

## **CAC-PIAC Meeting – November 12-13, 2010**

**Special thanks to Janet Simon, DPM, of New Mexico who compiled these notes for us. If you wish to see the complete presentations for these topics, visit the members APMA web site.**

### **A MC Policy Update: Key Issues. Henry Desmarais, MD, MPA**

Principal, Health Policy Alternatives (APMA's major health policy consultant)

#### “New” CMS Leadership :

Donald Berwick, MD, MPP – Activist talking about Triple Aim:” Better care; Better health; lower cost.” Things will not be the same. Berwick doesn't like acronyms and is changing many that physicians are familiar with. (PQRI > PQRS)

#### Physician Fee Schedule Update: Current to 11/30/10 – conversion factor \$36.87

Effective 12/1/10 – w/out congressional intervention \$28.39 (-25.8%)

CY 2011 with final rule published – 11/4/10:

- rebased MC Economic Index – impact on podiatry +1%.
- Decreased reimbursement for multiple PT/OT services (decreased by 25% for 2<sup>nd</sup> procedure)
- Many other changes in work and practice expense values; combined impact on podiatry: +3% in 2011, +6% longer-term
- Two new G-codes for application of tissue cultured skin substitutes to LE both with zero day globals.

#### Delivery System Reforms:

CMS Innovation (CMI, CMMI): Responsible for MC demonstration projects

-\$10 billion in new funding provides a very different context than the required budget neutrality of traditional projects.

- Wide arms to “try anything”

#### Accountable Care Orgs (ACO):

What are they? Org of providers that agrees to be accountable for the quality, cost and overall care of MC beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it. Assignments will be “invisible to the beneficiary and will not affect their guaranteed benefits or choice of doctor.

What forms of orgs may become an ACO?

- large groups
- networks of practices
- partnerships or joint venture arrangements between hospitals and physicians
- Other forms???

What are ACO requirements?

- legal structure to share savings
- Primary care providers need minimum of 5000 MC beneficiaries
- agree to participate for 3 yrs

What are payment models?

- Fee-for-service (Probably be initial model to get this off the ground in 2012)
- Partial capitation model
- Other forms???

Other ACO Issues?

- Methodology of knowing how pts have been assigned.

-ACO professional designated as MD, DO, PA, NP or clinical nurse specialist (What might this mean for other health professionals such as DPM, OD, PT ? – Answer lies in regulatory language.) Speaker responded to question about why this designation came about: “Congress was focused on primary care providers thus podiatry was not included. There also was concern that non-primary care providers would be able to form ACOs.”

#### Another System Reform: Bundling Payment System for 10 Dx Codes

- Voluntary 5 yr pilot program
- Single payment for 10 chronic care dxs starting with in-pt admission and then for 30 days.

#### E-Prescribe: G5503 will continue to be code to be used in 2011.

- More penalties in 2012 to be decided in first 6-months of 2011. (To be successful, must have 10 e-prescribe events in 6 months. Exemption from penalty if physician does not finish at least 100 of the 56 E/M codes that are the denominator codes.
- Hardship exemptions will be available.

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#### **HIT: Health Information Technology. Michael Brody, DPM and James Christina, DPM**

(Presentations on CD as well as in Webinar on APMA Website)

Meaningful Use: Defined by CMS to further communication between health care professionals and the patient.

- Priorities:
- Pt Engagement
  - Reduction of Disparities
  - Improved Safety
  - Increased efficacy
  - Coordination of Care
  - Improved population health

#### **DPMs are not included in the group for MCD incentives (Surprise, Surprise !).**

Use of EMR for 6 months need to be demonstrated in 2011 or 2012 for MC incentives. (75% of all Part B fees up to maximum listed- to get \$18,000 for year 1 \$24000 must be billed). See pg 9 Christina’s presentation.

To get bonus providers need to be:

- Enrolled in MC
- Have NPI
- Use certified A EMR : Program needs to be certified by one of 3 recognized entities.
- Will need to register on-line (not set-up yet pending 1/1/11).
  - April 2011 – Attestation for MC HER incentive program begins. May 2011 incentive programs begin.
- More Info : [www.cms.gov/EHRincentivePrograms](http://www.cms.gov/EHRincentivePrograms)

**2009 reporting of PRQI reimbursements were mailed in Oct 2010. CMS has on-line “Help” resource if payments were not received and are expected.**

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#### **Regulatory Issues for Podiatry: RAC and other ABC Audits; HIPAA;**

**OIG Work Plan; Stark and New Tools.**

**Howard Sollins, Esq. and Paul Kim, JD, MPH**

OBER/KALER

[www.OBER.com](http://www.OBER.com) – Many newsletters available

MCD Integrity Contractors (MIC):

Review MIC

Audit MIC

Education MIC

MCD Fraud, Waste & Abuse (FWA) – not much activity.

Look back period varies by State

No record request limitation, No photocopying reimbursement

Recovery Audit Contractors (RACs)

4 RACs

Overpayments & underpayments

About 12% contingency fee unless overturned

3 yr look-back period effective 10/01/07

10% of average monthly claim volume with maximum of 200 records per TIN q45 days

Photocopying reimbursement

Zone Program Integrity Contractors (ZPICs)

Program Safeguard Contractors (PSCs)

MC FWA

Up to 4 yr look-back period

No record request limitation but records must be submitted within 30 days.

No photocopying reimbursement

MC Appeal Process:

2010 Final Rule –“MACs are less likely to talk with folks about problems since this appeals process is in place.”

Discussion/Rebuttal: Available

Not part of claims appeal process

Discussion period with RAC: Up to 40 days for this discussion to occur.

Rebuttal period available with MAC within 15 days (“Utter waste of time.”)

Redetermination: “Almost always unsuccessful.”

Local MAC. 120 days to request. 60 days for decision

Reconsideration: 2<sup>nd</sup> stage of appeal

Qualified Independent Contractor (QIC): MAXIMUS Federal Service

180 days to request. 60 days for decision

Early and full presentation of evidence as well as new evidence

Paginated medical records

Escalation for delay

Administrative Law Judge (ALJ) Hearing: 3<sup>rd</sup> Level

Office of MC hearings & Appeals (OMHA): Arlington, VA

60 days to request

In-person hearing

Videoteleconference

Amount in controversy (AIC) = >\$120

Certificate of service

What to present at hearing?

CV of witnesses

Independent experts  
CMS or contractor participation- Limited Role  
ALJ request  
10 days notice  
MAC/DAB: 4<sup>th</sup> level  
Request for review  
60 days for request  
90 days for decision

Use templates for ALL APEALS:

Required data elements  
Allegations  
MC Requirements  
Clinical summary  
Rebuttal of each allegation  
-each with page references

Recoupment:

Redetermination request – Appeal request within 30 days  
Begins within 41<sup>st</sup> of after recoupment demand

Reconsideration – Begins 60 days after redetermination unless appealed.

Interest is earned on amounts in question to be recouped – not on any amounts that may be repaid by provider.

HIPAA – Business Associate Agreements

Tip: Establish a log monitoring system

BAA agreement is needed with medical device vendors (eg: VAC, Bone stimulators, Orthotic labs that make orthotics).

Fraud Enforcement and Recovery Act (FERA) of 2009 – Increased False Claims Act (FCA) scope

FERA expands obligation for overpayments. Now with PPACA 60 days to disclose.

In office Ancillary services -

New CMS Compliance Tool – On-line newsletter

[www.cms.hhs.gov/MLNProducts/downloads/MedQTRLYcomp](http://www.cms.hhs.gov/MLNProducts/downloads/MedQTRLYcomp) newsletter

OIG New Initiatives – Reviewing E/M codes.

Dx Testing  
GA/GY modifiers  
E/M during global surgery periods  
POS errors – Assisted Living facilities  
Excluded Providers  
MC payments for lower limb prostheses

Self Disclosure Protocol

Purpose is to resolve actual or potential violations of the physician self-referral law

Disclosure must be made in good faith

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## **MC Enrollment Issues: Avoid Risk of Nonpayment**

**Donna Senft, PT, JD OBER/KALER**

www.OBER.com

[www.Medicareforgeeks.com](http://www.Medicareforgeeks.com)

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Tip: Respond to ALL correspondences.

PECOS=Provider Enrollment, Chain, and Ownership system (Software)

Effective 6/2006 Sanctions for failing to provide timely updates. (CMS 855 Forms for change of address, etc)

Effective 8/2008: Implemented a one to 3 yr bar to MC reenrollment following a revocation.

Effective 1/2009: Changes Overpayment reporting relating to not keeping enrollment reporting current.

**Revalidation is required every 5 yrs.**

### DMEPOS Standards

9/27/10: New and revised DMEPOS supplier standards.

Operational practice location that is a minimum of 200 sq feet.

Permanent, durable sign visible at the main entrance that identifies the DMEPOS supplier. (3 yr phase-in; hrs of operation posted)

### MC Enrollment Forms

Leave no blanks – simply write N/A

Use Middle initial of name

Must match IRS data

CMS 855 form should be completed by military and providers who can refer for services but not bill for these services (i.e. medical students, residents).

### Ordering/Referring Requirement:

Labs, DMEPOS and HHCN claims will process with message that referring provider is not found in PECOS or have validly opted out. Phase 2 – claims will not be paid in future. Opt out information is maintained by MAC.

**Deactivate your MC number if you are retiring or not to be billing MC services.**

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## **Health Care Reform: What It Means to Employers and the Private Insurance Marketplace.**

**Eileen Quenell**, Health & Group Benefits Practice Leader, Towers Watson

### PPACA implementation-

Immediate coverage mandates:

Cover adult children to age 26 unless eligible for another employer's plan

Remove lifetime dollar limits

No preexisting condition exclusions for children under age 19

Eliminate rescission of coverage provisions

Introduce new grievance and appeals procedures

Prohibit salary discrimination

Cover preventive health services without cost-sharing

2014 -Increases HIPAA limit on financial incentives to 50%.

2014 - Pay or Play Mandate (>50 employees) – Employers will need to provide coverage at 30 hrs per week. Tax credit is available for these mandates (Reimburses 50% of employee coverage with an income limit of \$70,000.)

2018 – Excise tax on high-cost group health coverage exceeding specified thresholds. Vision and dental benefits are excluded but FSA/HSA are included.

Essential Health Benefits – PPACA does not require group health plans to cover essential health benefits.

Group health plans in existence when PPACA was enacted can be grandfathered but due to need to comply with PPACA most plans will not try to be grandfathered.

#### Impact on Insurers

Potential for 59 million new insureds raises the potential for huge profits despite the uncertainty of loss ratios under PPACA, but should lead to innovation in plan and network architecture (ACO, Tiered Networks).

State funding, or starvation, of exchanges will significantly impact the landscape.

Loss of underwriting, pre-existing conditions and lifetime maximums will create pressures on risk-ceding.

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#### **Vision 2015 Updates – Frank Spinosa, DPM, BOT APMA**

##### Competencies – Accomplished

All podiatric colleges have established a set of competencies to be used to evaluate graduates.

Residencies will all be 3 yr programs.

The unification of ABPS & ABPOPPM is not a requirement but the two have agreed to discern areas of commonality between them.

##### Health Care Community – On-going

Continued contacts with AACPM/AACM

##### State and Federal Recognition – on-going

Uniform practice act has been formulated.

State and Federal Legislative initiatives – Stay tuned for Faye’s report.

##### Podiatry College Applicants –

1. Manpower survey completed.
  2. Recruitment – on-going
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#### **RUC (Relative Update Committee) – Seth Rubenstein, DPM BOT APMA**

Reviews CPT codes and their reimbursements.

Surveys needing to be completed. (18 codes were surveyed.)

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#### **Legislative Updates – Faye Frankfort, APMA Legislative Director**

##### Overview of Key Issues:

MC Fee schedule – Nov. 30<sup>th</sup> cuts are scheduled. **No long term fix will occur.**

Nov. 17<sup>th</sup> National Call in for AMA. DPMs should try to call prior to Nov 17<sup>th</sup>.

##### Inclusion and Parity in MCD Parity-

Lost primary Senate sponsor ( Bunning D-KY)

Lost primary House sponsor (Castle, R-DE)

Lost Republican support during 111<sup>th</sup> Congress – Push back due to concerns of cost.

112<sup>th</sup> Congress – Advantages

Key Republican supporter elected to Senate.

Impact of Healthcare Reform

AMA will be submitting resolution in their HOD opposing Provider non-discrimination.

VA Parity

Malpractice Reform

Antitrust

And more..... Red Flag Rule; Truth & Transparency

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### **State Advocacy – Chad Appel, JD, APMA**

MCD – 41 states included

Scope of practice – 44 states plus DC allowed to treat ankle and above

Model Fee Parity Law (Available soon)

Hospital Privileging and Credentialing Resource Guide

Building relationships...state medical societies; legislators

Each member should know who their state legislators are.

[www.apma.org/stateadvocacy](http://www.apma.org/stateadvocacy)

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### **The Future of Reimbursement. Jon Hultman, DPM, MBA**

Proactive vs Reactive

1. Future contracts and pay-for-quality
2. Healthcare Reform
3. MCD
4. Health Insurance Exchanges
5. Union Health plans
6. MC
7. Private Insurance & Workers' Compensation

What can Assn's do? Convince members that change is going to occur.

Focus resources on parity:

Scope/physician (r1) definition

Reimbursement/parity "plus"

Inefficiencies (internal and external)

Txmt Variation

Physician Strategy – Join or build a group practice model

Employment opportunities:

Each employed Primary care physician removes 2000 pts from private practice pool.

Military

Academic Medicine and Research

Kaiser

VA

Group Practice

Hospitals

Mgt Positions

### Solo Models:

- Concierge
- Cash
- Niche
- Micro-practice
- Last 3-5 yrs of practice

### Group Practice –integrated financially and clinically

- Single specialty practice / networks of smaller practices  
(Messenger Model is available for a non-integrated network of practices.)
- Multispecialty
- ACOs

### Making practice more efficient :

- Identify the bottlenecks and reengineer these areas for better flow.
- Decrease error occurrences
- Reduce staffing ratios (Hultman’s UCLA practice was 1.7:1)

### Payers Contracts

- Efficiency and size
- Pay for quality and value delivered (data and EBM)
- Pt satisfaction
- Pt access
- Bundled payments
- Capitation (partial and full)
- Transparency

### Union Health Plans

- Access to plans

MCD – Will add 16 million enrollees due to PPACA.

Health Insurance Exchanges – Will develop as players in the future.

MC- SGR formula will need to change.

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### **The RBRVS and the AMA/RUC Process**

Frank Spinosa, DPM reviewed the slides provided by AMA with a phone conferenced representative from AMA.

As codes are reviewed updated procedures may very well be lower in value than similar codes (i.e. Chevron/Austin 28296 is now valued lower than McBride 28292).

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### **PIAC Issues. Laura Pickard, DPM, Chair, Health Systems Committee**

Outreach to Private Insurances June 2009- Introductory “at best”.

Letters sent out to insurances about “Major” problems-

1. Fee discrimination – ancillary fee schedules  
Insurances have multiple fees schedules and members are accepting lower fee schedules.

2. Orthotic policies
3. Frequent MC audits –“Multiple ICDs linked to CPT have lower audit frequency.”

APMA met with Humana June 2010.

“ “ met w/Wellpoint via webinar.  
Cigna/ Aetna –pending meetings

Current legal actions:

Lawsuit with Healthnet in Connecticut.

EBM Studies:

Insurances do not wish to review studies with fewer than 75 pts.

CPAC is conducting orthotic double-blind study.

Questions were asked about continuing denial of services that were prior authorized. Some insurance contracts do have “hold harmless clauses” thus pts are not able to be billed. Other contracts may allow non-reimbursed services to be billed to pt.

### **On-line Private Resource Insurance Manual for APMA Members.**

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### **Health Policy Committee Updates. Mark Block, DPM Chair HPC**

97597-- codes for selective debridements will be replacing the 11040/11041. No CCI edits exist with E/M. See below under CPT report for additional coding changes.

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### **Private Insurance Hot Topic: MC Advantage Plans**

**Kelli Back, Esq.** /Law Offices of Mark S. Joffe

573 MC Advantage (MAO or Part C) contracts exist in the USA.

Employers are looking to decrease costs with MC Advantage plans for their retirees.

MAOs are licensed under state laws. Laws regulating plans are preempted, for example prompt payment, recoupment or external appeal laws.

Types of MAOs: Coordinated Care plan (HMOs, Local PPO and regional PPO) vs Other plans (MSAs -only 2 of these exist or Private Fee For Service plans)

Special Needs Plans (SNPs):

Coordinate care plans that limit enrollment to either dual eligibles, institutionalized, chronic conditions. Must file and follow a model of care.

What are MAOs coverage obligations?

Must cover at least those benefits under Part A and B.

Must offer an optional Part D benefit.

Must comply with NCD and LCDs

Must cover options advertised in their bids

Type of participation status/Source of rights-obligations

In-Network/Law and written contract

Out-Network/Law

Deemed provider: Providers who furnish non-emergency services to PFFS members who do not have a written agreement with the plan. Obligations only extend to that DOS. / Law and plan's "terms and conditions"

Contracted Providers are required to:

- A hold harmless clause:

- Record retention and govt. audit and inspection requirements (10 yrs)

- A confidentiality term

- A Prompt payment term that is negotiated by the org and provider.

- Term requiring the provider to comply with the MAOs policies and procedures.

MAOs are prohibited from interfering with a health care professional's advice or pt advocacy, as long as acting within the scope of literature.

MAOs have antidiscrimination language but this does not prohibit using different reimbursement amounts for different specialities or for different amounts for same specialities.

Does not prohibit an MAI from refusing to grant participation to health care professionals in excess of the number needed or from implementing measures to control quality and control costs.

A few other rights are extended to "physicians" and DPMs have been considered under this definition:

- Right to appeal adverse network participation decisions to a panel with a majority of peers.

- There are limitations on physician incentive arrangements.

Physicians have the right to request an expedited organization determination or appeal. (Requests for expedited determination needs to be made within 72 hrs.)

- MAOs must have physician input into their medical policy, quality improvement.

Non-contracted Providers:

- HMOs must cover emergency and UC services furnished by non-contract providers without PA.

- PPOs must allow beneficiaries to receive covered services from any MC eligible provider without PA.

Although PA may not be required, a non-contract provider may voluntarily request an organization determination.

- MAOs must pay non-contract providers what they would have received under MC FFS.

- Non-contract providers are prohibited from "balanced billing" the pt.

Disputes for non-contracted providers:

- Contact MAO first.

- If service is not paid by MAO, non-contracted providers can bill pt or ask for appeal.

- ABNs do not apply to MAO although the organizations will argue this point.

If appeal is not resolved within 30 days, provider may ask for a decision through CMS Resolution Contractor First Coast Service options Inc (FCSO) that must be received within 180 days. ([www.fcsso.com](http://www.fcsso.com)) then follow links to "What we do". Decision must be made in 60 days.

Kelli: "If the MAO gives a PA, that should be "binding". A redetermination, however, can be done."

MAO Audits: RADV – Risk Adjustment Data Validation required by CMS.

Why? Capturing all diagnoses with accuracy. Diagnoses are supported by medical records.

The risk adjustment is based on hierarchical categories – more dxs, increased risk, higher payments.

If you are a non-contracted provider, you are not arguably not obligated to allow MAO to audit your records. You may want to agree to an audit, but could ask for reasonable compensation and that the timing of the audit should be convenient for the provider.

What's next for the MAOs?

- Payment cuts in some areas.

Pressure to improve quality  
Imposition of Medical Loss Ratio

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## **Reviewing Provider Contracts - Panel**

**Kelli Back, Esq./ Jon Hultman, DPM / Mike Tritto, DPM**

Contract Clauses that Come Back to Bite You:

### **Payment**

The plan should provide: **A fee schedule**

\*If fee schedule is not provided, you should submit a list of your most frequent repricing or secondary networks.

Any coding and bundling procedures or methodology

Info sufficient to understand any bonuses or risks.

### **Scope of participation (Secondary or rental networks)**

Determine to whom you are agreeing to provide discounted services. The contract may say that you are obligated to provide services to members of the PPO or that you provide services for all payors or members of payors.

Read all related definitions. The narrower and clearer the better. Provider can indicate s/he does not want to participate in secondary network.

Go online and look at the types of “products” the plan offers to health plans. IF it includes out-of-network

### **Reconciliation (recoupment)**

What is the “lookback” period? Many states regulate this and ask for a similar time period for reconciliation.

Is there language allowing offsets of future payments?

Can plan unilaterally amend contract? Do not accept. May be best to ask for 30 day review of amendments. (Right to Object)

### **Termination**

Ensure you may terminate with cause.

Many contracts do not allow termination within the first year. Attempt to modify.

Avoid long waiting periods prior to terminate the agreement.

Keep all copies of agreements and amendments. When you have questions about an organization’s practices, refer to the contract to make sure that the organization is meeting its responsibilities. If you wish to terminate the agreement, do so in accordance with the termination provisions and obtain proof of receipt of your termination notice or proof that it was sent.

Mike Tritto: “Changing language in contracts by orgs has not occurred but asking for fee schedule changes have occurred.” Policy and procedure manuals have gone to on-line only documents thus need to monitor on regular basis. He suggested development of website policy and procedure manual link for APMA members.

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## **DME Update. Paul Kesselman, DPM, APMA Coding Committee**

Internet Accessibility to MCR Beneficiaries Info for NGS (Cigna’s site soon to follow.)  
(Very tedious to register with.)

Current IVR

Cannot check across carriers

Eligibility to FFS	“”	Change the CWF
Deductible status	“”	Change Insurance
Secondary insurance	“”	?check on 2 insurance

#### DME “CAC”

Quarterly meetings with provider outreach & Education (PCOM)

POE has seminars & Webinars

Each DME MAC has a list serve

PECOS submission although on-line has documents that must be mailed to the MAC within 15 days of the on-line submission.

New providers will only have 30-day look-back from the day it's accepted to retroactively bills. It's unclear when the clock starts ticking as to the 30-days.

Fraud is rampant... Increased focus from the DME MACs.

Signature Attestation (verifying provider's signature is valid on medical records) may be beneficial to include with medical record.

#### Therapeutic Shoes Update:

Supervisory physician statement (SPS/CMN) must be signed within 3 months of shoe delivery.

Foot examination needs to be performed prior to the SPS/CMN being signed.

Foot examination must be cosigned by MD/DO.

#### Competitive Bidding

Only effecting walkers and accessories dispensed through your office. Need to bill with KL-modifier.

#### Tricare & DME

Healthnet Issue: DPMs are not defined as “physicians” and only physicians can prescribe DME as well as PT. Smith & Nephew have approached APMA for assistance.

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### CPT Updates. Phil Ward, DPM

11040/11041 will be deleted. Replaced with 97597/95598 –Selective Debridement codes

#### New Add-ons:

11042 subq for 1<sup>st</sup> 20 sq cm with add-on 11045 each additional 20 sq cm

11043 fascia for 1<sup>st</sup> 20 sq cm with add-on 11046 each additional 20 sq cm

11044 bone for 1<sup>st</sup> 20 sq cm with add-on 11047 each additional 20 sq cm

No anatomic modifiers for above.

Add-up all the surface areas for all ulcers for total sq cm.

97597 value approximately that of 11043.

LE US – 76880 deleted

New – 76881 Complete includes a joint and all structures around joint

76882 Limited exam – PF or tendon exam

Limited exams can be done on R and L extremities. 2 limited exams do not add up to a complete exam.

A complete exam on one LE can be done with a limited exam on the other LE.

Current RVUs for 76880 is 3.47

2011 RVUs for 76881 is 3.30

2011 RVUs for 76882 is 0.89

Dermal substitutes will most likely going to one code with “0” global.

E-Prescribe code G8553 will remain the same for 2011.

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ICD-10 : Webinars and info will be forthcoming. (Presentation on CD)

New APMA webpage for CAC-PIAC .