Thinking of a Cash Practice? Opting Out of Medicare?

If you're like many doctors, you dislike the hassles of complying with Medicare regulations. You may have even considered opting out of Medicare or becoming a cash-only practice. Here's what you should know before you do.

by Mario Fucinari, D.C. in Operational & Staff Risks on Monday, October 28, 2019

It is important to realize that opting out of Medicare is not an option for DCs.

The regulations state:

> "Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being nonparticipating are not the same things. Chiropractors may decide to be participating or nonparticipating with regard to Medicare, but they may not opt out." (MedLearn Matters SE0479).

In other words, a provider must be authorized to treat a Medicare patient.

Medicare wants to make sure you are who you say you are and there are no sanctions or red flags on your license. Participating should be viewed as being in-network, and nonparticipating is out-of- network in Medicare. Whether you are in-network or out-of-network, in Medicare, you must file a claim for all active care/treatment or if the patient requests that one be filed. Therefore, since you must file a claim, a cash-only practice is not possible if you are seeing Medicare patients.

The False Claims Act, Anti-Kickback Statute and HIPAA regulations mandate that an accurate claim must be filed when applicable or at the patient's request. Recently, CMS released the following statement, "One of the key legal issues is the extent to which the cash-only practice handles services that are routinely or statutorily covered by insurance—such as manipulation in Medicare."

Additionally, the Medicare Processing Manual §70.8.6, governs the timing for charging Medicare, "Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis. For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished…" In other words, if you see a Medicare patient, you and your corporation must file a claim for covered services within the following year.

Medicare matters for you, your patients and your practice. Make sure you are doing the right thing.

Examples

Following are some examples of how providers and their patients could be affected by participating, not participating and/or opting out of Medicare:

Example 1: Lois Smith, MD, is a family practitioner. She has opted out of Medicare. As such, she treats Medicare eligible patients, but informs them ahead of time that she does not accept Medicare. If the patient chooses to see Dr. Smith, the patient will most likely have to pay cash out of pocket. In this instance, Dr. Smith is a medical physician and has the opportunity to opt out of Medicare.

Example 2: Sam Jones, DC, has been approved by Medicare to treat Medicare beneficiaries. He has chosen to be a participating (in-network) provider with Medicare. When a Medicare patient enters the office for active care, spinal manipulation is considered a covered service (spinal manipulation is the only service currently permitted and covered by Medicare), therefore Dr. Jones *must* file a claim for the manipulation with Medicare. The patient will pay the 20 percent copay, if he or she does not have Medigap insurance. Any other services rendered not covered under Medicare would become the patient's responsibility for payment. Charges for the non-covered services are charged as your usual fee, also known as the "Charge Master" fee.

Example 3: Patricia Brown, DC, has been approved by Medicare to treat Medicare beneficiaries. She has chosen to be a nonparticipating (out-of-network) provider with Medicare. When a Medicare patient enters the office for active care, spinal manipulation is considered a covered service, Dr. Brown *must* file a claim for the manipulation with Medicare. The patient will pay the amount charged up to the limiting charge. A limiting charge is an upper limit on how much doctors who do not accept Medicare's approved amount as payment in full can charge to people with Medicare. Federal law sets the limit at 15 percent more than the Medicare-approved amount. The patient will then receive reimbursement from Medicare in most instances, and from the Medigap insurance, if the patient has coverage. Medicare pays 80 percent of the *approved* amount, the Medigap pays 20 percent of the approved amount. The remainder balance, up to the limiting charge, is paid by the patient.

Example 4: Thomas Waters, DC, has not applied to Medicare as a provider. He has opted out of Medicare. As such, he treats Medicare eligible patients, but informs them ahead of time that he does not accept Medicare. If the patient chooses to see Dr. Waters, he or she will probably have to pay cash out of pocket. **THIS IS NOT ALLOWED, SINCE CHIROPRACTORS ARE NOT ELIGIBLE TO OPT OUT OF MEDICARE.**

References:

Opting out definition and restrictions: https://med.noridianmedicare.com/web/jeb/enrollment/opt-out

Fraud and abuse laws: https://oig.hhs.gov/compliance/physician-education/01laws.asp

Medicare terms defined: https://www.medicareinteractive.org/resources/glossary