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by Dustin Kruse, DPM

Fee Schedule. CMS payer fee schedule finalized with a 0% change for podiatry this year

Discontinuation of Global Surgical Services Begins 2017. CMS plans to discontinue global surgical services by removing the 10-day and 90-day global periods beginning in 2017 and 2018, respectively. This means all post-operative visits will be a billable entity. The goal is to increase the quality of care with more follow up appointments. There is not a definite plan established which will show the change to physician fees in regards to surgery but we can assume there will be a definite reduction in the reimbursement for the actual surgeries. Currently, the reimbursement for a procedure includes a percentage of post-operative care and it can be expected that the current reimbursement will be decreased by this percent.

Medicare audits are on the rise. As a DME supplier you are treated as two separate entities: the practice and the DME practice. Medicare can perform random site inspection to verify your DME documentation is appropriate. One of the most common faults is in DME practice hours. If you post your office hours, someone must be present during all posted hours. This person does not need to be the physician but must have knowledge of the location of the Medicare DME contracts. A simple fix is to list hours as "by appointment". All Medicare DME dispensing requires a separate prescription written by the practitioner even if this prescription is to one's self. This cannot just be noted in the chart but must be a physical prescription. Any billing errors found must be self-reported within 6o days; they have established a 15% bounty for tipsters. The most commonly audited podiatry items are:

- E/M – all (-25 modifier)
- 11730 nail avulsions
- Wound Care Codes
- 11060/1 (I&D of abscesses)
- 11050 (paring skin)
- Orthotics Codes
- -59 modifier
- Injection codes

Beginning January 1, 2015 the -59 modifier will change to the –X_ modifiers. The CMS thought is that the 59 modifier is overused and inappropriately used. The X_ modifier system is intended to provide more detail. The 59 modifier is still available but coding rules state that you must use the most appropriate code which will be the X_ modifiers:

XE: Separate Encounter, a service that is distinct because it occurred during a separate encounter

XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure.

XP: Separate Practitioner, a service that is distinct because it was performed by a different practitioner.

XU: Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.

PQRS starts now. All physicians must begin Physician Quality Reporting System (PQRS) for the calendar year 2015 or will face a 2% reduction in CMS reimbursement. In addition, the PQRS will be used to judge the "quality care" provided by physicians. For groups of 10 or more physicians the maximum penalty is an additional 2% reduction (-4% total) while groups of 1-9 physicians will only have a 0% additional reduction. The incentive program is budget neutral. So "high quality" physicians will receive an incentive payment equal to the total penalties (i.e. up to +4%).

Sustainable Growth Rate. Congress must act by April 1, 2015 to prevent the sustainable growth rate (SGR) from going into effect. The consensus is that the SGR needs to be scrapped but an alternative has not been established. There will likely be another continuation.

2015 is the last year to attest for Meaningful Use or penalties will begin in 2015.

The **Affordable Care Act** has created more affordable exchange insurance programs with the same name as larger plans (i.e. Humana X, Blue Priority, etc.). These new plans have a narrower network of providers as a way to control costs. Most of these plans have a lower rate of reimbursement (17% on average less than larger carriers), and 70% of exchange plans exclude 30% of hospitals. The narrow networks consist of "efficient" physicians which essentially means cost effective. Many physicians across the country are being terminated from these contracts because of being too costly. With all exchange plans know the terms of your contract, verify patient eligibility prior to service rendered, and closely watch the name of the insurance plan because oftentimes the large carrier name is seen but it is actually an exchange plan.

Further information can be found on APMA's website at **http://www.apma.org/yourpractice** which should always be the first source of reference.

Please contact me with any specific questions—Dustin Kruse, DPM