

APMA's Joint CAC & PIAC Meetings: An Overview

Here's what was discussed.

BY PAUL KESSELMAN, DPM

In November 2015, the APMA held its annual joint Carrier Advisory Committee (CAC) and Private Insurance Advisory Committee (PIAC) meetings in Washington, DC. For those not familiar with the definition and function of the CAC and PIAC, the CAC has a professional delegate from each interested medical specialty and represents them at meetings held by their local Medicare jurisdiction. For each Medicare Part B Jurisdiction, there is a podiatrist who interacts with the Medicare Carrier's Medical Director, Policy Writers, and others at the Medicare Contractor who might influence reimbursement policy. The PIAC, in a similar way, represents specialty physicians in their states with private insurance companies within their state.

Both have delegates normally appointed by their state podiatric medical associations and monitor both Medicare and/or private insurance companies.

Certainly, the vast majority of this two-day meeting dealt with Medicare Part B and local private insurance issues regarding ICD-10 coding issues, ACO, and other hot Medicare topics. Continued access to private third-party payers for practitioners in small practices remains a high priority issue for the vast majority of podiatric practitioners, and this too was discussed.

During the meeting, DME issues were also under review. This month's DME for DPMS provides a summation of the issues discussed. At the end of the few paragraphs

below, a summation of changes for DME in 2016 will be presented.

Office of Inspector General (OIG) Issues and DME

Orthotic Braces

The OIG will determine the reasonableness of Medicare fee schedule amounts for orthotic braces. The OIG will compare Medicare payments made for orthotic braces to amounts paid by non-Medicare payers, such as private insurance companies, to identify potentially wasteful spending. In essence, the OIG is looking

were receiving multiple braces and the referring physician did not see the beneficiary) or were not documented in accordance with Medicare requirements. Medicare requires that such items be "reasonable and necessary. Further, LCDs issued by the four Medicare contractors that process DMEPOS claims include utilization guidelines and documentation requirements for orthotic braces. In essence, if your documentation does not meet the LCD requirements, then a refund will be the least of the issues you may need to deal with.

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to save CMS money by researching which payers pay less than Medicare and the reasonableness of effecting a lower reimbursement schedule.

New Orthotic Braces

The OIG will review Medicare Part B payments for orthotic braces to determine whether durable medical equipment, prosthetics, orthotics, and supplies and (DMEPOS) suppliers' claims were medically necessary and were supported in accordance with Medicare requirements.

Prior OIG research indicated that some DMEPOS suppliers were billing for services that were medically unnecessary (e.g., beneficiaries

CMS and Lower Limb Prosthesis

A draft policy would have excluded DPMS from assessing patients' needs and certifying their need for a prosthesis (e.g., Toe filler L5000). It would have created a new provider category (Licensed Certifying Professional) which only included MDs, DOs, PTs, NPs, and PAs. It would not have eliminated the DPM as either an eligible prescriber or supplier of LLP. Recently concluded hearings resulted in this draft policy being rescinded, but it is far from dead.

CMS is convening a multidisciplinary Lower Limb Prostheses Inter-agency Workgroup (Workgroup) in

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2016. The purpose of the Workgroup is to develop a consensus statement that informs Medicare policy by reviewing the available clinical evidence that defines best practices in the care of beneficiaries who require lower limb prostheses. The Workgroup will be comprised of clinicians, researchers, policy specialists, and patient advocates from different federal agencies.

ICD-10 and Laterality Issues with Respect to DME

Questions still exist on how to code the normal anatomical site when billing such items as custom fabricated foot orthotics which have a laterality issue within a diagnosis group (e.g. calcaneal spur). Questions have been submitted to various carriers and a higher up official at CMS regarding how this might impact the reimbursement of therapeutic shoes where a patient solely has a deformity or ulcer on the right foot but has a normal left foot. For now, the answer seems to be to simply use the ICD-10 code matching the pathological side, no matter which HCPCS code (LT RT) is being billed.

Educational Review Programs

Region B and C both have programs whereby suppliers may submit their documentation for review prior to formal submission of claims for reimbursement. This program is not a prior authorization program, nor does it have any veto power over a future audit by the carrier. Its intent is to educate suppliers on whether or not they have obtained the necessary documentation required by the carrier. This is a relatively new program by Regions B and C available for claims concerning only Therapeutic Shoes for Patients with Diabetes. Region A is currently testing such a program, with no information yet available for Region D. According to an outreach and education official from Region C, suppliers failing an educational review are now more likely to be subject to pre- or post-payment audits, and suppliers passing educational reviews are now less likely to be subject to audits. Many questions

remain about the efficacy of such programs.

Therapeutic Shoe Audits

Significant audits continue in many regions of the country with many suppliers, including podiatrists, either contemplating or outright abandoning the program. Most podiatrists subject to audits have ultimately won at numerous appeals, indicating that low-level auditors remain confused about podiatric suppliers and their role in the documen-

sation (PFA) have provided further clarification on this issue. This is available on each of these associations' websites.

Phone and face-to-face meetings are continuing with state component associations and insurance carrier medical directors. Readers who find themselves being down-coded on L30XX codes are advised to contact their state component society and insurance committees, who can take further action. This is often a long laborious issue, and one which is

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tation chain. Outreach and education continues at the carrier level in order to ensure a better playing field, as appeals are also costly to the carrier. Those who have embraced rigid standards and policies have found that after several audits in the beginning of a calendar year, they are ultimately left unscathed by auditors for the rest of the year.

Home Inspections by DME

Recently, a patient presented to the office and informed the office staff that a home inspector had visited them to ensure that the patient had received the therapeutic shoes which had been prescribed by another physician and dispensed by a commercial vendor. Further questioning of the patient found that the inspector was inquiring on whether the inserts were off-the-shelf or custom-fabricated. It is clear that Medicare is interested in ensuring that beneficiaries are receiving the billed items from suppliers.

Confusion Over L3000 Coding

Insurance carriers continue to be confused over the appropriate L30XX code to use for functional foot orthotics prescribed by podiatrists and orthotists alike. A jointly issued white paper by the APMA, American Orthotic and Prosthetic Association (AOPA), and Pedorthic Foot Care As-

usually well beyond the scope of appealing by a single individual practitioner.

L1940 Custom Fabricated AFOs

Medicare continues to audit most claims containing the L1940 (custom fabricated AFO) code due to poor documentation of medical necessity by suppliers. This code is the parent code for popular custom-fabricated ankle foot orthotics marketed to podiatrists. Often cited is a lack of compliance with the AFO LCD policy.

L4360 Pneumatic CAM Walker Custom-Fitted

Medicare continues to audit most claims containing the custom-fitted pneumatic cam walker (L4360) due to poor documentation of medical necessity. Podiatrists are advised that most pneumatic cam boots dispensed in their practices are more appropriately described by L4361 (Pneumatic Cam Walker Off-the-shelf). Pricing for L4360 and L4361 continues to be the same in 2016, as L4361 has not been placed into competitive bidding as of this writing. Any attempt to place L4387, L4361 and L4397 into competitive bidding will most assuredly be met with some resistance by the industry unless accompanied by a raise in the fee schedule for their custom-fitted brethren.

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DME Fee Schedule for 2016

This schedule is available on the CMS and on all four DME MAC web-

by podiatrists, including cam boots, therapeutic shoes, or plantar fascial night braces.

4) Reimbursement for pneumatic cam boots described as L4360 and

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sites. Interesting to note are:

1) Small increases across the board for all DME dispensed by podiatrists;

2) Inclusion of a rural zip code for DME. However, this only is effective for those items subject to competitive bidding. As such, this does not include typical items provided by podiatrists, including therapeutic shoes, AFOs, etc.

3) Competitive bidding is still not impacting most products dispensed

L4361 are the same;

5) Reimbursement for non-pneumatic cam boots described by L4386 and L4387 remain the same;

6) Reimbursement for static AFOs for non-ambulatory use (e.g., plantar fascial night braces) L4396 and L4397 remains the same.

Summary

DME suppliers are subject to many of the same pressures as

practitioners experience on the medical delivery side of practice. Staying abreast of the changes in reimbursement policy and audit issues is of particular importance in order to maintain a profitable margin. Continued vigilance by the podiatrist and/or a selected individual in your practice is a worthwhile task. **PM**



Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory

Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.