

Medicare Opt-Out Option to be Pursued with Care

By Chris Lowe, King & Ballou Partner & Healthcare Practice Member
clowe@kingballou.com

Physicians and practitioners who are concerned about the growing administrative burdens and unpredictable reimbursement rates of Medicare have the choice to “opt out” of Medicare. This decision must be made after careful consideration of the legal requirements and consequences in doing so.

Before pursuing any legal steps, providers should first consider any fundamental changes to the nature of their practice as a result of “opting out.” Trading Medicare reimbursement for private contracts with patients may or may not pay off financially for a practice. In addition, a practice may have contracts with other entities that would be affected by a departure from Medicare. “Opting out” may simplify a provider’s office procedures and account management, but the countervailing loss of patients to a practice after the switch must also be kept in mind.

Providers who have weighed and considered the advantages and disadvantages to their practice by “opting out” and made the decision to do so, should obtain counsel to ensure they are in full compliance with federal requirements. Several legal requirements must be followed if a provider elects to “opt out” of Medicare. First, the provider must submit an affidavit that meets the requirements of federal regulations to each Medicare carrier with which that provider would file claims in the absence of the “opt out.” The affidavit must be received by the Medicare carrier at least thirty days before the first day of the calendar quarter after the “opt out” date.

Second, providers who “opt out” will need to enter into private contracts with their Medicare patients. Federal law imposes requirements upon “opting out” providers who enter into private contracts with Medicare beneficiaries for items or services that would otherwise be covered by Medicare. Among other requirements, providers must ensure these private contracts are written and in type sufficiently large to ensure that the beneficiary can read it. Providers should

note that contracts with Medicare patients are not valid in cases involving emergency or urgent care.

Providers can “opt out” of Medicare for renewable two-year periods. Once a provider “opts out,” that provider is generally prohibited from submitting a claim to Medicare for items or services furnished to a Medicare beneficiary. In the event that a provider fails to follow the requirements to “opt out,” that provider’s contracts with Medicare beneficiaries are null and void, and the provider must submit claims to Medicare.

Once a provider has made the decision to “opt out,” appropriate notice of that decision should be given to the provider’s patients and anyone else who could be affected by that decision. A provider must also make the necessary changes in office procedures to ensure that no Medicare claims are filed during any “opt-out” period.

If you are interested in learning more about the legal requirements involved in “opting out” of Medicare, please contact me at (615) 726-5514 or clowe@kingballow.com.

For more information contact: Chris Lowe, Partner & Health Care Practice Member at King & Ballow, clowe@kingballow.com, phone (615) 726-5514.

For more posts of interest to health care professionals go to:
www.kingballow.com/healthcare.php

These opinions and comments are intended only for the purpose of providing recent updates and general information and are not intended, and should not be used, as a recommendation for any specific situation or entity or as a substitute for legal counsel. Always consult with an attorney for specific legal counsel concerning your particular situation.