Selecting the best Medicare payment option

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For most surgeons, Medicare reimbursement has steadily declined for more than a decade due to congressional action, payment policies developed by the Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration), and technical factors associated with the resource-based relative value scale (RBRVS) system. Surgeons have been vocal in expressing their concerns about how these payment cuts affect the viability of their practices and their ability to serve Medicare patients now and in the future. The College has had some success in increasing the values assigned to the work component of many services, but those improvements have been mitigated by reductions in reimbursement for practice expenses and in the Medicare conversion factor.

While there are ongoing efforts to persuade Congress and CMS that system-wide changes are needed, surgeons do have limited choices with regard to the nature of the financial relationship with the Medicare program and the patients it serves. They may choose to be either participating or nonparticipating physicians, or they may choose to opt out of the program altogether. There are benefits and drawbacks to each of these options, however, which surgeons may not understand sufficiently to make truly informed decisions. It is important to recognize that CMS publishes two Medicare fee schedules (MFSs), one for participating physicians (100% of MFS) and one for nonparticipating physicians (95% of MFS).

In general, three Medicare payment options are available to physicians:

1. Participating physicians with assignment.
2. Nonparticipating physicians with assignment.
3. Nonparticipating physicians without assignment.

Additionally, a physician may opt out of Medicare completely and work as a private contractor (see table below).

Participating physician option

Most physicians, particularly surgeons, have signed agreements with Medicare to serve as participating physicians. "Pars" agree to take assignment on all Medicare claims and to accept the program's approved reimbursement amount as payment in full for all covered services provided in the coming calendar year.

Every November, physicians receive a Medicare participating physician/supplier agreement (CMS 460) and a copy of the Medicare fee schedule for the next year. Those who are currently participating in the program *do not need* to take any action to maintain their status; it is automatically renewed for the coming year unless they make a change.

One of the principal advantages to participation is that the allowed reimbursement rate is 5 percent higher than the amounts paid in a separate MFS for nonparticipating physicians. Pars also follow more simplified billing procedures. Partici-

Payment options

Payment arrangement	Payment	Remittance	Example: Medicare allowable: $100
Participating physician	100% MFS	80% carrier direct to MD; 20% from patient, or secondary insurance (Medigap)	$80 remitted from carrier; $20 remitted from patient or secondary insurance (Medigap)
Nonpar + assignment	95% MFS	80% carrier direct to MD; 20% from patient, or secondary insurance (Medigap)	$76 remitted from Medicare carrier; $19 remitted from patient or secondary insurance
Nonpar w/o assignment	Limiting charge: 115% of nonpar MFS (109.25% of par FS)	Remitted from patient to MD	$109.25 remitted from patient
Private contracting	Negotiated with patient after completing opt-out procedure	Direct from patient to MD	No Medicare payment allowed except in emergency; rate negotiable with patient

pating physicians accept assignment and the local carrier makes payment of 80 percent of the allowed amount directly to the physician. They need only to collect the 20 percent copayment and any deductible from the patient or Medigap payor. Another significant advantage is that the par claims are reimbursed more quickly. In addition:

- Participating physicians are listed in Medicare directories that are distributed to many seniors' groups and, in many cases, are available on the Internet.
- Local carriers provide physician offices with a toll-free claims transmission service and send claims directly to many Medigap insurers.

Nonparticipating physician option

Electing to be a nonparticipating physician further restricts the "allowable" charges when compared to participating physicians.

Nonparticipating physicians assume a higher level of risk and effort to collect their fees. Nonparticipating physicians *who do not accept assignment* may seek limited balance billing of up to 115 percent of the nonparticipating Medicare rate. Surgeons who choose this option must notify their local Medicare carriers of their intent to become nonparticipating physicians by letter with a postmark no later than December 31 of each year. "Nonpar" agreements remain in force for a single calendar year. Current nonparticipating physicians do not need to submit any additional paperwork.

Nonpars may bill in two ways. They may still *take assignment,* but the allowed amount will be 5 percent less than the full Medicare fee schedule payment. Once a physician agrees to take assignment for a claim, it cannot be revoked. The physician must collect any deductible and the 20 percent coinsurance from the patient, but the Medicare payment is made directly to the physician. Again, the total collected from Medicare, the patient, and any coinsurance amounts to only 95 percent of the full fee schedule payment allowed for participating physicians.

Physicians *who do not take assignment* (that is, they select "No" in Section 27 of CMS 1500 or the electronic claim form) may balance bill up to 115 percent of the nonparticipating allowed amount (95% of the fee schedule amount). In other words, unassigned claims may total 115 percent of an amount equal to 95 percent of the Medicare fee schedule amount—for a total of 109.25 percent of the participating Medicare fee schedule. For example, insertion of a chest tube is reimbursed by the Medicare fee schedule at $184. Balance billing would allow a surgeon to charge $201.02 ($184 x 1.0925).

Physicians must file unassigned claims, but the patient receives the check from Medicare. The physician must then bill the patient directly for the services up to the limiting charge.

Some Medigap plans will cover the difference between the allowable charge and the limiting charge for nonparticipating providers. Surgeons may wish to contact the plans in their local area to determine which programs offer this coverage.

They also may want to consider the following practice management factors:

- Other contractual agreements (hospital privileges, insurance, or state regulations) that stipulate that Medicare assignment must be taken.
- Costs, patient mix, and collections rate to determine if the total amount from balance billing would exceed revenues that have normally been received as a participating physician. According to the AMA's *Medicare RBRVS: The Physicians' Guide,* the average physician would need to collect the full limiting charges (109.25%) at least 35 percent of the time to make balance billing viable for their practice.
- Medicare *only* routes assignment claims to the Medigap insurer. For unassigned claims, physicians must file with the Medigap insurer directly.
- Certain services are only paid on an assigned basis: (1) physician services to patients eligible for both Medicare and Medicaid; and (2) services provided by a nurse practitioner, physician's assistant, certified registered nurse anesthetist, midwife, clinical social worker, clinical psychologist, or clinical nurse specialist.

Private contracting

A private contract is one between a Medicare beneficiary and a physician or practitioner who has formally agreed to not bill the program *at all* for two years—for all covered items or services furnished to Medicare beneficiaries. These contracts must meet specific requirements.

To opt out, a physician must sign and file an af-

fidavit with the usual local carriers, agreeing to forego payments from Medicare for two years. This abstention applies both to direct Medicare payments and to those made through a Medicare managed care organization. The affidavit must be filed at least 30 days before the quarter in which the contract is to become effective (that is, 30 days prior to February 28, May 31, August 31, and November 30). There is a 90-day period during which a physician may change his or her mind and revert to a participating or nonparticipating arrangement. Surgeons exploring this option should check their other contracting relationships (hospital privileges, other insurers, and so forth) to determine if any of these contracts require them to be Medicare providers.

The patient, through a signed and explicit contract with the physician, gives up his or her benefits under Medicare and agrees to pay the opt-out physician directly for all items or services provided without regard to any limits (such as limiting charges). The document must demonstrate that the beneficiary has no access to Medigap insurance, will not bill Medicare or ask the physician to bill Medicare, and state that he or she had an opportunity to select another Medicare provider but chose this physician instead. There are a number of other elements that need to be included in this contract. Consult your local carrier to ensure this contract has all the required components. Copies of the patient contracts should be maintained in the physician's office.

In an emergency situation, a physician who has opted out of the program may treat a Medicare patient, file a claim, and balance bill. The emergency-related treatment should be fully documented on the patient's chart and in the supporting billing documents.

State law complications

Before considering any of the alternatives to full Medicare participation, it is important to note that many states have enacted more restrictive legislation. Following are some examples of state laws that affect Medicare payment.

Minnesota physicians treating Minnesota residents are precluded from balance billing any amount. The state does not, however, formally require participation in Medicare, although the balance billing prohibition is a powerful incentive for many physicians to continue participation.

Some states, including **Pennsylvania** and **Vermont** (33 VSA, Section 652), prohibit balance billing. This, in effect, means that participating physicians will receive the approved Medicare rate, while nonparticipating physicians will receive 95 percent of the allowed rate.

According to the Medical Association of **Georgia,** many of the state's private insurance plan contracts now prohibit balance billing. Therefore, balance billing is an offense sanctionable by the state medical board and it is actionable as an unfair business transaction under Georgia law.

It is also important to note that state laws may apply further limits to balance-billing charges. For example, revisions to **New York's** balance-billing law, effective August 29, 1994, reduce the amount a physician may bill a Medicare beneficiary to 105 percent of the Medicare-approved amount (105% of 95% for nonparticipating physicians is 99.75% of the participating rate). This law does not apply to CPT codes 99201-99215 for routine office visits, and codes 99341-99353 for routine home visits. Surgeons who would like more information should contact the New York State Department of Health at 518/478-1141 or refer to the following fact sheet: *http://www.ghimedicare.com/provider/download/ghipar02.pdf.*

Check with your local carriers for information about variations in state law that may reduce or eliminate entirely the financial benefits of balance billing and private contracting. Ω

Author's note: This article is not meant to provide legal or practice advice, but attempts to suggest that there are options available to surgeons. We have identified several state situations of which we are aware, but this is by no means a definitive listing. Before deciding which approach to take, we suggest that you consult your usual local carriers, state medical societies, your practice manager, or attorney. Questions may be directed to bcebuhar@facs.org.

This document contains excerpts from the AMA-published *Medicare RBRVS: The Physician's Guide,* 2002. For more information, go to *www.ama-assn.org/ama/pub/article/1751-5756.html.*