Practical Tips

Medicare Assignment and Participation: Excerpts From *Practical Tips for the Oncology Practice*

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The Medicare Physician Fee Schedule has presented significant challenges to oncologists this year, with a series of temporary patches to the sustainable growth rate (SGR) formula resulting in uncertainty about payment rates and delays in Medicare claims processing. In response to this situation, many physicians, including oncologists, have begun to ask questions about the Medicare program and specifically about participation and assignment of claims. This article, excerpted from ASCO's *Practical Tips for the Oncology Practice*, reviews definitions and requirements of the Medicare program for assignment, participation, and private contracts.^{1pp4-5,71-73}

Assignment of Claims

Physicians can elect to take Medicare claims on assignment. If a physician takes a claim on assignment, it means that the physician receives 80% of the Medicare-allowed payment amount directly from the Medicare program and bills the beneficiary for the remaining 20% copayment. A physician who takes assignment agrees to accept these two payments as full compensation and agrees not to bill the beneficiary for any amount above the 20% coinsurance (plus any part of the annual deductible).

If a physician does not take a claim on assignment, the physician does not collect anything directly from the Medicare program but instead looks to the patient for payment. The physician may generally charge the patient up to 115% of the Medicare-allowed payment amount. Medicare reimburses the patient and does not make any payment to the physician. Even if a physician does not take a claim on assignment, the physician is legally required to submit the claim form to Medicare on behalf of the patient.

Physicians must take assignment for claims related to laboratory services and for drugs and biologics. If a physician has an office laboratory, the physician must accept the Medicare payment amount as payment in full for laboratory services. There is no coinsurance requirement in the case of laboratory services; therefore, the payment from Medicare to the physician is the only payment received by the physician. In the case of drugs and biologics, the physician must take assignment and can charge only the 20% coinsurance to the patient.

Medicare-Participating Physicians

A physician can elect to be a Medicare participating-physician. A participating physician (sometimes referred to as a "par" phy-

sician) agrees to take assignment for all Medicare claims. The election to become a participating physician takes the form of an agreement (CMS-460 form). Late in each calendar year, physicians receive a letter from their Medicare contractors giving them the opportunity to decide whether they want to be a participating physician for the following calendar year. A physician's status remains unchanged unless the physician acts to change it.

Medicare reimbursement is greater for services furnished by participating physicians than for services furnished by nonparticipating ("nonpar") physicians. In the case of services furnished by nonparticipating physicians, the Medicare-allowed amount is 95% of the allowed amount for participating physicians. For example, if the fee schedule amount for a particular service is \$100, Medicare will directly pay \$80 to a participating physician and will pay \$76 (80% of \$95) to the patient of a nonparticipating physician. This 5% reduction for nonparticipating physicians also applies to drugs, even though they are not paid under the physician fee schedule and physicians are required to take assignment for drug claims.

The principal advantages of being a participating physician are (1) revenue that is primarily received directly from the Medicare program may be more dependable than collections from individual patients, and (2) some patients may be attracted to participating physicians as a way to reduce medical expenses.

The principal advantages of not being a participating physician are (1) the opportunity to bill patients somewhat more than the amount paid by Medicare for items and services not subject to mandatory assignment, although the permissible extra charge is relatively small (see Maximum Permitted Charges); and (2) depending on the patient population, collection may be faster from individual patients than from Medicare.

Maximum Permitted Charges

A physician who is a Medicare-participating physician, or who otherwise takes assignment of a Medicare claim, agrees to accept the Medicare-allowed payment amount as payment in full. The physician may bill the patient only for any deductible and the 20% coinsurance.

A nonparticipating physician who does not take assignment of a Medicare claim is subject to a "limiting charge" governing the amount the physician may bill the patient. The maximum

charge is 115% of the Medicare-allowed payment amount. The limiting charge applies to all physician services. The Medicare-allowed payment amount for services furnished by nonparticipating physicians is 95% of the normal fee schedule amount, and the maximum charge is therefore 107.25% of the fee schedule amount (115% of 95%). Because physicians are required to take claims for drugs on assignment, the limiting charge does not apply to drugs, and patients may not be billed except for the coinsurance amount.

The limiting charge applies regardless of the Medicare patient's private insurance situation. Even if the Medicare patient has private insurance that pays primary to Medicare, the maximum charge applies.

The limit on the maximum charge cannot be evaded by unbundling services. For example, a physician may not charge a patient personally for supplies used in chemotherapy on the theory that Medicare does not cover supplies. Inasmuch as Medicare considers the payment for supplies to be included in the payment for chemotherapy administration, any separate charge for supplies would violate the limiting charge if the physician's combined charges for supplies and chemotherapy administration exceeded the limiting charge applicable to the chemotherapy administration. The same policy prohibits charges for telephone calls, family consultations, and other services for which Medicare does not make a separate payment but which Medicare does consider to be covered by visit charges.

If a physician knowingly, willfully, and repeatedly charges patients amounts in excess of the permitted amounts, the physician is subject to a fine of up to \$10,000 per overcharge and exclusion from the Medicare program for up to 5 years.

A few states have laws that limit charges to Medicare patients. These are more restrictive than the 115% allowed under federal law and may prohibit any excess charge.

Private Contracts Between Physicians and Medicare Patients

There is an option for physicians to opt out of the Medicare program. Private contracts between physicians and Medicare beneficiaries are allowed in certain narrow circumstances. If the

conditions are satisfied, the physician and the patient may agree on any payment amount, regardless of the Medicare limits.

The government takes the position that the maximum charge limits apply to all services furnished to Medicare beneficiaries even if neither the patient nor the physician seeks reimbursement from Medicare. Therefore, it is ordinarily not permissible for a Medicare beneficiary to agree to pay an amount that exceeds the Medicare maximum charge.

Private contracts are permitted only in the following situation

- The physician must file an affidavit with the Medicare contractor stating that the physician will not submit any claims to Medicare and will not receive any payments from a Medicare Advantage plan for Medicare patients for a 2-year period. In other words, any Medicare patients treated in the 2-year period must be on a private-contract basis. These affidavits become effective only at the beginning of a calendar quarter.
- The patient must sign a written contract with the physician agreeing to pay the physician's charge and not submit any claim for reimbursement to Medicare.

The private contract cannot relate to a condition requiring emergency or urgent care.

Complete details on private contracts with Medicare patients can be found in the Medicare Benefit Policy Manual, Chapter 15, Section 40.²

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