

It has not been a particularly good year for “fee for non-covered services” concierge medical practices. The uncertainties created by the *Patient Protection and Affordable Care Act* signed into law in March (CMS has now nicknamed this new Act simply the “ACA”), especially the injection of the annual Personalized Prevention Plan Services (“3P Services”) into the mix, has been profound. CMS has now issued its Final Rules (published in the Federal Register the last few days of November) (the preliminary Rules were published in June), and there is no change that would affect or benefit FNCS practices.

The Final Rules are almost 700 pages long, and, of course, they deal with a good deal more than the 3P Services I have been concerned about. Spokespersons for CMS have been imprecise in referring to these 3P Service over the last several months, going so far as to call them an “annual checkup.” This led many to confuse these annual services with the “initial Medicare physical” (the “Welcome to Medicare” physical) and to conclude that the “initial” physical was now an annual one and covered by Medicare. The Final Rules are clear that the “initial” physical has NOT been disturbed or changed by the ACA or the Rules and that the 3P Services (which CMS has now nicknamed “AWV” (standing for “annual wellness visit”)) are new, separate services.

So, where are we? Here is a summary of my concerns:

1. Many concierge physicians provide an annual “wellness plan” in conjunction with the patient’s annual physical exam. I think the AWV services, set forth in the ACA and the Final Rules, by definition will overlap in some ways any “wellness plan” that a concierge physician is going to develop for a patient. Therefore, any physician who charges an annual fee for coming up with a “wellness plan” for the patient is likely charging for something that is now covered (as of 1-1-11) by Medicare.
2. I think the physician can continue to include an annual physical in the annual payment (since the “physical” is something different from the AWV services), although some caution is still warranted – the Final Rules acknowledge that there are some similarities and overlaps between the AWV services and an annual physical.

At the very least, in my view, a FNCS physician should eliminate from his or her contract any reference to the provision of an annual wellness plan. Just take it out and don’t develop one for patients unless he or she is charging for it outside of the annual fee. And the contract should, just to be safe, have the patient acknowledge that the annual fee does NOT cover the AWV.

Some might even consider eliminating the physical altogether and simply providing enhanced access services (“amenities”) in exchange for the annual fee. There does not appear to be any real question that such services are not covered by Medicare. We have been thrust into a gray and murky landscape with these new rules and regulations. I suspect that things may become clearer as we go along, but, frankly, I don’t hold out much hope for the short term.