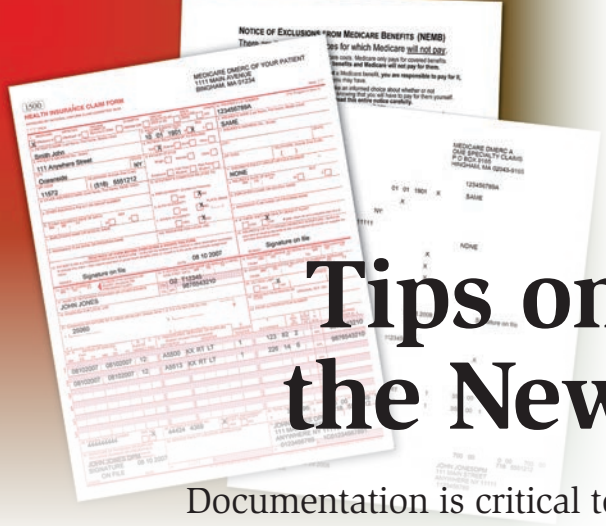

Tips on Navigating the New DME Rules

Documentation is critical to defending against accusations of fraud.

BY PAUL KESSELMAN, DPM

As healthcare providers, each new year we must address a myriad of issues. Insurance company and policy changes for our patients, deductible and co-payment collections and policies all must start anew. For Medicare and federal policies, the Office of Inspector General (OIG) also has announced new programs and focused reviews which will affect podiatric physicians. This article will provide some helpful tips to help navigate you and your patient through the first turbulent quarter of 2017.

Deductible(s) and Co-payments

As of January 1, 2017, your patients' deductibles, co-payments, and health savings accounts all reset. The deductible for some patients will remain the same as in 2016 and an attempt at collection must be done during their first encounter. For many (including Medicare), the deductible for all health care encounters (office, hospital, out-patient hospital) has likely increased from last year. Thus, it is imperative that you either use a commercial fee for service eligibility program or use the free provider portals available by many insurance carriers or their subcontractors. While these will not necessarily provide you with an up-to-date exact outstanding deductible amount due from patients at the time of their visit in your office, they will provide you with some guidance as to their overall deductible. Some carriers allow you to collect the deductible up-front whereas others require you to first process the claim.

The days of holding the claims until someone else "ate" the deductible in those states are long over.

For Medicare Part B, the deductible has risen from $166 to $183 while simultaneously your patient's monthly premium rose an average of 10%. For some, the premium is subject to an income-based surcharge, and thus it will vary. One should expect more grumbling this year than in the past few years as the deductibles and premiums had remained rather stable. These changes will come as a shock to some patients, and for those on a fixed income with a relatively small COLA increase, they will be difficult to afford. As in the past, there is no separate DME deductible under Medicare Part B. That is, any physician or supplier service is subject to the $183 deductible.

For dual eligible (Medicare and Medicaid) patients, it may behoove your practice to bill Medicare the same day as the service(s) are rendered. This is especially true in most states where your Medicaid carri-

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er will cover the annual deductible but will not pay for any of the 20% co-payment. Also, in most states, one cannot balance bill the patient for the 20% Medicare co-payments for covered services. The days of holding the claims until someone else "ate" the deductible in those states are long over. It is also important to note that in most states, this rule applies even if one is not enrolled as a Medicaid provider. That is, even if you are not a Medicaid provider, you cannot balance bill your patient for services covered under Medicare/Medicaid but not paid for by Medicaid (e.g., the co-payment). Since the rules have changed in many jurisdictions, it is imperative that your office checks with your Medicaid carrier and/or state association for more information.

DME deductibles may not be part of the annual physician deductible for private non-Medicare policies and may be reset to $0 for those non-Medicare patients. Be sure to check with the individual carrier/policy for your patients prior to providing any DME service, especially in the first quarter of the year.

Co-payment and Out-of-Pocket Maximums

Co-payments and out-of-pocket maximums exhausted (or not) in 2016 are all reset back to $0 met for 2017 and thus start all over again. While your office is checking deductible status, it is imperative that this information be collected. Especially for patients covered under a family policy, your office staff may have become adjusted to not collecting anything from a family during the last quarter of the previous year. Since the out-of-pocket maximum resets on the first of the year, collecting co-payments will again be something both staff and patients must adjust to.

2017 DME fee schedule: The DME fee schedule was not ready for release at the time this article was written (early December 2016). Some changes from 2016 include zip code-adjusted fees for each state to allow for the incorporation of more DME to competitive contracted bidding (CB). For now, most of the services provided by podiatric physicians from their offices are not subject to Competitive Bidding. Moving toward the future with paired or mirrored codes (e.g., L4360/L4361), it remains to be seen whether the Off-the-Shelf (OTS) version will move toward Competitive Bidding sometime in the future and whether an exception for those OTS devices subject to CB will be granted an exemption for contracting to those who provide OTS to their own patients.

Office of Inspector General (OIG)

Every year, the OIG issues a work plan for those items it will study; healthcare and Medicare payments are no exception. There are several items included for review, and some notable for podiatric physicians include:

Hyperbaric Oxygen (HBO)

The OIG will be reviewing whether or not the patient meets the criteria for receiving HBO, whether or not this has been properly documented, and whether or not the patient has exceeded the medically necessary allotted amount of treatment sessions. The take-home message here is to check the NCD on HBO to be sure your patient qualifies and the documentation meets the "sniff test".

Skilled Nursing Facility (SNF):

1) Was your patient incorrectly subject to the Consolidated Billing Rule?

If the patient was not admitted for at least a three-day stay, then Consolidated Billing does not apply. Translation: Review the DOA (date of admission) and DOD (date of discharge) to ensure that the patient's services are covered under Consolidated Billing.

2) Did Medicare Part B incorrectly pay the SNF for DME under a non-Part A stay?

Also of concern is whether or not Medicare part B paid the SNF for DME under Consolidated Billing or directly for a non-Part A stay, whether these payments should have been paid directly to a supplier, and whether those payments would have been lower (also whether the SNF should not have been paid by Part B for service at all). Translation: One should inquire as to the status of the Part A stay and the DOA and DOD so one may be able to calculate the "100 day stay" eligible for SNF Consolidated Billing and whether it applies to your patient or you can bill the DME carrier directly.

For those Part B medical services where another physician (e.g. MD/DO) is required (e.g. routine foot care), be sure that they enrolled in PECOS.

Reasonableness for AFO, Cam Walkers, etc.

Because the use of orthotic braces (e.g., custom and OTS braces) has doubled in the past seven years, the OIG is investigating their "reasonableness" as compared to the non-Medicare patient population. Translation: Does your chart document the medical necessity of these devices by meeting the litmus test of the LCD? If you wonder what is driving the recent increase in audits on pneumatic cam walkers (e.g. L4360) and hinged custom fabricated AFOs (L1970), you have to read no further than the OIG Work Force Plan for 2017 to find out.

The OIG will also be performing a comparison study on the pricing of these devices and whether or not Medicare has been overpaying for these devices as compared to non-Medicare carriers. Translation: Watch for even more audits and post-payment studies to compare utilization among various demographics and further inquiries on charges to various carriers vs. Medicare.

Bone Stimulators

Podiatrists typically do not dis-

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pense and bill for bone stimulators; nevertheless, this audit will affect anyone prescribing any type of bone stimulator. Because the utilization and costs for these devices have escalated, the OIG will be studying whether or not a monthly (rental) fee for these devices would save substantial expenditures as opposed to a one-time purchase. Translation: Vendors supplying these devices to your patients will require on-going medical necessity documentation for the patients' continued need and use of the device. Also since these devices are labeled by the FDA for "single patient use only", some substantial changes to the product label may be required by the manufacturers of these devices to facilitate multi-patient use of rental devices.

Laboratory Fees

This is especially important for those physicians with "in-house" laboratories which provide clinical diagnostic laboratory services. The OIG will be conducting a price review of non-Medicare vs. Medicare payments in order to further reduce Medicare payments for certain laboratory tests. The OIG does not provide any further information on which tests they will be reviewing (other than the top 25% of tests conducted). Translation: If you have an in-office lab and are performing the top 25% of tests (CBC and CMP are likely among this group), then beware and stay tuned.

Referring Provider

Are you eligible to refer and order services (e.g., x-rays, DME, etc.)? If you are not enrolled in the PECOS system, then any claim with you as the referring provider will not be paid (this does not include those who have legally opted out of Medicare). Medicare is still paying for services ordered and/or referred by non-PECOS enrolled physicians. Translation: It's hard to fathom that with all the policy announcements on this issue, Medicare continues to pay for services by non-PECOS enrolled physicians. If you are using a physician (other than yourself or not in your group) as the ordering physician for DME, you should stop! This is also a violation of the Surety Bond and Facility Accreditation exemption. For those Part B medical services where another physician (e.g., MD/DO) is required (e.g., routine foot care), be sure that they enrolled in PECOS.

Home Visits

Any provider reading this in an NGS MAC, particularly in New York, understands that Medicare has been successful in either denying payments or recovering payments for home visits (CPT 99341-99350 when used with a 25 modifier). The OIG will now be reviewing claims paid by your Medicare carrier for home visits even when billed without a 25 modifier. While the OIG report does not detail how it will determine the reasonableness of a home visit, it goes without saying that they will likely review any claim for a home visit when office or outpatient visits were submitted by other providers during the same time period. Sometime soon, the carriers will then follow up with demand letters for recoupment and/or your need to appeal, which should include the medical necessity for home visit(s) when other providers during the same period are billing for out-patient visits (e.g. 99201-99215). Translation: Be alert to the ruling on home visits and the requirements for patients to be sufficiently incapacitated so as not to be able to come to your office. If your patients are going to other physicians' offices, they should be able to go to yours as well.

High Use of Out-Patient Physical Therapy Services

While this likely will target physical therapists in independent practices outside a facility, it is noteworthy to report here. Even if you refer patients for physical therapy, those who utilize a larger than normal number of services or who require services beyond the cap may also be targeted. Your documentation will be required by the physical therapist in order for them to be properly compensated. Be ready for more physical therapists to demand more of your documentation prior to providing services to your patients. Translation: Those of you who perform or employ physical therapists in your practices should be prepared for further scrutiny of your own claims.

Collection Process from ZPICS, RACs, etc.

The OIG will be reviewing the collection process and effectiveness of those contractors who review your appealed claims or those which are subject to recoupment. Translation: You can bet that the OIG won't be looking for ways for the RAC or ZPIC to pay or refund you money back. Rather it will be looking at claims where the ZPIC or RAC allowed you to keep (or paid you) money on an appeal where it should have instead collected money from you.

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Money Paid to Providers for Dates of Service After the Beneficiary Date of Death

The OIG 2017 Work Plan does not mention how much was inappropriately paid in 2015 (most recent year statistics should be available). However, an Internet search revealed a 2013 OIG report which claims that in 2011, Medicare paid as much as $23M (mostly for Part C Medicare Advantage Plans) for services rendered after the date of death of the beneficiary. Translation: It boggles the mind that even in this age of

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computerization, CMS contractors continue to pay providers for services rendered after the date of death of the beneficiary.

MACRA Review

The OIG will be reviewing contractors to be sure they implement the MACRA milestones and payments correctly. Translation: You can bet the OIG will be siding with the contractor before paying you any incentive payments unless they are clearly documented.

Review of Payments for Incarcerated Beneficiaries

Unless otherwise specified, Medicare is not responsible for payment(s) for care of incarcerated individuals. Medicare contractor(s) have been conducting widespread post-payment reviews of claims going back several years. Apparently this is not sufficient for the OIG, and they are continuing to review improper payments by Medicare contractors for incarcerated individuals. Translation: If you contract to provide services to prison inmates, be sure that your office staff is following proper protocol and not separately billing Medicare for those prison inmates who are Medicare eligible. Also be leery of recently released individuals whose Medicare files may not have been updated, as Medicare may not pay their claims until their Common Work File (CWF) has been updated.

Payments for Compounded Pharmaceuticals

Payments for compounded topical prescriptions by Medicare Part D rose 3,400 percent in the last ten years to an astounding 224 million dollars. Because previous investigations into these medications revealed potential issues of potential fraud and abuse, the OIG will be conducting a formal review to identify fraud and abuse by both pharmacies and prescribers of these medications. Translation: Be prepared to provide sufficient medical necessity documentation why off-the-shelf (prescription or over-the-counter) medications are not appropriate for your patients' conditions. This is especially true if you are prescribing a large number of topical compound medications and using a single compound pharmacy.

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Single Dose Medications and Waste

There are many medications (e.g., biologic skin substitutes) which are packaged as single dose units. Wastage (that part not used) for many of these single dose packaged units must be reported using the JW modifier. This is done to assure that the amount ordered is as close as possible to what is needed. The OIG will be conducting audits of paid claims using the JW modifier to identify claims where a smaller sized packaging would have been more appropriate. Translation: Be sure to order products as close as possible to what is required in order to minimize wastage.

Summary

No matter the change in administration, Medicare and the OIG will continue to find ways to make it necessary to be more careful about your documentation. All healthcare providers will find it necessary to find even more efficient and effective ways at documenting what they did in order to avoid accusations of fraud and abuse. PM

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