic manipulative therapy to the spine (CMT) provided to correct a subluxation. Frequently, chiropractors, in order to meet a patient's needs and the standard of care, are called upon to provide their patients a number of professional services that are not covered benefits when performed by a chiropractor, such as examinations, x-rays and physical therapy.

A chiropractor who chooses not to enroll has freed him- or herself of all Medicare rules and requirements except one: he or she can't treat any person for any condition that is a covered service under Medicare.

Most Health Care Providers Can Opt Out

Medical doctors – but not chiropractors – may also opt out of Medicare. A provider who opts out of Medicare *can treat* Medicare-eligible patients and charge "private rates," but neither the provider nor the patient will be reimbursed for the service. Private rates are whatever the patient and doctor agree to for the service rendered, irrespective of the reimbursement rate set by Medicare, and no claims need, or can, be submitted to Medicare. Also, as provided under 42 CFR § 405.405, a provider who opts out cannot get back in to Medicare for two years. There are still some federal requirements that have to be followed, but opting out is basically choosing to give up Medicare reimbursement in exchange for the right to charge patients your private rates. In any event, the ability to opt out is a right available for medical doctors, not for doctors of chiropractic.

Medicare Participation

Enrolled providers (those who either have not opted out or cannot opt out), including chiropractors, do have the choice to either participate or be nonparticipating with respect to assignment of reimbursement of Medicare claims. Medicare rules provide that upon submission of the CMS 1500, payment may be made either to the beneficiary or directly to the provider pursuant to an assignment agreement with Medicare. When a provider agrees to participate in the Medicare program, the provider is agreeing to accept assignment. Under an assignment agreement, the beneficiary, as provided under section 1842(b)(3)(B) of the Act, transfers to the provider the beneficiary's right to Medicare benefits for the services received, and the provider accepts the Medicare approved charge for the items or services provided. Thus the beneficiary/assignee's bill for the services is paid in full when the approved charge is paid, and the coinsurance and deductible are collected from the patient.

Nonparticipating providers are those who have elected not to accept assignment and have not signed a participation agreement with Medicare. Nonparticipating providers collect payment directly from the Medicare beneficiary, but are nonetheless limited in the amount that they can charge for Medicare-covered services.

Payment for Medicare-covered services is based on the Medicare Physicians' Fee Schedule, not the amount a provider chooses to bill for the service. Participating providers receive 100 percent of the Medicare Allowed Amount directly from Medicare. In contrast, nonparticipating providers are permitted to bill the beneficiary up to the limiting charge amount, which is 115 percent of the Allowed Amount for participating providers, who are paid 95 percent of the participating provider fee schedule amount. For example, if the Medicare physician fee schedule amount is $100, then a nonparticipating provider could collect $109.25 in total for the service ($95 x 115% = $109.25).

Somewhat counterintuitive is the fact that “non-par providers” may still choose to accept assignment on a patient-by-patient or claim-by-claim basis. However, all such claims will be subject to the 5 percent reduction of the participating provider fee schedule amount.

Therefore, a non-par provider may: 1) accept assignment on a case-by-case basis, in which case the provider must accept the 80 percent of fee schedule amount as payment and collect copays from the beneficiary; or 2) not accept assignment with regard to any beneficiary or any procedure provided on a given day, and require the Medicare beneficiary to pay for the covered service up front, in which case the provider will be subject to the limiting charge amount for his or her services. The provider may not fragment bills by accepting assignment for some services and requesting payment from the beneficiary for other services performed for that *same beneficiary at the same place on the same occasion.* CMS Pub. 100-04, Medicare Claims Processing Manual, Ch. 1, § 30.2.2.

A non-par provider also needs to clearly indicate to all Medicare beneficiaries the provider's status in the program so that the beneficiary may make a choice as to whether to accept the services and pay for them up front or seek the services from a provider that accepts assignment. A written form of notification of the provider's non-par and non-assignment status along with the office payment policy should be given to each patient and maintained in the patient file.

Remember, all Medicare-covered services must be billed by the provider to Medicare using the CMS 1500, regardless of whether the provider is participating or nonparticipating in the program.

Covered Services May Not Be Reimbursable

To ensure program integrity and contain costs, Congress has legislated a number of statutory exclusions from services otherwise covered. Medicare, under section 1862(a)(1) of the Act, excludes from payment a number of covered services that might otherwise be reimbursable, including services not "reasonable and necessary for the diagnosis or treatment of illness or injury," but are primarily palliative and supportive. For example, Medicare covers chiropractice services for manual manipulation of the spine when medically necessary to correct a subluxation of the spine. However, chiropractic treatment is not considered to be medically necessary – and thus not payable under Medicare – when further clinical improvement cannot reasonably be expected from continuous ongoing care. These cost-control reimbursement limitations affect other health care providers, as well. The statute lists approximately 25 additional categories of care or situations for which no payment will be made for otherwise covered services, including personal comfort items, routine physicals, cosmetic surgeries and injuries sustained in war.

Surprisingly, Providers Must Bill for Covered, But Nonreimbursable Services

Creating, perhaps, another trap for the unschooled provider, Medicare requires that providers give their patients an Advance Beneficiary Notice (ABN) in a form mandated by CMS (CMS-R-131) when a provider has reason to believe that CMS is "likely to deny payment" on the basis of the exclusion for medical necessity.

Failure to give a correctly completed ABN to a patient, under most circumstances, will prohibit the provider from collecting for the service from the patient if Medicare denies the claim. If a nonparticipating provider collects the claim directly from the patient the provider is obligated to refund the amount collected to the patient. The purpose of the ABN is to inform the Medicare beneficiary, before the patient receives the service that otherwise might be paid for by Medicare, that on this particular occasion Medicare probably will not pay for this service. The ABN serves to alert patients that they can choose not to get the service or that if they do and payment is denied "they will be personally and fully responsible for payment to the provider."

The ABN provided to the patient must be in the form prepared by CMS and may not be altered. It provides for only two options: the patient can opt either to receive the services or not to receive the services. If the patient chooses the first option, the provider must submit the claim to the carrier. The provider, in completing the CMS 1500, is required to use the GA modifier in box 24d. The GA modifier indicates that an ABN was given to the patient and that the provider expects that Medicare will not pay the claim based on the service not being "reasonable or necessary."

A Few ABN Admonitions

The use of ABNs also comes with some perils and confusion. A few basic guidelines and cautions are worth noting, and help to give a sense of the intent and purpose of the ABN.

1. The reason for predicting the denial must be set out in some detail on the ABN. According to CMS, simply stating "medically unnecessary" is inadequate. It may be appropriate to indicate after a patient is stabilized or has reached the maximum point of recovery that care to be provided is palliative for a condition that cannot be further improved or the care is intended to stabilize and maintain a patient who has a chronic condition.
2. The ABN should not be given to all patients on a routine basis, but should be completed only when the provider believes that medical necessity may not be present.
3. ABNs cannot be signed in blank. They must be completed before being given to the patient for signature.
4. The ABN should be hand delivered to the patient. The patient should be given a copy and the provider should retain the original.

5. The ABN should be completed and delivered before a procedure is initiated.
6. Providers may obtain an ABN each time a patient presents for a treatment which may be determined not to be medically necessary. However, CMS will allow a single ABN covering an extended course of treatment, provided it identifies all items or services for which the provider believes Medicare will not pay. The extended course of care that is described in the ABN should have a reasonable term that relates to the next scheduled reevaluation. If care is still indicated after the reevaluation, but such care would still be determined not to be medically necessary, a new ABN for the next period of treatment could then be completed.
7. The ABN is not required for services which may be a Medicare benefit, but for which coverage requirements are not met. For services which a chiropractor might render, this would include things such as x-rays, examinations, or physical therapy. For a surgeon, it might be cosmetic surgery. CMS does require that in these circumstances some sort of notice be given to the beneficiaries advising them that Medicare will not pay for the services that are being provided. CMS provides a form that may be used as a guide.

Thus, if the service may be or has been determined to be excluded because it is not medically necessary, an ABN and CMS 1500 still need to be completed. If the service is covered by Medicare, but is otherwise excluded by statute, no ABN and no bill are necessary.

Billing for Noncovered Services

In short, providers may not bill Medicare for noncovered services, but, provided the patient has been informed that the service is not covered and still requests the service, the patient can be billed directly and will be personally responsible. Moreover, when a provider bills for a service that is not covered under Medicare (such as x-rays), the provider is not constrained by the Medicare limiting charge or physician fee schedule when charging a beneficiary directly for the noncovered service.

Billing *less* than the established “usual, customary and reasonable” (UCR) for noncovered services or chiropractic maintenance treatment can also be problematic when related Medicare-covered services have also been reimbursed.

Generally the provision of any item of value, which could be seen as encouraging a beneficiary to obtain any services that are reimbursed by Medicare, could be deemed an illegal kickback. For this reason, it is suggested that once a service is no longer reimbursable, consideration could be given to reducing the cost of service to be paid by the patient, but only if the reduction is based on financial need or hardship. Like the waiver of Medicare copayments, cost reductions should not be given out routinely and the basis of financial need for the reductions should be documented in the patient record. Similarly, while the CMT service is being reimbursed by Medicare and even thereafter, the patient should not be charged a rate other than the provider's UCR for other related, but noncovered, services such as physical therapy, x-rays and examinations provided by a chiropractor.

Ober|Kaler's Comments

In summary, a provider, whether participating or nonparticipating in Medicare, is required to bill Medicare for all covered services provided. If the provider has reason to believe that a covered service may be excluded because it may be found not to be reasonable and necessary the patient should be provided an ABN. When an ABN is completed, the provider is required to submit the CMS 1500 using the GA Modifier. Failure to follow these requirements may render the provider's bill uncollectable or mandate a refund to the patient. A provider can charge less for a service after Medicare indicates that the service will no longer be covered, but care

should be exercised to make sure that it does not appear to be done on a routine basis and as an inducement for initially seeking the covered care. For items or services that are not a covered service and do not meet the rules for reimbursement, such as x-rays and physical therapy provided by a chiropractor, no ABN is necessary. A bill does not have to be submitted under these circumstances unless demanded by the patient. Under those circumstances, a GY Modifier should be added indicating that the service is statutorily excluded other than on the basis of medical necessity or does not meet the definition of a Medicare benefit. It is not clear whether a chiropractor has to continue to submit CMS 1500s (unless expressly requested by the patient), or continue to obtain ABNs once a carrier has indicated that care is palliative. However, the provider can request payment of the UCR at the time of service for the noncovered services, regardless of whether the provider is participating or nonparticipating.

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