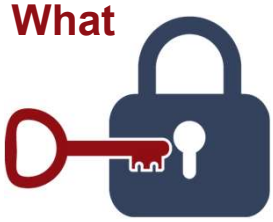
BCMS
BUSINESS & CLINICAL MANAGEMENT SERVICES, INC.

Medicare 2021 Physician Fee Schedule Cuts- What Are Your Options?



Mary R. Daulong, PT, CHC, CHP
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Course Objectives

At the end of this webinar the audience should be able to:

- List Medicare enrollment requirements and options
- Explain the difference between being enrolled as a participating supplier or non-participating supplier
- Evaluate the consequences of the MPFS reductions related to business viability
- Decide what enrollment path to take regarding the MPFS reductions

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Complimentary Resources & References

https://BCMS-clientportal.wildapricot.org/options

Exhibit A - Instructions for Terminating Participating Status
Exhibit B - Demographic Information Form for Conversion to Part B Non-Par
Exhibit C - MACs by State
Exhibit D - CMS-460 Medicare Participating Physician or Supplier Agreement
Exhibit E - Template Letter for conversion

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Submission for CEU/CCU's

We have prepared the following documents that are routinely needed for submitting CEU/CCU applications for those of you who want to, personally, apply for them.

Exhibit F - Course Power Point Presentation
Exhibit G - Course Evaluation
Exhibit H - Presenter's Resume
Exhibit I - Presenter's Biographical Sketch
Exhibit J - Course Objectives, Session Overview, Course References, and Attendance Attestation

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Terms & Abbreviations

MPFS: Medicare Physician Fee Schedule

Non-par: Non-participating provider or supplier

Non-par Limiting Charge: 115% over Medicare's allowable amounts

Par: Participating provider or supplier

PECOS: Provider, Enrollment, Chain & Ownership System (electronic platform)

Provider: Facilities (Rehab Agencies, Part B SNF, Part B Home Health Agencies and CORFs) providing Part A services

Supplier: Groups and therapists providing Part B Medicare services

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DISCLAIMER!

BCMS, Inc. is, merely, presenting alternatives for you, as a Medicare supplier, to consider regarding methods to offset the anticipated 9% fee schedule reduction scheduled for January 1, 2021.

It is imperative to understand that if you choose to change your participating status you cannot reverse it for the entire 2021 calendar year. The implications will be enumerated in subsequent slides.

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Announcement

Good news!

CMS announced on December 7, 2020, that they extended the date for submitting provider/supplier enrollment changes until January 31, 2021.

This extension gives you more time to analyze the impact of the cut on your practice.

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Options to Consider

- Eliminate all services to Medicare beneficiaries
- Cap services to Medicare beneficiaries

- Continue to treat Medicare beneficiaries as a participating supplier

- Continue to treat Medicare beneficiaries but change your status from a participating to a non-participating supplier

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Mandatory Enrollment

- Therapists in Private Practice under Part B *must*, individually, enroll in Medicare and obtain a PTAN (Medicare #) if they provide covered services to Medicare patients. Per SS Act (Section 1848(g)(4)). In most cases they will reassign their payment benefits to a Group Practice which then determines the participating or non-participating status.
- Therapists in Rehab Agencies, CORFs, Part B SNFs and Part B Home Health Agencies *do not* have individual enrollment requirements but rather provide covered services under the facility's umbrella and provider number. These providers cannot be non-participating providers.

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Therapists May *NOT* Opt-Out of the Medicare Program…Per CMS

While certain physicians and other practitioners may Opt-Out of Medicare others **cannot**. Those that cannot include:

Chiropractors

Physical & Occupational Therapists and SLP in private practices

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Evaluate the Impact of the 9% Cut

You must, minimally, analyze the following:

- What is your total (direct and indirect expenses) cost to provide a unit of service?
- What is your total cost (direct and indirect expenses) to provide an average visit (based on your average number of units)?
- What is your average revenue:
  - Per patient over the past 2-3 years (2020, by itself, might not be the best indicator)?
  - Per Medicare patient over the past 2-3 years?
- What is your percentage of Medicare patients based on payer mix over the past 2-3 years?
- Will the 9% reduction put your revenue per Medicare patient below your cost to provide the service?

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Option 1: No Medicare

- Could your practice survive if you eliminated Medicare services totally?
- Would your non-Medicare referrals suffer a negative impact?
- Would you have to decrease staff?
- Would your community public relations experience a negative impact?
- Could you professionally & psychologically accept your decision, especially if voiced on social media?
- How would you handle active Medicare patients if you discontinued accepting Medicare as a form of payment?

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Option 2: Cap Medicare Services

Could you, truly, enforce a firm cap on the number of Medicare patients? As an enrolled Medicare supplier, you are not required to accept every Medicare patient referred to you. You may not, however, 'cherry-pick', that is, you can't deny access that would be considered discriminatory under the Office of Civil Rights or per professional standards.

Note: This does not mean you cannot limit the types of diagnoses you decline to treat if they are outside of the scope of your practice.

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Option 3: Elect to Participate

- If participation is desired, it can be accomplished by completing the CMS 460 form (or Pecos equivalent)
- The participating therapist/group will be paid directly by Medicare at its allowable fee schedule
- The participating therapist/group cannot collect other than the deductible and 20% co-insurance from the beneficiary for covered services

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Participating Agreement

"Participating" (PAR) suppliers:

- Sign a participating agreement CMS 460
- Agree to accept Medicare's allowed charges[1] as payment in full for covered services
- Agree to accept assignment (no balance billing) on all Medicare claims
- Are not required to accept all Medicare patients who seek treatment from them

[1] Note: Allowed charges = Medicare's and the patient's portions

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Advantages of Participating

The advantages of being a PAR supplier are:

- Receive a fee that is 5% higher than for non-PAR suppliers
- Receive payment directly from Medicare
- Listed in directories of PAR suppliers
- Access to toll-free claims processing phone numbers by Medicare carriers

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Option 4: Elect Not to Participate

If the clinic/group elects not to participate (i.e., must accept Medicare but **does not** have to accept **assignment** in all cases but may on a case-by-case basis). It may accomplish this by:

- Not submitting the CMS 460 at enrollment

or by

- Terminating the previous affirmative election by providing the MAC with written notice during Medicare's Annual Enrollment Period (typically, November 15th through December 31st of each calendar year, however the deadline was extended to January 31, 2021 this year).

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Non-Participation

For those who are not participating (i.e. not accepting the allowable fee schedule or routine assignment of benefits) the following occurs:

The therapist must bill Medicare → The therapist may increase the patient's responsibility up to 15% (limiting charge) more than the allowable (total of 115%) → Medicare will pay the patient at the non-par allowable fee schedule (-5%) → The therapist collects the entire amount billed from the patient

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Non-Participating (cont.)

Non-participating (non-PAR) groups/practices may accept assigned Medicare beneficiary payments on a case-by-case basis:

Accepts Assignment	Does Not Accept Assignment
• If a non-PAR therapist accepts assignment Medicare will pay the therapist directly at the Medicare allowable at the non-par rate (95%); no 'balance billing' is allowed and the therapist can only collect 20% from the patient plus any applicable deductible.	• If a non-PAR therapist chooses not to accept assignment they may charge only up to the limiting charge (115% of non-par allowable). The therapist is responsible for collecting the balance directly from the patient. •

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Advantages of Non-Par

The advantage of being a non-PAR supplier is that there is:

- The potential to make more revenue than a PAR supplier

BUT this can only happen if the non-PAR supplier collects the full limiting charge on 35% or more of their Medicare visits.

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Non-Par & Par Payment Per AMA (prior to cut)

Payment Arrangement	Total Payment Rate	Amount from Medicare	Payment Amount from Patient
PAR therapists always accept assignment	100% Medicare Fee Schedule = $100	$80 (80% of the allowable rate) Medicare pays the therapist directly	$20 (20%) paid by patient or other insurance
Non-Par therapists determine assignment acceptance on a case-by-case basis	95% Medicare Non Par fee schedule = $95	$76 (80% of the non par rate) Medicare pays the therapist directly	$19 (20% based on $95) paid by patient or insurance
Non-Par therapists never accept assignment of benefits	115% of Non Par fee schedule rate ($95). Medicare fee schedule $95 x 115% = $109.25	All monies are paid to the beneficiary by Medicare	Medicare pays $76 (80% of $95) to the patient. The patient's co- insurance is $19 (20% of $95) + Limiting Charge of $14.25. Total due from patient is $76 + $19 + $14.25 = $109.25

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Non-Par & Par Payment at 9% Reduction

Payment Arrangement	Total Payment Rate	Amount from Medicare	Payment Amount from Patient
PAR therapists always accept assignment	100% Medicare Fee Schedule = $100 – 9% = $91.00	$72.80 (80% of the allowable rate) Medicare pays the therapist directly	$18.20 (20%) paid by patient or other insurance
Non-Par therapists determine assignment acceptance on a case-by-case basis	95% Medicare Non-par fee schedule = $86.45	$69.16 (80% of the non-par rate) Medicare pays the therapist directly	$17.29 (20% based on $86.45) paid by patient or insurance
Non-Par therapists that never accept assignment of benefits	115% of Non-par fee schedule rate ($86.45). Medicare fee schedule $86.45 x 115% = $99.42	$69.16 (80% of the non-par rate) is paid to the beneficiary by Medicare	Medicare pays $69.16 (80% of $86.45) to the patient. The patient's co-insurance is $13.83 (20% of $86.45) + the Limiting Charge amount of $16.43 ($69.16 + 13.83 + 16.43) Total due from patient is $99.42

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Option to Accept Assignment or Not

Remember, non-participating therapists may elect to accept assignment from patients who cannot pay more than their 20% co-insurance at the time of service. But be attentive if assignment is accepted:

- Medicare will pay the therapist directly for its non-par allowable of $69.16[1] not $72.80;
- The patient's co-insurance is $17.29[1] not $18.20;
- The claim must be marked to indicate accepting assignment, signature on file.

[1] Both based on $91 (-9% of 2020 $100/visit) charge reduced to $86.45 which is the allowable for non-participating suppliers with the patient paying 20% of the non-par rate.

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Par Payment Variance from 2020 to 2021

Practice Payment from Medicare

- 2020 = $80.00
- 2021 = $72.80

Patient Co-Share

- 2020 = $20.00
- 2021 =$18.20

Total Payment if Participating in 2021 with the 9% Reduction = $91.00

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Non-Par Variance from 2020 to 2021

Patient Costs not reimbursed by Medicare

- 2020 Patient out-of-pocket (co-insurance & limiting charge) = $33.25
- 2021 Patient out-of-pocket (co-insurance & limiting charge) = $30.26

Practice Payment from Medicare & Patient

- 2020 $109.25
- 2021 $ 99.42

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CAUTION! Provider Be Beware…

- **Changing your enrollment status to non-participating is a year long, non-negotiable matter**
- Changing your collection strategy could cause the patient to:
  - Be out of pocket the full cost of each visit for up to 14 days if you don't accept assignment (Medicare should pay them directly for the Medicare allowable under the non-par fee allowance)
  - Reduce the amount of visits
  - Change providers
  - Cause unfavorable patient relations
- Accepting assignment on a case-by-case basis, if regularly done, could fail to offset the 9% reduction
- Check your States Balanced Billing Laws because they could limit the "Limiting Charge' amount

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NOTICE!

- If you have inadequate collections at the time of service now, you will fail as a non-participating supplier.
- If your front office is not able to explain why payment is due and follow through with collecting at the time of service, you will fail as a non-participating supplier. *(Develop a script and stick with it!)*
- If you do not have a "united front" (all staff, including clinicians) about the need to go non-par, you will fail as a non-participating supplier.

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Additional Considerations

If Medicare 'pauses' or retracts the MPFS reductions or if Congressional legislation passes after you have changed to a non-participating supplier, you have two options:

- Accept assignment on all Medicare patients knowing that you will incur a 5% reduction in payment as a Medicare non-par supplier on all of your claims
- Follow-through with your election as a non-participating supplier and do not, routinely, accept assignment; your payment will be as indicated in the table in slide 21 (Non-Par Supplier prior to 9% cut)

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How to be Compliant and Collect Cash

- Enroll in Medicare Part B and comply with Conditions of Coverage;
- Decline to accept assignment (enrolled but not participating);
- **Collect both Medicare's and the patient's co-insurance and the "limiting charge" (115%) of the non-par fee schedule rate at the time of service;**
- File the patient's claim as a non-participating supplier (do not check assignment accepted on the claim);
- Take your money to the bank!

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As We Know

A claim must be submitted to the payer if a provider is required by State or other law to submit one for covered services.

If this is there is no law mandating claim submission a patient may exercise his/her right under HIPAA to restrict disclosure of his/her PHI to his/her payer and proceed to pay out-of-pocket for the services rendered.

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Exception to Mandatory Claims Submission

There is an exception to this rule which states[1]:

When a Medicare beneficiary (or the beneficiary's legal representative) refuses, of his/her own free will, to authorize the submission of a bill to Medicare… **a Medicare provider/supplier** is not required to submit a claim to Medicare for the covered service and may accept an out-of-pocket payment for specified services from the beneficiary despite the Mandatory Claim Submission regulation.

[1] Condensed language for the purpose of slide formatting.

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Penalties for Non-Compliance

Compliance to the mandatory claim filing is monitored by CMS!

- Violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation;
- Violations could result in exclusion from the Federal Program;
- Violations could result in a ten percent (10%) reduction of subsequent payments, IF the provider/supplier is allowed back into the program.

Note: Beneficiaries may not be charged for preparing or filing a Medicare Claim

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Summary

- Therapists do not have to enroll in Medicare, but they will not be allowed to treat Medicare patients for covered services if they are not enrolled;
- Therapists may limit the number of active Medicare patients they serve;
- Therapists have a choice when they enroll as a Part B supplier…to accept assignment or to decline to accept assignment and may change that status during the Medicare provider annual enrollment period (typically, November 15th through December 31st; extended in 2020 to January 31, 2021);
- Non-Par therapists may collect in full at the time of service at the non-par rate;
- A Medicare provider may collect cash from the Medicare patient if he/she refuses to authorize the submission of a bill to Medicare.

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QUESTIONS?

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Presenter's Biography

Mary Daulong has a very diverse practice background which includes private practice ownership, corporate managed services and hospital-based practice exceeding four decades. Her consulting company was established in 1985 and has been, for the past nineteen years, 100% dedicated to working with healthcare professionals in the areas of federal and state compliance, payment and coverage policy including billing, coding and documentation. Her company also provides Compliance Policies and Procedures Manuals specific to physical therapy, provider enrollment and credentialing services and on and off-site audits for regulatory compliance.

Mary has been certified in Health Care Compliance since 2002 and is a member of the Healthcare Compliance Association; she is also certified as a HIPAA Professional by the HIPAA Academy. She has been an active member of the APTA for nearly fifty years during which she served on and/or chaired multiple committees and task forces at the national and component level including but not limited to serving on the PPS' Payment Policy Committee for nine years. Mary was the chair of the Texas Physical Therapy Association's Payment Policy Committee for nearly ten years and continues to participate as a member of that committee. She held chairmanships for the TPTA of Governmental Affairs, Quality Assurance and Nominating Committees. She was appointed to the Texas Board of Physical Therapy Examiners and served on its Executive Council for PT and OT and Investigations Committee. Mary is a member of the Novitas Solution's Provider Outreach Education Advisory Group.

Mary has presented hundreds of courses related to compliance both on a federal and state level often being the featured speaker at National, Chapter and Section Annual Conferences.

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Disclaimer

These educational materials are current as of December 9, 2020. They have been prepared as tools to assist in teaching healthcare providers; they are not intended to create any rights, privileges, or benefits. Although every reasonable effort has been made to assure the accuracy of the information within these materials, the ultimate responsibility for complying with the federal and state laws lies with the provider of services.

Please note: These educational materials are summaries and must not be interpreted as legal documents. The official information is contained in the relevant laws and regulations

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Contact or Connect with us

Alicia Nevins Mahoney

mahoneya@bcmscomp.com

713-899-9812

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