Medicare 2011: What's Covered and How Physician Practices Can Deal With the Changes

More information on Medicare wellness visits in 2011 can be found here.

Information on the 2011 Medicare Part A and Part B deductibles and premiums can be found here.

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The extensive changes coming for Medicare Part B coverage in 2011 should have primary care practices and some specialty practices thinking about their current processes. If you meet with your team now to educate them about the Medicare changes and explore process tweaking, you'll be ready when January 1 rolls around.

Image via Wikipedia

Here are a few areas to think about:

1. Advance Beneficiary Notices (ABNs) – Many practices struggle with the who and when of ABNs and the new coverage might not make it easier. There are lots of services now covered with **new frequency limitations**, so practices must be on their toes to recognize when a service is covered and when it isn't. Sure, you can ignore ABNs and wait for Medicare to tell you a service is not covered, but then it's too late to collect from

the patient – not only too late, but also illegal to collect.

2. The annual wellness visit is going to be a special challenge because the timing is precise. Medicare patients will hear "annual visit", but won't realize it will not be paid for if performed within 12 months of a previous wellness visit (Welcome to Medicare exam or annual visit). I've not seen any practice management software that handles this really well, but maybe it's out there. I'd love to see Medicare patients scheduling their **annual visits during their birthday month** so staff would have a fighting chance of identifying the last annual visit and getting the date right. Of course, using your electronic recall will work too if you **schedule the next year's visit when the patient is checking out.** (Do you proactively contact your Medicare patients to invite them to come in for their Welcome to Medicare exam?) Also encourage patients to keep up with the preventive services they are eligible to receive by **registering with the My Medicare website** (https://mymedicare.gov/). This is their personal Medicare website for tracking their Medicare services. It will send them e-mail reminders when they are eligible for Medicare coverage of preventive services. Great idea!
3. **Who will be doing the counseling** about the "preventive services covered by Medicare" during the annual exam? Let's hope Medicare puts out a really great handout!
4. Most EMRs will let you load requirements for services based on diagnosis – for example, diabetes. Make sure you are taking advantage of the EMR's ability to **set up protocols for age, diagnosis and risk factors**. If you are not on EMR yet, use your **appointment schedule or recall system to set reminder appointments** to contact patients for their services.
5. **Don't forget your patients on Medicare who are not yet age 65.** Run a report to find these patients and flag

them to acknowledge that their Medicare services are at different times.

6. **Collections at time of service will change** too, of course, as most services listed below will not be applied to the deductible. Exceptions are glaucoma screening, diabetes monitoring and education, medical nutritional, and smoking cessation. Patients understandably will be confused, so make sure your check-out staff are crystal clear.

Medicare Benefits Beginning January 1, 2011

- **Medicare covers a one-time preventive physical exam within the first twelve months of having Part B**. The exam will include a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if needed. No Part B deductible and effective January 1, 2011 you pay nothing if the doctor accepts assignment.

- **Abdominal Aortic Aneurysm Screening** – People at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound at their "Welcome to Medicare" physical exam. Effective January 1, 2011 no deductible and no copayment.

- **New Annual Wellness Visit** – Effective January 1, 2011 Medicare will cover an Annual Wellness Visit that includes a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if you need it. It is available every 12 months (after first 12 months of Part B coverage) but not within 12 months of receiving either a "Welcome to Medicare" physical exam or another Annual Wellness Visit. No Part B deductible "" Medicare pays 100% of the approved amount.

- **Cardiovascular Screening Blood Tests** – Medicare covers cardiovascular screening tests that check cholesterol and other blood fat (lipid) levels every 5 years. Includes:
    - Total Cholesterol Test
    - Cholesterol Test for High Density Lipoproteins; and
    - Triglycerides Test
    - No Part B deductible "" Medicare pays 100% of approved amount.

- **Diabetes Screening Tests** – Anyone enrolled in Medicare identified as "high risk" for diabetes will be able to receive screening tests to detect diabetes early. Covers up to two screenings each year. Includes:
    - Fasting plasma glucose test
    - Post-glucose challenge test
    - No Part B deductible "" Medicare pays 100% of approved amount
- **Glaucoma Screening** – Must be done or supervised by an eye doctor (optometrist or ophthalmologist). Covered annually for:
    - Those with diabetes
    - Those with a family history of glaucoma
    - African-Americans age 50 and older
    - Hispanic-Americans age 65 and older
    - Other high risk individuals
    - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Bone Mass Measurement –** For those enrolled in Medicare at high risk for losing bone mass. Effective January 1, 2011 no Part B deductible "" Medicare pays 100% of approved amount.

- **Screening Mammography** (including new digital technologies) – For women age 40 and older enrolled in Medicare:

    - Covered annually
    - No Part B deductible ”“ Medicare pays 100% of approved amount beginning January 1, 2011.
- **Screening Pap Test & Pelvic Examination** (Includes clinical breast examination) – For all women enrolled in Medicare:
    - Covered once every two years for most
    - Covered annually for women at high risk
    - No Part B deductible ”“ Medicare pays 100% of approved amount for Pap test and effective January 1, 2011 pays 100% of approved amount for pelvic and breast exam.
- **Colorectal Cancer Screening** – For all those enrolled in Medicare age 50 and older:
    - Fecal-Occult blood test covered annually ”“ No Part B deductible & Medicare pays 100% of approved amount.
    - Flexible sigmoidoscopy once every four years or 10 years after a previous screening colonoscopy”“ No Part B deductible or copayment starting January 1, 2011.
    - Barium enema can be substituted for sigmoidoscopy or colonoscopy ”“ No Part B deductible – Medicare pays 80% of the approved amount. You will pay a higher coinsurance if the test is done in a hospital outpatient department.
    - Colonoscopy for any age enrolled in Medicare
    - Average risk – Once every ten years, but not within four years after a screening flexible sigmoidoscopy
    - High-risk – Once every two years
    - No Part B deductible and effective January 1, 2011 Medicare pays 100%.
- **Prostate Cancer Screening Tests** -For all men enrolled in Medicare age 50 and older:
    - Covered annually
    - Digital rectal exam ”“ Medicare pays 80% of the

approved amount after the deductible
    - Prostate Specific Antigen (PSA) test
    - No Part B deductible – Medicare pays 100% of approved amount.
- **Diabetes Monitoring and Education** – Covers Type I and Type II diabetics enrolled in Medicare who must monitor blood sugar (Not paid for those in a nursing home) Covered services:
    - Glucose-monitoring devices, lancets & strips
    - Education & training to help control diabetes
    - Foot care once every 6 months for those with peripheral neuropathy
    - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Medical Nutritional Therapy** – Covered for those with diabetes or kidney disease. Includes diagnosis of special nutrition needs, therapy and counseling services to help you manage your disease. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.

- **Smoking Cessation Services** – Medicare will cover up to 8 counseling sessions per year for individuals who have an illness caused or complicated by tobacco use or you take medication affected by tobacco use. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Flu Vaccination Annually** (Medicare pays once per season. You do not have to wait 365 days since your last one.) No Part B deductible ”“ you pay nothing if your doctor accepts assignment. My post on billing for the flu shot is **here.**
- **H1N1 Flu Vaccine** Medicare covers the administration of the H1N1 flu shot. You cannot be charged for the

vaccine. No Part B deductible or co-insurance.

- **Pneumococcal Pneumonia Vaccination**– Once per lifetime for all enrolled in Medicare. (A doctor may order additional ones for those with certain health problems.) No Part B deductible ”“ Medicare pays 100% of approved amount.
- **Hepatitis B Shots** – Covered for those who are at medium or high risk. Effective January 1, 2011, there will be no Part B deductible and Medicare pays 100%.

The ABN: The Most Misunderstood and Underutilized Document in Healthcare

There’s a new ABN form required to be in use in January 2012 – read about it **here in my article “Everybody’s Favorite Form: New Advance Beneficiary Notice of Noncoverage (ABN) Form Begins in 2012”**

Note from Mary Pat: The Advance Beneficiary Notice of Noncoverage (ABN) is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff person must step in, explain the rules and pricing and obtain the patient’s signature.

Blogger Charlene Burgett does a great job of explaining the ins and outs of using the ABN, and has agreed to share an article originally published on her blog ***"Conundrum"*** *with MMP readers.*

The use of the ABN is required by Medicare to alert patients when a service will not be paid by **Medicare** and to allow the patient to choose to pay for the service or to refuse the service.

If the practice does not have a signed ABN from the patient and Medicare denies the service, the charge must be written off and the patient cannot be billed for it. The only exception is for statutorily excluded services (those that Medicare never covers like cosmetic surgery and complete physicals for example). In this case, a practice can bill the patient for the non-covered service despite not having an ABN. It is, however, a good idea to have the ABN signed for non-covered services so the patient is made aware that they are responsible.

If the patient signs the ABN and is made aware of their financial responsibility **you may require the patient to pay for this service on the date the service is provided.** You may also charge the patient 100 percent of your fee. You do not have to reduce your charge to the Medicare allowable.

With a signed ABN, the practice has proof of the patient's informed consent to provide the service and their agreement to be financially responsible for the service. In the past, Medicare had a "Notice of Exclusion of Medicare Benefits" (NEMB) that we could provide to the patient (no signature required) to alert them of Medicare's non-covered services. The ABN has replaced the NEMB.

The typical reasons that Medicare will not cover certain

services and that would be applicable are:

1. **Statutorily Excluded service/procedure (non-covered service)**
2. **Frequency Limitations**
3. **Not Medically Necessary**

Statutorily Excluded items are services that Medicare will never cover, such as (not a complete list):

- Complete physicals (excluding Welcome to Medicare Screenings, with caveats)
- Most immunizations (Hepatitis A, Td)
- Personal comfort items
- Cosmetic surgery

For these items, it is a good idea (not a requirement) to complete the ABN and have the patient check the appropriate box under options and sign the ABN. For the sake of the billing department, I strongly encourage the use of ABN's for statutorily excluded items.

Frequency Limitations are for services that have a specific time frame between services. For example, Medicare allows one pap smear every 24 months if the pap is normal. If the patient wants one every 12 months for their peace of mind, Medicare will pay for year one and the patient will pay for year two and that pattern continues. The ABN needs to be on file for the year that the patient is responsible for paying. If the patient fits Medicare's guidelines for "high risk" they are allowed to have the pap every 12 months and no ABN is required.

Services that are not considered **Medically Necessary** are those that do not have a covered diagnosis code based on Local Coverage Determinations (LCD). One example is for excision of a lesion. If the lesion is being removed because the patient just doesn't like how it looks, that is considered cosmetic surgery. If the lesion is showing some changes (i.e. bleeding,

growing, changing color, etc), then it is considered medically necessary because it potentially can be malignant. The removal needs to have diagnosis coding to substantiate the medical necessity and Medicare has Local Coverage Determinations that list all the codes/coding combinations that Medicare will approve for payment.

A rule of thumb in trying to discern the necessity of ABNs is to ask yourself if there may be some times that the service isn't covered by Medicare. The times the service isn't covered, an ABN is required. To illustrate this point, here are two examples:

- *EKGs are covered for certain cardiac and respiratory conditions. The only time an EKG is covered for preventive screening is during the patient's first year enrolled in the Medicare program and when being done during the Welcome to Medicare screening. After that time, Medicare will never cover an EKG for preventive screening. To notify the patient of this and to show that the patient agrees to be financially responsible for the EKG, an ABN should be completed.*

- *Another example is for the Tetanus immunization. Medicare will cover tetanus when medically necessary; if the patient has cut themselves and the tetanus is provided due to that injury. If the tetanus is provided to the patient because it has been ten years since the last tetanus and the tetanus is not in response to a recent injury, then it will be non-covered because it is not "medically necessary"□ and the ABN will need to be on file.*

ABNs need to be completed in their entirety. The "Options"□ box can only be completed by the patient and it states that "We cannot choose a box for you"□. That would appear to be

coercion.

A “blanket” ABN, one that is signed by the patient for all services provided within a certain time period, is not acceptable and is illegal.

In addition, there is a small area to provide additional information that can be used by either the patient or the provider’s office. This could be anything pertinent to the information that the ABN covers. The bottom of the form is where the patient signs and dates. We keep the original ABN in the chart behind the progress note for that day. Providers **MUST** provide a copy of the signed ABN to the patient.

The current ABN form with instructions can be found **here.**

If a service is denied by Medicare and the physician does not have a signed ABN prior to the service being rendered, the service can not be billed to the patient and will need to be written off. Sometimes a patient may refuse to sign the ABN – if this happens it is appropriate for the physician to document the refusal and sign, along with having a witness sign. Medicare will accept this and the patient can be billed for the service if denied by Medicare.

How does Medicare know whether or not you have a signed ABN? You tell them, by adding a modifier to the CPT code when completing the claim form. The appropriate modifiers are:

GA: The ABN is signed, but the service may not be covered.

GY: A “statutorily excluded” service.

GZ: The service is expected to be denied as not reasonable or necessary. This is typically used when there is a secondary

payer that requires the Medicare denial before they pay benefits.

The use of the ABN is often misunderstood; however, it is the only way a patient can be informed about their financial responsibility prior to agreeing to a service being rendered. This is an issue that the OIG has reportedly been interested in investigating for fraud and abuse.

Charlene Burgett, MA-HCM

Note: Readers, how do you make the ABN work in your practice? Do you train the clinical staff, the physicians, or other staff to recognize the "ABN Moment"? How do you make it work? Please share your ideas by responding with a comment.