2016 Second Quarterly Newsletter

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NGS Revision to Routine Foot Care Policy Effective May 2016

NGS announced a revision to the routine foot care policy effective May 2016. One change denotes the exception of the requirement for listing the class modifier. The other added diagnoses that require the patient to be under the active care of a doctor (needing date last seen on the claim). Below is the announcement for NGS:

Routine Foot Care and Debridement of Nails (L33636)

The following explanatory note in the "CPT/HCPCS Codes" section was revised to include the exception to the class finding modifier requirement:

One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition **except** where the patient has evidence of neuropathy, but no vascular impairment, for which class findings modifiers are not required.

ICD-10-CM codes E08.41, E08.43, E08.44, E10.41, E10.43, E10.44, E11.41, E11.43 and E11.44 were added to Groups 1 and 3 in the "ICD-10-CM Codes that Support Medical Necessity" section.

An asterisk (*) which denotes the patient must be under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified nonphysician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service was added to M05.872, M06.071 and M06.072 in Group 1 in the "ICD-10-CM Codes that Support Medical Necessity" section.

An asterisk (*) was added to ICD-10-CM codes G35, M05.571 and M05.572 in Group 3 in the "ICD-10-CM Codes that Support Medical Necessity" section.

ePaces Adding a New Feature on June 1, 2016

Effective this June, ePaces will be introducing an additional level of security for providers who use online services - first, all providers must have a current browser (Internet Explorer 10, Mozilla Firefox, Google Chrome, or Apple Safari) to use the website. If a browser is not up to date, you will not be permitted to access ePaces for online transactions.

The other major change will be a level of verification, known as CAPTCHA, to confirm that a user is not a robot by selecting images related to a simple question. This feature is used for online banking, e-mail accounts, and various other services where security is a priority. CAPTCHA discourages automated processes that could automatically log into and compromise a system by mandating human input that will minimize fraudulent access.

Electronic Signature Coming to EDI Enrollment Forms

NGS announced a change in their EDI enrollment process that will take place in the summer of 2016. This should expedite the processing of enrollment forms by implementing an electronic signature. Below is their announcement:

"During the summer of 2016, EDI will implement electronic signature for online EDI enrollment forms. All EDI enrollment forms will be completed and submitted online through our website under **Claims & Appeals > Electronic Data Interchange** section. With the implementation of electronic signature, EDI customers will no longer be required to print, sign and fax the forms before they can be processed. EDI will be able to begin processing your enrollment request once it is submitted online. An instruction guide for the electronic signature process will soon be available on our website."

https://www.ngsmedicare.com

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Enhancements to the Provider Enrollment Process

As part of the Affordable Care Act, CMS is recommending additional provisions to be added to the provider enrollment process in order to prevent practitioners who are not entitled to be Medicare providers. The procedures have been increasingly difficult in recent years, with Medicare carriers enforcing periodic revalidations to confirm provider enrollment, requesting additional information to confirm the validity and accuracy of the provider, and mandating fingerprinting requirements. These enhancements are being considered in order to eliminate some of the financial risk to the Medicare program in a time when the ACA is attempting to curb Medicare spending where possible. Collectively, since 2011 to 2015, provisions from the ACA in regard to a more stringent enrollment process have saved the Medicare program well over two billion dollars. If passed, the following areas would be targets for CMS to crack down on fraudulent provider activity:

- More stringent reporting requirements for practices and facilities to report any individual who has current debt to the Medicare program or sanctions from CMS
- Extending sanctions for a healthcare provider if they willingly re-enroll in Medicare under a new name, provider number, or business identity while suspended from the Medicare program
- Giving CMS the ability to revoke a physician's enrollment due to questionable referring or ordering practices
- Imposing bans as long as 20 years from participating in the Medicare program, depending on the severity and frequency of offenses
- Denying or revoking enrollment from a provider that has a current ban with any other state or federal program or if the medical license of a provider has been revoked by the state
- Ordering/certifying providers must enroll with Medicare and specify whether they will be a participating provider or will formally opt out

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-25.html

NHS Jurisdiction A Implementation

As announced on December 18, 2015, Noridian Healthcare Solutions (Noridian) was awarded and will begin administering the Jurisdiction A (JA) DME MAC contract on July 1, 2016.
Providers may keep tabs on the upcoming implementation and any changes on NHS' JA Implementation site at med.noridianmedicare.com/web/jadme. According to Noridian, the objective is to minimize the impact on suppliers for a smooth transition:

- Local Coverage Determinations will not change.
- Listserve subscriber information will be provided to Noridian and used to update providers about implementation.

Any changes like address, phone numbers and forms and web contact will be published on the website prior to the effective date.

Noridian Jurisdiction A DME Updates as of May 9, 2016:

- Noridian Medicare Portal Roles, Registration and Functionality
  The Noridian Medicare Portal (NMP) registration process empowers suppliers to determine who in their office they want to oversee access of the employee and monitor their portal usage.
  https://med.noridianmedicare.com/web/jadme/article-detail/-/view/4546752/noridian-medicare-portal-roles-registration-and-functionality

- Appeal Requests Submitted On/After July 1, 2016
  Noridian will become the new Jurisdiction A (JA) contractor effective July 1, 2016. All reopening and redetermination requests submitted on/after July 1 must be sent to Noridian.
  https://med.noridianmedicare.com/web/jadme/article-detail/-/view/4546752/appeal-requests-submitted-on-after-july-1-2016

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Health Republic Insurance of New York – Latest Status

Health Republic Insurance of New York terminated all of its insurance policies as of November 30, 2015. Many top analysts state that the model was doomed to failure from the start. The insurer offered very low premiums and a choice of New York's top hospitals while their competitors were shrinking their networks of doctors to hold down costs. The low premiums and access to the state's top hospitals attracted members, including some of the sickest New Yorkers. On the first day that Health Republic offered coverage, in January 2014, five new enrollees were admitted to Memorial Sloan Kettering Cancer Center for expensive treatment. The insurer's costs skyrocketed. Regulators that initially approved the low premiums would not allow Health Republic to raise them once it became clear that the prices jeopardized the financial solvency of the company. Finances were in a state of chaos and never recovered.

On September 25, 2015, Health Republic was ordered to shut down by the same state and federal agencies that had given the insurer their blessings just two years earlier. In 20 months, from January 2014 through August 2015—as it became clear the insurer could not survive—Health Republic had accumulated tens of millions of dollars in losses. The company was ordered to close its doors effective November 30, 2015; leaving 209,000 enrollees to scramble for new coverage.

The Department of Financial Services has an ongoing investigation and a restructuring firm at Health Republic is still trying to determine the total of unpaid claims. It is widely believed that the carrier leaves behind about $200 million in unpaid claims for hospitals and physician practices. On April 22, 2016, the Superintendent commenced a liquidation proceeding for Health Republic and a hearing has been set for May 10, 2016 to consider the appointment of a superintendent and the approval of the liquidation process to commence. Health Republic has agreed to the liquidation. As per their website page: "*The goal of the proceeding will be to maximize distributions to claimants while minimizing the duration and cost of the liquidation proceeding, to the extent possible. Payments from Health Republic's estate will be made in a fair and equitable manner in accordance with statutory requirements, upon approval by the Court*."
The site also confirms: "*Based on the information available to date, however, it is highly unlikely that Health Republic will have sufficient funds to satisfy any claims against Health Republic other than (1) claims for administrative expenses (i.e., expenses incurred in administering the liquidation proceeding) and (2) a portion of the claims under Health Republic policies submitted by providers and members*."

Providers should have submitted all their claims by March 31, 2016--there is no need to resubmit. Any and all relevant and applicable explanations of benefits pertaining to outstanding claims will be submitted to providers as soon as possible. Please note, providers are prohibited from billing patients for claims unpaid by Health Republic unless they receive an EOB stating the balance (coinsurance, copay, etc.) is the patient's responsibility.

The Balance Between Increased Quality of Patient Care with Reduced Spending

A focal point of lowering the amount that is spent per patient on healthcare has been reconsidering how providers are reimbursed from Medicare. Thought has been given from possibly migrating from a FFS system (which rewards quantity of care provided to a beneficiary) to bundled payments through alternative payment models, which encourages providers to focus on the quality of care while being more conservative with the resources to treat patients. Starting in 2011, the program has increased as more providers are seeing the benefits of coordinated care, with 30% of all Medicare payments being made through this alternative method as of January, and an aim to have 50% of all Medicare payments made by alternative methods by the end of 2018. Accountable Care Organizations are the backbone of the Medicare Shared Savings Program, where individual doctors, hospitals, and other providers voluntarily pool resources to find the balance between quality care while reducing costs.

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html