Statutorily Excluded

Statutorily excluded refers to Medicare benefits that are never covered according to law. “Statutory” refers to written law.

Medicare does not pay for all health care costs. Certain items or services are program or statutory exclusions and will not be reimbursed by Medicare under any circumstances. When a patient receives an item or service that is not a Medicare benefit, they are responsible for payment, personally or through any other insurance that they may have. Most practices use the Advance Beneficiary Notice of Nonpayment (ABN) to alert the patient to their personal financial responsibility for the service, although use of the ABN is not required for statutorily excluded services. See the Library tab for a link to the current ABN form.

Some items that are statutory exclusions are:

- Personal comfort items
- Routine immunization(s); other than pneumococcal, flu and hepatitis B
- Self-administered drugs and biologicals
- Cosmetic surgery
- Routine physical examinations (exception is the Welcome to Medicare Exam); laboratory tests and X-rays; other than covered screening diagnostic tests (e.g. mammography)
- Eyeglasses or contact lenses (in the absence of aphakia or surgical removal of cataracts)
- Eye exams for the purpose of prescribing, fitting or changing eye glasses or contact lenses in the absence of disease or injury to the eye
- Eye refractions
- Hearing aids
- Routine dental services (e.g., care, treatment, filling,
removal or replacement of teeth)
• Supportive devices for the feet
• Routine foot care (e.g., cutting or trimming of corns or calluses, unless inflamed or infected; routine hygiene; palliative care, trimming of nails)

The recently passed healthcare reform bill has the potential to change some of the benefits listed above. Note also that some Medicare Advantage plans provide additional benefits beyond the scope of original Medicare.

Forget January 3, 2011! PECOS Date Moved 6 Months Closer for Referring & Supplying Providers New Date is July 6, 2010

NOTE: The date has been changed to July 5, 2011. delayed indefinitely.

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Physicians and “eligible” providers received a jolt today in the May 5, 2010 Federal Register as the date for enrollment in PECOS was moved up (pending the comment period and any changes resulting from the comment period) six months for providers that order or supply durable medical equipment (DME) for Medicare patients. Instead of the January 3, 2011 date previously announced by CMS, the Patient Protection and
Affordable Care Act (Affordable Care Act or PPACA) has provisions to move the go-date to July 6, 2010, just 60 days away.

What does this mean to you? Unless something changes based on public comments, beginning July 6, 2010:

1. Providers with a National Provider Identifier (NPI) must include it on their Medicare and Medicaid enrollment applications and claims.

2. Providers of medical items/other items/services and suppliers that qualify for a National Provider Identifier (NPI) must include their NPI on all applications to enroll in the Medicare and Medicaid programs AND on all claims for payment submitted under the Medicare and Medicaid programs.

3. The ordering/referring supplier must be a physician or an eligible professional with an approved enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) thus changing the previously reported January 3, 2011 date given by CMS.

4. Claims that do not meet these requirements will be rejected by Medicare contractors.

You can read the rule in its entirety [here](#).

Want to read the comments on this interim final rule when they are published? Go [here](#).

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**Balance Billing**

Every health organization has a standard fee schedule that it discounts for volume health services payers such as Blue Cross or Aetna. When one agrees to accept a discounted fee
schedule, it is not legal to bill the patient the difference between your standard fee schedule and the discounted fee schedule. This practice is called balance billing and is only allowable if you do not have a contract with the payer.

The slight exception to this rule is Medicare, which regulates the amount above the Medicare allowable that you may bill the patient, but only if you are a non-participating provider. If you are a participating provider with Medicare, you may only bill the patient for their unmet deductible and for co-insurance which is 20% of the allowed amount.

A health care organization’s attempt to collect from the patient the difference between the standard charge amount and the allowed amount approved by a contracted carrier such as Medicare. Balanced billing is a contract violation and may be illegal. The practice should be avoided.

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**Carve-Out**

A carve-out is a group of services that are not covered under the primary contract, but are addressed under a separate agreement. For instance, a practice may have a contract with a payer whereby the all services will be reimbursed to the practice at a specific percentage of Medicare. There may also be a carve-out, whereby 10 procedures are paid at a contracted dollar rate, not a percentage of Medicare.
Assignment

Accepting assignment means that:

1. you will accept as payment in full the allowed amount established by the payer (Medicare or any other payer you are contracted with) and
2. the payment will be sent directly to the provider for services rendered.

Providers may accept assignment on a case-by-case basis unless they are contracted with the payer, in which case they usually are participating with the payer and accept assignment.

Dear Mary Pat: How Do I Handle Chart Audit Requests From Payers?

When a payer or health plan calls your practice and requests records or requests an on-site visit to review charts, follow this guideline:

1. Be professional at all times. Audits can be nerve-wracking and can be a drain on internal resources, but there is always something to be learned from the process.
2. Ask for the request in writing, to include the names of the patients whose charts will be accessed, the dates of service covered under the audit, the name of the auditor, the specific reason for the audit, what the result from the audit will entail (warnings, sanctions,
grading, etc.) and if the result will be published in any form anywhere. Request that the specific information culled from the audit be shared with your practice in an usable form.

3. Review your contract with the payer for any language related to the payer’s rights to access information, the description of the information, and any payment due to the practice for the labor and resources used in producing the records. Check with your state insurance laws for any information regarding such requests. Note that Medicare Advantage plans do not have contracts with practices, so you do have the right to charge for the labor and resources necessary to produce records.

4. When the information arrives from the payer, confirm that the patients named in the audit have records in your practice.

5. If the explanation for the audit is unclear, request more in-depth information in writing.

6. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.

7. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the entire chart to the auditor.

8. If you are satisfied that all requirements are being met by the payer, schedule the audit, or arrange for records to be sent. If coming on-site, arrange for a quiet place for the auditor to review records, preferably close to you so you can observe, answer questions and ask questions.

9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off on any compliance plan updates.
Chart Audit Request Management

When a payer or health plan calls your practice and requests records or requests an on-site visit to review charts, follow this guideline:

1. Be professional at all times. Audits can be nerve-wracking and can be a drain on internal resources, but there is always something to be learned from the process.

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7. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.

8. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the auditor access the system, as their permission to review records is limited.

9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off on any compliance plan updates.

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**Ten Reasons Why (Some) Physicians Aren’t Rushing to Adopt EMRs**

1. Everyone is waiting for the other shoe to drop on Medicare payments.

2. Private practices may not have the in-house expertise to implement an EMR and may not be able to afford a consultant (although some states are receiving grants to help practices – check your state’s grant [here](#)).
3. There is a lot of confusion on the parts of Meaningful Use that have been clarified and of course, on those that haven’t.
4. Administrators are distracted by RAC, PECOS, HIPAA, PQRI, eRx and RCM.
5. Some practices have spent years avoiding Medicare and Medicaid patients and now don’t have the patient numbers to participate.
6. Everyone and their uncle is selling an EMR – who can tell the long-timers who are about to be bought from the short-timers who might last forever?
7. Physicians are worried about the drop in production that (some say) happens when a practice launches an EMR.
8. There seems to be as many horror stories as there are success stories with EMRs.
9. Practices that are affiliated with a hospital are nervous about tying themselves to the hospital in such a serious way as hopping on their EMR package.
10. Because two practices can have absolutely opposite experiences with the same EMR, no one can find consistent recommendations for any single product. (It’s not the product, it’s the implementation!)
11. Bonus Reason: lots of people are confused about how to qualify for the ARRA money (read my post about this here.)

The Healthcare Bill, Rage, Concierge Practices, Cuts,
HEALTHCARE BILL IMPACT ON INDIVIDUALS AND RAGE

A number of people asked me about the impact of health reform on them as individuals. Here is a great story from the Atlanta Journal-Constitution that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents’ health insurance policies until age 26.
- A high-risk insurance pool will open for people with pre-existing conditions who have been uninsured for six months.
- In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow every year until it is eliminated in 2020. People in the “doughnut hole” could receive a $250 rebate this year.

I have to say that I’ve been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but this story placed the fury into a different perspective for me. It’s a good read.
What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

- The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from $1500 to $1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not, such as physicals, phone consultations, wellness counseling and patient education.

- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the $5,000 to $15,000 range) and all primary care is provided for that amount. The patient still needs to carry insurance for prescriptions, hospital services and sub-specialist services. *Imagine being a manager in this type of practice – no pre-authorizations, no insurance department, no eligibility checking, no refunds…*

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003, the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are approximately 5,000 physicians using the concierge model in
the United States today.

MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again **hold claims for services provided from April 1 to April 10** to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.

Amidst this craziness, a voice of sanity is heard and it is Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and **probable Obama pick for the head of CMS**. If you don’t know Don Berwick or the IHI, click [here](#) to read an interview with him about the IHI’s “100,000 Lives Campaign” or watch the video below of him speaking about the dimensions of quality. Good stuff!

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NCCI (National Correct Coding Initiative)

The CMS (Centers for Medicare and Medicaid Services) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT manual,
national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs (Fiscal Intermediaries) as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.

More information from CMS [here.](#)