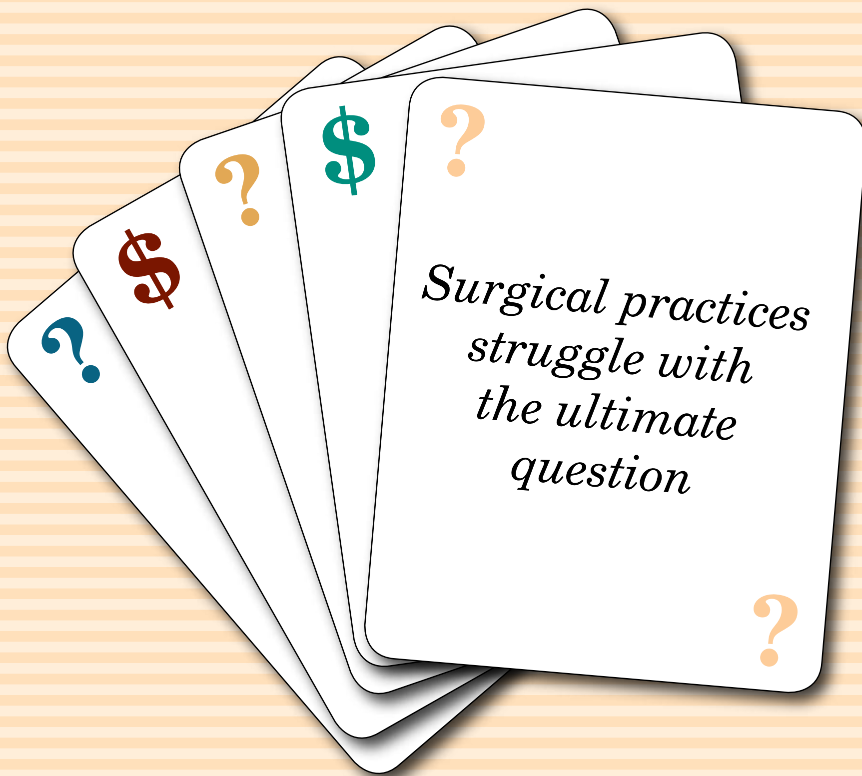
Is opting out of Medicare the answer?



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It is a decision many surgical practices across the country are struggling with: Should we stay in the Medicare program? As reimbursement rates drop and regulations and costs increase, many surgical practices are scouting out alternative business plans that either reduce or exclude Medicare patients. While decreasing rates and skyrocketing costs are nothing new, in many parts of the country surgical workforce shortages have added a new element to the mix. Simply put, with fewer surgeons and a growing number of private pay patients, Medicare nonparticipation may soon be a realistic option.

The options

There are four different approaches surgeons may take with regard to Medicare participation:

- *Enroll in Medicare and sign a participation agreement.* By signing the participation agreement, a physician becomes a "participating physician." Currently, 94.7 percent of physicians in the U.S. choose this option. Ironically, this number has increased significantly since the mid-1990s, when the participation rate hovered at approximately 80 percent, despite continuing reductions in Medicare payment rates. Participating physicians agree to accept the Medicare physician fee schedule amount—the

allowed charge—for all services they provide to beneficiaries. Physicians who "accept assignment," as it is called, are not obligated to see all or any Medicare patients. Accepting assignment merely means that physicians who do see Medicare patients accept the fee schedule rate as payment. Currently, 80 percent of physicians accept all or most new Medicare patients (which means at least 14% of participating providers limit the number of Medicare patients they see).

• *Enroll in Medicare and do not sign a participation agreement*. Physicians who enroll in Medicare but do not sign participation agreements are considered "nonparticipating physicians." Under this option, physicians decide whether to accept assignment on a case-by-case basis. Physicians who accept assignment receive a percentage of the Medicare fee schedule rate directly from Medicare. This option is discussed in more detail later in this article.

• *Opt out of the Medicare program*. Under this option, physicians and beneficiaries enter into private contracts for services. There is no limit on what physicians may charge, and beneficiaries pay the full amount with Medicare paying nothing. This option is also discussed in more detail later in this article.

• *Do not enroll in Medicare*. In this case, physicians are prohibited from seeing Medicare patients at all and from ordering any services payable by the Medicare program. In other words, physicians would drop their Medicare line of business completely.

Participate or not?

The Medicare nonparticipation option is often misunderstood. Being a "nonpar" physician is not related to whether a physician sees Medicare patients, but instead centers on reimbursement levels and distribution. Participating physicians must accept assignment and, therefore, must accept the Medicare physician fee schedule amount as full reimbursement. A key advantage to accepting assignment is that Medicare pays its share of the fee directly to physicians, and, currently, Medicare makes these payments in a reliable and timely fashion compared with many private payors.

Nonparticipating surgeons decide on a case-by-case basis whether to accept assignment. Nonparticipating physicians who accept assignment will receive 95 percent of the Medicare physician fee schedule amount for the service, and Medicare will pay its portion of the bill directly to the physicians (less the copayment). In other words, administratively the system works the same as for participating physician, except that reimbursement is 5 percent less.

Nonparticipating physicians who decide not to accept assignment for a particular service may charge patients 115 percent of the 95 percent of the Medicare physician fee schedule amount (or 109.25% of the fee schedule amount). This amount is called the "limiting charge" and is the most physicians may charge when Medicare is the payor. Although physicians are able to charge and receive more money per service, the trade-off is that they must collect the full fee from their patients. Medicare reimburses the patient, not the physician, for its share.

Obviously, it only makes sense to go nonpar for physicians who anticipate submitting the majority of claims as unassigned. On average, a physician would have to collect the full limiting charge (the 109.25%) approximately 35 percent of the time in order to come out ahead of a participating physician. For example, a nonpar surgeon who bills half of his or her claims assigned (receiving 95% of the fee schedule amount) and half unassigned (receiving 109.25% of the fee schedule amount) would receive more total reimbursement than a participating physician who performed the same procedure the same amount of time.

For general surgeon Jay Gregory, MD, FACS, of Muskegee, OK, the choice was easy. He is a nonparticipating physician and decides whether to accept assignment on a patient-by-patient basis.

"I work for my patients, not for the government," Dr. Gregory said. "A rare patient will get upset that I am not a participating physician. But, once I explain why I am not and discuss with the patients their obligation to me, as well as my obligations to them, there is no problem. It all hinges on the patient/physician relationship and open communication with the patient."

Dr. Gregory determines whether to accept assignment after talking to his patients. In most cases, he does not accept assignment, unless he

believes there is no way the beneficiary could make the payments. These instances tend to involve very elderly patients or patients who have a person with out-of-state power of attorney managing their financial affairs. For cases where he does not accept assignment, he develops a payment plan that meets the needs of the patient.

"It is my firm belief that no doctor should be a participating physician in the Medicare program," Dr. Gregory said. "What is the advantage? I have had no problems with referring physicians. Also, I have very few problems with collecting the payments from beneficiaries because we have discussed exactly what is expected and have come to an agreement. I think that step is skipped when physicians participate in Medicare and are just trying to collect a 20 percent copayment," he said.

Opting out

In addition to choosing whether to be participating or nonparticipating physicians, surgeons may opt out of Medicare. Under this option, surgeons still see Medicare patients, but reimbursement is determined in a private contract between the physicians and their beneficiaries, and patients pay directly for the service. The limiting charge does not apply. This option differs from nonparticipation because, in this case, Medicare does not pay for the service at all, and there is no limit on the fees physicians charge. Because Medicare pays neither the physician nor the beneficiary for the service, no claim is submitted.

Physicians who decide to opt out must do so for a period of two years. Physician cannot opt out for some services but not others. Participating physicians may opt out at the beginning of each calendar quarter: January, April, July, or October. To do so, surgeons must submit a valid affidavit to their Medicare carriers at least 30 days before the first day of the quarter. Nonparticipating physicians may opt out at any time by submitting an affidavit to their respective carriers. Several sample affidavits are available from the Centers for Medicare & Medicaid Services (CMS)—check with your Medicare provider for a specific sample—but, in general, the affidavit should simply state that the physician agrees not to submit any claim to Medicare for any item or service provided to any beneficiary for two years and agrees not to receive any Medicare payment for any items or services provided to Medicare beneficiaries.

It is important to understand that when physicians opt out of Medicare, they cannot receive any payments from Medicare, including payment for in-office ancillary services, such as imaging and laboratory services. These services also would have to be paid for under the private contract, or opt-out physicians would have to refer their patients to providers that do accept Medicare. Opt-out physicians may still order covered services, including hospital services, as long as they are not receiving any remuneration for those services.

For example, if an orthopaedic surgeon opted out and a beneficiary agreed to enter into a private contract with the surgeon for a knee replacement, the private contract would only cover the surgeon's professional fees and, assuming the surgeon does not own any of the equipment, all of the patient's preoperative and postoperative tests and imaging, as well as the hospital bill and rehabilitation, would be covered by Medicare. If the surgeon did own the imaging equipment, the private contract would have to cover the surgeon's professional fees as well as any imaging provided on that equipment.

The exception to the prohibition against billing Medicare is when beneficiaries face emergency or other urgent health care situations. Under the law, opt-out physicians cannot enter into private contracts with beneficiaries needing emergency or urgent care. Instead, opt-out physicians would file the claims with Medicare and receive the limiting charge from Medicare.

For example, if an opt-out general surgeon is on call and a Medicare beneficiary comes into the emergency department with a ruptured appendix, the opt-out physician could not enter into a private contract with the beneficiary; instead, he or she would bill Medicare directly and receive the limiting charge. Medicare does not cover follow-up visits. Once the patient is stabilized, the physician and beneficiary should agree on a private contract or the physician should transfer the patient's care to another physician.

The law defines an emergency situation as a condition with symptoms of such severity that a prudent layperson could reasonably expect the absence of immediate medical attention to lead to serious adverse consequences. The law defines urgent services as those furnished to a beneficiary who requires services to be furnished within 12 hours to avoid the likely onset of an emergency medical condition. If the physician has a preexisting private contract before the onset of the emergency or urgent symptoms, the contract remains in effect, and Medicare is not billed. However, an opt-out physician cannot enter into a private contract with a beneficiary after the onset of the emergency or urgent symptoms.

In addition to the affidavit, the law also requires that the contracts between the beneficiaries and physicians contain specific language ensuring beneficiaries understand their options and the mechanics of being treated by an opt-out physician. Multiple examples of private contracts are available. (Check with your Medicare carrier for a specific sample.)

Finally, physicians who fail to properly opt out effectively render all private contracts null and void and must submit all claims to Medicare. They also must reimburse beneficiaries for anything over the limiting fee for nonpar physicians and fee schedule rate for participating physicians. Physicians who fail to properly maintain their opt-out status (usually either by submitting a claim to Medicare or violating the emergency care provision) void all private contracts from that point forward and are prohibited from collecting any payment from Medicare for the remainder of the opt-out period. In other words, physicians who do not follow the opt-out provisions will essentially be prohibited from treating Medicare beneficiaries for the remainder of the two-year opt-out period because they would have no way to collect fees from their patients or from Medicare.

To date, psychiatrists make up the largest percent of opt-out physicians. Before 2002, solo practitioners made up a large majority of opt-out physicians. However, in recent years, several large orthopaedic surgery practices have chosen to opt out. Vascular surgeons, urologists, neurosurgeons, and ophthalmologists have opted out. One factor many of these practices struggle with is in-office ancillary services. Many offices are leery of tinkering with a profitable business line; however, many ancillary services were drastically cut under the Deficit Reduction Act of 2006, and more reductions may be on the way as Congress grapples with the overall Medicare physician payment problem and ways to generate savings.

Leaving altogether

The idea of not treating any Medicare patients seems implausible to many physicians. However, many surgeons have found this tactic quite effective when dealing with private payors. In Midland, TX, Russell Sawyer, MD, FACS, negotiated for years with his payor to obtain reasonable rates. At one point, his practice just walked away from the table and dropped the payor altogether.

“We told [the company] that we were leaving. There was no caveat. It was just not going to work for our practice.” Dr. Sawyer said. “They did not even acknowledge our letter.”

Ironically, after the payor picked up one of the largest contracts in the county, it discovered it could not adequately provide coverage without Dr. Sawyer and his partners. Not surprisingly, the payor approached Dr. Sawyer’s group with a new attitude, and new rates.

Like most surgeons, however, Dr. Sawyer is hesitant to pull out of the Medicare program altogether. “With private payors, I have no issues with pulling out. But Medicare and Medicaid are the last two I would consider pulling out of. I would much rather see them fix it. I already chose to leave my practice in California’s wine country because of reimbursement, and I do not know where I would go from here,” Dr. Sawyer said. Ω