



Medicare Participation Options for Physicians

The continuing threat of steep Medicare payments cuts has forced many physicians to make adjustments to their practice that include staff layoffs, deferral of investments in health information technology, and reducing access to care. Many physicians may also wish to adjust their Medicare participation options.

Physicians who wish to change their current Medicare participation or non-participation status for 2011 must do so by December 1, 2010. **Once finalized, Medicare participation and non-participation decisions are binding for the entire year.** Participation decisions are binding for the entire year. CMS also publishes Medicare Learning Network articles for physicians outlining changes that will be in effect for the following year.

To help ensure that physicians are making informed decisions about their contractual relationships with the Medicare program, the Infectious Diseases Society of America (IDSA) and the American Medical Association (AMA) have developed the following brief overview of the various participation options that are available to physicians.

Neither the IDSA nor the AMA are advising or recommending any one of the three options described in this document. The purpose of the document is to ensure that physician decisions about Medicare participation are made with complete information about the available options.

The three options

There are three Medicare contractual options for physicians. Physicians may sign a PAR agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. They may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims. Lastly, they may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves.

Physicians who currently are participating (PAR) and who want to remain PAR for 2011 do not need to do anything to maintain their current status. Likewise, physicians who are currently nonparticipating (non-PAR) and who want to remain non-PAR for 2011 do not need to do anything to maintain their current status. To switch from being PAR to non-PAR for the coming year, however, or from non-PAR to PAR, physicians will need to notify their Medicare carrier in writing before December 31, 2010.

Once made, the decision will be binding throughout calendar year 2011 except where the physician's practice situation has changed significantly, such as relocation to a different geographic

area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. **Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. In addition, some states have enacted laws that prohibit physicians from balance billing their patients.**

Participation

PAR physicians agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (which is the 80 percent that Medicare pays plus the 20 percent patient copayment) as payment in full for all covered services for the duration of the calendar year. The patient or the patient's secondary insurer is still responsible for the 20% copayment but the physician cannot bill the patient for amounts in excess of the Medicare allowance. While PAR physicians must accept assignment on all Medicare claims, Medicare participation agreements do not require physician practices to accept every Medicare patient who seeks treatment from them.

Medicare provides several incentives for physicians to participate:

- The Medicare approved amount for PAR physicians is 5 percent higher than the Medicare approved amount for non-PAR physicians
- Directories of PAR physicians are provided to senior citizen groups and individuals who request them.
- Carriers provide toll-free claims processing lines to PAR physicians and process their claims more quickly.

Non-participation

Medicare approved amounts for services provided by non-PAR physicians (including the 80 percent from Medicare plus the 20 percent copayment) are set at 95 percent of Medicare approved amounts for PAR physicians, but non-PAR physicians can charge more than the Medicare approved amount. Limiting charges for non-PAR physicians are set at 115 percent of the Medicare approved amount for non-PAR physicians. However, because Medicare approved amounts for non-PAR physicians are 95 percent of the rates for PAR physicians, the 15 percent limiting charge is effectively only 9.25 percent above the PAR-approved amounts for the services.

With the prospects of future Medicare payment cuts combined with the decision to eliminate payments for consultation codes, many physicians may consider balance billing as one means to make up the difference in payments. When considering whether to be non-PAR; however, physicians should consider whether their total revenues from Medicare, including amounts the program pays, patient copays and balance billing, would exceed their total revenues as PAR physicians, particularly in light of collection costs, bad debts, and claims for which they do accept assignment. The 95 percent payment rate is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians. When non-PAR physicians accept assignment for their low-income or other patients, their Medicare approved amounts are still 95 percent of the approved amounts paid to PAR physicians for the same service. **Non-PAR physicians would need to collect the full limiting charge amount roughly 35 percent of the time they provide a given service in order for the revenues from the service to equal those of PAR physicians for the**

same service. If they collect the full limiting charge for more than 35 percent of the services they provide, their Medicare revenues will exceed those of PAR physicians.

Assignment acceptance, for either PAR or non-PAR physicians, also means that the Medicare carrier pays the physician the 80 percent Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

Example: A service for which Medicare fee schedule amount is \$100			
Payment arrangement	Total payment rate	Amount from Medicare	Payment amount from patient
PAR physician	100% Medicare fee schedule = \$100	\$80 (80%) carrier direct to physician	\$20 (20%) paid by patient or supplemental insurance (eg, Medigap)
Non-PAR/ assigned claim	95% Medicare fee schedule = \$95	\$76 (80%) carrier direct to physician	\$19 (20%) paid by patient or supplemental insurance (eg, Medigap)
Non-PAR/ unassigned claim	Limiting charge of 115% of 95% Medicare fee schedule (effectively, 109.25%) Medicare fee schedule = \$109.25	\$0	\$76 (80%) paid by carrier to patient + \$19 (20%) paid by patient or supplemental insurance + \$14.25 balance bill paid by patient

Private contracting

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to privately contract to provide health care services outside the Medicare system.

However, private contracting decisions may not be made on a case-by-case or patient-by-patient basis. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period.

Private contracts must meet specific requirements:

- **The physician must sign and file an affidavit agreeing to forego receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following two-year period** (either directly, on a capitated basis, or from an organization that received Medicare reimbursement directly or on a capitated basis);
- Medicare does not pay for the services provided or contracted for;
- The contract must be in writing and must be signed by the beneficiary before any item or service is provided;
- The contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary:

- gives up all Medicare payment for services furnished by the “opt out” physician;
- agrees not to bill Medicare or ask the physician to bill Medicare;
- is liable for all of the physician’s charges, without any Medicare balance billing limits;
- acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and
- acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. **There is a 90-day period after the effective date of the first opt-out affidavit during which physicians may revoke the opt-out and return to Medicare as if they had never opted out.**

This document contains excerpts from the AMA-published *Medicare RBRVS: The Physicians’ Guide*. The complete guide is available from the AMA Press by calling toll free (800) 621-8335.