What is your enrollment status? Reviewing

The Centers for Medicare and Medicaid Services (CMS) requires all physicians and non-physician practitioners who render, order or refer items or services for Medicare beneficiaries to have current enrollment records in Medicare or to have submitted a valid opt-out affidavit.

Although some OMSs may choose not to treat Medicare patients, understanding provider status and participation options may be helpful when coding and billing questions arise.

Providers have three Medicare contractual options. They may enroll and sign a participating (PAR) agreement and accept Medicare's allowed charge (based on the Medicare Physician Fee Schedule) as payment in full for all Medicare patients.

As an alternative, they may enroll and elect to be a non-participating (non-PAR) provider, allowing providers to make assignment decisions on a case-by-case basis and bill patients for slightly more than the Medicare allowance (limiting charge) for unassigned claims.

Or, they may opt out and become a private contracting provider, agreeing to bill patients directly and forego any payments from Medicare.

Expanded descriptions of the three Medicare contractual options are:

- PAR providers agree to take assignment on all Medicare claims, meaning they must accept Medicare's allowed amount (generally, Medicare pays 80 percent of the allowed amount and beneficiaries pay 20 percent) as payment in full for all covered services. The patient is still responsible for the 20 percent copayment, but the provider cannot bill the patient for amounts more than the Medicare allowance.
- Non-PAR providers who accept assignment agree to be paid 5 percent less than the participating provider fee schedule. However, non-PAR providers not accepting assignment may charge up to 15 percent more than Medicare's non-PAR-allowed amount for the cost of services received (dependent on whether assignment is accepted – known as the limiting charge). This means the patient is responsible for up to 35 percent (20 percent coinsurance plus 15 percent limiting charge) of Medicare's allowed amount for covered services.
- Opt-out providers sign an agreement to be excluded from the Medicare program and do not submit claims to Medicare. A provider choosing to opt out can charge the beneficiary their usual, customary and reasonable (UCR) fees provided they have the patient sign a private contract acknowledging this and agreeing to pay prior to rendering services. Opt-out providers do not bill Medicare for services unless emergency or urgent care services are provided. In those particular cases, services may be billed to Medicare using the appropriate modifiers.

Example of $100 Medicare service

Provider enrollment	Total payment rate	Reimbursement expected from Medicare	Payment expected from patient
PAR provider	*100 percent Medicare Fee Schedule = $100*	*$80 (80 percent) payment to provider*	*$20 (20 percent) paid by patient*
Non-PAR provider accepting assignment	*95 percent Medicare Fee Schedule = $95*	*$76 (80 percent) payment to provider*	*$19 (20 percent) pay by patient*
Non-PAR provider NOT accepting assignment	*Limiting charge/109.25 percent Medicare Fee schedule = $109.25*	*$0 Medicare payment sent directly to patient*	*$76 (80 percent) paid by MAC to patient + $19 (20 percent) paid by patient + $14.25 additional limiting charge paid by patient*

Medicare enrollment options and reimbursement

A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and contains the provider's National Provider Identifier (NPI). All enrolled providers (PAR, non-PAR and opt-out physicians) are included in the PECOS database. If a provider who furnished services or referred an item or service to a Medicare beneficiary does not have a current Medicare enrollment record (identified by the provider's NPI), claims submitted to Medicare may be rejected.

The Social Security Act requires providers to submit claims for Medicare beneficiaries whether they participate. AAOMS strongly encourages all OMSs who render, order or refer services for Medicare beneficiaries to enroll in PECOS.

In some instances, OMSs choose not to participate in Medicare. However, if the OMS is called to treat a Medicare patient in an emergency situation, the OMS would still need to be enrolled in the PECOS database in order to be reimbursed for services. Medicare enrollment and reimbursement options are:

Participating provider

- **Enrollment requirements:** Participation requires submission of the Medicare Participating Physician or Supplier Agreement Form CMS-460. This form is submitted in conjunction with the Medicare Enrollment Application CMS-8551.
- **Payment assignment/private contracting:** Participating providers agree to always accept assignment for all services furnished to Medicare beneficiaries. Participating providers who accept assignment agree to the Medicare-allowed fee schedule amount as payment in full and cannot collect more than the Medicare deductible and coinsurance from the beneficiary.
- **Reimbursement:** Participating providers accepting assignment are paid 80 percent of the Medicare-allowed fee schedule amount for covered procedures. The remaining 20 percent may be billed to the beneficiary or a secondary carrier.

Non-participating provider

- **Enrollment requirements:** Non-participating providers must still enroll in Medicare by filling out the Medicare Enrollment Application CMS-8551. Non-participating providers also must submit all covered services on behalf of the beneficiary.
- **Payment assignment/private contracting:** Non-participating providers choose to be reimbursed at 95 percent of the participating provider fee schedule. A non-participating provider has two options:
  - Choose not to accept assignment and receive reimbursement directly from the patient. However, the provider must submit for services rendered so the beneficiary may be reimbursed for the portion of charges Medicare is responsible.

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  - Choose to accept assignment of benefits and be reimbursed 5 percent less than a participating provider.

- **Reimbursement:** The Medicare allowed fees for non-participating providers are 95 percent of the rates for participating providers. The Medicare beneficiary is responsible for paying their 20 percent co-insurance and the 15 percent limiting charge along with any deductible and standard co-insurance amounts that apply. Monetary penalties and/or exclusions from the Medicare program may apply to non-participating providers failing to abide by the limiting charge.

Formally opted out of Medicare

- **Enrollment requirements:** Providers must complete and submit an Opt-out Affidavit to each Medicare contractor to which Medicare claims are submitted in order to formally opt out and privately contract with Medicare beneficiaries. CMS does not have a standard affidavit form. However, many Medicare Administrative Contractors have a form available on their website. AAOMS also offers a sample affidavit on AAOMS.org.
- **Payment assignment/private contracting:** A provider who has formally opted out must enter into a private contract with every Medicare beneficiary presenting for care. Once an eligible provider is opted out, the opt-out status will remain active and auto-renew every two years from the effective date of the opt-out period.
- **Reimbursement:** Providers electing to opt out and privately contract with Medicare beneficiaries can find additional information, including Opting out of Medicare, on the CMS.gov website.

AAOMS recommends periodically checking the PECOS website to confirm the status of the provider is accurate. Providers who wish to change their status from PAR to non-PAR or vice versa may do so annually.

Once status is confirmed, the status is binding until the next annual contracting cycle, except in instances when a provider's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice.

To opt out and become a private contractor, providers 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 they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be a PAR provider.

CMS.gov offers additional resources regarding PECOS, provider enrollment applications and opt-out affidavits at CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.

AAOMS provides information, such as what needs to be included within the opt-out private contract, and Medicare FAQs at AAOMS.org/practice-resources/coding-reimbursements/information-material/Medicare/opting-out-of-Medicare. ■

More information on opting out

Q If an OMS has opted out of Medicare, is the OMS allowed to submit Medicare medical/dental plans without jeopardizing the opt-out status?

A When a provider opts out of Medicare, he or she also is opting out of Medicare Advantage (MA) plans. MA plans will contract with third-party payers (e.g., Delta Dental) and contain all-product clause language in the contract stating if you accept one product, you accept them all. All-product clauses prevent providers from privately contracting with patients and require all services to be submitted to the carrier.

It is important to check third-party payer contracts and understand obligations as a contracted provider. It also is important to confirm all payer benefit information to ensure affiliation between third-party payers and MA plan.