CAC-PIAC MEETING
Private Insurance Advisory Committee
Leslie Campbell, DPM

Kelly Beck, J.D. – Attorney and APMA Consultant
Once again, Kelly Beck presented a lecture on the private insurance environment. She led the discussion by asking "What did your contract say and did you appeal? She suggested that physicians should highlight the risks and listed concerns within any contract prior to negotiating with any insurance carrier.

She also noted that this is the best time of the year for Medicare Advantage and new applications are due in February. In order for the MA plans to exist, there must be an algorithm of physicians required to be enrolled within their network. If a new plan is introduced, States require network adequacy standards providing a degree of negotiating power by the individual physician. Bigger groups tend to have more negotiating power. Are you currently seeing this payor's members as an out-of-network provider? This is also a point that can be posed to the payor as negotiating leverage: i.e. As an out-of-network provider, why should I accept your rates?

NEGOTIATING PAYOR CONTRACTS: (Terms to Consider) "If you don't ask, you won't get changes"

1. Payments: State law frequently includes requirements related to disclosure of payment rates/methodology. *If the payment does not offset the cost of doing business, do not enter into the contract!!!! Important points:
   a) Most employer based coverage offers out-of-network coverage therefore you can still see these patients; in essence it functions as an open network.
   b) Understand what you will be paid. Health plans should be providing a fee schedule (the top 20 CPT codes), any coding and bundling procedures or methodology as well as sufficient information to understand any bonuses or risks. The carrier needs to provide enough information for you to make an informed contractual decision.
   c) Nature of the Organization Offering the Contract: Understand the type of entity offering the contract - if you don't know, Google them! Are they an insurer or just a network? If it is an insurance network, question what type of services they are offering. Do they offer repricing or secondary networks? If you wish only to participate in a primary network, be sure that the contract obligates the organization to make you a preferred provider by including you in the primary network provider directories and providing for advertised differentials in cost sharing in order to provide patient steerage. You should be in the most favorable cost sharing level.
2. Scope of Participation: (Secondary/Rental Networks) Determine to whom you are agreeing to provide discounted services. The contract may say that you are obligated to provide service to members of the "plan", PPO or that you provide services for all payors or members of payors. Ensure that the number/volume of insureds is not too high. Read all related definitions. The narrower and clearer this obligation, the better. Carefully read the entities to which you must provide discounts or to which you agree to provide services. DO NOT agree to a definition that is overly broad. As in the case of UHC, the affiliates can be broad.

3. Scope of Agreement: Make sure that the assignment clause is as narrow as possible to avoid allowing the network to inappropriately assign it ability to pay at discounted rates to other organizations.
4. Reconciliation and Recoupment: (Payors trying to recoup payments made to physicians) This information is typically located in the "payment section" of the provider manual however, it may also be listed under "audits" or "overpayment". Recoupments are sought in the form of retroactive denials if individuals were not enrollees of the plan at the time of service; if the service was not covered; in circumstances of coordination of benefits when it is subsequently determined that another payor was responsible or in the cases of physician down coding. The question commonly asked by physicians: "Did the health plan reserve the right to do reconciliations?" It is important for physicians to know what the "lookback period" is (the timeframe during which the plan has the right to request recoupment of funds. Many states regulate this and APMA has a compilation of state laws listed on their website. The physician should ask for a similar period in which you can request reconciliation. Two additional questions that are pertinent to this topic are: "Does the plan have the right to offset the amount against future payments? Do you have an appeal right? Ensure prior to signing any contract that you have the right to appeal!
5. Amendment: The health plans will often send amendments to the contract and these are typically not favorable to the physician. Queries: Can the health plans unilaterally amend the contract? And if so, under what circumstances? It is common to allow the plan to amend unilaterally where required by law. Are there notice requirements for the amendment? Generally, it is easier to get an amendment that allows a right to object that one that requires approval for an amendment to be effective. For example, an amendment automatically becomes effective if you do not object within 30 days.
6. Termination: Look for an important provision – "Termination without cause" This provision should be available to both parties and is typically a mechanism by the payor to downsize their networks. This is common in "Multiplan". Ensure that you can terminate the contract without cause. Avoid particularly long waiting periods to terminate the agreement. Waiting periods tied to notice before the renewal date can be particularly burdensome. Inquire whether there is an opportunity to terminate during the first year.
7. Best Practices: Appeals: N*umber 1 Rule: If you feel your claim was improperly denied/down coded: APPEAL!* This question is the first question which will be asked of you by your state insurance committee representative or PIAC representative. Failure to appeal can: result in a lost opportunity to get a systems issue fixed in a timely manner; reinforce a payor's belief that this practice is acceptable; deprive APMA of evidence to identify systematic practices and bring them to the attention of the payors. *The appeals process will vary depending on the line of business and payor. For the payors or lines of business that you bill the most or have the greatest degree of difficulty with, the appeals information should be documented and readily available for quick reference to avoid looking it up.

   Understand the Process: Each employer group, individual health plan, Medicare Fee For Service (FFS) or Medicare Advantage (MA) plans (both Contracting and Non-contracting providers), Medicaid FFS or Plan and MMPs all differ in their appeals processes. *Most State laws address member appeals or non-contracting provider appeals. Few prescribe

a process for contracting providers. The same holds true for Federal law. However, denial notices are often regulated and directions on how to appeal are required. Some State and Federal laws also require websites to include explanations of how to appeal.
*_For ERISA/ACA:_ The process applies to claimants (i.e., members and their dependents) this includes plan beneficiaries and their AUTHORIZED REPRESENTATIVES. Becoming an authorized representative essentially allows the physician to stand in the shoes of the beneficiary in order to use the member appeals process. APMA has a model form to be appointed as an authorized representative.

The Appeals Process: Important Steps

a) Evaluate the denial: Take a close look and make sure your claim was submitted correctly and appropriately. If not, ask for a reopening or otherwise file a corrected claim.
b) Submitting your appeal: Send it to the appeals department as directed. DO NOT include legal accusations. DO include a straight-forward explanation. Appeals reviewers are often nurses. In order to deny, the law often requires review by a physician.
c) Include relevant evidence: For Medicare Advantage (MA) appeals, include FFS EOBs that show that the claim(s) was paid/service being a covered service. Include EOBs showing the claim has been paid in the past for the same service. Include any past appeal overturns on the same issue. Include any relevant portions of the medical record.
d) Keep Appealing!! – If your appeal is denied, determine whether there are additional levels of appeal. Under the ACA (member process), Medicare FFS, Medicare Advantage (non-contracting providers) and Medicaid there are additional levels. * Under these programs, you can obtain review by an external, independent entity.

TRENDS AND DEVELOPMENTS:

1. Physician Payment by Private Health Plans: These plans are continuing to adopt value-based payment mechanisms. There is a trend that the plans are being increasingly funded by MLR savings (Medical Loss Ratio) with payments based upon quality outcomes. One study showed that in 2011, 46% of payment arrangements had a value based feature; this trend is expected to increase to75% by 2017. Medicare Advantage (MA) plans are now contracting with ACOs and in this scenario, the MA is allowing the ACO to take the risk.
2. Part D Coverage of Drugs Dispensed In-Office: Under Part D, physicians' offices are considered out-of-network for purposes of Part DCoverage. Under certain circumstances, Part D plans cover drugs/vaccines dispensed out-of-Network when an enrollee cannot reasonably be expected to obtain such drugs at a Network pharmacy. The enrollee may not access covered Part D drugs at an out-of-network pharmacy on a routine basis. Plans cannot generally pay for more than a 30-day supply of drugs from an out of network pharmacy. However, the regulations provide that Part D sponsors must ensure that enrollees have adequate access to vaccines and other covered Part D drugs appropriately dispensed and administered by a physician in a physician's office.
3. Part D. Coverage of Drugs Dispensed in-Office: Plans may set forth policies for coverage of drugs obtained out-of-network (including cost sharing policies) as long as they meet the non-routine standards. One large PBM has recently begun terminating all contracts with physician dispensers. CMS has backed up the PBM's interpretation of the Part D requirements. Given the concerns over this issue, regulatory changes are likely to be set forth in the future.

4. New Medicare Advantage Demonstration: A new "Value Based Insurance Design" starts January 1, 2017 and runs five years. The first 7 test states available for the demonstration were: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania and Tennessee. In 2017, there are 11 plans including BCBS Mass HMO Blue, Fallon, Tufts, Geisinger, Aetna, Keystone, Highmark, and UPMC. *The next round of plans is applying now and Alabama, Michigan and Texas will be added as test states. The "Value Based Insurance Design" creates an exception to the uniformity of benefits rule. *This could offer opportunities for podiatrists*. This design allows for varied plan benefit design for enrollees with the following conditions: *diabetes*, COPD, CHF, Past CVA, HTN, CAD or mood disorders. The changes inherent in this benefit design may include reduced cost-sharing and/or offering additional services to targeted enrollees. This would be beneficial since it would provide: *Reduced Cost Sharing for High Value Services; Reduced Cost Sharing for High-Value Providers; Reduced Cost Sharing for Enrollees Participating in Disease Management or Related Programs; Coverage of Additional Supplemental Benefits.*

NON-DISCRIMINATION: An Update

1. Dominion Pathology Labs versus Anthem Health Plans of Virginia: The plaintiff is a 3 physician practice that provides biopsy diagnostic services. Anthem unilaterally cut payment for services by 60%. The physicians negotiated with Anthem and entered an agreement, but also sued. A suit was filed under Section 2706, an Anti-Discrimination claim as a breach of contract claim. Both parties agreed that there is no private right of action under Section 2706. The Court recently denied a motion to dismiss, but upheld Anthem's right to terminate its contract with the group.
2. Fox-Quamme, Hess, Redfield, Chapman and Clark versus Health Net Health Plan of Oregon, Inc., and American Specialty Health Group, Inc. **This is the case to watch since this equates to Podiatry as it pertains to lower reimbursement rates.* Oregon Association of Naturopathic Physicians (OANP) filed a class action suit in federal court against the Health Net Health Plan of Oregon and its contracted benefits provider American Specialty Health (ASH), alleging "unlawful and discriminatory practices." The plaintiffs are the naturopaths and patients. OANP is not named as a party in the suit. The complaint seeks to establish a class comprised of all enrollees in Health Net's employer benefit plans.

   The discriminatory Health Net/ASH practices cited in the lawsuit include: An annual limit on the Number of reimbursable visits to naturopathic physicians; the requirement of a Medical Necessity Review form that other providers are not required to provide; a $1,500 maximum reimbursable cap for the use of naturopathic medical services; a limitation on certain types of medical care performed by naturopathic physicians that are within their scope of practice including, but not limited to, the delivery of preventative services and reimbursing naturopathic doctors at up to 80% less than other providers for the same service rather than varying reimbursement rates based on objective quality or performance measures*. ** This is the case to watch since this equates to Podiatry as it pertains to lower reimbursement rates*.

3. THREE CLAIMS FOR RELIEF**:** The Defendants violated Section 2706 by discriminating against naturopathic doctors (NDs) with respect to participation under the Plans or coverage of services provided under the Plans Resulting in reduced benefits to Plaintiffs and members of the Class, including denied services and reduced access to care. Patient plaintiffs and the class are entitled

to recover benefits owed, to enforce their rights under the plans, and to clarify rights to future benefits. They are also entitled to attorney's fees.

a) As a result, Defendants retained funds that should have been reimbursed to NDs, and, in some cases, to the patient plaintiffs and Class. Defendants have also profited from reduced access to medical care caused by their discriminatory practices. Patient plaintiffs and the class are entitled to equitable relief, including an injection prohibiting Defendant from discriminating against NDs with respect to participation under the plans or coverage of services provided under the Plans, and attorney fees.

b) Unless this Court resolves the controversy be declaring the rights of the parties, defendants will continue its discriminatory practices. Thus, plaintiffs seek a declaration by this Court that defendants cannot discriminate against NDs with respect to participation under the Plans or coverage of services provided under the plans.

The class action seeks several remedies, including:

- Reimbursement to individuals who have been denied benefits under their Health Net health insurance plans;
- Repayment of profits retained by Health Net as a result of its discriminatory practices
- Enforcement of non-discriminatory practices in the future; and
- A court order for Health Net and ASH that clarifies which of their practices are unlawfully discriminatory.

Actions: HealthNet filed a motion to dismiss. The motion was partially granted. The judge dismissed the first complaint without prejudice and directed OANP to file an amended complaint. OANP filed an amended complaint. The judge dismissed the third claim stating that only patients harmed (not providers) can seek redress under ERISA. OANP is moving forward with discover on the other 2 claims.

Additional Private Insurance Issues:

1. New Jersey: New plans are being introduced into the New Jersey market place that have a tiered system of hospitals and providers. The systems are being devised with credentialing standards that are not transparent and can be discriminatory toward physicians (the standards can be based upon academic credentialing or monetary credentialing and the standards are not transparent nor published). Tier 1 Hospitals are academic teaching institutions and have lower co-pays (these hospitals are less expensive to run and healthcare can be provided by less costly physician coverage). Tier 2 Hospitals have higher copays. The market is driving patients to places of service based upon these standards and affecting provider/patient relations.
2. Humana: APMA has met with Humana on several occasions over the past several years, representing podiatrists whose claims have been denied with the -59 modifier. Humana claims that the appeal rate was only 20% and that clearly there was no problem with Humana's claims processing. It has been identified that when claims are appealed, they are not overturned in 60% of the cases. In an effort to assist its members, APMA requested the following from Humana: A defined pre-payment audit period, definition (an example) of a clean claim (by Humana standards), exclusion list that is clearly defined. Humana responded that they felt uncomfortable providing the above criteria. Additionally, Humana has told APMA that the -59 modifier has been misused. *Many physicians have signed contracts with Humana that contain

arbitration clauses preventing members from suing. APMA can support a class action to advance this.

APMA LEGISLATIVE UPDATE

Benjamin J. Wallner, Director, APMAPAC; Associate Director, Legislative Advocacy

PlANS FOR THE 115th CONGRESS (2017-2018)

HELLPP ACT: (HR 1221/S626) Current Status and Plan

The plan for the 115th Congress is to reach out to Representative Bill Johnson ® Ohio since Representative Rene Elders previous sponsor from NC lost her bid in the primaries and Representative Diana DeGete (D) CO and Senator Chuck Grassley ® IA will be the lead sponsor for the GOP and on the democratic side, Chuck Schumer (D) who previously sponsored the Bill will likely become the House Minority leader and will turn back all legislation, but if the Senate remains in control, he will remain the primary sponsor of the Bill. He has 30 Bills he has kept and APMA's Bill is one of them. Currently, APMA has proposed to attach the Bill to the CHP Reauthorization Bill.

VA Provider Equity Act (HR 2016/S2175) Current Status & Plan

APMA is hoping that this will be passed during the Lame Duck session. The Senate currently has its own version of the Omnibus VA package. We are not included in this package and there is no indication for amendments to this Bill on the Senate side. Chairman of the Senate VA Committee is working with the majority leader in the Senate to schedule a vote on the bill during Lame Duck. If there is an APMA Call to Action, APMA will need to generate as much attention as we can for the Section 101 of the House package. Our Bill is included in the House package and we will need grass roots effort. If it doesn't pass, APMA will work with the current sponsors for 2017/2018.

115th Congress:

In the 2016 election, 34 Senate seats were up for election. All of the House Seats were up for election. The GOP presided in the 2016 election and the GOP has gained control of both the House and Senate and now reigns as the majority party in the 115th Congress.

Changes in Sight

Leadership: With the retirement of Senator Harry Reid (D-NV), the leadership will be changing and Senator Chuck Schumer is slated to take on the role of leadership vacated by Senator Reid.
Committees: There will also be a change in the status of the Committees attributed to retirements and the results of the election, and the Majority party will gain a greater number of the Committee slots.
Lame Duck: In both the House and Senate schedules, the following will occur during the Lame Duck session: Passing of the Budget whether for the remainder of the fiscal year or the ensuing two years, MACRA Rollout, the Election results, shuffling of Committee assignments due to retirement and term limits, Appropriations – CR, 21st Century Cures focused on attention to Opioids/NIH Funding, Drug Pricing and REGROW Act; Chronic Care and the Supreme Court Selection.

Looking Ahead 115th Congress (2017-2018)

In the congressional year 2017-2018, the 115th Congress will be looking at CHIP Reauthorization, FDA Reauthorization, Budget, Appropriations, the Debt Ceiling, 21st Century Cures (if not completed in the 114th), Chronic Care, the MACRA ongoing rollout, the VA/Military/Tricare (ensure that podiatrists in the medical corps receive recognition status afforded other physicians in the military services), the NHSC/HIS and Medicaid (the HELLPP Act). APMA is going to redo the way they achieve success on the Medicaid bill which has failed over the last 10 years by focusing on smaller programs that have less cost and have successes because each of these will lend credence to our role as physicians in the Medicaid program. If we are already physicians in multiple branches within the government, this lends to the argument as to why the federal government needs to change our status as physicians under Medicaid. If we are already physicians in Medicare, in the National Health Service Corp, in the Indian Health Service Corp, the Military, Tricare, DOD then we should be physicians in Medicaid. APMA is asking the CBO to take a look at our bill on the shoe provision.

CLINICAL DATA REGISTRY AND CLINICAL AFFAIRS UPDATE
Diane Tower, DPM, MPH, Director, APMA Clinical Affairs

Biography: Dr. Tower became Director of APMA Clinical Affairs in October 2016. She graduated From Scholl College of Podiatric Medicine in 2009 and did a PMSR/RRA residency in Colorado. She went on to complete a Masters in Public Health at Dartmouth Institute and took a position at Dartmouth on the academic faculty in the Department of Orthopedics. APMA recently hired Dr. Tower where she now oversees the Department of Clinical Affairs.

Qualified Clinical Data Registry (QCDR): The QCDR is an entity that goes through a CMS qualification process and will be a way for APMA to collect data. The data will demonstrate our value to the healthcare system and allow podiatric medicine the ability to improve our position in the healthcare arena. The QCDR will be utilized to report our data to the federal program and will be a member benefit which would otherwise be predicted to cost APMA members $300-$500.

Value Based Care: We are moving away from fee for service (FFS) into Value Based Care (VBC). The U.S. is currently at 17% of our GDP. There are 35 countries who have on a comparative basis, a better GDP. In relationship to other countries, our GDP is far greater and yet our life expectancy is less than these countries in part because we have the greatest number of obese individuals. Relatively, we spend the greatest amount of health care dollars and have the least quality of care. The United States needs to increase value while reducing costs, improve safety and track the information. The QCDR will allow us to track our data.

Next Steps: EHR integration will be required and APMA currently has 25 launch partners as well as other partners with partial involvement all of whom will be integrated into the system throughout the course of 2017. The major part of the equation will be acquiring data from APMA members reporting Quality Measures. APMA must self-nominate the QCDR with CMS for 2017; working with partners in IT to work on the infrastructure to try to launch the system in 2017 so that it will be fully operational in 2019.. As you are aware by now, a minimum of one Quality Measure will be required for submission in 2017. However, QCDR has endless possibilities and APMA is looking to the membership to provide robust data collection. APMA will anticipates fully recouping the funds invested in this project as the process moves forward.

Young Physicians Program (Physicians who have graduated within the last 10 years)

The Young Physicians program is conducted annually at PICA headquarters in Franklin, TN. The program allows young physicians to determine the type of practice that they want to assimilate into, how to build a practice, hiring and firing staff as well as discuss methods of dealing with indebtedness incurred through the course of their education. It is a venue in which the young members acquire leadership skills to prepare them for involvement in APMA at the committee level. Each component is encouraged to send a young member to the YPI.

PM Expo and Coding Seminar: The next PM Expo and Coding Seminar will be conducted on May 20-21, 2017 at the Gaylord National Hotel in Maryland.

Dr. Tower will be involved in the track formation and speaker coordination for APMA's National in Tennessee. She encourages members to contact her directly @ detower@apma.org; 301-581-9250 with any issues of interest.

BEST PRACTICES TO WORKING WITH THE STATE INSURANCE COMMISSIONER and LATEST TRENDS IN STATE INSURANCE REGULATIONS:
Alfred Redmer, Jr., Commissioner for the State of Maryland's Insurance Administration and Member of the National Association of U.S. Insurance Commissioners

Commissioner Redmer feels that education of members is a key component regarding the intersection between healthcare providers and patients, especially when you add payors to the mix. It is important that the payors be a complement to the system and not complicate it. Regulators are the referee in this entire process helping to ensure that the healthcare system is of high quality, effective and affordable. There is a Department of Insurance Regulators for every state in the Union. Each state has its own state Regulator.

Insurance 101: Insurance contracts are legal contracts between the insurance carrier and the consumer and the contract is a written promise for the carrier to pay on behalf of the consumer when a healthcare need arises. A team of financial experts (CPA and financial examiners) are mandated to scrutinize the financial statements of the insurance carriers and ensure that the carrier is taking an appropriate piece of the insurance premium, setting it aside so that when the "promise" comes up down the road that there are enough cash reserves in the bank - to ensure that the insurance carrier is solvent for the future. There is a team that focuses on life and health and they review every insurance contract before it can be offered for sale. The team reviews these provisional contracts to ensure that each provision within the contract complies with the law. The administration also deals with consumer complaints. The department receives thousands of complaints over the course of a year. The most common complaints are on the property and liability side: (i.e. my car insurance was cancelled; my claim wasn't paid). There are also general complaints regarding the interaction between the consumer and the insurance carrier. The Department also handles appeals and grievances. These are cases in which coverage is denied because of medical necessity. There are standards in the law as to how the department has to respond. There are regulators that are available for the emergency situation on a 24/7 basis, 365 days per year. With the appeals process, they have rules at their disposal to force the carrier to do what they don't want to do. Examples include but are not limited to: when the carrier is trying to cancel a policy and the Department doesn't think it is appropriate; making the carrier pay claims that they don't want to pay and make the carrier grant the performance of services that they don't want to allow if they are not complying with the law.

Actuarial Department: The Actuarial Department exists to review policies (proposed rates) before they are enacted. The best example to provide information regarding concerns over the rise in premiums is the ACA. In 2017, the average national rate of increased premiums for the ACA is predicted to be 25% with some states reporting increase in premiums as high as 59%.

The Process: Each year on May 1st the insurance carriers must provide their proposed rates for the following year. The insurance carriers look at their expenses and reserves in May 2016, and have to project what the new rate will be in January 2017 and that rate is locked in until January 2018. This is not an easy process for the carriers and there is little room for error, so the rates are based upon not only actual experience, projected medical trends and changes in morbidity within the population. The proposed rates are received in May of each year, and the Actuaries scrub the data and have hearings and at the end of the day the rates are approved by Labor Day of each year. The law is very clear regarding the standard of approving or disapproving the proposed rates. The rates are determined by:

a) Rates must be actuarial justified
b) Rates cannot be excessive
c) Rates cannot be inadequate – too little. They must prevent the carriers from charging
    - the low justifiable premiums; they can't knowing lose money and place themselves in
    - financial stress which would create a solvency issue.
d) Rates cannot be unfairly discriminatory in nature.

Compliance and Enforcements:

Investigators: Investigators in response to consumer complaints and pattern of concerns who approach the insurance carrier and perform a market exam looking at the business conduct of the carrier. They scrutinize the business activities by looking at claims, applications and all businesses processes to ensure that there is no inappropriate systemic activity. Investigations are also carried out on independent brokers and Third Party Administrators. If there is egregious or intentional, the Investigators have the right to suspend or revoke licenses.

Fraud Department: For those carriers who conduct fraudulent activity, there is a Fraud Unit Including retired policemen, forensic auditors, troopers from the state police and attorneys from the AG's office whose role is to identify, investigate and prosecute fraudulent activity.

Team for Consumer Education and Advocacy: This team was created by the commissioner in response to Hurricane Isabel to educate and advocate for consumers during the rebuilding process occurs and in response to natural disasters to disseminate information to the public to assist with disaster relief.

Life and Health Unit: This unit fines insurance carriers all the time. It is recommended that the practitioner file a complaint to get a different set of eyes on the claim. Each month, compliance investigators review anecdotal complaints that come into the department and if there is a common pattern of complaints the department will investigate the complaints to ensure that there is not a systemic complaint.

The Insurance Departments are all part of the Executive Branch of Government, appointed by Governors. There are 11 Commissioners around the country that are elected by state-wide elections. The laws in each state are created by the state legislature, and the state legislature hands then to the Executive Branch of government and it is the role of the Executive Branch to implement the laws. Laws are nothing more than a broad statement of public policy and the broad public policy has as many answered questions as unanswered questions. (Think of the ACA which was created by Congress (at least one side of Congress) but was followed by thousands of pages of regulations that was created by the bureaucracy of the Federal government). The states legislature creates a law of public policy to fill in the blanks and to answer the unanswered questions. The local Insurance Department creates

regulations and the regulations provide the necessary details to implement the Law. Regulations must past the following tests:

a) Legal
b) Regulatory
c) Smell Test

Everything that Regulators do is grounded by Law. Regulators enforce the Law; no more, no less. At the end of the day, then it is incumbent upon the Regulators to take their concern to the State Capitol to the General Assembly who plays referee of how to find the request in Law or not. If you are an insurance carrier, you can do what you want to do, when you want to do it and how you want to do it without any repercussions as long as the existing Law is not violated.

State Regulators:

a) Enforce the insurance arm; they do not regulate providers or hospitals.
b) They also regulate everything except what they can't regulate (i.e. A large employer with an employer sponsored health plan that is self-funded and not fully insured, the Regulator can't touch it since it is protected by the state ERISSA laws. It is exempt from state Regulators by the federal ERISSA laws (and these are allegedly regulated by the Department of Labor).
c) They do not regulate Surplus lines (Lloyd's of London)
d) They do not regulate Medicaid except the solvency piece of the MCO's
e) They do not regulate Medicare except the solvency piece of the equation: MA plans
f) They do not regulate flood insurance

National Issues:

1. Cyber Security: A draft proposal at the National Association of Insurance Commissioners which is under consideration to impose universal standards regarding cyber security.
2. Network Advocacy: The national statues are more of an objective rather than quantified standards. Regulators are trying to add quantitative and non-quantitative standards to these networks.
3. Rising Rate for long-term care policies: The industry is young. The population is aging and mentally and physically debilitated with increase in the number of claims and increase in the length of stay. This is raising rates tremendously.

ACA: 2 Issues Regarding the ACA

1. The Cost and burden of beaurocracy – it is costlier, more burdensome and more dysfunctional than imaginable.
    a) In 2005 CareFirst (BCBS MD) had to be worried about the MD Insurance Administration and the MD General Assembly.
    b) In 2016 CareFirst has to be worried about the MD Insurance Administration, the MD General Assembly, as well as Congress, CMS, Department of Justice, the Office of Personnel Management as well as the State or the Federal Exchange. Now, they spend an incredible amount of money dealing with the added beaurocracy of the Exchange which amounts to a small insignificant part of their business. This level of beaurocracy is expensive.
    c) Co-Ops: Co-Ops have been created by the ACA to add competition to the market place and to focus on improved medical outcomes. In Maryland, the Co-Op was created by a former physician and public health officer who surrounded themselves with experts in the insurance industry who have collectively created a good business model. There is

good disease management, good healthcare management, improved medical outcomes, good financials HOWEVER, they are on the brink of imploding due to the rules of the federal government.

2. Rates are unsustainable

The Commissioner closed the lecture educating the audience regarding how we as physicians change the environment? How do we engage and improve the lives of our patients and the consumer?

a) Education and knowledge are the key and we must know the laws and state regulation, what are own contracts say, what our appeal rights are, what the rules of engagement say with the insurance carriers and with the Department of Insurance.
b) Identify a mentor – someone who has been around who has engaged in the battles and who would like to introduce us to those they already know.
c) Call the local legislator and introduce yourself and most are happy to do it if you introduce yourself as a resource of information.

PRIVATE PAYOR (PIAC) GROUP DISCUSSION

Moderators: Laura Pickard, DPM and Len LaRussa, DPM

Horizon: In N.J., Horizon is recouping a lot of money for the *L3000 codes for orthotics*. The state association and APMA have coordinated efforts in disputing this and there has been a lot of push back from the carrier despite these efforts. At this time, it is in discovery phase, and the recommendation has been made for each of the member physicians to review their policy. Dr. Kesselman, who has been leading the charge to assist in this matter cautioned the practitioners that they must look at their policies to determine if their minimum requirements for coverage of orthotics. He cautioned that the private carriers have the right to interpret reimbursement for the device. They can't reinvent the definition of the device however they can say that if the patient doesn't meet a certain standard, the device will not be covered.

People use inches instead of millimeters for heel cup depth 3/8 comes up 1/100 inch short for reimbursement. The company is also holding the standard of a picture of a UCBL device as their standard. The recommendation has also been made to get these measurements off the lab requisitions. In some instances, referring to a court case in California which upheld the fabrication of a functional device via a Root Biomechanics casting methodology was successful in winning the case. This insurance company is recouping the payment along with recovery of trebling damages that is resulting in millions of dollars of fees.

*The take home message is to look at your policy and determine the minimum requirement(S) for orthotic coverage. Instruct your local lab to remove the term "UCBL" from the orthotic order form. It is preferable that measurements be converted to millimeters on the requisition as well.

Anthem: In October 2015, the GY modifier was excluded from Medicare coverage. If it was stripped off the Medicare EOB and sent to the secondary carrier, BCBS Federal, it was paid. If Medicare is the primary carrier and the secondary is BCBS Federal, they are no longer paying for orthotics with or without the GY modifier. There is no current

Custom Molded Shoes: The issue is the necessity to cast every year for a new custom molded shoe or inserts. Medicare feels that this is necessary. PFA and APMA is drafting a document to be submitted to

CMS that states that a new impression does not need to be made every year especially if the patient is responding well to treatment and there has been no structural changes of the foot or ankle since the last casting. Inherent in this is that a good positive cast has been made on the patient's behalf historically. To force the practitioner to perform casting on a yearly basis is counterproductive if the patient is progressing well.
*You must *appeal all claims*! Dr. Kesselman feels that APMA should provide members with a comprehensive mechanism

Coding Resource Center: Quick AFO diagnosis set which will be updated by Harry and Dave.

Appropriate documentation for diabetic shoes can be found @: **www.APMA.org/dme.** This information was provided for APMA members to assist them reimbursement of diabetic shoes. This was sponsored by PICA and the information is guided by PICA's attorney, Kevin West, J.D. Another important address on the APMA website is **www.APMA.org/back**tobasics to provide information on future webinars.

Members do not know how to document! APMA will continue to do webinars to assist members with documentation: Another important address on the APMA website is **www.APMA.org/back**tobasics to provide information on future webinars.

Medicare Advantage Plans: It is to your advantage to list all pertinent diagnoses – the carriers are looking for as many primary diagnoses in reviewing records so that they can extrapolate as a maximum amount of money from the Medicare. Many payors are looking for the systemic diagnoses: diabetes with peripheral neuropathy; diabetes with peripheral angiopathy or PVD. It is recommended that these covered diagnoses be listed first, as the primary diagnoses on the claim form. This will typically keep the auditors happy!

UHC MA: Has been denying x-ray claims. Appeal the claims and use -26 modifier on the claim form to avert this.

Medicare Advantage: APMA has proposed doing a pre-payment audit with MA plans. Some people have responded negatively to this proposal. This will be taken under consideration however, APMA must have data regarding denials so that they can confront the carrier with factual trends of denials. If you appeal and are placed on an exclusion list, you must contact APMA to determine with the patients APMA needs to know about denials! You must appeal all claims and contact APMA with any information.

United Health Care:

1. Economic Credentialing: UHC is performing economic credentialing in all specialties across the board with the exception of podiatry.
2. Denials have been seen in CA for dispensing a wound vac for DFU in an outpatient setting. UHC requires a peer-peer review and podiatrists to not qualify by licensure to take part in the peer-peer review process (Only MD, DO and NP). Stay tuned
3. E/M with procedure with modifier. Denial of procedures with the assessment codes has taken place in CA. As a strategy to combat this, the employer is contracted with the carrier to provide services on behalf of their employees and requiring the patient to present for evaluation and rescheduled for a procedure costs the employer money. In these instances, approach the employer and advocate for the patient, not yourself. Often these denials will be scrutinized by the employer HR department and be overturned!

UHC: United Health care has been requiring pre-authorization for surgeries and orthotics now on all plans including PPO plans. The review process can take as long as 10-14 days, so beware!

Aetna: Has historically required the following documentation for authorization for bunion surgery: During the pre-authorization phase, the carrier has required the following:

1. Documentation of 6 months of conservative care
2. Designating that the IM angle: 13 and HA angle: 35
   *These requirements can change on a whim. Please notify the insurance representative so that we can be apprised of these issues.

Anthem: Orthotics Coverage: Anthem software does not recognize the GY modifier. Claims are being denied for orthotics submitted with GY modifier. Appeal and resubmit as a paper claim without the GY modifier and the claim will be paid.

GY Modifier: Orthotics: Medicare primary is submitted with -GY modifier. When you receive the denial from Medicare, the solution for payment entails dropping the claim to paper and removing the –GY modifier. The claim should be paid. (This is occurring in the software loop since Anthem and BCBS Fed do not recognize the –GY modifier.)

Humana: Humana has been denying claims for more reasons known to man. If you have problems with Humana, please notify the state insurance representative, Don Blum or myself and we will assist you with appeals. Please be advised that in the market place, there has been a great degree of push back from Humana and states have been advised to work through your state representatives and we will contact APMA to assist in the appeal process.

BCBS: Insurance cards have changed and you must verify eligibility. The cards may designate the patient as having PPO coverage. In actuality, the plan may be an HMO product. In reality, the patient may be an HMO patient and the card designates it as a PPO product. This coverage allows the HMO patient to travel out of state and the claim will be paid with PPO rates as out-of-network coverage. VERIFY ELIGIBILITY!!!