

Medicare's Billing Guidelines for Elective Surgery

If you are a plastic surgeon who is non-participating with Medicare but who cares for Medicare patients, make sure you and the billing staff understand the rules surrounding billing for elective surgery. HCFA has outlined specific guidelines for how you may bill an elective case, if the charge is greater than \$500 and if you plan not to accept assignment. Failing to get the patient's signature prior to surgery may result in your having to refund a portion of what you collected.

Read HCFA's guidelines and customize the sample Beneficiary Form for use with your Medicare patients. Contact your state carrier for specifics about how the Guidelines for Elective Surgery apply in your state.

Document Reference: MCM 4360

HCFA defines elective surgery as surgery that can be scheduled in advance, is not an emergency, and if delayed, would not result in death or permanent impairment of health.

A non-participating physician who submits a non-assigned claim for an elective surgical procedure of at least \$500 must provide the following information in writing to the beneficiary before the surgery:

- The estimated actual charge for the procedure
- The estimated Medicare approved charge
- The excess of the physician's actual charge over the approved charge
- The coinsurance amount

Physicians must furnish Medicare beneficiaries with a written notice similar to the sample letter below. If the physician does not notify the beneficiary prior to rendering the services, he or she must refund any money collected from the beneficiary in excess of the Medicare approved charge.

If a physician does not refund the money, he or she may be subject to civil monetary penalties and/or exclusion from the Medicare program.

Remember when performing multiple surgeries on the same date of service, the special reimbursement rules apply and the proper multiple surgery reductions must be taken in order to calculate the correct limiting charge for the required estimate to the patient. If you are unsure of how to calculate the correct multiple procedure reductions, please contact the Customer Service Department in your state.

The exception to this rule is that the surgeries in the 90000 series listed in the CPT do not require the elective surgery notice.

A physician who is not sure of the approved charge for a service should first review the fee schedule to find the approved charge and, if the physician still has questions, he or she should contact the Customer Service Department in their state.

Physicians must document the beneficiary's receipt of the required information by getting the beneficiary's signature on the following letter and having the beneficiary return the letter for the physician's file.

Sample Beneficiary Notice-Customize to Your Needs

Dear Patient:

I do not plan to accept assignment for your surgery. The law requires that when assignment is not accepted, and the charge is \$500 or more, an estimate of the charge and your liability must be provided prior to surgery. These estimates assume you have already met the \$100 deductible.

Type of Surgery: _____

Estimated Charge: \$ _____

Medicare Approved Amount: \$ _____

Your Estimated Payment
(including Medicare coinsurance): \$ _____

Beneficiary's Signature and Date: _____

Beneficiary's Printed Name: _____