Any or all portions of this document may be used by meeting participants in their communications with their state components and fellow members.

Thank you to Janet Simon, DPM for her input.

Henry Desmarais, MD, MPA, Health Policy Alternatives, Medicare Policy Issues for DPMs

- **Medicare Physician Fee Schedule**
  - Predicts that the final rule will be published Friday, November 22 but it could be published Wednesday, November 27 at the latest. Many questions about how effective date determined and handled.
  - The projected net impact on podiatry is 0%. This process is budget-neutral and ignores the sustainable growth rate (SGR). Unlikely to happen, but if the SGR-induced cut takes place, payments will decrease by 24.4%.
  - Conversion factor? Unlikely to see change but Congress must act prior to January 1.
  - **Relative Value Issues**
    - Know about the search for potentially overvalued services. Reallocation of values undervalued services, especially towards primary care.
    - Two new private contractors hired to work on RVU issues: RAND (validation model to look at RVUs) and Urban Institute (collect objective time data, to compare against RUC time data because of RUC critics).
  - **PQRS**
    - PQRS was originally voluntary. But now, if you don’t participate, you will be penalized.
    - CMS generally proposes to increase measure reporting to at least 9 measures. Today, it is 3. Henry does not believe it will be 9 because of physician pushback. More likely will be 6.
    - CMS proposes to implement the Congress-mandated qualified clinical data registry reporting option. This registry would have benefits for specialty groups.
  - **Value-Based Payment Modifier**
    - Probably something you are not paying attention to but you should pay attention because it will affect fee schedule payments.
    - Start with the fee schedule amount. Adjust based on performance (variety of measures, such as quality, cost, resource).
    - In the past and currently, this modifier only applied to mega-groups (100 or more eligible professionals). Under the proposed rule, in CY 2016, modifier would apply to groups of physicians with 10 or more eligible professionals.
    - By 2017, every physician is supposed to be affected by the modifier.
Remember that CMS looks back at performance from two years earlier to determine payment.

The amount of payment at risk would increase from 1 percent to 2 percent in CY 2016 and continue to increase.

Medicare spending per beneficiary (MSPB) measure is controversial. It is a complicated formula and one example of a cost measure.

See “2016 Value-Based Payment Modifier Amounts for the Quality Tiering Approach” table in Henry’s presentation.

Once CMS knows how many people will be penalized, they know what the rewards are that will be allocated (budgetary-influenced methodology).

### Hospital Outpatient Prospective Payment System
- CMS proposed the expansion of items and services packages paid together as opposed to being line items paid separately.
- Medicare has been grouping related services and paying as a bundle. In proposed rule, calling for major expansions in what is included in payment. Big deal for hospitals not physicians, but also big deal for ASCs.
- Packing would include all drugs and biological that function as supplies or devices in a surgical procedure. Specifically at issue are skin substitutes, despite the fact that prices for these products and the way they are used vary significantly. APMA commented against this.
- Momentum at CMS to keep outpatient packaging the same as inpatient.

### Medicare Delivery System Changes
- **Medicare ACOs**
  - Continuing to become a major component of Medicare
  - As many as 4 million Medicare beneficiaries (about 8% of total enrollment) now being served by accountable care organizations.
  - Under the Medicare Shared Savings Program (MSSP), 27 ACOs began serving beneficiaries on April 1, 2012, 89 more on July 1, 2012, and another 106 on January 1, 2013.
  - Now about 250 ACOs in all, with a wide geographic distribution.
  - CMS has accepted applications for 2014; further growth in the number of ACOs expected.
  - Many ACOs in MA.
- **Bundled Payments**
  - Another initiative that you may not have been paying attention to. (i.e. 2 Midnight Rule at hospitals aimed at decreasing observational care stays.)
  - A voluntary program where people can raise their hands and give CMS a discount on certain bundle of services. If they do better than what was agreed upon initially, they share savings with the physicians they are partnering with.
- Four different models with different amounts of packaging. Not terribly relevant to DPMs because right now, only focused on inpatient. It may just be inpatient care but the bundle may be big and incorporate post-acute care.
- Physicians and hospitals get paid normally and then later on, they figure out the rest. Model 4 payment is made on a prospective basis.
- Gain sharing possible under all models.

  - SGR Reform – Henry’s opinion is another short term fix of SGR 3-6 months with continued legislative discussion.
    - Annual threat of significant reductions in the conversion factor under the Medicare Physician Fee Schedule.
    - Formula says that if actual payments are higher than benchmark, then conversion needs to be adjusted to offset. This has been threatened every year since 2002. Since 2002, Congress has stopped this methodology from being applied. They let it happen in 2002.
    - Everyone agrees that SGR should but replaced but no agreement on with what. Enormous cost with replacing the SGR (see CBO estimate).
    - E&C Bill, HR 2810
      - Made it the furthest out of all legislation on this issue. Passed the E&C committee unanimously. Repeals the SGR and provides for an annual 0.5 percent update to the PFS conversion factor for 2014 through 2018 (period of stability). Beginning in 2019, updates to the conversion factor for each physician or physician group would depend upon their performance on certain quality measures and, if applicable, clinical practice improvement activities. Baseline updates would continue to be 0.5 percent annually. But actual updates could range from -0.5 percent to +1.5 percent annually.
  - Quality Update Incentive Program
    - Eligible professionals decided into peer cohorts. Self-select among available options. Each cohort would have its own core measure set.
    - Quality measures would address 5 domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. A 6th domain under the National Quality Strategy, efficiency and cost reduction, is not included.
    - Unclear how scoring works. Seems to be like a report card. Score determines quality adjustment and then total update. It is possible for everyone to get full update? Or is there a percentile issue (curving)? Bill has not made clear. It may intentionally leave to CMS to determine. If you are participating in APM, then do not need to worry about this. Not sure what APMs will be applicable.

  - House Ways & Means and Senate Finance SGR Reform Discussion Draft
    - Would repeal SGR but substitute a 10-year freeze (through 2023)
Could earn incentive payments in 2017 based on quality, resource use, clinical practice improvement activities, and HER meaningful use but payment distribution would be budget neutral (winners and losers); or beginning in 2016, if physicians are participating in an advanced alternative payment model involving two-sided risk and a quality measure component, they would receive a 5-percent annual bonus through 2021 (not subject to preceding performance-based incentive program).

Performance-based incentive payments: aggregate incentive payments would be equal to eight to ten percent or more of the total estimated spending for eligible professionals. But there will be losers paying the winners due to budget-neutral methodology.

Stakeholders have until November 12 to comment on this draft. APMA has commented. This proposal is likely to evolve and must be converted into legislative language.

- House and Senate must both approve the same reform plan or approve another short-term fix. The Congress could approve a “short-term fix” to give themselves additional time to consider more fundamental SGR reform in 2014.

Julie Taitsman, JD, MD, Chief Medical Officer, Office of Inspector General and Geeta Taylor, JD, MPH, Office of Counsel to the Inspector General, Office of Inspector General, US Department of Health and Human Services, OIG Enforcement Actions and Physician Compliance

- Mission to protect the integrity of HHS programs and the health and welfare of program beneficiaries. Carry out mission through audits, evaluations, inspections, and enforcement. OIG thinks of providers are partners with them in promoting program integrity and preventing fraud waste and abuse.
- According to IOM, 30% of health care expenditures are lost to waste by all payors. Only part of that waste is fraud. Looking to health care providers to reduce this number. Money could be spent on quality care for beneficiaries.
- Government generally trusts providers to bill properly. Most claims processed automatically by computer. If we suspect a problem, will look behind the claims. Will get assessed by auditors and investigators.
- Who is investigating? OIG, DOJ, FBI, States (MFCU – Medicaid Fraud Control Units)
- Examples of enforcement
  - Upcoding, unbundling and billing for medically unnecessary services are common trends.
  - One method of identifying potential offenders is peer comparison.
- It is for providers to settle case, enter integrity agreement, and will not be excluded. Integrity agreement consists of implementation of a compliance program and completing training and education for themselves and staff. They will also perform audits of claims and send these audit results to OIG.
One of OIG’s main enforcement tools is exclusion. Two types: permissive (discretion of OIG) and mandatory. The most common type of exclusion is due to loss of license because of suspension or revocation. Exclusion means that the excluded individual or entity cannot be paid by federal health care programs.

**Compliance programs**

- OIG believes that the most important provision of the ACA is mandatory compliance programs. CMS will issue guidance but no time frame has been provided.
- 7 fundamental elements of compliance plans for all provider types: (1) written policies and procedures, (2) compliance professionals, (3) effective training, (4) effective communication, (5) internal monitoring, (6) enforcement of standards, and (7) prompt response.
- Guidance available on website (www.oig.hhs.gov) for compliance for different provider types. Review OIG’s *Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* (PDF), which has an accompanying PowerPoint and video presentation.
- It is important to address the following in your compliance plan:
  - **Interaction with industry (vendors).** Providers have different levels involvement. It is up to you if you accept free drug samples. But if you do accept, make sure you do not break laws. It is legal to give patients these samples for free. Do not bill for these free samples or ask patients to pay.
  - **Billing.** Physicians generally have an oversight role and must make sure billing is accurate. Common billing abuses include: upcoding, unbundling, duplicate billing, billing for services not rendered, and billing for medically unnecessary services (e.g., power wheel chairs at times).
  - **Documentation.** Lack of documentation means that the medical record cannot support the claim. Compliance plan should address medical records and documentation. Do professionalism sales pitch to your employees. Explain patient safety aspects. Important to keep records to be able to treat patient appropriately. Will be good to share with other providers they see.
  - **Example of medical record that is less than ideal (MA).** Can get more money if show beneficiary was sicker (here, chronic renal failure). Provider sent chart and highlighted CRI (chronic renal insufficiency). Problem here is that provider added this during audit. Falsifying record makes it worse.
  - **Make an audit plan.** The audit group is the largest group at OIG. Proactively audit coding, contracts, and care internally.
  - **Policies and procedures should be up-to-date and user-friendly.** Act promptly when issues arise. Take and document corrective action.
  - **Enforce policies and procedures.

- **HEAT Provider Compliance Training** – On-line webcasts/Podcasts www.oig.hhs.gov
13th Annual Joint National Podiatric CAC – PIAC Representatives’ Meeting
Renaissance Washington, DC Dupont Circle · Washington, DC · November 8-9, 2013

- Make sure you are not employing individuals on the OIG List of Excluded Individuals and Entities (LEIE), who are excluded by Medicaid (check with your state), and/or are debarred by OPM.

- **Questions**
  - State law determines licensure and scope of practice. HHS determines and enforces payment issues.
  - “Incident to” billing by licensed podiatrist under Medicare. State law determines what medical assistants can do.
  - HIPAA issues: OCR is primary enforcement. OIG does security audits for COPs for hospitals (test to see if can get on networks and access patient information).
    - CME by CMS (Julie and CMS official): Great suggestions about HIPAA security. Medical identity theft for patients and providers as well.
    - Julie: NEJM article contains tips for patient privacy, including suggestions on how to protect data. Table from OCR on how to secure information on computers and laptops.
    - OCR released information about portable devices (including smartphones) and how to protect data on those.
  - OIG directed representatives to CMS for supervision information.
    - Direct to CMS for supervision information.
  - Compounding pharmacies. OIG has indirect involvement. State pharmacy boards and FDA make policy decisions and enforcement. OIG performs oversight of FDA.

**Gina Simms, JD and Howard Sollins, JD, Ober Kaler**

- **Reaction to OIG:**
  - You can make yourself crazy worrying that someone is out to get you. Be mindful. It is ridiculous to bill for less than the care you are providing. Be thoughtful in a well-rounded well-documented medically necessary way.
  - If your office has someone visit for compliance concerns: Ask who they are. Get their business card immediately and “be professional”. If what is being asked to be review sends flags to you, contact your off legal counsel for guidance. People who do compliance work talk to each other a lot. If ZPIC, they have a fraud and abuse mission despite not being from OIG or FBI.
  - It is a recent development to look at flow of claims in real-time.

- Howard highly recommends: Date stamp all in-coming mail.. Do basic housekeeping.
- Ever shrinking government budgets necessitate law enforcement communication and pooling resources. May start at RAC, MAC or ZPIC level. Inquiry may be simple at first. But depending on what they see, they may refer to state and/or federal investigators. Collaboration going on all the time between state and federal to pool resources.
- HEAT teams are set up in target cities and are law enforcement folks and data analysis folks and clinicians. Look at claims real-time and historically. They look at who is billing more (outliers)
in an area, which could be nation-wide, or for a geographic region, and for indicia of fraud. They target individual businesses (covert, overt). They may seek the help of one of your employees when investigating you.

- Government has resources at their disposal to investigate. Think about how to prepare yourself.
- Health care is highly regulated industry. You are likely to be target of audit or investigation.
- You need to have good compliance plan for being able to document for when your claims show up as an anomaly.
- A new area for Enforcement focus is provider enrollment.
  - Know that your NPI can be turned off for a variety of reasons.
  - Form 855. Make sure to update this even if administrative (e.g., change of address).
    - Payments can be turned off if there is a discrepancy in office addresses.. Also transfer of assets into a new trust, etc.
- Check Excluded provider lists – 3 lists that should be checked monthly (MC/MCD/Debarment). Three lists to check:
  - OIG LEIE-MC Exclusions
  - Medicaid exclusion list
  - OPM debarment list

  Example: You hire a nurse who had been on excluded list for not paying federal student loans. Nurse did not request after loans were paid to have exclusion status resolved thus remains as an excluded individual. All claims that the excluded nurse touched are toast because you billed services rendered by excluded individuals. Excluded individuals will need to apply for reinstatement. You are responsible as the provider billing to know this.

- Responding to the OIG case examples: Two instructive themes: (1) patient interviews, and (2) documents and data.
  - Explain to your patients the care you are providing them. Frequent patient OIG complaints relate to patients not understanding what treatment was being done.
  - Data and documents.
    - Data mining/peer comparison is conducted to determine whether you are an outlier.
    - According to CMS, if procedures are not documented, they did not occur. Gina explained an example of John Nataly, a vascular surgeon outside of Chicago. He had thousands of patients and jumped from one to another. He sometimes completely forgot to dictate pre- and post-operative notes for each patient. He was indicted for false statements. Documentation must be comprehensive!
- 60-day rule: If you receive an overpayment that you knew or should have known was an overpayment, you are required to repay this amount within 60 days of identification of the overpayment.
  - Reverse false claims: If you were paid money but did not know it was a result of improper payment, then that is innocent. But if you find out that it was improperly paid
and knowingly do not pay the money back, it is a false claim. If you know you are not entitled, give it back. Do not wait for CMS. If not sure, then that is different (meaning you may need to respond to a request for repayment).
  • Don’t wait. Every contractor has a program integrity unit.
  • Ober attorneys are big fans of prospective in-house self-audits. Pull 10 claims that you are about ready to submit and look at everything before sending out. This is a great compliance tool. If look at past claims, may identify overpayments that you need to pay back.
  • HIPAA compliance: Mainly in the world of OCR that is separate from OIG. But it doesn’t mean that they don’t talk to each other.

Mitchell Resnick, DO, Working with Carrier Medical Directors and Novitas Update
  • Dr. Resnick will address: MAC characteristics, CAC characteristics, LCDs, CAC functions
  • MAC characteristics:
    o CMDs have different specialties and contacts with community. Comfortable with writing LCDs.
    o Different resources among contractors.
  • CAC characteristics
    o Format differs. Some states have a single meeting for their state and others have multi-state meetings. MAC meets with CAC representatives. Both work.
    o Podiatry is an active participant compared to MD/DO!
  • LCDs
    o Reasons to write LCDs: data analysis, provider request, uniformity across jurisdictions.
      ▪ Uniformity: Adopted LCDs from outgoing contractors when overtook business. Need to combine these policies to create one set of policies (medical review, coding, appeals, etc.). One set of policies would be the best way to go.
      ▪ ICD-9 to ICD-10 transition may be factor in whether to retire LCD
    o Can’t stress enough: When you develop an LCD, what allows the LCD to stand on its own two legs is the quality of the evidence that goes in it. It’s the literature, the evidence-based literature that is supported. Many challenges by industry, legally, by providers, by associations. They are under vigorous challenges on many levels but it comes back to evidence. Are there randomized controlled trials done? Small case studies may not provide the substance required. Challenge to sort through world of evidence-based medicine to determine whether there is good, strong evidence.
      o MAC may adopt/adapt other existing contractor LCDs 1st and work collaboratively.
  • CAC functions
    o From Dr. Resnick’s perspective, it takes a different skill set than what we are used to with patients in exam room. Of course using evidence-based medicine is major factor. Writing LCD is more academic. It really is teasing apart the evidence and deciding how long it is. Reaching out and learning about a certain disease state, treatment, evaluation. It matters because LCD always stands on its own two feet based on literature that supports it even
though opinions and input provided. Always should be based on strength of evidence. Having unbiased input, fact-based more than opinion-based is most needed in his opinion.
  o CAC members should obtain feedback from interested colleagues.
• April 10, 2014 will have new L numbers because of ICD-10. This is considered a new policy but these policies will not be open to comment (direction they were given by CMS).

### Kelli Back, JD, Emerging Issues in Private Insurance

- Emerging issues include health-care reform, market trends, and Medicare Advantage.
- **Health-care reform/ACA**
  - **Provider Non-Discrimination Interpretation under ACA**
    - Prohibits health plans from discriminating against providers acting within the scope of their licensure. Not an any willing provider law. Health plans can still vary reimbursement based on quality and other performance measures. It does have broad applicability. Doesn’t apply to grandfathered plans, Medicare, or Medicaid.
    - FAQ guidance issued by CMS: Not going to issue regulations on provider non-discrimination prior to effective date. Expecting health plans to make good faith efforts and interpret reasonably.
      - FAQ went beyond statute
      - Said does not affect reimbursement rates in FAQ. But it is qualified under the law (quality, performance, market performance).
      - CMS is taking a position. APMA has been involved with repealing this guidance.
      - Also seeing states’ interpretation.
  - **Contracting**
    - Consider whether you wish to participate in health plans offered through exchanges or with Medicaid health plans.
    - Look at your existing contracts to determine whether you are already obligated to participate in such plans.
    - Network issues: Using smaller networks of “most efficient” providers. They already went through review for network adequacy. They are probably not looking for providers to add to the plan.
    - States may expand Medicaid in the future. Consider Medicaid expansion benefits (benchmark coverage, essential health benefits, non-discrimination does not apply). 25 percent of states did not opt to expand Medicaid. State hospitals have lost DSH payments.

- **Market trends**
  - Massachusetts (MA) as a model. Instructive to look at MA. Seeing ripple effect. They had legislation that looked similar to ACA. Achieved goal of insuring almost everyone
Goal to health care cost inflation has not really happened. Key issues: There were large provider organizations with major market shares that were getting three times what other provider organizations were getting. Transition to alternative payment methodologies. Tiering means required the offering of a tiered network for the small group market. Saw it first in MA. Plans tiered differently (e.g., level at individual providers)

- **Provider consolidation**

- **Alternative payment methodologies**
  - **Medicare Advantage Organization (MAO)**
    - **Cause and Effect**
      - Payment decreases due to increased pressure to ensure diagnostic data is captured, increases in cost sharing under plans, increased utilization control mechanisms, desire to streamline networks.
      - Quality provisions due to increased focused on obtaining quality data (and get star rating).
      - MLR requirement due to focus on lowering administrative costs.
    - **APMA questions to Kelli:** MAO not covering same benefits as Medicare FFS, termination from networks, and record requests/audits.

- **Termination**
  - Written notice of termination. If data involved, must provide relevant data. Can still appeal if terminated without cause. MAO plans must have appeals process. Hearing panel has to be made up of majority of peers. Hearing may be paper only. Only for providers with contracts.
  - Kelli recommendation to APMA members who may be facing MAO termination: Providers can send letter to patients with info about all the MAOs that provider are contracted with as well as info about out of network benefits.
  - Being a non-network provider does have protections more so than network providers.

- **Coverage**
  - It is a payment or coverage issue?
    - MAOs must offer at least the same benefits as Medicare FFS.
    - Not required to pay contracted providers same as Medicare FFS.
    - May add utilization review requirements that are not present in Medicare FFS.
    - MAOs not required to use the same modifiers as MC.
    - Kelli recommends the providers send MAO blinded copy of MC EOB for similar services to show how payment edits are used in MC.

- **Records Requests – Some MAOs are beginning to pay for records request.**
Is physician network or non-network provider?
Purpose for the request? Diagnostic data? Medically necessary services? Other?
If network provider, does contract provide for payment?
If non-network provider, may ask for payment for records provided for quality or diagnostic purposes.
Like FFS, when issue is medical necessity, physicians must furnish data or face denial.
MAOs are not subject to 3 yr look back period – Need to check your contracts,

- Dual eligible demonstrations
  - 15 states
  - To extent state uses managed care system, may facilitate enrollment in plans.
  - Not technically MA plans but will operate under same rules.
  - Organizations with MA contracts participating in the demos.

Brian Webb, Manager, Health Policy, National Association of Insurance Commissioners (NAIC), What Provides Need to Know About State Exchanges

- NAIC develops models for states to use.
- ACA did not take power away from states. It is not the states fault.
- Insurance regulators nervous about December 15. If you don’t enroll in plan by this date, then your coverage does not begin January 1. Will have a gap in coverage.
- Waiting to get coverage (currently uninsured or underinsured)
- Cancellations – how many plans have been cancelled? We have no idea. Plans always have been able to cancel.
  - HIPAA said that in individual market, can’t just cancel for an individual insured. Can cancel everyone on an entire policy. Must give 90-days’ notice and offer another plan. People are getting that notice now. Will be effective on January 1. Not always easy to change plans.
- Biggest problem is Medicaid. First step in exchange is to see whether eligible for Medicaid. Huge backlog of people who can’t determine whether eligible. This backlog will allow a gap in coverage for these patients.
- Network adequacy and who regulates – State dependent-either DOH or DOI.
  The new exchange plans will have their own networks and all providers need to check and not assume they are a part of these networks. Caution: Exchange Discounted Contracts will supersede your other contracts. Be Aware.
  - Carriers decided best way to control costs is to narrow networks and lower fee schedules.
- New regulation next year based on quality
- Insurance commissioners do not get involved in contracting issues.

Laurence Clark, MD, Carrier Medical Director, NGS, Working with Carrier Medical Directors and NGS Update (Laurence.clark@wellpoint.com)
• CMS is encouraging contractors to be consistent. They are working on synergistic policies.
• Peripheral pain issue. Thinks that Cheryl Ray’s (WPS) policy for EMG and nerve conduction will be adopted across the US.
• Many NCDs come from CMDs.
• It helps when policies are standard across the country. On the other hand, and historically, programs need to respond to local concerns.
• Basic collaboration for LCDs is a good way to standardize the program across the country. Sounds like that is what legislators want. CMDs coming together next week to discuss policies.
• He thinks that this is a very advanced group.
• Thinks that pain management policies will be synergistic across the country.
• NGS accepting a higher evidentiary bar at CMS’s recommendation/demand. That is the only way to ensure fairness.
• LCDs are not going to be same across the country. Will always have local concerns that will be addressed. But you will see more standardization.
• Medicare policy
  o Breaks down to three things: NCDs, coverage provisions in interpretive manuals. NCDs – supersede ability of ALJs to alter the outcome. They are standard. They are subject to contractor’s interpretation to supplemental articles.
    • HBO subject to NCD. It is very strictly defined. NGS has an article but not much.
    • Coverage provisions in interpretive manuals
      • Not everything is covered by a policy. If you are submitting a clean claim, why do you want a policy?
      • Portable x-ray. Interpretive manual required. That is fairly standardized.
    • LCDs – you have input.
  o Evidence supporting LCDs
    • Looking to be synergistic and work together with other contractors.
    • List of things are what they are looking for.
    • They are going to be looking at skin substitutes. It is uncharted and not well defined. Need appropriate documentation of wound healing. Thinks this will be a collaborative effort.
    • Have multi-disciplinary effort on how to deal with pain. 13 specialties involved. CMS involved in this effort.
  o Role of CAC member
    • Go to providers in your area and solicit information from them about the procedures they are performing.
    • We want letters of support from your society. We want you to be known. We want you to provide members feedback from the CAC meetings.
    • You are lobbying for your colleagues and good practice of podiatric medicine.
    • Disclose your conflict (e.g., participating in a trial).
• Issues of Interest to Podiatry
  o Modifiers 76 and 91 – working with states. Came out of Cahaba. Software update. Cahaba said to use 76 instead of 59.
  o Collaborative billing reports – NGS will be doing it but not at a charge. They are working on it. Can call up First Coast and get it.
    ▪ How do we go about doing this? Is there a charge?
    ▪ He understands they will be doing more of this.
  o Skin substitutes
    ▪ LCD
  o Will be seeing more supplemental articles from NGS.

CAC-PIAC Breakout Session Recaps

PIAC
• Group 1:
  o In CA, Multiplan medical director was sympathetic regarding pay parity issues but unfortunately it is a corporate decision. Multiplan is expanding so may be potentially more problematic across the country. Similar issue with Humana.
  o Perhaps have a consultant negotiate contracts on your behalf.
  o Certain representatives have been told that they cannot dispense DME. They had to dispute and educate.
• Group 2:
  o Diagnostic ultrasound
  o Discrimination against podiatry issue in Michigan
  o Termination letters from MA plans
  o Hopes that APMA staff can provide protocol and steps to take when termination letter received.
  o Refer to L3000 white paper. Result of orthotics meeting with AOPA and fabricators.
  o DME and coverage for L1971, which was downcoded. But add attachment and then recode it.
• Group 4:
  o Issue whether order and dispense DME. Order has to come from primary care. Need order from primary care to be able to dispense. DPM cannot order.
  o CIGNA – not appropriate code. Decompression osteotomy. CIGNA denied procedure because no prior authorization obtained. How to get prior authorization when in surgery? Appeals were not successful.
  o Amending contracts – what to do? We should be contracting attorneys especially with ICD-10.
  o Exchanges.
o Stark Laws – possibility of repealing some of the exemptions. Possibility of not being able to provide certain services in offices.
  o Mass – issues with IPAs. May or may not have been including podiatry.
    ▪ ACOs – many in MA.
  o Certain health care insurance companies pulling out, resulting in less competition.
  o CT law change. Problems with orthopedists and residencies not allowing podiatrists to train in foot and ankle.

• Group 3:
  o DME. What we need from certifying physician. Thinks that sample letters could be shared through list serve (APMA could facilitate?)
  o Policy problems:
    ▪ Younger physician not able to be on BCBS panel because not board certified and board qualified is not enough.
    ▪ In GA, podiatrist on panel has been with BCBS, terminated because not board certified (will be taking test next year because he is board qualified).
    ▪ Tiering physical therapy. Using utilization management company.
    ▪ Letter to United about old fee schedules. Fee schedules determined by the market.
    ▪ Because copays and deductibles going up, not enough information provided on websites about providing more information to patients. Work with APMA to write to insurers so that more information is provided electronically (e.g., 70% for inpatient surgery, etc.)
    ▪ What about recoupment if patient is long gone?

• Utilize APMA insurance complaint form.

CAC
• Group 2 (Novitas)
  o ICD-10. When will CAC committee members review? Starting a list serve within group.
  o One region might not want a certain LCD from another. Want the best LCD for the area. Done through list serve of the Novitas representatives.
  o NJ: EMG and NCDs. Now denied but still being paid in PA. Boiled down to scope of practice and board definition issue.
  o Concerns about potential for further scope exclusions and misinterpretations.

• Group 4 (Cahaba)
  o Skin substitutes. Policy pending. Due to rapid change in industry.
    ▪ Carrier/CMS
      • Consolidation of policy criteria
        o Duration of wound
        o Location of wound
        o Type of skin substitute
        o Location of service
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- Policy coverage limits
  - Modifier 25
    - Letters from RAC, disallowing for initial E&Ms submitted from surgical codes. Not sure whether specific to nail debridement codes or all surgical codes. Brought attention to carrier but haven’t heard back. Making members aware that this is an issue with RAC. Paul said he had that issue in 2010. Paul to send information to Mark.

- Group 3 (Noridien)
  - CA just became a member of Noridien again.
  - Developing a list serve for DME. Denied on can walkers for appropriate diagnoses. Using the wrong code? Need proper documentation. i.e. For pneumatic walkers, diagnosis of edema needs to be linked to code for billing.
  - If you are getting paid, you may not be paying properly. Could be an error. If you know it is not proper, you need to send it back.
  - Wound care, skin substitutes – proposed bundling or non-coverage for in-hospital procedures. Expensive skin substitutes will have to be covered by patient or hospital will have to eat the cost. Be cognizant of how much skin substitute costs.
  - Hiring consultants to fill out A-55 forms may be money well spent. These forms are complicated. Hire attorney to make template with annotations.

David Freedman, DPM, BMAD Data

- Most current data is 2012 Medicare data:
  - Clean claims stats – Vermont is having 96% of its claims paid cleanly. Low percentages in the teens for some states. NM is at 13%. The MAC transitions play a roll in this stat calculation.
  - 99213 - #1 code
  - 99214 – Still low frequency but improved since previous year. Podiatry should be billing higher frequency of 99214.
  - Continuing overutilization of 11730. It is being targeted by law enforcement.