Changes for providers who opt out of Medicare

Medicare Advantage (MA), or Medicare Part C, is an alternate coverage pathway to traditional Medicare that also offers additional or supplemental benefits generally excluded under Medicare Parts A, B or D. MA plans are provided and managed through Medicare-approved private companies. While these entities must follow rules set by Medicare, CMS has granted some flexibility in designing MA benefits as well as in expanding the types of supplemental services these plans may offer.

Enrollment in Medicare Advantage has doubled during the past decade, and patients presenting with MA dental plans are likely to become more commonplace in the years to come. It is imperative to understand the recent regulatory changes governing provider reimbursement for select services, especially for OMSs who have opted out of traditional Medicare.

Dental coverage is one of the core additional offerings across MA, making it the leading source of dental insurance for Medicare beneficiaries. In 2021, 94 percent of individuals enrolled in MA plans had some level of dental coverage; 86 percent of beneficiaries had access to more extensive coverage including services such as oral surgery and prosthodontics[1].

Traditionally, doctors who do not accept Medicare are automatically considered opted out of all products in the federal payment program, including MA plans. Effective Jan. 1, CMS amended its policy to allow such providers to receive reimbursement for supplemental MA benefits, including dental benefits as long as the services are excluded under Part A and Part B – as most dental services are.

When opted out of traditional Medicare, OMSs are not entitled to Medicare or MA reimbursement for services that are covered under traditional Medicare Part A or Part B. If a service is covered under Part A or Part B, this updated policy will not apply. Consequently, the OMS would not receive reimbursement under the MA plan for such a service and would be required to follow opt-out guidelines.

ABNs for oral pathology services

Generally, Medicare excludes coverage for biopsies and related pathology when the diagnosis is associated with a benign lesion or an otherwise odontogenic condition. Despite any clinical indications for the procedure, Medicare may deem services as not medically necessary based on such diagnoses and exclude services under the dental exclusion. Likewise, Medicare will typically deny any claims from the pathologist and/or laboratory related to the non-covered procedure(s) or service(s).

The Advance Beneficiary Notice of Noncoverage (ABN) is supplied by providers to Medicare beneficiaries when a procedure or service is expected to be denied. The ABN allows the patient to make an informed decision about whether to proceed with a service or procedure for which he or she may be personally financially responsible. To clarify, Medicare does not require an ABN for statutorily excluded services, as most dental services are. For oral pathologies, an ABN is most appropriately used to notify a patient that a procedure billable under Medicare is anticipated to be denied based on the diagnosis, rather than the procedure itself.

When information regarding a potential Medicare denial is properly communicated to the beneficiary and documented in accordance with CMS's requirements via a signed ABN, it allows the OMS to transfer financial liability to the beneficiary when such a denial is received. If an ABN is not on file prior to rendering services, and those services are denied as not medically necessary, the OMS is prohibited from billing the patient.

Providers supplying ancillary services in relation to oral pathology, such as pathologists and laboratories, may not be able to obtain an ABN directly from the patient, facing similar billing restrictions as the OMS, should the services be denied. Thus, in the case of oral pathology services for which a denial is anticipated, it is recommended for OMSs to include on the ABN a list of other providers supplying any related services, allowing ancillary providers to hold the patient financially responsible for non-covered services. OMSs also are encouraged to notify such providers of their inclusion in the ABN and be able to provide a copy of the waiver should it be required for claim submission.

AAOMS offers additional resources on Medicare enrollment options and use of the ABN at AAOMS.org/CodingReimbursement. CMS also provides ABN guidelines, available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN. ■

[1] Freed, M., Ochieng, N., Sroczynski, N., Damico, A. and Amin, Krutika. (2021, July 28). *Medicare and dental coverage: A closer look*. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/