Cash-Based Payment and Medicare Services: No Exceptions to the Rules

Article

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Among physical therapists pursing cash-based practice models, questions often arise about possible exceptions to the laws that require PTs who treat Medicare beneficiaries to (1) be enrolled in the Medicare program, (2) submit claims for covered services to Medicare, and (3) bill for appropriate amounts determined by Medicare.

The short answer is that no exceptions allow PTs to bypass these requirements.

APTA has sought guidance and developed the scenarios below to address potential situations. (While this information is based on guidance from legal counsel, it is not intended to provide legal advice or opinion. You should not act, or refrain from acting, on the basis of this general information without the assistance of legal counsel familiar with your unique set of facts.)

First, a few general points:

- Medicare laws regarding claims filing and the limiting charge apply to those enrolled in Medicare and to those who are not, meaning that PTs don't avoid penalties for noncompliance by not being enrolled in the Medicare program. Any PT who furnishes Medicare covered services and privately bills and collects payment directly from a beneficiary is in violation of the law.
- Medicare-enrolled physical therapist private practices can choose to be either participating providers or non-participating providers. (In contrast, a rehabilitation agency must be a participating provider.) Participating providers sign an agreement to accept assignment for all Medicare-covered services, meaning they accept Medicare-approved amounts as payment in full. Non-participating providers do not sign an agreement to accept assignment for all Medicare-covered services, but can still choose to accept assignment on a case-by-case basis. Non-participating providers are paid 5% less than the approved amount for participating providers. When a non-participating provider does not accept assignment, the provider is allowed to charge more than the Medicare-approved amount up to a limit, which is called the limiting charge, which is 115% of the non-participating fee schedule amount. APTA's Fee Schedule Calculator can help you determine the limiting charge, as well as the amount to expect if you are a non-participating provider who does accept assignment.
- Physicians and other providers specified in the law are eligible to opt out of the Medicare requirements for claims submission and limiting charges under the program's private contracting provisions in some circumstances. The provision allows Medicare beneficiaries to contract privately with physicians for Medicare-covered services as long as several requirements are met. The private

contracting rules do not apply to PTs because they are not within the opt-out law's definition of either a "physician" or "practitioner."

- Legal challenges to Medicare's limiting charge and private contracting rules have been unsuccessful—such as challenging due process, equal protection, or Congress's authority to attach conditions on the receipt of Medicare funds.

Here are some scenarios to consider:

Scenario 1: The patient became a Medicare beneficiary after he or she began being treated by PT who is not enrolled in the program.
Once a patient enrolls in Medicare Part B, they come under the Medicare law's beneficiary protection provisions. The rules do not provide for an exception that would allow the patient and PT to enter into an arrangement to continue treatment outside of Medicare if the services are covered by Medicare. The PT must either stop providing care to that patient or enroll in Medicare and submit claims for Medicare-covered services.

Scenario 2: The patient receives a combination of covered and noncovered services.
If the PT provides both covered and noncovered services to a Medicare beneficiary, the PT must be enrolled in the program and file claims for the covered services in the amount within the limiting charge. The noncovered services can be billed directly to the patient for out-of-pocket cash payment and are not subject to the limiting charge.

Scenario 3: The patient of a non-enrolled PT requests, under HIPAA, not to disclose private health information to Medicare.
Medicare law is clear that the "patient-refusal" exception—excusing the provider from submitting a claim because the patient refuses to authorize it for privacy reasons—is available only to enrolled providers. A PT can't use this "patient-refusal" argument in sidestepping the requirement to file claims by not enrolling in the program, because only enrollees are eligible for it.

Scenario 4: The patient seeks covered services from a non-enrolled PT after failing to receive successful outcomes from PTs who accept Medicare payment.
Nothing in the rules allows for a non-enrolled PT to provide Medicare-covered services to a beneficiary simply because the patient prefers seeing the non-enrolled PT rather than a PT who is enrolled in the Medicare program. The patient's lack of success with a Medicare-enrolled PT is irrelevant.

Scenario 5: The PT owns a business that accepts Medicare as a group practice and employs enrolled providers, but the owner is not individually enrolled.
While an independent practice can enroll in Medicare and bill as a group, only the individually enrolled PTs within the practice can provide services to Medicare beneficiaries.

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