

Introductions / Reminders

2009 Coding Resource Center – Order through APMA. Available in 1/2009

Comprehensive billing/coding electronic resource – Price \$169 until 12/31/08./ \$189 thereafter. This coding resource will be accessible through the web with a passcode. Regular updates will occur to the information in this resource. ICD/CPT/HCPCs will be searchable on-line with print capabilities.

PQRI – Jim Christina, DPM (APMA Staff)

Physician Quality Reporting Initiative – Congress legislated in 2006 for voluntary physician reporting.

The quality measures have been developed through coalitions of interests that has included APMA in-put. The 2007 PQRI program had 74 eligible measures that APMA identified 6 measures that related to podiatry. A very complicated formula was devised for payments and at this time very few participants have been “bonused”.

2007 MMSEA – Congress reauthorized PQRI for at least 2 yrs. No cap on payments.

153 measures can be reported that are broadly applied through disciplines. Two of these measures were ones that APMA submitted on neurologic exams and fitting of shoes in DMs. APMA has identified 15 measures overall that podiatry can report. Only 3 measures need to be reported but they have to be reported on 80% of the eligible MC population that you see.

Final rule was published on 10/31/08 that increased “bonus” payment from 1.5% to 2.0%. It also requires CMS to post on its website the names of eligible professionals who satisfactorily report PQRI measures. Additional 2% “bonus” can be obtained by reporting E-prescribing but the final guidelines about these measures have not been published. So...a potential of 4% bonus total could be achieved if you report PQRI measures and E-prescribing.

Measure groups that aggregate reporting items have been developed but these do not apply to podiatry.

Alternating reporting periods – 1/1/09 – 12/31/09 or 7/1/09 – 12/31/09.

If you report for full year you may be bonused for the 12 months versus only be bonused for the 6 months of the second period.

If you go to the PQRI website (<http://cms.hhs.gov/PQRI>) worksheets are available outlining the specifics for reporting each measure. These worksheets give the CPT codes that would need to be reported along with the G-code that indicate the measure was performed at that visit. The measures are reported per individual provider with payments being made to the group NPI number if your practice submits billing under a group. This means that not all providers in a group need to report measures.

McHUMOR by T. McCracken



“There's really no need for confusion with this Medicare stuff. Page 95, section 33, paragraph L clearly in the instructions quite clearly explains...”

MC RAC (Recovery Audit Contractors) – Melanie Combs-Dyer, RN from CMS-Division of Demonstrations, Mgt Financial Services Group

IPIA = Improper Payment Information Act authorized demo project under MMA section 306 and then permanently authorized under Tax Relief and Healthcare Act of 2006, Section 302.

“Improper Payments” include over- and under- payments.

Last year's rate of errors was 3.9% ~ 10 billion \$ in improper payments.

Demo RACs identified found \$1 billion in improper payments after reviewing \$317 billion in claims. E/M codes were not allowed to be reviewed during the demo. As this program goes forward E/M codes will be reviewed that should increase the percentage of underpayments. Demo RACs repaid \$37 million to providers.

85% of these improper payments were MC Part A/ 2.8% were from physicians and the remainder from labs, ambulance services, etc.

Contingency fees initially were not paid on underpayments only on overpayments. The permanent program will be paid a contingency fee on underpayments and overpayments.

In the permanent program an independent validation contractor will be reviewing each RACs' performance in a report card format.

Selection of Claims: RACs choose issues to review based on data mining techniques, OIG, and GAO reports, CERT reports and the experience/knowledge of staff.

- 3 year look back period but not further back than 10/1/2007.
- New issues for review will be posted to RACs website.

Qui Tam lawsuits = Whistleblower suits are filed by a private citizen on behalf of the Federal Govt alleging that the defendant is guilty of some Federal offense for which reimbursement is due to the govt. If the suit is successful the citizen plaintiff shares in the govt's recovery.

If your office is visited by auditing entities other than FBI with search warrant in hand your standard office policy is to ask them to have a seat and then have the physician/owner notified.

DME Accreditation: Sandra Bastinelli, MS, RN , Director Medical Review, CMS – Financial Mgt.

Physician-suppliers are currently exempt for accreditation and DMEPOS quality standards. All new physician-suppliers do not have to be accredited although there still may be DMEPOS that have not gotten the word as of yet. This current exemption is considered temporary and can be changed by CMS administration.

Action Step: All DME physician suppliers need to check their enrollment forms (855) to identify how they are enrolled as physicians and not also as DME suppliers. If dual categories are checked on these enrollment forms there is a good chance that on October 1, 2009 claims may be denied.

Health Care Reform: Debbie Curtis, Chief of Staff, Representative Pete Stark

MC bill will need to be passed by Congress by 12/2009. Redesigning the SGR and DME is a necessity but is not an easy fix. New administration has on their priority list health reform but its not clear where on the list it lies. Quick action on a kid's health care bill will probably occur since current legislation expires March 2009.

Rep. Stark supports a single payer system (Americare) for those uninsured similar to MC. Individuals who currently have health insurance through their employers will be able to keep this coverage.

It is widely known that fee schedules significantly vary and there is no stated reason for the discrepancies. Insurers due to proprietary information do not have to divulge fees publicly. It may be helpful for our elected officials to know what is actually occurring with fee schedule inequities. Obtaining this information may be helpful as new health policy is being formulated. (Developing a spreadsheet with fees identifying MC and private insurers can be done if the private insurers are not named publicly.)

Many questions were fielded during the Q&A regarding reform of physician fees, regulation of health insurers, CMS reform, etc.

Views Across the Chasm: Clinicians and Health Insurers: Charles Medani, MD, (Pediatric Nephrologist) CareFirst Blue Cross Blue Shield

Dr. Medani related the "deer-in the headlights" look he identified after he was with the insurance for a few months. He was talking to a group of physicians and saw the clear lack of understanding of what his jargon was referring to.

So many of the misunderstandings stem from a lack of understanding of what insurance companies do and why and how they do it. For profit insurance companies purposes are to maximize shareholder wealth.

How does an insurance company work?

Business jargon: Outside the box

Drill-down

Roll-up

Paradigm Shift

Off-line

Proactive

To Transition

Pinch Point

Insurance Company Jargon: Plan, Member, Provider

Health Insurance Products: Indemnity, HMO, PPO, Opt-out, POS

& more words: Product, Network, Par/Depar, Auth, Denial/Adverse Decision, Cosmetic, Experimental/Investigational, Not medically necessary.

Role of the Employer: Risk, Non-Risk(Self-insured)

Mandates: States legislate certain services that must be provided by the plan.

Contract rules over medical necessity except for mandates where they apply.

Revenues – Costs = Profit (Residuals in non-profits.)

One of the costs of doing business: MLR = Medical loss ratio = $\frac{\$ \text{ for Medical Care}}{\$ \text{ of Revenue}}$

CareFirst's MLR= 90% that means 10% is spent on administrative services.

Average MLR – 80-90%

Overview of a Health Plan: Operations, Finance, Sales & Marketing, Contracting & Provider Networks, Govt Affairs, Legal Affairs, Information Technology, Medical Mgt.

Why do Medical Mgt? Cost, Quality of care, Quality of providers, Ensuring reasonable decisions by plan, Certification, Avoiding unnecessary expenses, Fraud.

Medical Mgt: Preservice review, Utilization review, Case Mgt/Discharge planning, Appeals, Pharmacy, Quality improvement/NCQA, Credentialing, Medical Directors, Physician Consultants – local, national.

Community & Internal Committees: Quality advisory, Credentialing, Pharmacy & Therapeutics, Hospital Appeals, Technology assessment, Care Mgt, Medical Policy, Special Investigations.

Accreditation/Oversight of Insurers: State level, NCQA, URAC, CMS, Employers

Response of insurers to increasing cost: Care mgt, Disease mgt, Pay for Performance (P4P).

Recommendations:

Develop friendly relations with medical directors.

Discuss fee schedule concerns with network staff, not the medical director.

Q&A

28293 – Bunionectomy w/ implant. A trend with many private insurances has occurred with calling this code Investigational and Experimental. For 30 yrs Aetna had been paying for this code then they stopped based on I&E and then changed their minds reversing their I&E claim. This trend in deeming 1st MPJ implants I&E seems to have occurred within several insurances at the same time. Suspicion that there may be collusion on the part of these insurances.

Denials for supplemental supplies very often fall under contractual issues. Suggestion is to talk with medical director about these type of denials.

Recommendation: Identify that numbers that are being given to office staff for services are authorizations and not just tracking numbers.

New 2009 CPT Codes

CPT 64455 – Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g. Morton’s neuroma) Reimbursement should be similar to

CPT 64632 – Destruction by neurolytic agent; plantar common digital nerve.

The above code may be used 2-3 times at a 50% or > concentration. This is not considered the code for using 4-6% sclerosing agents.

For 4-6% sclerosing agent injections 64450 (Theurapeutic, nerve block) may be the code to use.

New ICD-9 codes

038.12 MRSA septicemia

041.12 MRSA in conditions classified elsewhere and of unspecified site

078.12 Plantar Wart

No reason to use following codes:

249.00-249.91 Secondary DM series

Ulcer series based on the National Pressure Ulcer Classification Scale. These new codes replace the generalized decubitus code. Anatomical ulcer codes are still to be used with non-pressure ulcerations.

Pressure ulcers should only be used for erosions strictly due to pressure.

707.20 Pressure ulcer, unspecified stage

707.21 “ stage I

707.22 “ stage II

707.23 “ stage III

707.24 “ stage IV

707.25 “ unstageable

729.90 Disorders of soft tissue, unspecified.

729.92 Nontraumatic hematoma of soft tissue

729.99 Other disorders of soft tissue

V02.53 Carrier or suspected carrier of MSSA

V02.54 Carrier or suspected carrier of MRSA

V12.04 Personal hx of MRSA

V13.51 Personal hx of pathologic Fx

V13.59 Personal hx of other musculoskel disorders

V15.51 Personal hx of traumatic Fx

V15.59 Personal hx of other injury

V46.3 Wheelchair dependence

BMAD Data for 2006 with prior years comparisons

Available on the APMA Members website

Data analyzed by Ken Malkin, DPM

1105- series NM is aberrant with increased percentage for 11057.

E-Prescribing: Mike King, DPM

What E-Prescribing should do?

- Electronic, accurate, error-free and understandable
- End of the year bonuses paid to those participating (Additional 2%) to those participating. Final rule on the bonuses due out on 11/15/08.
- Report with quality measure #125
- Formulary plus individual pt benefits accessible
- Pt medical hx and pharmacy record accessibility

After 2013, fee reductions for those providers not e-prescribing.

Estimated costs: Free - \$3000 to install necessary programs. Maintenance program costs \$80-400 per month. Obviously many unanswered questions exist.

Drawbacks:

- Controlled substances – how these will be handled is in question.
- Complacency – Pts may not be as aware of their polypharmacy.
- Lack of completeness – Does not include OTCs
- HIPPA compliance absolutely necessary.

APMA will be discussing with vendors of these programs once the regulations are known.

Learn more....www.LearnAboutEprescriptions.com

www.GetRxConnected.com

CMS website

Opting Out of MC: Frank Spinosa, DPM

WHAT: A 2- yr private contract

WHEN: 30 day advance notice to CMS by affidavit

WHY: No MC restrictions on pt care

WHO: MC beneficiaries, who remain protected by federal regulations and sign a Doc-pt contract

WHERE: All practice locations of the provider

How do I Opt-Out?

- Send CMS an affidavit stating your intentions at least 30 days prior to the requested “opt-out” date.
- Do Not complete CMS Form 855I for deactivation of your provider #. If you wish to return to the MC program when the 2 yr opt-out period ends you will be able to do so without re-applying for provider status.
- Consult a healthcare attorney.

May I bill MC for any txmt during the opt-out period? You may submit a bill to MC when txing a “true emergency”.

Can my pts submit their bill to MC? Yes they may submit and expect a rejection (code B7). The only time that this may be useful is when a secondary insurance may be involved.

What happens if my office forgets to have a MC pt sign the opt-out contract, or if the pt refuses to sign it? Federal regulations protect the pt. An Opt-out provider must not treat a pt who hasn't signed a contract, thus implying that they are not informed of their rights.

What are the penalties for opt-out violations? The provider will lose his/her opt-out status and will be precluded from treating any MC beneficiary. The provider is subject to fines of \$10,000 per violation.

Is opting out for you? Consider the demographics of your pt population. Opting out may be a viable option if you practice in a high income area or your practice is a “boutique” type.

RUC Updates – Frank Spinosa, DPM

RUC-HCPC (Health Care Professionals Advisory Committee)

- Lloyd Smith, DPM – RUC-HCPAC Co-chair & APMA Rep.
- Alt. APMA reps – Frank Spinosa, DPM, Robb Mothershed, DPM, Tim Tillo, DPM.

RUC is an AMA committee consisting of 28 specialty groups , one HCPAC rep, and 3 CMS reps.

Purpose: Value physician time & practice expense for any and all CPT codes. Meets 3X per year, plus a 4th time for 5 yr reviews.

Why is it difficult to have codes review? The history is when codes have been reviewed in the past the reevaluation of their reimbursements have always been lower. The example given was with bunion codes and the consensus from APMA is that bringing the concerns regarding the disparity in fees for bunion codes would open up “Pandora’s Box”.

CPT Update 2009 – Mike King, DPM
Continuation from earlier presentation.

New codes are not to be used until 1/1/09.

Neuroma coding - Will continue to be an area of confusion (anesthesia v. neurolysis v. steroid)

The new code 64455 should be incorporated into Trailblazer’s LCD. On-going discussion with the Trailblazer’s medical directors are happening to get further clarification on how to properly use this code.

On-going Workgroups in CPT:

- Excision and Debridement definitions
Could change 11040-44 series due to heavy abuse of -43 and -44. Could potentially have us using 97---- series for 11040 levels.
- Foreign Body definition
Does not appear to be changing a lot.

New Issues:

- Multi-layer compression dressings (could effect unna boots)
- Dermagraft – Vendor is pursuing a new code for there has been on-going reimbursement issues.

How to Deal with Payment and Recoupment Issues – Kelli Back, Esq.

Strategy Basics:

- Research the issue – Understand the scope of the problem and avoid jumping to conclusions.
- Determine your legal rights with regard to the issue
- In working with the plan – develop a strategy that appeals to what plans care about.
- Communicate with the correct people at the plan.
- If you escalate to policymakers, cast the issue in terms of public policy. Identifying that the consumer/public is being effected in an adverse way will be of interest to the DOI.

What plans care about:

- Meeting their legal obligations and meeting their contractual obligations to their clients.
- The bottom line – saving money.
- Attracting and retaining members and groups.

What laws apply?

Medicaid – State/Federal

Medicare – Federal

Military – Federal

Direct Purchase – State

Uninsured – State

Employer Plans – ERISA

- Insured are regulated by state and federal law – if it is in the insurance code, it probably applies.
- Self insured are regulated by federal law.
- How am I supposed to know? In firms with 5,000 or more employees, 89% of workers were covered by self-insured arrangements in 2006. Performing a google search can be helpful in finding out or calling the plan administrator.

Recoupments – Common Reasons

- Overpayment
- Retroactive denial (Individual was not eligible; Service was not covered.)
- Miscoordination of benefits – it was subsequently determined that another payor was responsible.

You get the letter asking for money back, what next? Be sure you have enough information to evaluate their claim that you owe money – if not ask for additional information. REVIEW your contract and understand what your rights are.

Contractual provisions to be aware of:

- Did they reserve the right to do recoupments?
- Do they have the right to offset the amount against future payments?
- Is there an appeal mechanism specified, and if so, does it include timelines?

Is there any applicable law regulating recoupments?

- Determine what law is applicable (Federal, state, program-specific)
Laws regarding retroactive denials and other recoupments are frequently found in the section of the state code that sets forth prompt-payment laws, laws concerning unfair or fair insurance practices, or claims settlement rules.

Issues commonly addressed by the law:

- Prohibition on retroactive denials for preauthorized services.
- Timelines for recoupments or retroactive denials.
- The information that a health plan must furnish if it requests a recoupment.
- Whether an offset is allowed and, if so, whether an appeal must be allowed.

Are there other issues to consider?

- If the recoupment is due to the fact the beneficiary was not “eligible” for coverage, you can bill the beneficiary.
- If the recoupment is the result of a payor coordination issue, is it timely enough that you can receive the funds from the other payor?
- Does the recoupment affect the amount you should have received as pt cost sharing?

Next steps:

- If there is an available appeal process, file an appeal.
- Write a letter to the plan citing any contractual provisions and laws that you believe are violated by the recoupment. If the recoupment changes the amount you should have collected in cost sharing, note your intent to collect the additional funds.
- Call the plan and ask to discuss the issue with either the head of claims or provider relations.
- Using a multi-prong approach with increase the chances that your concerns will reach someone who cares and someone in a positions to address the situation.
- Keep records of your correspondence on the people you speak with.

Escalating the issue:

- If it appears that you can't come to agreement with the plan and you fee that escalation is appropriate contact the agency in charge of enforcing the relevant law. Provide concise facts regarding the issue. Provide history of your efforts to resolve it and to the extent possible, cast the issue in terms of public policy.

Experimental and Investigational (E&I) Coverage Exclusions:

- Private plans typically cover only items and services that are medically necessary and appropriate.
- Plans typically exclude coverage for services that are E&I. Confusion arises because plans may be imprecise in how they categorize denials based on such exclusions.
- Private plans generally have complete discretion to define and interpret what they consider E&I.
- Some states have laws requiring insurers to disclose their criteria for determining what is E&I, but do not impose requirements regarding the plans definition.
- There is a broad range of plan definitions of what is E&I. FDA approval is generally only one criteria used by plans. There is no obligation for private plans to cover all FDA approved items and services and few do.
- Medicare Advantage plans must cover at leas the same benefits as MC – that is they must generally follow local and national coverage decisions.

- Plans such as Aetna and Cigna which act as both insurers and administrators of employee benefit plans have different definitions depending on the group.

State External Appeals

- 44 states and the D.C. have laws that provide for external, independent review of health plan decisions.
- Physicians in some states may be able to request external reviews or in some states the beneficiary/patient has to request the review.
- The internal plan appeals process before being able to request an external appeal.

Strategies to combat E&I denials:

- Work in unison to compile a library of data. It doesn't always work with the plan, but it can be persuasive to an external reviewer or potential advocacy partner.
- Determine whether you have allies. Patients and employers can potentially be allies on coverage-type issues. Plans listen to their customers.
- Escalate the issue by contact the agency in charge of enforcing the relevant law.

Q&A:

Are there lawsuits giving precedent to services that had been covered but are kicked over to E&I status? Yes – autologous bone cases exist but so far cases have been disappointing in changing the E&I status.

Legal Issues: Coverage, Billing and Documentation:

Susan Turner, Esq. and Lisa Stevenson, DPM, Esq. , Ober, Kaler, Grimes and Shriver.(40 attorney health care group)

Documentation:

1. Rule of thumb – if you didn't write it down, it didn't happen.
For every service billed, indicate the specific sign, symptom or complaint necessitating that service.
2. Utilize an addendum rather than squeezing information between lines.
3. For late entries, record the current date and start the note with "LATE ENTRY" followed by recording the appropriate additions and/or clarifying statements and ending with signature.

What are you certifying when you submit a claim?

- Services or supplies were provided as billed.
- Services or supplies were medically necessity.
- Services meet standard of care.

False Claims Act: Health care prosecutions is the #1 area where claims are being filed. OIG pays back our Govt for each dollar found to be false \$23 and OIG has not reneged on their promise to do so.

- Prohibits filing or causing to be filed false or fraudulent claims.
- Intent: Known or should have known. Knowing includes: Actual knowledge; Deliberate ignorance and reckless disregard of their truth or falsity.
- "Intent to defraud" is not required.

- Examples:
 1. Billing for services not provided.
 2. Billing for substandard medical care.
 3. Billing for higher level of service than actually provided (upcoding).
 4. Utilizing a lower fee schedule for MC/MCD than non-MCMCD pts.
Presenters recommended that one fee schedule be used.
 5. Splitting of surgical procedures on multiple claims to get greater reimbursement.
- Liability: 3 X damages or \$5500 to \$11000 per claim.
 - HC provider - \$100000 damages X 3 = \$300,000
 - 2000 (# of claims) x \$11000 = \$22000.00
 - Total Liability = \$223000.00

Other Penalties:

- Administrative remedies imposed by OIG.
- Exclusion from participation in all federal health care programs.

Anti-Kickback Statute

Criminal offense to knowingly & willfully solicit or receive or offer or payment of remuneration.

Transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

This is extremely broad and our govt immediately identified that the above would shut our health care system down.

Acceptable or Prohibited?

- Hospital paying private practice physician for referrals. NO
- Clinic renting space to practitioner and waiving rent for 3 months – NO
(This might be a yes if a deferral of rent is given.)
- Pharmacy rep providing lunch for office staff – NO
- Medical supply company paying airfare for practitioner to attend healthcare conference - Yes

Statutory Exceptions:

- Bona fide employment relationships
- Certain copayment waivers
- Certain managed care arrangements\
- Discounts

Regulatory Safe Harbors:

- Certain Joint Ventures
- Personal Services
- Space rental

Penalties:

- Criminal fines & imprisonment:
 - Up to 25K in fines
 - Up to 5 yrs in prison

Civil money penalty of \$50000 plus 3X the amount solicited, offered, paid or received.

Exclusion from federal health care programs.

Stark Self referral Ban

Physician may not refer MC/MCD pts for “designated health services” to an entity with which the physician or an immediate family member has a “financial relationship”.

Designated Health Services:

PT Prosthetics Clinical labs Orthotics

OT Outpt drugs DME & Supplies Hospital Services

PEN Radiology Home Health Radiation Oncology

Financial relationship = Ownership interest or Compensation arrangement

Does not prohibit doctor from having a financial relationship with an entity, but can not refer a pt to that entity and bill for that service unless it meets an exception.

General exceptions:

- In-Office ancillary services
- Physician Services
- Services by Federally-Qualified HMO or prepaid HP w/ MC contract.
- Regulatory exceptions where no “risk of program or patient abuse”.

Stark Exceptions:

Ownership Exceptions-

- Publicly held companies with equity exceeding \$75,000.00
- Rural providers
- Ownership of hospital as a whole (Admitting privileges required).

Compensation Exceptions-

- Rental of office space
- Bona fide employment
- Personal Services exception
- Certain physician incentive plans
- Hospital remuneration unrelated to DHS
- Certain physician recruitment incentives
- Isolated transactions
- Payments by physicians

Regulatory Exceptions-

- Academic Medical Ctrs. (Phase I)
- Services furnished under certain payment rates (PhaseII)
- Implants in an ASC (Phase I)
- Fair market value exception (Phase I)
- Non-monetary compensation up to \$300 and medical staff incidental benefits (Phase I)
- Risk-sharing arrangements
- Compliance training
- Anti-kickback safe harbors
- Professional courtesy
- Charitable donations by a physician
- Preventative screening tests, immunizations and vaccines

- EPO and other dialysis-related OP Rx drugs furnished in or by an ESRD.
- Intra-family rural area referrals
- Certain arrangements involving temporary noncompliance
- Retention payents in underserved areas
- Community –wide health information systems.

Stark Sanctions:

- Denial of payment
- Refund of amounts collected as a result of improper billing
- Civil money penalties of \$15000 per item/claim plus 2X the amount claimed.
- Civil money penalties of \$100,000 for “circumvention schemes”.
- Exclusion
- False Claims Act Liability?

Auditing/Medical Reviews

RECOMMENDATIONS:

Every office should have an internal compliance program such as an internal audit process.

Prospective review audits on claims being submitted:

- Pull claims before they are submitted and review them.
- No overpayment.
- Negative impact on revenue-claims held until review complete.
- Not always possible-issue discovered after claims submitted.

Retrospective reviews:

- Pull claims after they have been submitted and review them.
- Potential overpayment.
- No initial impact on revenue-claims submitted before review complete.

Repayment obligations – To Whom?

Payor – MC carrier

- Routine overpayments – honest mistakes.

OIG voluntary disclosure programs

- Contacting OIG with identified problem before the OIG contacts you !

Be careful offsetting overpayments and underpayments. If the offsetting is agreed upon by payor, document and it can be acceptable.

Don't forget about refunding patients copays and deductibles.

Important to have - Claims Tracking Process

Maintain a claims denial log:

- DOS
- Ticket or claim number
- CPT, HCPCS, modifier, and/or ICD-9 code
- Specific reason for denial
- Disposition of claim (rebilled, charge adjusted, physician query)

- Provider name or identifying number
- Dollar amount of denial
- Analyze and prepare a report summarizing claims denial information – include action steps to reduce identified denials.
- Share report with key staff decision-makers.

Education/Training Efforts

- Denial trends can identify areas where additional education and training is needed.
- Effective education and training is key to reducing future denials.
- Ongoing process

Follow-up Reviews:

- Claims denial mgt and compliance should work together to ensure that potential problems are resolved.
- Identify false claims intent.

What to do if an investigator arrives:

Before Visit even occurs –

- Designate one or more employees to have the responsibility to respond to investigators' inquiries.
- Establish a process to secure the immediate assistance of competent counsel, who specializes in responding to govt and law enforcement inquiries and investigations.

When Investigator arrives:

- Request appropriate identification from the investigator.
- Investigator should be referred to designated employee who is readily available.
- Immediately contact counsel. Access to premises or records should be coordinated through counsel.
- Make note of the following –
 1. Any documents requested by the investigator.
 2. Any individuals approached or asked questions by the investigator.
 3. Any location accessed by the investigator.
 4. Any and all statements and observations made by the investigator.

The presenters have available from their practice 2 e-mail newsletters – Payment Matters and Health Law Review. E-mail to be placed on their mailing list: saturner@ober.com

EMR – Paul Kinberg, DPM

Legal Issues:

- Vicarious liability (design flaw or other problems)
- Privacy Violations
- Acts of Commission (i.e. turning off computer warning systems)
- Acts of Omission (failure to use computer systems to help in diagnosis and/or txmt.)

Special EMR Legal Issues:

- Federal rules – all electronically stored data equally discoverable.
- Other items can be obtained if used (i.e. e-mails and instant messaging, peer-to-peer communications, voicemail)
- Identity theft – protect PHI.

EMR system requirements:

- Accurately documents services rendered to pt.
 - Provide outcomes mgt for peer review, quality and utilization review.
 - Reimbursement tracking.
 - Tracking record of all viewing, charting, editing or record so that audit can be made.
 - Lock completed record but allows addendums.
 - “Prompt” physicians to discuss certain information.
 - Remind physicians to review clinical alerts.
 - Document effectiveness of care to justify future clinical decisions made or not made.
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EMR/EHR : Jon Hultman, DPM

Predictable Failures:

1. All physicians have to be on board in practice.
2. EMR is only one piece of the puzzle. Patient – EMR – and Practice Mgt must be fully integrated and work as one seamless system.
3. Time involved to document is increased over “old” systems.
4. High price of systems.

Learning Curve:

- Over 300 EMR software programs available.
- 51 CCHIT certified ambulatory products as of 2007.

Establish “The Goal” – Begin with the end in mind.”

- Is your goal dictation replacement?
- Is your goal to write E-prescriptions?
- Is your goal to eliminate filing and chart movement?
- Is your goal to reduce paperwork beyond charting?
- Is our goal digital x-rays?
- Plus++++
Increased volume, efficiency, productivity, quality, pt satisfaction, profitability, EBM, error prevention, P4P, etc.

System requirements:

- Touch screen
- Mouse
- Keyboard
- Voice activation
- Macros
- Wireless
- Digital photos
- E/M checker
- PDR
- Scanning
- ASP (Internet) or in-house server
- Integrated database (EMR & PM)
- Searchable database (EBM)
- Number of hours and type of training provided
- Efficient, logical workflow

- Vendor relationship and quality of support
- Level of physician commitment
- Ability to prevent errors and track care
- Costs: out of pocket, opportunity, time and ROI.

Need for Certification :

The risk of purchasing a product that does not meet the provider's needs is one of the major barriers to widespread adoption of EHRs. Private sector certification processes would minimize this risk by assuring that the certified products meet specific criteria for functionality, security, and interoperability. As such, this process would not only protect the clinician purchaser, but would also allow the federal govt.

CCHIT:

The Certification Commission for Healthcare Information Technology or CCHIT is a recognized certification body for electronic health records and their networks, and an independent, voluntary, private-sector initiative. Their mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program.

EMR vs EHR

- The principal difference is the ability to exchange info interoperably.
 - An EMR aligns with the prevailing state of electronic records today (whether the record is branded an EMR or EHR).
 - Eventually the term EMR will be retired when the information will be exchanged interoperably.
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Medicare Advantage Program: Marty Ablen, Team Leader CMS, CPC, MCAG

MA plan types(MC Part C): Plans are capitated and receive monthly payments that will vary.

- HMO
- PPO
- Private fee for service (PFFS)
- Special need plans(SNP)
- MC Medical Savings Account (MSA)

Who can join MA plans?

Eligibility requirements:

- Live in service area
- Have MC Part A & B.
- Not have ESRD at time of enrollment.

When can eligible beneficiaries enroll in MA plans?

- MC beneficiaries can join a MC C plan when first eligible for MC and during specific enrollment periods.

When can beneficiaries change MA plans?

- Annual election period
- Open enrollment periods – 1st quarter of the year.

How do MA plans work for members?

- Get MC-covered services through the plan
- Can include Rx drug coverage

- May have to see certain doctors or go to certain hospitals to get care.
- Benefits and cost-sharing may be different than in original MC.

In MA plans beneficiaries are:

- Still in MC program
- Still have rights and protections
- Still get regular MC-covered services
- May get extra benefits such as vision, hearing, dental care.
- May be able to get Rx drug coverage.

Out-of-pocket Costs for benies:

- Generally must still pay Part B premiums
- May pay additional monthly premiums.
- Pay other out-of-pocket costs – varies by plan.

Relationship to Part D Rx Drug plans:

- Most MA plans offer at least one MA plan w/ Rx plan in its service area.
- MA plans offering a Rx drug plan (MA-PDs) follow all of the Part D requirements.

How does MA differ from traditional MC?

Physicians and others providing services are paid according to the contract they have with the MA contractor.

Non-contracted providers can provide services on a non-emergency basis may or may not get paid for services and these services should be billed at MC fees.

Medigap plan cannot be used with an MA plan. It supplements original MC benefits only. It is illegal to sell someone already in an MA plan a Medigap plan.

MA Numbers: 3495 plans exist
 9,760,000 beneficiaries
11.6 million estimated for 2009.

Determining that a beneficiary is enrolled in a MA plan – the presenter will be investigating access to a CWS website.

A third party contractor will be in place in 2009 to deal with provider/beneficiaries-MA disputes. Providers and/or beneficiaries would have to exhaust the appeal process with the MA plan before pursuing the third party appeal. First Coast is the contractor.

Resources for MA plans:

www.cms.hhs.gov/manuals
www.cms.hhs.gov/managedcaremarketing
www.cms.hhs.gov/healthplansgeninfo/

Break-out CAC session:

There is a draft Nail policy that is being reviewed with APMA's assistance. Harry Goldsmith is initiating acquiring a resource of all the LCDs on foot care in hopes that some standardization may be possible. This resource is hopefully going to evolve into other LCDs such as injections.