Getting Paid: Master the ABN Advance Beneficiary Notice

One of the most popular topics I've written about over the past 10 years, and the one I get the most email on, is the ins and outs of using the Medicare Advance Beneficiary Notice of Noncoverage – the ABN – also known as form CMS-R-131.

Why is getting an ABN so important?

The answer to this question is simple. If you supply a service to a Medicare patient and Medicare does not pay for it, you can only collect payment from the patient if you've communicated to the patient what the cost is and that the cost will be their responsibility AND the patient has agreed. If you routinely supply services to patients that Medicare does not cover and do not use the ABN, your practice will be missing income that is rightfully yours. Read on for more information on the appropriate times to issue ABNs for Medicare (and non-Medicare patients).

Why do practices find it difficult to use ABNs?

The 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.

Which insurance plans require the ABN?

Although you can use the ABN for Medicare Advantage Plans (commercial insurance plans that offer Medicare replacement coverage) only original/traditional Medicare (sometimes referred to as the "red, white and blue card" Medicare) **REQUIRES** the ABN.

Commercial non-Medicare plans have also started asking physicians to issue ABNs when a service will not be covered by the plan and the patient will be paying for the service out-of-pocket. I've developed a non-Medicare ABN that you are welcome to have a copy of – just drop me an email (marypat@managemypractice.com) and request it. I think ABNs are not a bad idea at all to give to non-Medicare patients as it formalizes the process and drives home to the patient what the cost for something they ask for will be and that they've agreed to pay for it.

The ABN is not a replacement for a good financial policy

Please don't use a blanket ABN in place of a solid financial policy. Your financial policy should state that patients agree to be responsible for payments for services their plans don't cover. The ABN is meant for specific individual services or series of services that the insurance plan is not going to cover, not as a catch-all for whatever insurance does not pay for. **Note that the ABN is not meant to cover any dollars for which you are contractually obligated to write-off.**

What version of the ABN is current?

As of last summer (6/21/2017), there is an updated ABN. You should be using the one that has the date of 03/2020 in the lower left-hand corner. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has been

revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.

Copies of the current ABN are available in English and Spanish here.

Who uses the ABN?

The ABN is to be used by all providers, practitioners, and suppliers paid under **Medicare Part B**, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under **Medicare Part A.** Since 2013, home health agencies (HHAs) providing care under Part A or Part B issue the ABN instead of the Home Health Advance Beneficiary Notice (HHABN) Option Box 1 to inform beneficiaries of potential liability. The HHABN has been discontinued.

When should the ABN be used?

The ABN's purpose is to allow the physician practice to collect from the patient for services that the patient wants but are not covered by Medicare. Practices are not expected to give ABNs to patients to cover services that are never covered (called statutory exclusions), however, many practices find that supplying this form to patients helps patients understand why they are responsible for the paying for the service. Practices may collect in full at time of service for services that are never covered by Medicare, but if you are not sure if Medicare will or will not pay, you may want to wait for Medicare to adjudicate the claim before collecting from the patient.

Note that the ABN must be completed and signed **BEFORE** providing the items or services that are the subject of the notice.

Also note when the ABN is used as a voluntary notice (i.e. for statutory services), the beneficiary is not required to choose an option box or sign the notice.

The four broad categories of items and services not covered under Medicare are:

1. Services and supplies that are not medically reasonable and necessary
2. Non-covered items and services (statutory exclusions)
3. Services and supplies denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge

The brochure that describes in-depth of what Medicare does not cover is available here.

Can you give an example of when to use an ABN?

A Medicare patient wants an EKG even though she does not have any symptoms or diagnoses that would point to an EKG being medically necessary. She is not in her first 12 months of Medicare coverage, therefore she does not qualify for an EKG as a part of her Welcome to Medicare Visit (not an exam.) She believes there may be something wrong with her heart, even though she cannot name any symptoms that would warrant a diagnostic EKG. In this case, without a diagnosis to support the EKG, an ABN would be appropriate. You would advise the patient that Medicare may not pay for the EKG, in fact probably won't pay for the EKG, and you complete the ABN, showing the patient what she will be paying out of pocket for the test. In the case of Medicare not covering the test, you may charge the patient your full rate for an EKG and are not restricted by the Medicare allowable. If the patient agrees to have the test and signs the ABN stating she understands she

will be responsible for the cost of the test if Medicare does not pay, you will provide the patient with a copy of the signed form and will will attach the completed form to the patient's encounter form or somehow note in the EMR that an ABN has been obtained so the EKG will be billed with the modifier "GA" which indicates an ABN was executed for a service that might not be covered by Medicare. In the case where a service is never covered (i.e. statutory exclusions) you may append a modifier "GY" to the service to indicate an ABN is on file.

The ABN can be scanned with the encounter form or any other financial paperwork from the visit so it can be retrieved if requested by Medicare during an audit. If you do not archive your paperwork electronically, you can file the ABNs alphabetically by patient name by month. You can also scan the ABN into your EMR if you choose.

What are statutory exclusions (services that are never covered) under Part B?

- Oral drugs and medicines from either a physician or a pharmacy. **Exceptions: oral cancer drugs, oral antiemetic cancer drugs and inhalation solutions.**
- Routine eyeglasses, eye examinations, and refractions for prescribing, fitting, or changing eye glasses. **Exceptions: post cataract surgery. Refer to benefits under DME prosthetic category.**
- Hearing aids and hearing evaluations for prescribing, fitting, or changing hearing aids.
- Routine dental services, including dentures.
- Routine foot care without evidence of a systemic condition.
- Injections which can be self-administered. **Exceptions: EPO, and clotting factors.**
- Naturopath's services.
- Nursing care on a full-time basis in the home and

private duty nursing. (Refer to benefits under Medicare Part A).
- Services performed by immediate relatives or members of the household. Services payable under another government program.
- Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay.
- Immunizations. **Exceptions: Influenza, Pneumovax and Hepatitis B.**
- Wheelchair van ambulance services.
- Cosmetic surgery.
- "Annual Physicals" best described by codes 99387 or 99397. This is a long discussion for another post, but note that Medicare does not pay for annual preventive EXAMINATIONS, although they pay for annual wellness visits, which are not physical examinations. They do, however, pay for screening pelvic and breast exams and pap test collection at specific intervals.

How do you complete the "Estimated Cost" Section F of the ABN?

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). CMS expects that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:

- Any dollar estimate equal to or greater than $150
- "Between $150-300"
- "No more than $500"

For a service that costs $500:

- Any dollar estimate equal to or greater than $375
- “Between $400-600”
- “No more than $700”

What about estimating the costs for a series of services?

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices,but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

How do I use modifiers to indicate the ABN is present?

The modifiers can be confusing! Focus on using the GA and GX modifiers as best practice.

GA Modifier – Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case – ABN Needed and Obtained

Use this modifier to report that an advance written notice was provided to the beneficiary of the likelihood of denial of service as being not reasonable and necessary under Medicare guidelines.

- Report when you issue a mandatory ABN for service as required and is on file.
- You do not need to submit a copy of the ABN but it must be available upon request.
- The most common example of these situations would be services adjudicated under a Local Coverage Decision (LCD).
- The presence or absence of this modifier does not influence Medicare's determination for payment.
- Line item is submitted as covered and Medicare will make the determination for payment.
- If it's determined that the service is not payable, the claim denial is under "medical necessity denial."
- It is inappropriate to use the GA modifier when the provider/supplier has no expectation that an item or service will be denied.
- Do not use on a routine basis for all services performed by a provider/supplier.

GX Modifier – Notice of Liability Issued, Voluntary Under Payer Policy – No ABN Needed But Was Issued Nonetheless

Use this modifier to report when you issue a voluntary ABN for a service that Medicare never covers because it is statutorily excluded or is not a Medicare benefit.

- Line items submitted as non-covered will be denied as beneficiary liable.
- You may use this modifier in combination with the GY modifier.

GY Modifier – Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit – No ABN Needed and None Issued

Use this modifier to report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. Use this modifier to notify Medicare that you know this service is excluded.

- Services provided under statutory exclusion from the Medicare Program; the claim would deny whether or not the modifier is present on the claim.
- It is not necessary to provide the patient with an ABN for these situations.
- Situations excluded based on a section of the Social Security Act.
- Modifier GY will cause the claim to deny with the patient liable for the charges.
- Do not use on bundled procedure or on add-on codes.
- Line items submitted as non-covered and will be denied as Patient Responsibility
- You may use this modifier in combination with the GX modifier.

GZ Modifier – Item or Service Expected to Be Denied as Not Reasonable and Necessary – ABN Needed But Not Obtained

Use this modifier to report when you expect Medicare to deny

payment of the item or service due to a lack of medical necessity and no ABN was issued.

- This modifier is an informational modifier only.
- Medicare will adjudicate the service just like any other claim.
- If Medicare determines that the service is not payable, denial is under "medical necessity." The denial message will indicate that the patient is not responsible for payment.
- If either the beneficiary or provider requests a review, the modifier tells us an ABN was not given, and this could help in completing the review quickly.
- Medicare will auto-deny services submitted with a GZ modifier. The denial message indicates that the patient is not responsible for payment; deny provider liable.
- If either beneficiary or provider requests a review, the modifier tells us that an ABN was not given.

For in-depth instruction from Medicare on completing the ABN, click here.

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2013 Medicare Parts A, B, C and D Deductibles and Premiums

The Part B Medicare deductible for 2013 is $147.00.

What should you do with this information? You should avoid taking a **big financial hit** in the first quarter of 2013 by collecting deductibles at time of service. How do you do that?

- Let all patients know in advance that you collect deductibles by making it part of your communication with them. Put it in your financial policy (get a copy of my preferred financial policy below), put it on your website, and let patients know when you schedule their appointment, or make an appointment reminder with verbiage like:

> ***"We look forward to seeing you at your appointment. Please bring your insurance cards and all medications to your visit. We will collect your co-pay, your deductible, and any co-insurance required by your insurance plan."***

- Explain what a deductible is. Get my sample patient handout explaining deductibles below.
- Train front desk staff on deductibles and get them comfortable discussing deductibles with patients and answering their questions.
- Do not collect deductibles for Medicare patients who also have Medicaid, or for Medicare patients with supplemental insurance as there most likely will not be a balance that the patient will owe.
- It is ideal to use a Credit Card On File program to charge the patient's credit card at time of service, or when the EOB (Explanation of Benefits) arrives in 15 days.

Other important Medicare numbers for 2013

Part A: Hospital Insurance Premium for 2013– $441.00 per month. Most 65+ patients get Part A for free if they already receive retirement benefits from Social Security or Railroad Retirement due to taxes paid during working years. Part A includes coverage for:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care – skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, dietary and home health aides (100% covered with no co-pay) for homebound patients after a 3-day hospital stay

Part B: Medical Insurance Premium for 2013 – $104.90 per month for most, but not all patients. Some patients automatically get Part B, others may have to pay more based on their IRS tax return from 2011. Part B includes coverage for:

- Services from doctors and other health care providers
- Outpatient care (includes emergency room and observation services for physician charges)
- Home health care – services provided to a homebound patient when the patient has not been hospitalized for 3 days prior to need
- Durable medical equipment
- Some preventive services

Part C: Medicare Advantage Plans – also called a Medicare Replacement Plan because it replaces traditional or original

Medicare with a plan offered by a Medicare-approved private insurance company (BCBS, UHC, etc.) Premiums vary with individual Medicare Advantage Plans. Medicare Advantage Plans:

- Include all benefits and services covered under Part A and Part B
- Usually include Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost
- Cannot be used in combination with a Medigap policy

Part D: Medicare Drug Coverage for 2013 – monthly premiums will vary based on income, and whether or not Part D is included if the patient opts for Part C coverage. Some plans have deductibles and some do not. Most drug plans have a coverage gap referred to as the "donut hole", which means coverage is temporarily limited after the patient and drug plan have spent a certain amount for covered drugs. In 2013, once the patient reaches the donut hole, they pay 47.5% of the plan's cost for covered name-brand drugs and 79% of the plan's cost for covered generic drugs until the end of the donut hole is reached. In every successive year after 2013, the donut hole will shrink until 2020 when the donut hole will cease to exist.

Medicare Supplement Insurance (also called Medigap) – Policies are sold by private insurance companies and help pay some of the health care costs that Medicare doesn't cover. Patients have a one-time 6-month Medigap Open Enrollment Period which starts the first month they are 65 and enrolled in Part B. This period gives patients a guaranteed right to buy any Medigap policy sold in their state regardless of their health status.

Click here to receive a free copy of a financial policy and a

patient handout explaining deductibles.

CLICK HERE to Download the Financial Policy and Deductible Handout!

2013 OIG Workplan: You're Doing it Wrong

The 2013 Work Plan for the OIG has been released and here are some of the top items that relate to medical practices. This is a great list to use for review and discussion – ***Is your medical practice doing this correctly?***

Incident-To Services Performed by Nonphysicians

Reasons why practices are not billing these services correctly:

- Lack of understanding of incident-to
- Trying to avoid the 15% reduction in reimbursement for services provided by credentialed nonphysicians
- Difficulty in documenting who provided the services for charge entry

The OIG Workplan says: We will review physician billing for "incident-to" services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess Medicare's ability to monitor services billed as "incident-to." Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians' billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality. Medicare's Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

Place-of-Service (POS) Coding Errors

Reasons why practices are not billing these services correctly:

- Confusion over place of service when the practice is owned by a hospital
- Confusion over place of service when the technical and professional components of a service are performed in two different places (NOTE: this will be somewhat rectified in April 2013 when new POS rules for Medicare will be in effect)
- Confusion over place of service when a nursing facility has several different places of services within one facility
- Providing services (or saying you are) wherever the reimbursement rate is highest

The OIG Workplan says: We will review physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ambulatory surgical center. (OAS; W-00-11-35113; various reviews; expected issue date: FY 2013; work in progress)

Evaluation and Management Services

– Potentially Inappropriate Payments in 2010

Reasons why practices are not billing these services correctly:

- Confusion by physicians and other providers on how to document properly and how to choose a code based on what has been documented
- Over-reliance on EMR templating and macros to paste the same or very similar verbiage into the medical records of all or most patients seen by the same provider

The OIG Workplan says: We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported. (CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress)

Evaluation and Management Services – Use of Modifiers During the Global Surgery Period

Reasons why practices are not billing these services correctly:

- Confusion over the length of the global period

- Confusion over what services are included in the global package and what services can be legitimately charged with a modifier as distinct from the global package

The OIG Workplan says: We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period were in accordance with Medicare requirements. Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period. (CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 30. (OAS; W-00-13-35607; various reviews; expected issue date: FY 2013;
new start)

Non-Hospital-Owned Physician Practices Using Provider-Based Status (New)

Reasons why practices are not billing these services correctly:

- Confusion over split billing – billing separately for the professional fee and the facility fee
- Confusion over the term "provider-based status"

The OIG Workplan says: We will determine the impact of non-hospital-owned physician practices billing Medicare as provider-based physician practices. We will also determine the extent to which practices using the provider-based status met

CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)

Medicare News for the Week of February 13, 2012: PQRS, eRX and EHR, EHR and EHR

(PQRS) AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data **(jump to story)**

(PQRS & eRX) National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program**(jump to story)**

(Purchasing) National Provider Call: Hospital Value-Based Purchasing Program **(jump to story)**

(eRx) Electronic Prescribing (eRx) Incentive Program: Updates for 2012 **(jump to story)**

(Observation) Some Medicare Beneficiaries Receive Large Bills

Over "Observation Care" Status **(jump to story)**

CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs **(jump to story)**

(EHR) CMS Has Updated the EHR Information Center with New Self-Service Options **(jump to story)**

(EHR) Updated and New FAQs Added to the CMS EHR Website **(jump to story)**

(EHR) Stay Informed via the CMS EHR Incentive Programs Listserv **(jump to story)**

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AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data

According to coverage in AM News, "…doctors have only this year to report data to the program voluntarily." …doctors who don't report data will not only not be eligible for a bonus but may be dinged with a 1.5% penalty on their payments in 2015." **Read more in AM News.**

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National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Registration Now Open

Tue Feb 21; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing (eRx)

Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview of claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive Program
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/PQRS/04_-CMSSponsoredCalls.asp** in the "Downloads" section of the page.

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National Provider Call: Hospital Value-Based Purchasing Program – Registration Now Open

Tue Feb 28; 1:30-3pm ET

The Centers for Medicare & Medicaid Services (CMS) will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/Hospital--Value-Based-Purchasing** in the "Downloads" section of the page.

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Electronic Prescribing (eRx) Incentive Program: Updates for 2012

The Medicare Electronic Prescribing (eRx) Incentive Program, which began January 1, 2009 and is authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the eRx Incentive Program is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ERxIncentive.

Under section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Physician Fee Schedule (PFS) payment adjustment applies to eligible professionals who are not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the PFS amount for covered professional services during the year shall be a percentage less than the PFS amount that would otherwise apply.

The following are key changes for the 2012 eRx Incentive Program:

Group Practice Reporting Option (GPRO) changes

Group practices (who self-nominated and were selected by CMS to participate in the Group Practice Reporting Option) can qualify to earn an eRx incentive if it is determined that the practice is a successful electronic prescriber. This incentive payment is equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges under the group practice's Taxpayer Identification Number (TIN). The minimum number of

times a group must report the eRx measure is 2,500 for large group practices participating in eRx GPRO participants (100 or more individual eligible professionals), 625 for small group practices participating in eRx GPRO (25-99 individual eligible professionals).

Important Changes for the 2013 eRx Payment Adjustment

- Added a second reporting period to avoid the 2013 eRx payment adjustment (6-month reporting period, January 1-June 30, 2012)
- Eligible professionals can report on any billable Medicare Part B PFS service to avoid the 2013 payment adjustment.
- Hardship exemption requests are available for eligible professionals who are unable to report the eRx measure.

Avoiding the 2013 eRx Payment Adjustment

- In order to avoid the 2013 payment adjustment, eligible professionals are now able to report the eRx Quality-Data Code (QDC) on any billable Medicare Part B PFS service. In previous program years, eRx events could only be reported with specified encounter codes. Please note that reporting denominator- eligible events is still required to earn an incentive payment for 2012.
- Additional information on how to avoid future eRx payment adjustments can be found in the Electronic Prescribing (eRx) Incentive Program – Future Payment Adjustments document located on the CMS eRx website at http://www.cms.gov/ERxIncentive.asp, under the "Educational Resources" section.

2012 Hardship Exemption Requests to Avoid the 2013 Payment Adjustment

- Individual eligible professionals requesting hardship exemptions from the 2013 eRx payment adjustment will be able to submit their request using the CMS Quality

Reporting Communication Support Page located at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234.

- CMS will announce when the Quality Reporting Communication Support Page becomes available for requesting a hardship exemption for the 2013 eRx payment adjustment.
- For more information on the 2012 eRx hardship exemption categories and on the process for requesting an exemption visit the CMS Electronic Prescribing Incentive Program at http://www.cms.gov/ERxIncentive.

Additional Information

- For more information on the 2012 eRx Incentive Program, go to https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp
- For more information on avoiding future payment adjustments, go to https://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp

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Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status.

CMS, in an effort to reduce spending, requires medical necessity for a patient to be admitted to the hospital. Many times, however, it cannot be determined immediately if patients do require admission to the hospital. In these cases, patients are admitted to observation (today commonly called the CDU, or Clinical Decision Unit) to try to determine if the patient does need to be admitted or can be released. Observation is considered an Outpatient Service (even though the patient is in a hospital bed in the hospital), just as

Emergency Room care is considered outpatient service. Patients who have received Observation Care, once they return home and receive a bill, are stunned to find that they are paying according to Medicare Part B. Part B has a deductible plus a 20% co-insurance for all services they received in the hospital as an outpatient. Read more here: **Wall Street Journal**

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CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs

Central line-associated bloodstream infections (CLABSIs) are among the most serious of all healthcare-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the US healthcare system. On Tue Feb 7, CMS announced that *Hospital Compare* will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in US hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about *Hospital Compare* is online at **http://www.HospitalCompare.-HHS.gov**.

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing *Hospital Compare*, visit the **CMS YouTube channel**.

The full text of this excerpted CMS press release (issued Tue Feb 7) can be found at **http://www.CMS.gov/apps/media/-press/release.asp?Counter=4260**.

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CMS Has Updated the EHR Information Center with New Self-Service Option

Following months of review and collective input, the Electronic Health Record (EHR) Information Center Interactive Voice Response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. CMS is proud to announce that providers can now obtain information through an extensive IVR Self-Service option. Included in this option is a reinforced privacy protection module that requires your individual National Provider Identifier (NPI), the last five digits of your Tax Identification Number (TIN), and your EHR registration ID. Once accepted, this newly enhanced Self-Service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information

- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing **888-734-6433**, pressing 3 for Self-Service, and entering the authentication elements. These options will be available on the IVR effective Thu Feb 16.

EHR Information Center Hours of Operation: 7:30am-6:30pm CT, Monday through Friday, except federal holidays. (Note that General Information and Self-Service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the **FAQs section of the EHR Incentive Programs website, where users can search for any questions they have about the Medicare or Medicaid EHR Incentive Programs.**

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Updated and New FAQs Added to the CMS EHR Website

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer.

- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer.
- For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations? Read the answer.
- In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? Read the answer.
- For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. Read the answer.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Stay Informed via the CMS EHR Incentive Programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR Incentive Programs. The **CMS EHR Incentive Program listserv** provides timely information on program requirements and changes in the EHR Incentive Programs.

By subscribing to this listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new **Frequently Asked Questions** that are published on the CMS EHR Incentive Programs website. **Join** the listserv and visit the **listserv section** of the EHR Incentive Programs website to take a review some of the recent messages we have sent. We encourage you to let others know about the CMS EHR Incentive Program listserv, and to share its messages.

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs** website for complete information about the CMS Medicare and Medicaid EHR Incentive Programs.

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2012 Medicare Deductibles and

Premiums: Is This the Year You'll Collect Deductibles at Time of Service?

CMS just announced the new numbers for premiums and deductibles for 2012. Now is the ideal time to think about Medicare deductibles and what your policy is on collecting deductibles at time of service.

If you've been hesitant to collect deductibles, ask yourself if you can handle the loss or delay of payment of $140 per Medicare patient. Most practices can't. If you are thinking about collecting deductibles and other front-end collection techniques, my book "The Smart Manager's Guide to Collecting at Checkout" is your guide to making it happen for your healthcare group. **Click here** to read more.

MEDICARE PART B (covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items)

- In 2012, the **Part B deductible will be $140**, a decrease of $22 from 2011.
- The standard Medicare Part B monthly premium will be **$99.90 in 2012**, a $15.50 decrease over the 2011 premium of $115.40.
- The standard premium is set to cover one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over, plus a contingency

margin. The contingency margin is an amount to ensure that Part B has sufficient assets and income to (i) cover Part B expenditures during the year, (ii) cover incurred-but-unpaid claims costs at the end of the year, (iii) provide for possible variation between actual and projected costs, and (iv) amortize any surplus assets. Most of the remaining Part B costs are financed by Federal general revenues. (In 2012, about $2.9 billion in Part B expenditures will be financed by the fees on manufacturers and importers of brand-name prescription drugs under the Affordable Care Act.)

- The largest factor affecting the contingency margin for 2012 is the current law formula for **physician fees, which will result in a payment reduction of about 29 percent in 2012.** For each year from 2003 through 2011, Congress has acted to prevent smaller physician fee reductions from occurring. The 2012 reduction is almost certain to be overridden by legislation enacted after Part B financing has been set for 2012. In recognition of the strong possibility of increases in Part B expenditures that would result from similar legislation to override the decrease in physician fees in 2012, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2012 is adequate to accommodate this contingenIn 2012, Social Security monthly payments to enrollees will increase by 3.6 percent. The dollar increase in benefit checks is expected to be large enough on average to cover the increase in the Part B premium of $3.50 that most beneficiaries will experience. For those who were paying the standard premium of $115.40, their benefits checks will only increase.

MEDICARE PART A (inpatient hospital, skilled nursing facility, and some home health care)

- Approximately 99% of Medicare beneficiaries do not pay a premium since they or their spouses have at least 40 quarters of Medicare-covered employment
- Some enrollees age 65 and over and certain persons with disabilities who have fewer than 30 “quarters of coverage” obtain Part A coverage by paying a monthly premium **($451 for 2012)** set according to a statutory formula.
- Those who have between 30 and 39 “quarters of coverage” may buy into Part A at a reduced monthly premium rate which is **$248 for 2012**, the same amount as in 2011.
- The Part A deductible paid by a beneficiary when admitted as a hospital inpatient will be **$1,156 in 2012**, an increase of $24 from this year’s $1,132 deductible.
- The Part A deductible is the beneficiary’s cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional **$289 per day for days 61 through 90 in 2012**, and **$578 per day for hospital stays beyond the 90th day** in a benefit period.
- For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit period will be **$144.50 in 2012,** compared to $141.50 in 2011.

MEDICARE PART D (medications)

- The estimate for the average **2012 Part D premium for basic coverage is $30.** This is slightly lower than the actual average for 2011 of $30.76.

- The estimate for the average 2012 Part D premium for supplemental coverage is $8. The estimate for the **average 2012 total Part D premium is $38.**

MEDICARE ADVANTAGE PLANS (replacement for traditional Medicare)

- On average, Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment to increase by 10 percent.
- Of people with Medicare, 99.7 percent continue to enjoy access to a Medicare Advantage plan, and benefits remain consistent with those offered in 2011.
- Those who enroll in Medicare Advantage plans may have different cost-sharing arrangements. On average Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment will increase

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My Notes on Today's CMS Call on the Initial Preventive Physical Exam (Not a Physical Exam) and the Annual Wellness

Visit

Today’s CMS call reviewed the guidelines for the IPPE (Initial Preventive Physical Exam) and the AWV (Annual Wellness Visit), what they include and how to code for them.

What is the IPPE (also called the “Welcome to Medicare Visit”)?

The IPPE is a one-time visit, covered within 12 months after the effective date of Part B coverage and including:

- Review of medical and social history.
- Review of risk factors for depression.
- Review of functional ability and level of safety.
- Measurement of height, weight, body mass index, blood pressure, visual acuity, and other factors deemed appropriate.
- Discussion of end-of-life planning, if agreed upon by the patient.
- Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (a/k/a EKG, ECG).
- Note that although the IPPE has the word “exam” in it, there is NO physical exam associated with it. Most practices attempt to call it the **Welcome to Medicare Visit** and try never to use the word “exam” in association with it.

Who can provide the IPPE?

- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner including nurse

practitioner physician assistant or Clinical nurse specialist

How is the IPPE Billed?

G0402
Initial preventive physical examination (not really an examination); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, plus ONE of the following if a electrocardiogram is done.

G0403
Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.
G0404
Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.
G0405
Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.

What if the IPPE is provided in a facility?

These services typically are provided in a physician office, however, when the services are provided in a facility, the following institutions can bill as follows:

- Hospitals for inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities for inpatients (TOB 22X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

What diagnosis code should be used?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the IPPE; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code.

How often can the IPPE and the screening EKG be performed?

The IPPE (G0402) is a one-time benefit that must be provided within 12 months of the effective date of a beneficiary's Medicare Part B coverage. The screening EKG (G0403, G0404, G0405), when done as a referral from an IPPE, is also only covered once during a beneficiary's lifetime.

How does the provider collect for the IPPE at time of service?

Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the IPPE (G0402) only. The deductible and coinsurance still applies to the screening EKG.

What about screening for the abdominal aortic aneurysm (AAA)?

A one-time only ultrasound screening for an Abdominal Aortic Aneurysm (AAA) can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors. The code for billing the AAA ultrasound screening is:

G0389

Ultrasound, B-scan and or real time with image documentation; AAA screening

Effective for dates of services on or after January 1, 2011, the co-insurance or co-payment and deductible are waived for the AAA ultrasound screening (G0389). For more information on the AAA ultrasound screening done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Pub. 100-04, chapter 18, section 110 on the CMS web site.

Please Note!
• The IPPE is a preventive wellness visit and not a routine physical examination.
• Medicare does not provide coverage for routine physical exams.

What if other services are provided during the IPPE?

If other evaluation and management services are provided in conjunction with the IPPE, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- **Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.**
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the IPPE?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn't already have them;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the AWV?

The Annual Wellness Visit (AWV) was created by the Affordable Care Act (ACA) and is a new benefit for 2011. Medicare beneficiaries are eligible for one AWV every 12 months after they have had Medicare Part B for more than 12 months. This is a "visit" and not a physical examination. Patients have a tendency to hear the word "Annual" and think they are getting an annual physical.

The beneficiary does not need to receive an IPPE to be eligible for an AWV. However, if the beneficiary did receive an IPPE, –s/he is eligible for an AWV 12 months following the IPPE.

What is included in the AWV?

Medical/family history

- List of current providers/supplier.
- Blood pressure, height, weight, and other routine measurements.
- Detection of any cognitive impairment.
- Review (potential) risk factors for depression, functional ability, and level of safety.
- A written screening schedule (such as a checklist) for next 5-10 years.
- Documentation of risk factors and conditions where interventions are recommended.
- Personalized health advice and referrals for health education and preventive counseling.

Subsequent AWVs:

- Update of medical/family history.
- Update of list of current providers/suppliers.
- Measurement of weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Update to the written screening schedule.
- Update to the list of risk factors and conditions where interventions have been recommended.
- Update to the personalized health advice and referrals for health education and preventive counseling

Who can provide an AWV?

A “health professional” meaning a:

- Physician
- Physician assistant
- Nurse practitioner

- Clinical nurse specialist
- Medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician

How should the AWV be coded?

The following G-codes identify the AWV for Medicare payment:
G0438

Annual wellness visit, including Personalized Prevention Plan Service, first visit
G0439

Annual wellness visit, including Personalized Prevention Plan Service, subsequent visit

Who can bill for the AWV?

These services typically are provided in a physician office. When the services are provided in a facility, the following institutions can bill:

- Hospital inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities inpatients (TOB 22X) and outpatients (23X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

Note: Medicare makes a single fee schedule payment for a beneficiary’s AWV when provided in a physician office or hospital outpatient department.

What diagnosis should be used for the AWV?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the AWV; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code or contact the local Medicare contractor for guidance.

How often can the AWV be performed

- First visit (G0438) – once in a lifetime
- Subsequent (G0439)-annually (after 12 full months have passed since the last AWV)

What should be collected at the time of service?

Effective for dates of services on or after January 1, 2011 co-payment or co-insurance and the Medicare Part B deductible are waived.

Please Note! AWV is a preventive wellness visit and not a routine physical examination. Medicare does not provide coverage for routine physical exams.

What if additional services are provided at the same time as the AWV:

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by

the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (co-insurance, co-payment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
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NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the AWV?

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- Medical records, including immunization records if the provider doesn't already have it;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and

improved communication about medication can take place.)

What is the proposed refinement to the AWV?

Medicare Physician Fee Schedule CY 2012 Proposed Rule suggests incorporating the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the AWV.

- The proposed rule text is available **here.**
- We welcome public comments before 5pm on August 30, 2011.
- Electronically through www.regulations.gov
- Hard copy (see instructions in the proposed rule)
- CMS staff cannot discuss this topic on today's call.

Q & A From the listeners (my favorite!)

Q: As a RHC, we usually submit one line item for all services provided on a UB92. How are we supposed to bill this if we are providing both a preventive service and an E & M on the same day?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are an Article 28 Institution (place of service 22) – do we still bill the APC separately from the facility?

A: There is not a separate facility payment available, so a single payment is made to the physician or the facility.

Q: We are a Critical Access Hospital – when we receive an order for an EKG or ultrasound AAA, what diagnosis is supposed to come from the physician so that it will pass muster in a review?

A: The initial answer said the EKG should have a screening diagnosis and the AAA should have a risk factor diagnosis, but after a discussion, the listener was asked to send the question to the following email: nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Does the IPPE have a physical exam as a component? If a physical exam is provided, should it be billed as a separate E & M?

A: No physical examination is included. If it is provided, it should be coded separately.

Q: Are there specific identified screening tools that must be used for the depression or mental acuity screening?

A: The physician may choose the screening tool for depression or mental acuity.

Q: We do provider-based billing and our system automatically splits the G code between facility and professional fees. How will we recoup the facility portion?

A: Only one payment is made based on the physician fee schedule.

Q: If Physician Assistants can perform IPPEs and AWVs, does this mean that the patient must be established since mid-level providers cannot care for new Medicare patients?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Is the EKG and AAA screening benefits on the IPPE visit only? Will CMS ever add the EKG and AAA screening benefits to the AWV since so many patients don't take advantage of the IPPE?

A: We will take this under advisement.

Q: Can G0102 (digital rectal exam) be billed with an AWV?

A: Yes.

Q: RE: Referrals to personalized health advice, health education, etc? Are these services covered under Medicare or would these be out-of-pocket expenses for Medicare patients?

A: Would be out-of-pocket unless a covered service.

Q: Will mid-level providers performing AWVs be reimbursed the same as a physician providing the service?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Will everyone get the answers that were not provided today or just the person who sent the email?

A: CMS will not be compiling the answers, but will post frequently asked questions on their website.

Q: We are getting edits when billing the EKG with the IPPE and the EKG is being denied.

A.This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Can V70.5 (unspecified health examination) be used as a diagnosis for IPPE or AWV?

A: Yes, any diagnosis can be used.

Q: Can a medically-necessary EKG (93000) be billed with a IPPE or AWV?

A: Yes.

Q: What should we do when a Medicare patient refuses the AWV and wants a traditional preventive visit? Do we get an ABN signed and charge the 99397 per the patient's request?

A: Yes. Treat the preventive service the way you would any other non-covered service.

Q: Can an IPPE be provided with a pap and pelvic?

A: Yes.

Q: If providing an IPPE, pap and pelvic, breast exam and a physical examination to a Medicare beneficiary, can the physician choose NOT to bill the patient for the physical exam?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are having problems with Medicare beneficiaries turning down the IPPE or AWV, asking for an annual physical examination (preventive service), then getting a bill, then calling Medicare and the Medicare rep telling the patient that they should never have been charged.

A: The speakers asked for details about the caller's experience in an email to: nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: On the Medicare Preventive Physical Exam form, what is the "Up and Go" test?

A: This question was not able to be answered due to the form not being recognized. The listener was asked to send the form to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: We are having problems with patients asking for the AWV, but presenting with medical issues. The patients want the service without having to pay the deductible or co-insurance.

A: You can bill for an E & M in addition to the AWV, but the deductible and co-insurance will apply.

Note: if you have a question that was not answered today, you can send it to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.” Every question will not be able to be answered, but they will try to answer as many as possible.

Mary Pat’s Suggestions to CMS for future calls:

1. Don’t make presenters with laryngitis participate.
2. Coach all presenters in speaking for an audio presentation – speak slowly, speak loudly, don’t move your head around (causes volume spikes and dips) and be cautious of the auditory disruption turning papers and coughing causes, OR
3. Have a professional or experienced speaker present the slides – no commentary is being given so the CMS experts aren’t needed to speak through the slides.
4. Have one facilitator delegating each question to a specific expert to answer it.

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week's CMS Call

First the facts on what has taken place so far in the 2011 EHR Incentive Programs.

- As of June 30th, the total of ***Medicare*** EHR Incentive Program payments is over $94 million.
- As of June 30th, over $166 million has been paid in ***Medicaid*** EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania, and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.
- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

1. **Register** for the EHR Incentive Program
2. **Attest** to meeting all the incentive payment eligibility criteria

Let's start with information on the two different incentive

programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.

Step One: Are You Eligible for the EHR Incentive Programs?

Medicare Eligible Professionals:

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, or chiropractor) – mid-levels do not qualify
- Must have Pa rt B Medicare allowed charges
- Must not be hospital-based which is defined as having 90% or more of their covered
  professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
- Must be enrolled in PECOS
- Must be living (Social Security records are examined)

Medicaid Eligible Professionals:

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, **OR** a Physician Assistant who is the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) **OR** must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)

- Must not be hospital-based, which is defined as having 90% or more of their covered
  professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital

Step Two: How much EHR Incentive Money is Available From the Two Programs?

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP's Medicare Fee-for-Service allowable charges.
- Maximum incentives are $44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

- First eligible year for the program is 2011.
- Maximum incentives are $63,750 over 6 years.
- Incentives are the same regardless of the year started.
- The first year's payment is $21,250.
- Must begin by 2016 to receive incentive payments.
- No extra bonus for health professional shortage areas.

- Incentives are available through 2021.
- EPs will receive only 1 incentive payment per year.

How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
    - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of $21,250 from Medicaid. Remember the payments are for each provider. Don’t forget the 10% HPSA bonus if you participate in the Medicare program.
    - Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway is defining the criteria for eligibility for incentives and there are no plans for payment

reductions as a part of the program.

4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.

Getting Ready for the Registration Process

1. Make sure you have your provider's **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you're in that record, make sure all the provider's information is correct and completely up-to-date. You'll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.
2. Make sure your provider's enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS).** You can see if s/he has a record in PECOS here – scroll down this page to "OrderingReferringReport". This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)
3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS

Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.

4. Payee Tax Identification Number (if you are reassigning your benefits to a group or a hospital).
5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

Step by Step Directions to Register for the Medicare/Medicaid EHR Incentive Programs

NOTE! You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS which is required for all Medicare eligible professionals. If you plan to register for the Medicaid program, your state's Medicaid program must be up and running. Check to see if your state has launched a Medicaid EHR Incentive Program here.

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.
2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters

their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.

3. Once the user has logged into the system, the links and tabs displayed in the top right hand corner are shown on every page.
    - The **Home** hyperlink navigates the user to the Welcome page.
    - The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
    - If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
    - The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
    - The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
    - The **Account Management** tab allows the user to proceed to the I&A system in order to change their account information.
    - Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.
4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this

Registration" page. **Write this number down** for tracking purposes.

7. There are three topics that an Eligible Professional must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The "Begin Submission" button cannot be selected until all of the topics are complete. Select the **"Start Registration"** button to navigate to the first topic.
8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the "Apply" button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the "Apply" button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible Professional is required to indicate whether they are currently using a certified EHR.
   A provider's EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the **Certified Health IT Product List (CHPL)** for a listing of "certified" EHR products and to identify a product's corresponding certification number.Select the "Save and Continue"

button to navigate to the next topic.

10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.
11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional's NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional's NPI record. E-mail Address is also a required field and must be

entered with the correct email address format. Select the “Save and Continue” button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk
    to resolve any of these issues.
17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.
18. A registration must be Active in order to proceed with

Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The registration can also be cancelled, which would end the Eligible Professional's participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.

Q & A from the listeners (always the best part!)

Q: Do you have to have paid for an EHR to receive the money? Can you use a Free EHR and still receive the incentive money?

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

Q: Is there a certain amount of time after registering that an EP must attest for Medicaid?

A: Once an EP registers, there is no deadline for attesting. Once an EP has attested, payment will be received in 45 days or less.

Q: Is the denominator for the meaningful use measures all patients that an EP sees, or just all Medicare or Medicaid

patients seen during a specific period?

A: The denominator is all patients that the EP sees during the applicable period.

Q: Are radiologists eligible?

A: Yes. The radiologist must use a certified ambulatory care EHR. There is no guideline as to where the information going into the EMR comes from, with the exception of the CPOE measure. Many radiologists have expressed concerns as they do not actually "see" patients – CMS will be addressing this in the future.

Q: Where does the certification number needed for the EHR Incentive Program registration come from?

A: The certification number comes from the **CHPL website.** Get the EHR Vendor's certification number, enter that number into the CHPL site and a registration/attestation number will be provided from the CHPL program to enter into the registration/certification program.

nursing home visits

Q: Is attestation the last step after completing the 90-day reporting period and collecting the data for the Medicare meaningful use program?

A: Yes.

Q: Do visits count if an EP sees patients in nursing homes?

A. Nursing home visits can count if a certified ambulatory EHR is being used, for instance if the EP carries a laptop with him, or if the visit information is later entered into the EP's EHR.

Q: Can an administrator or other third party complete the registration and attestation?

A: Yes, if the third party goes through the Identity and Authority Management system, they can register and attest. The system will ask for the third party's social security number as they will be legally attesting to the information entered.

Q: What is the latest 90-day period an EP can use a certified EHR to receive an incentive payment for 2011?

A: October 1, 2011 – December 31, 2011 is the latest 90-day period. EPs must start using a certified EHR by October 1, 2011 and must demonstrate meaningful use by providing data via the attestation process before 60 days after the close of the 2011 calendar year.

Q: What if due to the EP's specialty none of the meaningful use measures can be met?

A: The EP must exhaust all core, alternate and menu measures by answering "0", exhausting all 38 of the measures by attesting "0" to all 38.

Q: If state does not accept any electronic submission of public health information, is the EP excluded from having to meet this requirement?

A: Yes.

Resources:

EHR Information Center

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time)
Monday through Friday, except federal holidays.
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

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%.

Medicare for 2010: Deductibles and Premiums Update

Medicare is a federal health insurance program created in 1965 for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Part A – 99% of patients don’t pay a premium for Part A (hospital insurance) because they or a spouse already paid

for it through their payroll taxes while working. The $1,100 deductible for 2010, paid by the beneficiary when admitted as a hospital inpatient, is an increase from 2009. Part A helps cover:

- inpatient care in hospitals (excluding the physician fees), including critical access hospitals
- skilled nursing facilities (not custodial or long-term care)
- some hospice care
- some home health care

Medicare Part B – Part B (outpatient/doctor insurance) base premium for 2010: $96.40/month (no change from 2009.) Premiums are higher for single people over 65 making more than $85K per year and for couples making over $170K. Part B premiums cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. In 2010, the Part B deductible is $155. Part B helps cover:

- physician fees in the hospital
- physician fees in their offices and other outpatient locations
- other outpatient services (x-rays, lab services)
- some services of physical and occupational therapists
- some home health care

Medicare Part C – Medicare now offers beneficiaries the option to have care paid for through private insurance plans. These private insurance options are part of Medicare Part C, which was previously known as Medicare+Choice, and is now called Medicare Advantage. Medicare Advantage expands options for receiving Medicare coverage through a variety of private insurance plans, including private fee-for-service (PFFS)

plans, local health maintenance organizations (HMOs) and regional preferred provider organizations (PPOs), and through new mechanisms such as medical savings accounts (MSAs), as well as adding payment for additional services not covered under Part A or B.

Medicare Part D – Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. The so-called "doughnut hole" is the amount the patient pays between the initial coverage limit of $2,830 and the out-of-pocket threshold of $4,550 – a total of $1720 that the patient is responsible for.

- **Initial Deductible:** $310
- **Initial Coverage Limit:** $2,830
- **Out-of-Pocket Threshold:** $4,550

COMPARISON OF MEDICARE PLANS

Original Medicare Plan

WHAT? The traditional pay-per-visit (also called fee-for-service) arrangement available nationwide.

HOW? Providers can choose to participate ("par") or not participate ("non-par".) Participating providers accept the Medicare allowable and collect co-insurance (20% of the allowable.) Reimbursement comes to the providers. Non-participating providers may charge 15% more (called the "limiting" charge) than the Medicare allowable schedule, but the patient will receive the check, which is why some non-par

practices require payment at time of service for Medicare patients. To be able to charge patients for non-covered services, patients must sign an ABN before the service is provided.

Original Medicare Plan With Supplemental Medigap Policy

WHAT? The Original Medicare Plan plus one of up to ten standardized Medicare supplemental insurance policies (also called Medigap insurance) available through private companies.

HOW? Medigap plans may cover Medicare deductibles and co-insurance, but typically will not cover anything Medicare will not. Medicare primary claims will "cross-over" to many Medigap secondary claims so the practice does not have to file the secondary Medigap claim. Patients may still have a small balance that is cost-prohibitive to bill for.

Medicare Coordinated Care Plan

WHAT? A Medicare approved network of doctors, hospitals, and other health care providers that agrees to give care in return for a set monthly payment from Medicare. A coordinated care plan may be any of the following: a Health Maintenance Organization (HMO), Provider Sponsored Organization (PSO), local or regional Preferred Provider Organization (PPO), or a Health Maintenance Organization (HMO) with a Point of Service Option (POS).

HOW? You have to have signed a contract or be grandfathered in (called an "all-products" clause) under an existing contract to see patients and get paid. Primary care providers may have to provide referrals and/or authorization for specialty services and providers. A PPO or a POS plan usually provides out of network benefits for patients for an extra out-of pocket cost.

Private Fee-For-Service Plan (PFFS)

WHAT? A Medicare-approved private insurance plan. Medicare pays the plan a premium for Medicare-covered services. A PFFS Plan provides all Medicare benefits. Note: This is not the same as Medigap.

HOW? Most PFFS plans allow patients to be seen by any provider who will see them. PFFS plans do not have to pay providers according to the prevailing Medicare fee schedule or pay in 15 days for clean claims. Providers may bill patients more than the plan pays, up to a limit. It would be a good thing to notify patients if your practice intends to bill above the plan payment.

Need more? Click on **CMS** (provider-oriented) or **Medicare** (patient-oriented.)