



Medicare Participation Options for Physicians

On December 19, President Obama signed into law legislation that postpones a 21.2% cut in the Medicare physician payment conversion factor for two months. The cut, which had been scheduled to take effect on January 1, 2010, now will be delayed until March 1. **All other changes promulgated in the 2010 final physician fee schedule rule took effect on January 1, 2010** and as a result, the new conversion factor of \$36.08 is slightly higher than the 2009 conversion factor of \$36.07. Without further Congressional action, the conversion factor would fall to \$28.39 on March 1.

Congressional leaders say that prior to the new deadline they want to enact legislation that would stop the cut and eliminate the formula that has created the annual threat of ever-steeper physician pay cuts. In addition, pending health system reform legislation would make additional changes in payments for some physician services and some localities. However, there is no guarantee that Congress will act before March 1 and because there are differences between the House and Senate health system reform bills, the impact of further legislation on individual physicians is not yet clear.

In the face of such uncertainty, the Centers for Medicare and Medicaid Services has extended the deadline for physicians to change their Medicare participation or non-participation status in 2010 to March 17. This means that physicians who have not already changed their status still could do so and those who made a change could now retract it. Because the decision is retroactive, however, those who switch from non-par to par would have to refund any balance billing collected from their patients between January 1 and their new decision date.

To help ensure that physicians are making informed decisions about their contractual relationships with the Medicare program, the AMA has developed the following brief overview of the current situation with respect to the Medicare payment updates for 2010 and the various participation options that are available to physicians. **The AMA is not 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.**

Special considerations in the 2010 participation decision

Congress is considering legislation which would stop the 21.2% cut. The House has enacted legislation that would permanently repeal the SGR, eliminate pay cuts that have built up in the system, provide a 1.2% payment increase in 2010 and create two more generous targets for future years. An attempt to pass a permanent SGR repeal failed in the Senate, but the AMA is lobbying aggressively for Senate passage of a permanent solution and Senate Leader Harry Reid has said he will bring another long-term bill to the floor when Congress reconvenes in 2010. Although they differ in their details both the House and Senate measures would increase payments for some primary care services and after a concerted AMA effort, neither bill would fund these increases through cuts in other physician payments. Both bills also include provisions aimed at reducing geographic variation in Medicare payments and spending, and some of these would redistribute money among physicians. **As noted above, CMS has extended the participation decision period to March 17 to allow more time for Congress to complete its work and give physicians a clearer picture of what Medicare will pay them in 2010. Additional actions by**



Congress and/or CMS will be provided at the AMA Web site at www.ama-assn.org and this document will be modified as appropriate to reflect those actions.

Physicians who want to continue their current par or non-par status do not need to do anything to maintain their status. Those who want to switch their status need to notify their contractor in a written document that is received or post-marked on or before March 17, 2010.

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 wish to change their status from PAR to non-PAR or vice versa are required to do so before March 18, 2010. The decision will be retroactive to January 1 and unless CMS reopens the enrollment period, once made, the decision is binding throughout the calendar year 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 a 21.2 percent cut possible on March 1, many physicians may consider balance billing an extra 9 percent as one means of helping close the gap between 2009 and 2010 payment amounts. 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.

A physician who has not been excluded under sections 1128, 1156 or 1892 of the Social Security Act may, however, order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the physician is not paid, directly or indirectly, for such services (except for emergency and urgent care services). For example, if a physician who has opted out of Medicare refers a beneficiary for medically necessary services, such as laboratory, DMEPOS or inpatient hospitalization, those services would be covered by Medicare.

To privately contract with a Medicare beneficiary, a physician must enter into a private contract that meets specific requirements, as set forth in the sample private contract below. In addition to the private contract, the physician must also file an affidavit that meets certain requirements, as contained in the sample affidavit below. **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.**

Emergency and Urgent Care Services Furnished During the “Opt-Out” Period

Physicians who have opted-out of Medicare under the Medicare private contract provisions may furnish emergency care services or urgent care services to a Medicare beneficiary with whom the physician has previously entered into a private contract so long as the physician and beneficiary entered into the private contract before the onset of the emergency medical condition or urgent medical condition. These services would be furnished under the terms of the private contract.

Physicians who have opted-out of Medicare under the Medicare private contract provisions may continue to furnish emergency or urgent care services to a Medicare beneficiary with whom the physician has not previously entered into a private contract, provided the physician:

- Submits a claim to Medicare in accordance with both 42 CFR part 424 (relating to conditions for Medicare payment) and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).
- Collects no more than the Medicare limiting charge, in the case of a physician (or the deductible and coinsurance, in the case of a practitioner).



Note that a physician who has been excluded from Medicare must comply with Medicare regulations relating to scope and effect of the exclusion (42 C.F.R. § 1001.1901) when the physician furnishes emergency services to beneficiaries, and the physician may not bill and be paid for urgent care services.

Sample Medicare Private Contract and Affidavit

The sample private contract and affidavit below contain the provisions that Medicare requires (unless otherwise noted) to be included in these documents. If you determine that you want to “opt out” of Medicare under a private contract, we recommend that you consult with your attorney to develop a valid contract containing other standard non-Medicare required provisions that generally are included in any standard contract.



**SAMPLE MEDICARE PRIVATE CONTRACT
IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D**

This contract is entered into by and between [insert name of physician] (hereinafter called “physician”), whose principal medical office is located at _____ and [insert name of Medicare beneficiary] (hereinafter called “beneficiary”), who resides at _____, and shall become effective on this ___ day of _____, 20__ and shall expire on the ___ day of _____, 20__ (the “opt out period”), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The physician acknowledges that [he or she] [is or is not] excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that [he or she] must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that [he or she] must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.



The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

[Optional provision, not required by Medicare to be included in the affidavit]: I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Name of Physician (printed)

Signature of Physician

Date

Principal Office Address

Telephone Number

National Provider Identifier

Name of Beneficiary (printed) or
His/Her Legal Representative

Signature of Beneficiary or
His/Her Legal Representative

Date

Home Address

Telephone Number



**SAMPLE MEDICARE PRIVATE CONTRACT “OPT-OUT” AFFIDAVIT
IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. §405, SUBPART D**

I, _____, attest under the penalty of perjury that the following is true and correct to the best of my knowledge, information and belief:

1. Except for emergency or urgent care services (specified in 42 C.F.R. § 405.440), during the opt-out period, I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of paragraph 42 C.F.R. § 405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.
2. I will not submit a claim to Medicare for any item or service furnished to any Medicare beneficiary during the two-year period beginning on the following effective date: _____ (the “opt out period”), nor will I, or any entity acting on my behalf, submit a claim to Medicare for services furnished to a Medicare beneficiary during this two-year period, except as specified in 42 C.F.R. § 405.440.
3. I understand that during the opt-out period, I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage (formerly called Medicare+Choice) plan.
4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
5. I promise that, during the opt-out period, I will be bound by the terms of both this affidavit and the private contract(s) into which I have entered with a Medicare beneficiary.
6. I acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
7. I have signed a Part B participation agreement, and I acknowledge that such agreement terminates on the effective date of this affidavit. (This provision is not required for physicians who have not signed a Medicare Part B participation agreement.)
8. I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of 42 C.F.R. § 405.440 apply if I furnish such services.
9. [For non-participating Medicare physicians:] I understand that I must file this affidavit with all carriers who have jurisdiction over claims that I would otherwise file with Medicare and that this



affidavit must be filed no later than ten days after the first private contract to which this affidavit applies is entered into.

[For participating Medicare physicians]: I understand that I must file this affidavit with all carriers who have jurisdiction over claims that I would otherwise file with Medicare and that this affidavit must be filed with all such carriers at least 30 days before the beginning of the selected calendar quarter, and such selected calendar quarter shall begin on the following date: _____. The furnishing of any items or services to a Medicare beneficiary under such the private contract to which this affidavit applies before the beginning of the selected calendar quarter is subject to standard Medicare rules.

Name of Physician (Printed)

Signature

Date

Principal Office Address

Telephone Number

National Provider Identifier

(If an NPI has not been assigned, include the physician's uniform provider identification number (UPIN), and if a UPIN has not been assigned, include the physician's tax identification number (TIN).)

This document contains excerpts from the AMA-published *Medicare RBRVS: The Physicians' Guide* 2009. The complete guide is available from the AMA by calling toll free (800) 621-8335.