Psychiatry Coding & Reimbursement Alert

Mythbuster: Clarify These Non-Par Misconceptions Before You Land in Hot Water

Recognize the difference between opting out and being a non-par provider.

Once you decide to become a non-participating (i.e. "non-par") provider in the Medicare program don't imagine that you've said goodbye to Medicare compliance. You still remain bound by certain reimbursement restrictions, subject to audits, and required to follow electronic health record (EHR) rules. Read on to learn what it means and doesn't mean to be a non-par provider.

Non-Par Providers May Still See Medicare Patients

Although the name may suggest otherwise, non-par providers still see Medicare patients; they just aren't considered "participating physicians."

"Participating in the Medicare program simply means that you agree to accept assignment for all services furnished to Medicare patients," Part B Medicare administrative contractor (MAC) **Cahaba GBA** says on its website. "By accepting assignment, you agree to accept the amount approved by Medicare as total payment for covered services."

Non-par providers can choose to accept assignment or not on a claim by claim basis, but if they don't accept assignment, they can't charge more than 115 percent of the Physician Fee Schedule amount for any particular service. Furthermore, the non-par Medicare allowance is only 95% of the Medicare allowance for participating physicians. If these facts surprise you, then you may be really shocked to hear the following three common misconceptions about being a non-par provider, straight from the mouths of the carriers.

Myth 1: You'll Never be Audited

If your vision of being a non-par provider involves assigning CPT® codes willy-nilly and withholding necessary modifiers because auditors don't care about non-par claims, think again. The reality is that reviewers are watching all claims that involve the government's money.

"Any Medicare claim submitted can be audited/reviewed," the **Centers for Medicare & Medicaid Services** (CMS) says in its MLN document Misinformation on Chiropractic Services. "The participation status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors."

Translation: If you expect Medicare, Medicaid, **Tricare,** or any other government-funded source to pay for your services, you should expect the same scrutiny from reviewers, no matter what your filing status is. This means you must bill and code accurately at all times, even if you have non-par status.

Myth 2: You Can Avoid EHR Penalties

When CMS announced that Medicare providers who don't use a qualified EHR or who don't report quality measures would face penalties, many non-par providers sighed with relief that they didn't face such pay cuts. However, those same physicians were surprised to see negative adjustments in their reimbursement checks, because non-par providers do

take the hit just the same as participating practices.

"The negative payment adjustment applies to all eligible professionals (EPs), regardless of whether the EP elects to be 'participating' or 'non-participating' for purposes of Medicare payments," CMS says in MLN Matters article MM8667.

Translation: Whether you are "participating" or "non-participating," you have to adhere to Medicare's rules, which require you to report quality measures and use an EHR or else take a hit to your pay.

Myth 3: Your Money Will Roll in as Always

If you are non-par with Medicare and treat a Part B beneficiary, payment from your MAC may go to the beneficiary. It depends on whether or not you accept assignment on the claim. If you do, the MAC will pay you the portion for which Medicare is responsible. However, if you do not accept assignment, payment goes to the beneficiary who, in turn, must pay your charges up to the limiting charge (i.e. 115% of the non-par Medicare allowance). As Part B MAC **WPS Medicare** states in its "General Medicare FAQs." "When a provider does not accept assignment on a claim, Medicare sends its payment directly to the beneficiary, not to the provider."

WPS Medicare also says, "A non-participating provider may collect full payment directly from the patient at the time of service." So, you should carefully calculate the amount that Medicare will allow for the service based on your non-par status. If you are not accepting assignment on the claim, you can charge and collect up to 115% of that amount to the patient on the date of the visit, since the MAC won't pay you directly. For assigned claims, you may collect up to the Medicare allowance. In either case and especially on assigned claims, you must show on the claim form any amount you have collected from the beneficiary for your services. This information is essential for correct payment of the benefits due to either you or the beneficiary.

Translation: The maximum that you can charge and collect from the Medicare beneficiary and whether the MAC sends a check to you or the beneficiary depends on whether or not you accept assignment. If you choose to have the patient send you a check after she receives it from the MAC, make a notation in your system to bill the patient in a pre-set amount of time to ensure that you collect for the service.