

# SUGGESTED MODIFICATIONS TO FEE FOR NON-COVERED SERVICES CONCIERGE PRACTICES AS A RESULT OF NEW HEALTHCARE ACT

By

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## I. Introduction

After the publication of my recent article<sup>i</sup> about the new Patient Protection and Affordable Care Act (the “Act”), some concierge physician clients have discussed with me how best to handle the new annual Personalized Prevention Planning Services (“3P Services”) created by the Act. I suggested in that article one method (which I will explain in more detail below) to accommodate these new wellness/preventive services within the normal structure of a “fee-for-non-covered-services” (“FNCS”)<sup>ii</sup> practice, but it would require a fundamental change in the financial structure of these practices.<sup>iii</sup>

From a legal standpoint, FNCS practices are based on the principle that a physician may bill Medicare only the approved rate for a given service and cannot charge the patient anything for the service other than an applicable co-pay and deductible. Of course, this rule applies only to services that are actually covered by Medicare; it does not apply to services that are not covered. The concluding element of this legal syllogism is that if the service for which a fee is paid is not covered by Medicare, the physician is not restrained by the Medicare laws as to what she can charge the patient.

Most FNCS practices today are built around an annual wellness physical (that is, one prompted not by any injury or malady but one simply scheduled on a periodic basis) and a personalized wellness plan. The following is language used in typical agreements:

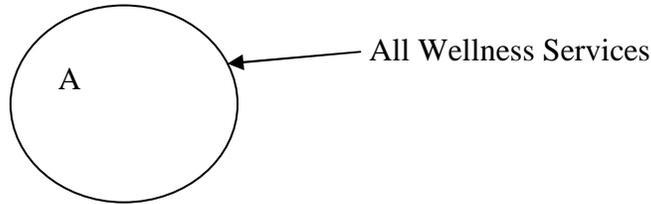
*The fee You have paid is for an annual in-depth “wellness physical examination and evaluation” (“Wellness Evaluation”) to be provided by the Physician at no additional charge. As part of the Wellness Evaluation, the Physician will develop for You a written health, exercise, and dietary health plan for You to follow.*

Annual wellness physicals and wellness plans were historically not covered by Medicare, which means that a physician could charge a Medicare patient whatever he and the patient could agree upon as a fee, unrestrained by the Medicare rules.<sup>iv</sup>

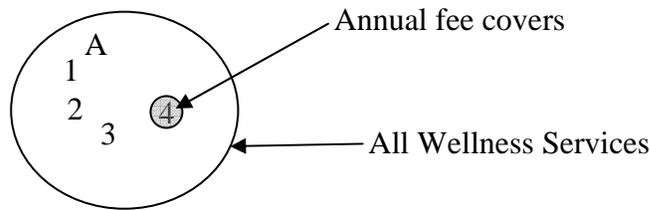
Some of my clients have asked whether the approach taken to accommodate the new 3P Services could be a modification of the services included in the annual wellness evaluation. In other words, once the 3P Services provisions of the Act become effective, could they offer other wellness services that are not covered by Medicare? It is the point of this article to examine the legal advisability of this approach.

## II. Defining The Question

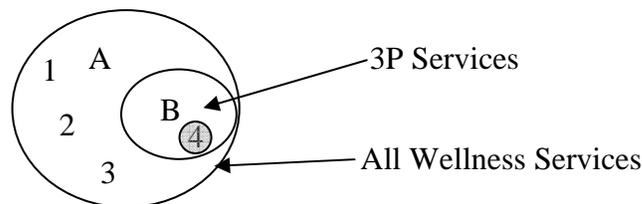
Assume that we have a universe (call it universe A) of preventive planning or wellness services (“**Wellness Services**”) that a physician can offer. Here’s how that universe would look:



Then assume that universe A includes, in addition to many other things, four specific Wellness Services (1 through 4) that are not covered by Medicare. One of them, number 4, is the service that our traditional concierge practice is providing in exchange for the annual fee.<sup>v</sup> Here is how the diagram would look:

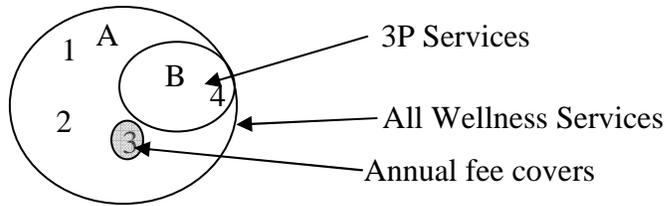


Now let’s assume that Congress comes along and creates a new subset of A called B. B is defined as the 3P Services, which encompasses #4. Here’s how our diagram would now look:



Note that service #4 is all of a sudden covered by Medicare AND our doctor also charges for it as part of the patient’s annual fee. If we go back to our legal syllogism, we’ll see that this changes our dynamic dramatically, since our practice can no longer charge for service #4 because it is now covered by Medicare. To charge the patient for it via the annual fee, and then Medicare again for it when service #4 is rendered to the patient, would be illegal.

The question posed by the physicians is whether they could alter the Wellness Services they offer for the annual fee by making sure they do not fall within the B universe. Assume that the decision is made to offer wellness service #3 in place of #4. Here’s how our diagram would look:



This solution has a certain logical appeal to it. If we make all the assumptions we make above about the legal fundamentals of FNCS practices, then legally it should work. But there are at least three problems with this approach.

- (A) ***Is there Any Wellness Service Left?*** Section 4103 of the Act altered the provisions of Section 1861 of the Social Security Act (42 USC 1395x) by adding a new paragraph (hhh). This new paragraph created the 3P Services. Specifically, these services include a new “health risk assessment” of the patient. The Assessment is to meet the requirements of the Secretary, and on June 25, 2010, CMS published proposed Rules providing for these requirements. Here is what they said:

***§410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.***

*(a) Definitions.*

*Detection of any cognitive impairment, for the purpose of this section, means assessment of an individual’s cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.*

*Eligible beneficiary for purposes of this section means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.*

*Establishment of, or an update to the individual’s medical and family history for purposes of this section means, at a minimum, the collection and documentation of the following:*

- (i) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.*
- (ii) Use or exposure to medications and supplements, including calcium and vitamins.*

*(iii) Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.*

*First annual wellness visit providing personalized prevention plan services for purposes of this section means the following services furnished an eligible beneficiary by a health professional as those terms are defined in this section:*

*(i) Establishment of an individual's medical and family history.*

*(ii) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.*

*(iii) Measurement of an individual's height, weight, body-mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history.*

*(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.*

*(v) Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.*

*(vi) Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.*

*(vii) Establishment of the following:*

*(A) A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.*

*(B) A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under §410.16 of this subpart), and a list of treatment options and their associated risks and benefits.*

*(viii) **Furnishing of personalized health advice** and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.*

*(ix) Any other element determined appropriate through the National Coverage Determination process.*

*Subsequent annual wellness visit providing personalized prevention plan services means the following services furnished an eligible beneficiary by a health professional as those terms are defined in this section:*

*(i) An update of the individual's medical and family history.*

*(ii) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first annual wellness visit providing personalized prevention plan services.*

*(iii) Measurement of an individual's weight (or waist circumference), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.*

*(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.*

*(v) An update to the following:*

*(A) The written screening schedule for the individual as that schedule is defined in paragraph (a) of this section for the first annual wellness visit providing personalized prevention plan services.*

*(B) The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services.*

(vi) **Furnishing of personalized health advice** to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.

(vii) Any other element determined appropriate through the National Coverage Determination process.

(b) Conditions for coverage of annual wellness visits providing personalized prevention plan services. Medicare Part B pays for first and subsequent annual wellness visits providing personalized preventive plan services that are furnished to an eligible beneficiary, as described in this section, if they are furnished by a health professional, as defined in this section.

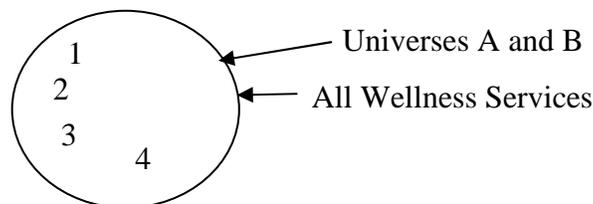
(c) Limitations on coverage of an annual wellness visit providing personalized prevention plan services.

(1) Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is not an eligible beneficiary as described in this section.

(2) Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is an eligible beneficiary as described in this section and who has had either an initial preventive physical examination as specified in section 410.16 of this subpart or either a first or a subsequent annual wellness visit providing personalized prevention plan services performed within the past 12 months.

(d) Effective date. Coverage for an annual wellness visit providing personalized prevention plan services is effective for services furnished on or after January 1, 2011.

The essential problem with the language of the Act and the proposed Rules is the phrase “furnishing of personalized health advice” highlighted above. If we are searching for a recognized and defined wellness service that is not included in the new 3P Services, we would have to be searching for something that does not constitute the “furnishing of personalized health advice.” Is there such a thing? Can there be any annual wellness services rendered to a Medicare patient that does NOT include such medical advice? In this circumstance, our two universes (A and B) would merge, and would look like this:



The conclusion that ANY annual wellness service rendered to a Medicare patient would by necessity include “personalized health advice” means that no annual wellness service could be rendered that is not clearly covered by Medicare. And if that is true, then there is no wellness service that could be paid for by the annual concierge fee.

In light of the items included in the list of 3P Services, particularly the “furnishing of personalized health advice,” it will be risky to assume that a wellness-type service offered to a Medicare patient will clearly be a non-covered medical service. It is a fair assumption to make that CMS will favor a presumption that if a service is “arguably” a covered service, then it will be for our purposes. One need look no further than the Inspector General’s March 31, 2004, Fraud Alert for evidence of this.

The Alert dealt with a doctor in Minneapolis who had accepted \$600 per year from patients in exchange for certain services, three of which were mentioned in the Alert: “coordination of care with other providers”; “a comprehensive assessment and plan for optimum health”; and “extra time” spent with the patient. The Alert, without telling us which of the three was a covered service, simply said that “at least some of these contracted services were already covered and reimbursable by Medicare.”

While the Alert did not make complete sense, one concept emerged: if a service is covered in some circumstances, then for purposes of concierge physician services it will be deemed covered in all circumstances. For instance, while Medicare does not pay simply for spending extra time with patients, it does cover it in certain circumstances: CPT codes 99354-99359 cover extending “prolonged services” to patients. (See <http://www.cms.gov/ContractorLearningResources/downloads/JA5972.pdf> for a description of these CPT codes.)

The short lesson here is that it is difficult, and dangerous, to conclude that after December 2010, there will be a wellness service out there that would not, at least in some cases, fall within the definition of 3P Services, particularly “furnishing of personal health advice.” We are in untested waters, and a cautious approach would be the prudent one.

- (B) ***The Moving Target.*** While it may be possible in 2011 to identify a certain wellness service that is not covered by Medicare (that is, not covered by the 3P Services) to justify an annual concierge payment, there is no assurance that that situation will endure. Here is what I said in my previous article about the possible moving target:

*Section 4105 of the Act is entitled "Evidence-Based Coverage of Preventive Services in Medicare." Section 4105(a) provides that Section 1834 of the Social Security Act is amended by adding the following paragraph (n):*

*(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2011, if the Secretary determines appropriate, the Secretary may*

*(1) modify*

*(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and*

*(B) the services included in the initial preventive physical examination described in sub paragraph (B) of such section; and*

*(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.*

*We now have a situation where it is impossible to tell what services the Task Force may add to those that are covered or not covered by Medicare. What is not covered one day may be covered the next, and it will be virtually impossible for FCNS practices to keep pace. A fundamental restructuring of these practices will have to occur.*

And the proposed Rules carry this forward by providing that the services will include “any other element determined appropriate through the National Coverage Determination process.” See proposed 42 CFR 410.15. And see page 319 of the proposed Rules, where it is said that:

*In addition, to facilitate future consideration of coverage of additional elements in the definition of...annual wellness visits in Section 410.15(a), we are proposing that the determination of other required elements for those purposes will be made through the National Coverage Determination (NCD) process. The NCD process is evidenced based, transparent and furnishes the opportunity for public comment, and is describe in sections 1862(1) of the Act.*

**(C) *Form Cannot Trump Substance.*** When one deals with Medicare, substance needs to rule. A physician just cannot “say” he is offering a wellness service that is of little or no consequence and trip merrily along charging an annual fee for what he has been doing all along. What you say you are going to do, you must do. It may not be a complete answer to say that FNCS practices, in face of changing Medicare coverage, can simply continue with an effort to chase services that are not covered by Medicare and charge an annual fee for them. That is a bit shallow, and it is somewhat disingenuous for a physician to say that she is all about wellness and prevention when she keeps changing what she is providing to make sure it is not covered by Medicare.

### III. My Suggestion – The “Credit”

My suggestion as to how to deal with this situation is, in essence, to abandon any effort to suggest that the annual fee is being charged for a service that is not covered by Medicare. Instead, perhaps it is better to provide expressly that the annual fee paid by the Medicare patient does not duplicate the amount billable to Medicare for a particular service. Here is an example of this concept in the form of possible contract language:

*The Services provided to You in exchange for the annual fee are as follows:*

*Wellness Evaluation. You will receive an annual “physical and wellness examination and evaluation” (“**Wellness Evaluation**”) to be provided by the Physician at no additional charge. As a result of the Wellness Evaluation, the Physician will develop for You a written health, exercise, and dietary health plan for You to follow (“**Your Individual Plan**”). As used in this Agreement, the term “Wellness Evaluation” means a physical examination and wellness evaluation provided to You not in connection with any illness or injury.*

*The Wellness Evaluation will not include the one-time “Initial Preventive Physical Examination” (“**IPPE**”) available to Medicare patients during their first year of Medicare coverage. This is a separate examination and will be billed to Medicare (except for co-pays and deductibles, for which You will be responsible). To accommodate this Medicare coverage, for the year in which You are eligible for the IPPE, You will be given a credit against your annual fee equal to the amount billable to Medicare for such IPPE.*

*Your Individual Plan will likely include services included in the “personalized prevention plan services” (the “**PPPS**”) defined in Section 1861(s)(FF) of the Social Security Act and in 42 CFR Section 410.15 as being provided to Medicare patients. If You are a Medicare patient, the annual fee will be reduced by the amount payable from time to time by Medicare under HCPCS codes for CY 2011 GXXXA (Annual wellness visit; includes a personalized prevention plan of services (PPPS), first visit) and GXXXB (Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit) in order to accommodate the Medicare coverage of these PPPS.*

Assume, for instance, that our annual fee is \$1,600 and that the physician can bill Medicare \$300 for the Welcome to Medicare physical. In the year that this physical is given to the patient, that is, the patient’s first year of coverage under Medicare, the Medicare patient only pays \$1,300, not \$1,600. Although the amount a physician can bill Medicare for the 3P Services is unknown at this time, let’s assume it will be \$400. As soon as the concierge patient becomes eligible for Medicare, the annual fee paid by the patient would go down to \$1,200. Even if the Medicare patient did not request the 3P Services during the year, the fee would still be reduced, since, in effect, the annual fee paid by the patient would not include services (that is, the 3P Services) that were not requested by the patient and never provided by the physician.<sup>vi</sup>

A cautionary remark about what we might call the “qualitative” aspect of this credit suggestion. Assume that a physician performs individual services 1 through 10 for ALL his

patients, every year, as part of his annual wellness visit with them. Each service costs \$50, so the total charge to the patient is \$500. Assume that CMS defines the 3P Services to include ALL ten of these services. And, finally, let's assume that Medicare will pay \$300 for the 3P Services. The physician cannot charge an annual fee (say \$1,600) for all ten services and charge Medicare patients only \$1,300. That won't work, since the patient is still paying \$1,300 for services that are included in 3P Services. In order for this credit idea to work, the annual fee must still include services OTHER than those that could be deemed 3P Services. For instance, it is pretty clear that a physician can charge for non-medical "amenities," like 24/7 access, no wait appointments, etc. These are services that could be included in the \$1,600. For those practices who want to continue with the "wellness" approach only, however, the \$1,600 is going to have to define a wellness service IN ADDITION to those that already are not now, and likely will not become, 3P Services.

Note that the credit suggestion brings us back to the same position we're now in – our annual fee is paid for services that are not covered by Medicare. That was our starting point and the basic principle of FNCS practices in the first place, before the advent of the 3P Services.

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<sup>i</sup> "New Health Care Act Deals Serious Blows to Concierge Medicine," see <http://wnj.com/publications/List.aspx?Industries=4b93a886-a6d2-4b56-a97b-01f1b60a2ebf>

<sup>ii</sup> These practices are based on the premise, now fairly well-established, that a physician may charge a flat fee to a patient for services that are not covered by Medicare. See "Legal Issues Involved in Concierge Medicine," [http://www.wnj.com/concierge\\_medical\\_practices\\_jrm\\_3\\_2005/](http://www.wnj.com/concierge_medical_practices_jrm_3_2005/)

<sup>iii</sup> For an explanation of these provisions from another perspective, see the following URL: <http://assets.aarp.org/rgcenter/ppi/health-care/fs180-preventive.pdf>, where the following is said:

"In addition to the initial exam for new enrollees, starting on January 1, 2011, Medicare will cover an annual wellness visit and accompanying personalized prevention plan for all beneficiaries. The law specifies that the personalized prevention plan be free, with no cost sharing, but the law is not clear on whether the annual visit itself must be free. Guidelines from the Centers for Medicare & Medicaid Services (CMS) will specify what, if any, cost sharing beneficiaries will have for the annual wellness visit. The free personalized prevention plan includes the following:

- A health risk assessment, for which the Department of Health and Human Services is to develop guidelines;
- An updated medical history;
- A list of current providers providing care;
- A list of prescription medications;
- Height, weight, and blood pressure measurements;
- A screening schedule for appropriate preventive services over the next five to ten years; and
- A list of risk factors the patient faces, along with treatment options for those risks.

"New enrollees may not receive both the Welcome to Medicare exam and the annual wellness visit during their first 12 months of enrollment. The Welcome to Medicare exam is available during the first 12 months of enrollment, and the annual wellness visit is available each year after that. The two services appear to be similar, though exactly how similar may depend on the guidelines developed for the annual health risk assessment. These guidelines are not due until March 2011."

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<sup>iv</sup> This did not, of course, apply to the so-called “welcome to Medicare” physical, which Medicare covered.

<sup>v</sup> There is no magic to an annual fee. Many concierge physicians charge the fee on a biannual basis, quarterly, or even monthly. How the fee is charged is not relevant to the issues discussed in this article.

<sup>vi</sup> These comments do not include consideration of similar issues faced by physicians dealing with a privately insured patient. If the patient’s private insurance includes coverage for what amounts to the PPPS, then seemingly the same theory should apply – if the patient’s annual fee includes these equivalent services, then the patient should be given a similar credit for whatever the insurance company pays for them.