Medicare: Understanding the Difference Between Non-Participating and Opting-Out

When it comes to chiropractic and treating Medicare patients, the time has come to make some big decisions for you and your practice. In the final 6 weeks of every calendar year, chiropractors may elect to be Par or Non-Par providers. Don't confuse this with the ability to opt out of Medicare, a luxury not afforded to chiropractors and a select few other health care providers (Noridian Healthcare Solutions, 2018).

Before making a decision on your status with Medicare, it is of the utmost importance that you understand your rights and responsibilities when it comes to your provider status.

Participating Providers (Par) accept Medicare and always take assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as payment in full. You are required to submit a claim to Medicare. Medicare will process the claim and pay you directly. The benefits for Medicare patients seeing a participating provider, include paying a 20% coinsurance for their covered services (98940, 98941, 98942).

Non-participating Providers (Non-Par) accept Medicare but do not agree to take assignment in all cases. This means that you have signed up with Medicare and can treat Medicare patients, but you cannot accept your regular fee and may only collect the limiting charge from the patient. You will bill Medicare the limiting charge and they will reimburse the patient, 80% of the non-par allowance (assuming the deductible has been met).

Opt-Out Providers (Chiropractors <u>CANNOT</u> opt out) do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. They can charge whatever they want for services but must follow specific rules to do so. Medicare will not pay for care received in a provider's office that has opted out, except in emergencies, which puts the responsibility of payment solely on the patient. The provider must provide a contract describing the charges in their office and obtain a signature from the patient that they are aware they are responsible for the full cost of care without reimbursement from Medicare.

It shouldn't be surprising, that this is also the time of year when we receive the most calls from providers looking for ways to circumvent Medicare and "opt out" without the actual ability to opt out, because so little of what we do is covered. The reality is that we won't win the fight on either front if we continue to see reports published from the Office of Inspector General (OIG) on improper payments for chiropractic services for services that are deemed not medically necessary. Unfortunately, when a chiropractor doesn't respond to the request for records, it automatically is considered not-medically necessary!

Why should we be given the benefit of more covered services for our patients, when CMS's Comprehensive Error Rate Testing (CERT) program shows chiropractic as having the highest improper payment rates among Medicare Part B providers? From fiscal years 2010 through 2015 (includes claims from April 1, 2009, through June 30, 2014), the improper payment rate

ranged from 43.9% to 54.1% and the estimated overpayments ranged from $257 million to $304 million (OIG U.S. Department of Health and Human Services, 2018).

We must work diligently to understand Medicare's rules for chiropractic billing, coding and documentation. We'll likely see the OIG continue to put pressure on CMS to prevent further fraud, waste, and abuse and protect the Medicare Trust Funds. So, until we improve our own understanding of Medicare compliance in these areas and quit trying to circumvent the system, we will continue to see increased audits directed at our profession. If you are looking for webinars that help clear up the confusion on Medicare, click here.

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