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2016 Fourth Quarter Newsletter

2017 MACRA Final Rule Hits!

The Department of Health & Human Services (**HHS**) released its final rule on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This act, which will go into effect **January 01, 2017**, reimburses eligible Medicare physicians based on the quality of care they deliver through the government's Quality Payment Program, which replaces the Sustainable Growth Rate (SGR) formula for physician reimbursement.

MACRA's flagship program, the one specifically focused on quality data reporting, is the Merit-based Incentive Payment System (MIPS). It replaces the Value-Based Payment Modifier (VM) program, which allowed for differential Medicare payments based on the quality and cost of care provided.

CMS indicated that it will allow non-eligible providers to participate in MIPS on a voluntary basis during the 2017 and 2018 reporting years.

For additional resources please click on link: **https://qpp.cms.gov/education**

Pre-Payment Audit of Podiatry Specific DME Items

Since June, Noridian Medicare, the DME MAC for jurisdiction A, has begun to perform pre-payment audits on a number of different items that are billed by DME suppliers. These audits are being done after an analysis of the items that are frequently billed by different specialties, but are not considered medically necessary when documentation is submitted and reviewed. For podiatrists, the two items that were targeted are AFOs (limited to HCPCS codes L1970, L4360, and L4361) and prefabricated diabetic shoes (A5500). The key to payment with these audits is to make sure that all of the required documentation is submitted according to each items respective LCD policy- any piece of information that is illegible, incomplete, or missing will be cause for a denial.

Documentation checklists for the items listed above can be used as an aid through the following links to ensure proper documentation during an audit:

- https://med.noridianmedicare.com/documents/6547796/6558244/ankle-foot_knee-ankle-foot_orthoses.pdf/69becb3a-b555-4c80-b9e7-6ab894f5e806
- https://med.noridianmedicare.com/documents/6547796/6558244/Therapuetic+Shoes+Checklist/41b967dd-73b8-411b-884a-df690ea1eef2

Inappropriate Billing of Qualified Medicare Beneficiaries

Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Medicare providers must accept the Medicare payment and Medicaid payment (if any, including any Medicaid cost-sharing from the beneficiary) as payment in full for services rendered to a QMB individual. Make sure your billing staff is aware of this aspect of your Medicare provider agreement.

Medicare Administrative Contractors will issue compliance letters to providers who violate this provision, instructing them to refund erroneous charges and recall any past or existing billing. Medicare providers who violate these billing prohibitions may be subject to sanctions.

For more information, see MLN Matters Article MM9817.
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-13.html

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Medicare Requesting Fingerprints

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier. Note that the high level of risk category applies to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier's screening level from "limited" to "high" or "moderate" to "high" if any of the following occur (click here to view CMS's classifications of high risk categories):

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1417.pdf

Billing for Custom Orthotics Not Picked Up by Patient

A. Date of Incurred Expense

If a custom-made item was ordered but not furnished to a beneficiary due to:

- Individual passing away
- Order cancellation by the beneficiary
- Beneficiary's condition changing and the item no longer being reasonable, necessary or appropriate.

Payment may be made based on the supplier's expenses. The expense is considered incurred on the date of any of the above. Payment may be made on either an assigned or unassigned claim.

B. Determination of Allowed Amount

The allowed amount is based on:

- The services furnished and materials used.
- Up to the date the supplier learned of the beneficiary's death or of the cancellation of the order.
- The item was no longer reasonable, necessary or appropriate.

The Durable Medical Equipment Regional Carrier **(DMERC)**, carrier or intermediary, as appropriate, determines the services performed and the allowable amount appropriate in the particular situation. The carrier takes into account any salvage value of the device to the supplier.

If a supplier breaches an agreement to make a prosthesis, brace, or other custom-made device for a Medicare beneficiary, such as an unexcused failure to provide the article within the time specified in the contract, payment may not be made for any work or material expended on the item. Whether a particular supplier has lived up to its agreement, of course, depends on the facts in the individual case.

There are slight variations in the procedure of each DME carrier. The provider has to call, find out and follow those, but for the most part they are similar to what is outlined below:

1) Submit a claim with the FULL billing amount you usually bill.
    a. Date of Service should be Date of Refusal or Date of Death
2) Include in the narrative section a brief explanation of the situation. Mention that the item 'has no salvage value and is a complete loss'.
3) After receipt of claim, carrier may ask for more information such as a receipt of the purchase of the item, explanation of your other related costs such as staff time, your own time, etc. Payment is at the discretion of the carrier depending on many factors such as:
    a. Frequency of claims.
    b. Total amount involved.
    c. DME history of patient and provider.
4) Based on the above, the carrier will pay whatever they deem appropriate, even up to the full amount billed or nothing at all.
5) This decision can be appealed up to the various levels following usual procedures.