Idaho Medical Association

Private Medicare Contracts

Between Medicare Beneficiaries and Physicians/Practitioners

"Opt Out"

The Idaho Medical Association is providing the following in response to your request for information regarding opting out of Medicare. The provision of this packet to you by the IMA does not constitute legal advice. The IMA strongly recommends physicians obtain competent legal counsel when considering opting out of Medicare.

The information contained in this packet has been obtained from The Federal Register, Noridian Medicare, and the Centers for Medicare and Medicaid Services. The IMA does not warrant and accepts no responsibility for the accuracy or legality of the procedures or advice set out in these materials. The physician, in conjunction with his or her attorney, is solely responsible for assuring compliance with the applicable regulations governing the opt out process.

The furnishing of this packet does not constitute, nor should it be construed to constitute, advice from the IMA regarding participation in the Medicare program. Each independently practicing physician or group must make that decision in consultation with legal counsel.

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Noridian Medicare

Overview

Opting out, also known as private contracting, was made possible by Section 4507 of the 1997 Balanced Budget Act. The Act states that nothing in Medicare Law "shall prohibit a physician or practitioner from entering into a private contract with a Medicare beneficiary for any item of service" if certain conditions are met. The provision clarified that private contract with Medicare patients are legal if the contracts meet certain conditions specified in the law, most notably that the physician agrees not to submit any Medicare claims or receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years. Note that if opting out, not only will Medicare and Medicare Advantage plans not be responsible for reimbursement of services, but any entity to whom reassignment of payment is made will also be affected, unless the services are for emergency care or urgent care.

According to section 4507, certain Medicare physicians and practitioners are permitted to opt out of Medicare for two years for all covered items and services that he or she furnishes to Medicare patients.

Code of Federal Regulations (CFR), section 422.220 provides guidance for Medicare Advantage (MA) plans and private contracts stating, "An MA organization may not pay, directly or indirectly, on any basis, for services" (other than emergency or urgently needed services as defined) furnished to a Medicare enrollee by a physician/practitioner who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner, and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

To opt out of Medicare:

- Participating physicians must first terminate their Medicare part B participation agreement.
- Participating providers are only permitted to opt out at the beginning of each calendar quarter. To do this, a provider must submit a valid affidavit at least 30 days before the first day of any quarter (January, April, July, or October).
- Non-participating physicians and practitioners, may opt out at any time.
- Physician/Practitioner Who Has Never Enrolled in the Medicare program and wishes to opt out, the physician/practitioner must provide the carrier with a National Provider Identifier (NPI) and file an opt out affidavit. The physician/practitioner must not receive payment during the opt-out period (except in the case of emergency or urgent care services).
- The Opt Out contract is for a two-year period – from the date the physician or practitioner files and signs an affidavit notifying Medicare that he or she has opted out of Medicare. After the two-year period is over, the physician or practitioner could elect to return to Medicare or to opt out again.
- Certain healthcare provider categories cannot opt out of Medicare. These include chiropractors, doctors of oral surgery, physical therapists in independent practice, and occupational therapists in independent practice.

Private contracts must be in writing and signed by the beneficiary before any item or service is provided, and they must indicate whether the physician is excluded from Medicare participation (example provided on page 22).

The contract cannot be entered into when a beneficiary is facing an emergency or urgent healthcare situation.

The physician or practitioner must file an affidavit stating that, for the following two-year period, he or she will not submit any claims nor receive any payment from Medicare for services provided to a beneficiary. In other words, physicians who privately contract with even one Medicare patient cannot participate or receive any payment from the Medicare program for two full years (example of affidavit on page 20).

Some situations have become confused with private contracting. A beneficiary who pays out of pocket for services and items not covered by Medicare is not involved in private contracting and would have no need to engage in private contracting. Beneficiaries must use their own resources to pay for preventive health visits, as Medicare does not cover all preventive healthcare services.

Paying out of pocket without the need for a private contract is also allowed for all services and items provided to patients who choose not to enroll in the Medicare Part B program that covers physicians' services.

Under current regulations a physician can obtain payment for a service when the question of whether Medicare will cover it is uncertain. In such cases the physician can provide an enrollee with an Advanced Beneficiary Notice (ABN)," stating that the service may not be covered by Medicare and that the enrollee will have to pay for it in full if Medicare does not pay. The ABN provides a mechanism for a physician who has **not** opted out to receive reimbursement even if Medicare denies a claim for it. ABN's are not applicable for opt-out physicians (cms section 40).

To be paid for Medicare services, an enrolled physician may accept assignment and be paid at the Medicare-approved rate or choose not to accept assignment and bill the beneficiary the limiting charge.

Private Contracts Between Medicare Beneficiaries and Physicians/Practitioners

The CMS Manual System, publication 100-02, Medicare Benefit Policy, Section 40, provides Medicare guidance on Opt Out regulations.
The publication was last updated June 27, 2008, and may be found on the CMS website at:
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

Section 1802 of the Social Security Act, as amended by §4507 of the Balanced Budget Act of 1997, permits a physician or practitioner to opt out of Medicare for two-year time periods for all covered items and services furnished to Medicare beneficiaries and enter into private contracts with Medicare beneficiaries if specific requirements are met. In a private contract, the Medicare beneficiary agrees not to seek Medicare payment for services furnished by the contracted physician or practitioner and to pay that physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

The term physician is limited to doctors of medicine and doctors of osteopathy who are legally authorized to practice medicine and surgery by the State in which such function or action is performed. The opt out law does not define physician to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery, therefore, they may not opt out of Medicare and provide services under private contract. Practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwifes, clinical psychologists, or clinical social workers to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements.

No services provided by a physician or practitioner who opts out of Medicare are covered by Medicare and no Medicare payment can be made to that physician or practitioner directly or on a capitated basis. In addition, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician/practitioner who has opted out of the program. Under the statute, the physician or practitioner cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others.

If an opt out physician or practitioner, whether salaried or not, is employed in a hospital setting and submits bills that are prohibited, the Part B Medicare Carrier will investigate and contact the facility to inform it that a reduction in the amount of its payment by the amount of Medicare money involved in paying the opt out physician or practitioner will be made.

Once a physician or practitioner has opted out, the physician/practitioner must enter into a private contract with each Medicare beneficiary to whom he/she furnishes covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's service to the Medicare beneficiary), with the exception of a Medicare beneficiary needing emergency or urgent care.

Physician/Practitioner Who Has Never Enrolled in Medicare (Rev. 92; Issued: 06-27-08; Effective/Implementation Date: 09-29-08): For a physician/practitioner who has never enrolled in the Medicare program and wishes to opt out of Medicare, the physician/practitioner must provide the carrier with a National Provider Identifier (NPI). The carrier must annotate its in-house provider file that the physician/practitioner has opted out of the program. The carrier can get the full name, address, license number, and tax identification number from the physician's/practitioner's opt out affidavit. All other data requirements should be developed from other data sources (e.g., the American Medical Association, State Licensing Board, etc.). The physician/practitioner must not receive payment during the opt-out period (except in the

case of emergency or urgent care services). If the carrier needs additional data elements and cannot obtain that information from another source, it may contact the physician/practitioner directly. It must notify the physician or practitioner that in order to refer or order services for a Medicare patient, the physician or practitioner must have an NPI. If an opt out physician/practitioner provides emergency or urgent care service to a beneficiary who has not signed a private contract with the physician or practitioner and the physician/practitioner submits an assigned claim, the physician or practitioner must complete Form CMS-855 and enroll in the Medicare program before receiving reimbursement. Under a similar circumstance, if the physician or practitioner submits an unassigned claim, the carrier must pay the beneficiary directly without requiring a completed Form CMS-855. It may use the information from the affidavit to begin the enrollment process.

Medicare will make payment for covered, medically necessary services that are ordered by a physician or practitioner who has opted out of Medicare if the ordering physician or practitioner has acquired a National Provider Number and enrolled in Medicare and provided that the services are not furnished by another physician or practitioner who has also opted out.

When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner (Rev. 92; Issued: 06-27-08; Effective/Implementation Date: 09-29-08): Payment may be made to a beneficiary for services of an opt out physician/practitioner in two cases:

- The services are emergency or urgent care services furnished by an opt out physician/practitioner to a beneficiary with whom he/she has not previously entered into a private contract; or
- The opt out physician/practitioner failed to privately contract with the beneficiary for services that he/she provided that were not emergency or urgent care services. CMS expects this case to come to the carrier's attention only in the course of a request for a redetermination of a denied claim or as a result of a complaint from a beneficiary or the beneficiary's legal representative.

In an emergency or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he or she does not have a private contract and bill for that treatment. In this case the physician or practitioner may not charge the beneficiary more than what a non-participating physician would be permitted to charge and must submit a claim on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with the physician or practitioner.

Emergency or urgent care services modifier GJ (opt out physician or practitioner emergency or urgent services), must be submitted with the procedure code(s) for services by an opt out physician or practitioner. Applying this modifier indicates a private contract has not been signed with the beneficiary on or after the date the physician or practitioner opted out. When the opt out physician or practitioner performs an emergency surgical procedure that requires follow up care, the procedure needs to be billed with modifiers, 54 (surgical care only) and GJ. The physician or practitioner needs to obtain a private contract from the beneficiary or transfer care to a Medicare provider to complete the follow up care.

If the claim is submitted without the GJ modifier, the claim will be denied and the beneficiary will be able to appeal. A claim will also be denied for emergency or urgent care items and

services to both an opt out physician or practitioner and the beneficiary if these parties have entered into a private contract.

Private Contracts: A private contract is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for **all** covered items and services the physician/practitioner furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge. Pursuant to the statute, once a physician/practitioner files an affidavit notifying the Medicare carrier that the he/she has opted out of Medicare, the physician/practitioner is out of Medicare for two years from the date the affidavit is signed (unless the opt out is terminated early, or unless he/she fails to maintain opt out. After those two years are over, a physician/practitioner could elect to return to Medicare or to opt out again. A beneficiary who signs a private contract with a physician/practitioner is not precluded from receiving services from other physicians and practitioners who have not opted out of Medicare.

Physicians or practitioners who provide services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and to opt out of Medicare.

Requirements of the Private Contract: Since Medicare rules and regulations do not apply to items or services not covered by Medicare, a private contract is not needed to furnish such items or services to Medicare beneficiaries. A private contract is needed only for items or services that would be covered by Medicare and where Medicare might make payment if a claim were submitted. Examples of non-covered services by Medicare include cosmetic surgery and routine physical exams.

Similarly, where a beneficiary, who is enrolled in a Medicare Advantage plan, goes out of plan to acquire a service and the plan does not cover it, the enrollee is liable for the full charge for the service and the physician or practitioner does not need to sign a private contract to collect payment for the noncovered service.

Mandatory claims submission does not apply once a physician or practitioner signs and submits an affidavit to the Medicare carrier opting out of the Medicare program, for the duration of the opt out period, unless a term of the affidavit is knowingly and willfully violated by the physician or practitioner.

A private contract must:

- Be in writing with print sufficiently large to ensure that the beneficiary is able to read the contract and signed by the Medicare beneficiary or legal representative in advance of the first service furnished under the agreement. The contract needs to be retained with original signatures of both parties, by the physician/practitioner for the duration of the opt out period;
- Be provided (a photocopy is permissible) to the beneficiary or to the beneficiary's legal representative before items or services are furnished to the beneficiary under the terms of the contract;
- Be made available to CMS upon request;
- Clearly indicate if the physician or practitioner is excluded from participation in the Medicare program under §1128 of the Social Security Act;

- State the expected or known effective date and expected or known expiration date of the opt out period;
- Be entered into for each opt out period;
- Be signed by the beneficiary or the beneficiary's legal representative and by the physician/practitioner
- Indicate that by signing the contract, the beneficiary or the legal representative:
    - Agrees not to submit a claim or to request the physician or practitioner to submit a claim for payment under Medicare, even if Medicare would otherwise cover such items and services;
    - Acknowledges that Medigap plans do not, and other supplemental insurance plans may choose not to, make payment for items and services furnished by the physician or practitioner under the contract;
    - Agrees to be responsible for payment of the physician or practitioner's charge for all services furnished by the physician/practitioner;
    - Acknowledges that no reimbursement will be provided by Medicare for such items and services;
    - Acknowledges that the physician or practitioner is not limited in the amount that he or she may charge the beneficiary for the items and services furnished;
    - Acknowledges that the beneficiary has the right to have such items and services provided by other physicians/practitioners who have not opted out of the program, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have opted out.

To be valid, the agreement cannot be signed by the beneficiary or the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health care situation.

Requirements of the Opt Out Affidavit (Rev. 92; Issued: 06-27-08; Effective/Implementation Date: 09-29-08): A valid affidavit must:

- Be in writing and be signed by the physician/practitioner;
- Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number (if one has been assigned), or, if an NPI has not be assigned, the physician's or practitioner's tax identification number (TIN);
- State that, except for emergency or urgent care services during the opt out period the physician/practitioner will provide services to Medicare beneficiaries only through private contract that meet the criteria for services that, but for their provision under a private contract, would have been Medicare-covered services;
- State that the physician/practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt out period, nor will the physician/practitioner permit any entity acting on the physician's/practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified;
- State that, during the opt out period, the physician/practitioner understands that the physician/practitioner may receive no direct or indirect Medicare payment for services that the physician/practitioner furnishes to Medicare beneficiaries with whom the physician/practitioner has 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 plan;

- State that a physician/practitioner who opts out of Medicare acknowledges that, during the opt out period, the physician's/practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the physician's/practitioner's services, directly or on a capitated basis;
- State on acknowledgment by the physician/practitioner to the effect that, during the opt out period, the physician/practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the physician/practitioner has entered into;
- Acknowledge that the physician/practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician/practitioner during the opt out period (except for emergency or urgent care services furnished to the beneficiaries with whom the physician/practitioner has not previously privately contracted) without regard to any payment arrangements the physician/practitioner may make;
- With respect to a physician/practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;
- Acknowledge that the physician/practitioner understands 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 apply if the physician/practitioner furnishes such services;
- Identify the physician/practitioner sufficiently so that the carrier can ensure that no payment is made to the physician/practitioner during the opt out period; and
- Be filed with all carriers who have jurisdiction over claims the physician/practitioner would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

Failure to Maintain Opt-Out (Rev. 92; Issued: 06-27-08; Effective/Implementation Date: 09-29-08):
A physician/practitioner fails to maintain opt out if during the opt out period one of the following occurs:

- The physician/practitioner has filed a valid affidavit and has signed private contracts in accordance with regulations but, the physician/practitioner knowingly and willfully submits a claim for Medicare payment (except as provided) or the physician/practitioner receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided); or
- The physician/practitioner fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, or enters into private contracts that fail to meet the specifications; or
- The physician/practitioner fails to comply with the provisions regarding billing for emergency care services or urgent care services; or
- The physician/practitioner fails to retain a copy of each private contract that the physician/practitioner has entered into for the duration of the opt out period for which the contracts are applicable or fails to permit CMS to inspect them upon request.

If a physician/practitioner fails to maintain opt out in accordance with the provisions outlined, and fails to demonstrate within 45 days of a notice from the carrier that the physician/practitioner has taken good faith efforts to maintain opt out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom the physician/practitioner did not sign a private contract), the following will result effective 46 days after the date of the notice, **but only for the remainder of the opt out period:**

1. All of the private contracts between the physician/practitioner and Medicare beneficiaries are deemed null and void.
2. The physician's or practitioner's opt out of Medicare is nullified.
3. The physician or practitioner must submit claims to Medicare for all Medicare covered items and services furnished to Medicare beneficiaries.
4. The physician or practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt out period, except as stated above.
5. The physician or practitioner is subject to the limiting charge provisions.
6. The practitioner may not reassign any claim except as provided in the Medicare Claims Processing Manual, Chapter 1, General Billing Requirements.
7. The practitioner may neither bill nor collect any amount from the beneficiary except for applicable deductible and coinsurance amounts.
8. The physician or practitioner may not attempt to once more meet the criteria for properly opting out until the two-year opt out period expires.

Violation <u>not</u> discovered by the carrier during the two-year opt out period: In situations where a violation is not discovered by the carrier during the two-year opt out period when the violation actually occurred, the requirements of 1 through 8 listed above are applicable from the ***date that the first violation occurred until the end of the opt out period*** during which the violation occurred unless the physician or practitioner takes good faith efforts, within 45 days of any notice from the carrier that the physician or practitioner failed to maintain opt out, or within 45 days of the physician's or practitioner's discovery of the failure to maintain opt-out, whichever is earlier, to correct his or her violations. Good faith efforts include, but are not necessarily limited to, refunding any amounts collected in excess of the charge limits from beneficiaries with whom he or she did not sign a private contract.

Renewal of Opt Out: A physician or practitioner may renew an opt out period without interruption by filing another affidavit with each of the original carriers of the first opt out period. The physician or practitioner should also file an affidavit to any carrier that a claim was submitted to during the previous opt out period. The affidavits must be filed within 30 days after the current opt out period expires.

If a physician or practitioner decides to be in the Medicare program once their opt out period has expired, they must re-enroll with a CMS 855 application. An application may also be needed for each location for which the physician or practitioner reassigns their benefits to the entity.

Early Termination of Opt Out: If a physician or practitioner changes his or her mind once the affidavit has been approved by the carrier, the opt out may be terminated within 90 days of the effective date of the affidavit. To properly terminate an opt out a physician or practitioner must:

- Not have previously opted out of Medicare;
- Notify all Medicare carriers where an affidavit was filed of the termination of the opt out no later than 90 days after the effective date of the opt out period;
- Refund to each beneficiary under private contract all payment collected in excess of the Medicare limiting charge or the deductible and coinsurance;
- Notify all beneficiaries who entered into private contracts of the physician or practitioner's decision to terminate opt out;
- Notify all beneficiaries of their right to have claims filed on their behalf with Medicare for services furnished during the period between the effective date of opt out and the effective date of the termination of the opt out period.

When a physician or practitioner properly terminates opt out, the physician or practitioner (who was previously enrolled in Medicare) will be reinstated in Medicare as if there had been no opt out.

For complete guidance, the Medicare Benefit Policy Manual, publication 100-02, Chapter 15 may be found online at:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Questions and Answers on Private Contracts

Below are a number of questions and answers pertaining to opting out of the Medicare program.

Q1. What is a private contract and what does it mean to a Medicare beneficiary who signs it?

A1. As provided in §4507 of the Balanced Budget Act of 1997, a private contract is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Q2. What has to be in a private contract and when must it be signed?

A2. The private contract must be signed by both the beneficiary and the physician or practitioner before services can be furnished under its terms. It must state plainly and unambiguously that by signing the private contract, the beneficiary or the beneficiary's legal representative agree to the following terms:

- Gives up all Medicare coverage of, and payment for, services furnished by the opt out physician or practitioner;
- Agrees not to bill Medicare or ask the physician or practitioner to bill Medicare for items or services furnished by that physician or practitioner;
- Is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare;
- Acknowledges that Medigap will not pay towards the services and that other supplemental insurers may not pay either; and
- Acknowledges that he/she has the right to receive items or services from physicians and practitioners for whom Medicare coverage and payment would be available.

A contract must also indicate whether the physician or practitioner has been excluded from Medicare.

A contract is not valid if it is entered into by a beneficiary or by the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health situation.

Q3. Who can opt out of Medicare under this provision?

A3. Certain physicians and practitioners can opt out of Medicare. For purposes of this provision, the term “physician” is limited to doctors of medicine and doctors of osteopathy who are legally authorized to practice medicine and surgery by the state in which such function or action is performed. No other physicians may opt out. For purposes of the provision, the term “practitioner” means any of the following to the extent that they are legally authorized to practice by the state and otherwise meet Medicare requirements:

physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker.

The opt out law does **not** define physician to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery; **therefore, they may not opt out**. Physical therapists and occupations therapists in independent practice cannot opt out.

Q4. Can physicians or practitioners who are suppliers of durable medical equipment (DME), independent diagnostic testing facilities, clinical laboratories, etc., opt out of Medicare for only these services?

A4. No. If a physician or practitioner chooses to opt out of Medicare, it means that he or she opts out for all covered items and services he or she furnishes, even if those items or services are covered under a different benefit. Physicians and practitioners cannot have private contracts that apply to some covered services they furnish, but not to others. If a physician or practitioner provides laboratory tests or durable medical equipment incident to his or her professional services and chooses to opt out of Medicare, then he or she has opted out of Medicare for payment of lab services and DME as well as for professional services. If a physician who has opted out refers a beneficiary for medically necessary services, such as laboratory, DME, or inpatient hospitalization, those services would be covered. In addition, because suppliers of DME, independent diagnostic testing facilities, clinical laboratories, etc., cannot opt out, the physician or practitioner owner of such suppliers cannot opt out as such a supplier.

Q5. How can participating physicians and practitioners opt out of Medicare?

A5. Participating physicians and practitioners may opt out if they file an affidavit that meets the criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., 1/1, 4/1, 7/1, 10/1). They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

Non-participating physicians and practitioners may opt out at any time. The affidavit must be filed with all Medicare carriers to which he or she would submit claims, advising the he or she is opting out of Medicare. The affidavit must be filed with 10 days of entering into the first private contract with a Medicare beneficiary. The opt out affidavit is for a period of two years. It may be extended for two more years after the end of the first opt out period.

Q6. What happens if a physician or practitioner is a member of a group practice or otherwise reassigns his or her Medicare benefits to an organization opts out?

A6. When a physician or practitioner opts out and is a member of a group practice or otherwise reassigns his or her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for the services that physician or practitioner furnishes to Medicare beneficiaries.

However, if the physician or practitioner continues to grant the organization with the right to bill and be paid for the services he or she furnishes to patients, the organization may bill

and be paid by the beneficiary for the services that are provided under the private contract.

The decision of a physician or practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and practitioners who have not opted out of Medicare.

Q7. Can organizations that furnish physician or practitioner services opt out?

A7. No. Corporations, partnerships, or other organizations that bill and are paid by Medicare for the services of physicians or practitioners who are employees, partners, or have other arrangements that meet the Medicare reassignment-of-payment rules cannot opt out since they are neither physicians nor practitioners.

Physicians and practitioners who reassign benefits to organizations that participate in Medicare may not opt out because they are bound by the participation agreement signed by the organization that bills and is paid for their services. If a physician or practitioner has reassigned benefits to an organization that participates in Medicare and wants to opt out, either the organization should terminate its participation agreement or the physician or practitioner should terminate the reassignment of Medicare benefits to the organization.

Q8. Can a physician or practitioner have private contracts with some beneficiaries but not others?

A8. No. The physician or practitioner who chooses to opt out of Medicare may provide covered care to Medicare beneficiaries only through private agreements regardless of who bills and is paid for the services.

To have a private contract with a beneficiary, the physician or practitioner has to opt out of Medicare and file an affidavit with all Medicare carriers to which he or she would submit claims, advising that he or she has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary.

Once the physician or practitioner has opted out, such physician or practitioner must enter into a private contract with each Medicare beneficiary to whom he or she furnishes covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's services to the Medicare beneficiary), with the exception of a Medicare beneficiary needing emergency or urgent care.

Physicians who provide services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and to opt out of Medicare under §4507 of the BBA.

Q9. What has to be in the opt out affidavit?

A9. To be valid, the opt out affidavit must:

- Provide that the physician or practitioner will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the two-year period beginning on the date the affidavit is signed;
- Provide that the physician or practitioner will not receive any Medicare payment for any items or services provided to Medicare beneficiaries;
- Identify the physician or practitioner sufficiently that the carrier can ensure that no payment is made to the physician or practitioner during the opt out period. If the physician has already enrolled in Medicare, this would include the physician or practitioner's national provider identifier (NPI) or billing number (if one has been assigned), or, if an NPI has not be assigned, the physician's or practitioner's tax identification number (TIN);
- Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into; and
- Be in writing and be signed by the physician or practitioner.

Q10. Where and when must the opt out affidavit be filed?

A10. An opt out affidavit must be filed with each carrier that has jurisdiction over the claims that the physician or practitioner would otherwise file with Medicare and must be filed within 10 days after the first private contract to which the affidavit applies is entered into.

Q11. How often can a physician or practitioner opt out or return to Medicare?

A11. Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he or she has opted out of Medicare, he or she is out of Medicare for two years from the date the affidavit is signed. After those two years are over, a physician or practitioner could elect to return to Medicare or to opt out again.

Q12. Can a physician or practitioner opt out for some carrier jurisdictions but not others?

Q12. No. The opt out applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries, regardless of the location where such items or services are furnished.

Q13. What is the effective date of the opt out provision?

A13. A physician or practitioner may enter into a private contract with a beneficiary for services furnished on or after January 1, 1998. The physician or practitioner must submit the affidavit to all pertinent Medicare carriers within 10 days of the date of the first private contract is signed by a Medicare beneficiary.

Q14. Does the statute preclude physicians from treating Medicare beneficiaries if they treat private pay patients?

A14. No. Medicare does not preclude physicians from treating Medicare beneficiaries if they treat private pay patients, whether they are persons under age 65 or are individuals who are entitled to Medicare benefits but have chosen not to enroll in Part B.

Q15. Do Medicare rules apply for services not covered by Medicare?

A15. If a service is one of a type that Medicare categorically excludes from coverage, Medicare rules, including opt out rules, do not apply to the furnishing of the non-covered service. For example Medicare does not cover hearing aids; therefore, there are no limits on charges for hearing aids, and beneficiaries pay completely out of their own pocket if they want hearing aids.

If a service is one that is not covered because, under Medicare rules, the service is never found to be medically necessary to treat illness or injury, no claim need be submitted.

If a service is one which Medicare has determined is medically necessary where certain clinical criteria are met, but is not medically necessary where these criteria are not met, a claim must be submitted since it is possible that the carrier may determine that the service is covered in the individual beneficiary's case, even where the physician or practitioner who has not opted out believes that it will not be covered and has given an Advance Beneficiary Notice (ABN) to that effect. In this case, if Medicare denies the claim on the basis that the service was not medically necessary, the physician or practitioner who has given the ABN notice prior to the service (modifier GA) may bill the beneficiary.

Where a physician or practitioner has opted out of Medicare and agreed to provide covered services only through private contracts with beneficiaries that meet the criteria specified in the law, the physician or practitioner who has opted out is prohibited from submitting claims for covered services.

Q16. Is a private contract needed for services not covered by Medicare?

A16. No. Since Medicare rules do not apply for services not covered by Medicare, a private contract is not needed. A private contract is needed only for services that are covered by Medicare and where Medicare may make payment if a claim were submitted.

A physician or practitioner may furnish a service that Medicare covers under some circumstances, but which the physician anticipates would not be deemed reasonable and necessary by Medicare in that particular case (e.g., multiple nursing home visits, some concurrent care services, two mammograms within a 12-month period, etc.). If the physician or practitioner gives the beneficiary an Advance Beneficiary Notice (ABN) that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to permit the physician or practitioner to bill the beneficiary if the claim is denied.

Q17. What rules apply to urgent or emergency treatment?

A17. The law precludes a physician or practitioner from having a beneficiary enter into a private contract when the beneficiary is facing an urgent or emergency health care situation.

Where a physician or a practitioner who has opted out of Medicare treats a beneficiary with whom he does not have a private contract in an emergency or urgent situation, the physician or practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare on behalf of the beneficiary for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary.

Q18. Will Medicare make payment for services that are ordered by a physician or practitioner who has opted out of Medicare?

A18. Yes, provided the opt out physician or practitioner ordering the service has acquired National Provider Number (NPI) and a physician or practitioner who has also opted out does not furnish the services.

Q19. Clinical psychologists and clinical social workers are currently not recognized by and enrolled by Medicare unless they meet certain criteria specified by CMS, some of which are voluntary. Are the requirements for opting out of Medicare different for these practitioners?

A19. No. A clinical psychologist or clinical social worker must meet the affidavit and private contracting rules to opt out of Medicare.

Q20. What is the relationship between an Advanced Beneficiary Notice and a private contract?

A20. There is no relationship between these instruments. A physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed reasonable and necessary under Medicare program standards in the particular case. If the beneficiary receives an Advance Beneficiary Notice (ABN) that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, and payment for the service is denied as a medical necessity denial, a private contract is not necessary to bill the beneficiary if the claim is denied.

Q21. Are there any situations where a physician or practitioner who has not opted out of Medicare does not have to submit a claim for a covered service provided to a Medicare beneficiary?

A21. Yes. A physician who has not opted out of Medicare must submit a claim to Medicare for services that may be covered by Medicare unless the beneficiary, for reasons of his or her own, declines to authorize the physician or practitioner to submit a claim or to furnish confidential medical information to Medicare that is needed to submit a proper claim. Examples would be where the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone.

The balance billing limits applicable to the physician or practitioner would still apply. Moreover, if the beneficiary or their legal representative later decides to authorize the

submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

Q22. How do the private contracting rules work when Medicare is the secondary payer?

A22. When Medicare is the secondary payer, and the physician has opted out of Medicare, the physician has agreed to treat Medicare beneficiaries only through private contract. The physician or practitioner must, therefore, have a private contract with the Medicare beneficiary, notwithstanding that Medicare is the secondary payer. Under this circumstance, no Medicare secondary payments will be made for items and services furnished by the physician or practitioner under the private contract.

NOTE: It is wise to keep a copy of all of the contracts and affidavits in case CMS requests to see them. CMS requires that the affidavits and contracts be re-executed for each opt out period.

Opt-Out Affidavit

Provider Name

_____

(First) (Middle) (Last) (Cred)

Provider Address

_____

(Street) (City) (ST) (Zip)

Social Security Number: _____ Date of Birth: _____Specialty _____

Medicare PTAN(s)_____ NPI Number _____

Telephone (___)_____ License Number _____

Contact Name:_____ Phone #: _____ Fax #_____

Contact Email _____

• Except for emergency or urgent care services (as specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §3044.8 for services that, but for their provision under a private contract, would have been Medicare-covered services. **The opt out period is 2 years and the contractor will notify me of the effective date of this opt out period.**

• I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual.

• During the opt-out period, I understand that 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+Choice plan.

• I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

• I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.

• I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the 2 year 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.

• I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit. My affidavit should be submitted to the contractor within 30 days of the end of the quarter.

• I acknowledge and 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 Chapter 15 Section 40 of the Medicare Benefit Policy Manual apply if I furnish such services.

• I have identified myself sufficiently so that the contractor can ensure that no payment is made to me during the 2 year opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN and NPI, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to be assigned a PTAN.

• I will file this affidavit with all contractors who have jurisdiction over claims that I would otherwise file with
Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

_____ _____

Provider Signature Date

NOTE: please submit a private contract with your affidavit. When submitting this contract to Medicare Part B, only the provider's signature is needed.

Private Contract

• I _____ (provider's name), have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act.

• I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by _____.

• I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what _____ may charge for items or services furnished.

• I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask _____ to submit a claim to Medicare.

• I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by _____ that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

• I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not 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 expected or known effective date and expected or known expiration date of the opt-out period is _____(effective date) and_____(expiration date).

• I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

• I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

• I _____ (provider's name) will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

• I _____ (provider's name) will supply CMS with a copy of this contract upon request.

• I _____ (provider's name) understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____	_____
(Provider's Signature)	(Date)
_____	_____
(Patient's Signature)	(Date)
_____	_____
(Patient's Legal Representative Signature)	(Date)
_____	_____
(Witness)	(Date)

The IMA strongly recommends physicians obtain competent legal counsel when considering opting out of Medicare.

The furnishing of this packet does not constitute, nor should it be construed to constitute, advice from the IMA regarding participation in the Medicare program. Each independently practicing physician or group must make that decision in consultation with legal counsel.