Carrier Advisory Committee & Private Insurance Advisory Committee Representatives'

Orientation Manual

APMA
American Podiatric Medical Association

2014

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2014–2015 Health Policy & Practice Committee (HPPC)

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Chair, Medicare & Public Payer Subcommittee: Edward Prikaszczikow, DPM
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Health Policy & Practice Committee

The Health Policy & Practice Committee (HPPC) develops policies, programs, and other activities to position the doctor of podiatric medicine as the recognized foot and ankle care specialist within public and private health care delivery and financing systems. HPPC advocates federal administrative agencies, private insurance plans, and other health care delivery systems to end barriers to services provided by podiatrists, to foster better access to medically necessary care by podiatrists, and for fair and equitable payment for podiatrists. The Health Policy & Practice Committee advises the APMA Board of Trustees on matters affecting the profession, including those associated with Medicare, Medicaid and related federal health policy and private insurance issues.

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Private Insurance Subcommittee

The Private Insurance Subcommittee advises the Health Policy & Practice Committee on issues related to private insurance plans, including but not limited to, preferred practice organizations (PPOs), employer insurance carriers, health maintenance organizations, commercial accountable care organization and other alternative health-care delivery and payment systems. The Private Insurance Subcommittee develops and/or recommends resources to help educate members on private insurance plans and policies, and recommends marketing activities to promote the profession within private insurance plans.

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Medicare and Public Payer Subcommittee

The Medicare and Public Payer Subcommittee advises the Health Policy & Practice Committee on issues related to public payer plans and federal health policy, including Medicare, Medicaid, Veteran's Affairs, and Tricare. The subcommittee reviews and provides advice on national coverage determinations and develops positions for NCDs. The Medicare and Public Payer Subcommittee also offer guidance to Carrier Advisory Committee representatives (CAC) on local coverage determinations. In summary, the Medicare and Public Payer Subcommittee recommend the development of resources and educational materials to foster member understanding of public payer reimbursement and compliance issues.

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DME Workgroup

The DME Workgroup advises the Health Policy & Practice Committee on issues related to public payer plans and federal health policy, including Medicare, Medicaid, Veteran's Affairs, and Tricare. The workgroup reviews and provides advice on national coverage determinations and develops positions for NCDs. Additionally, the workgroup offers guidance to Carrier Advisory Committee representatives (CAC) on local coverage determinations. In summary, the DME Workgroup recommends the development of resources and educational materials to foster member understanding of public payer reimbursement and compliance issues.

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APMA Resources

www.apma.org

➢ CAC & PIAC Information	www.apma.org/cacpiac
➢ APMA Coding Resource Center	www.apmacodingrc.org
➢ Coding Resources	www.apma.org/coding
➢ Compliance Materials	www.apma.org/compliance
➢ DME Resources	www.apma.org/dme
➢ HIPAA Privacy & Security Manuals	www.apma.org/hipaa
➢ ICD-10 Resources	www.apma.org/icd10
➢ Medicare Part B (BMAD Data)	www.apma.org/medicarepartb
➢ Physician Payment Sunshine Act	www.apma.org/sunshineact
➢ Private Insurance Resource Guide	www.apma.org/pirg
➢ Reimbursement Resources	www.apma.org/reimbursement
➢ State Components	www.apma.org/statecomponents

National Podiatric Carrier Advisory Committee (CAC)

Background of the CAC

- In 1992, the Health Care Financing Administration (formerly HCFA, now Centers for Medicare and Medicaid Services, or CMS) required all Medicare Part B Carriers to establish a Physician's Carrier Advisory Committee
    - Originally called a Physician Advisory Committee

Purpose of the CAC

Medicare Program Integrity Manual, Chapter 13, Section 13.8.1.1.

- A formal mechanism for physicians in the State to be informed of and participate in the development of a LMRPILCD in an advisory capacity
- A mechanism to discuss and improve administrative policies that are within carrier discretion
- A forum for information exchange between carrier and physicians

Carriers shall clearly communicate to CAC members that the focus of the CAC is Local Coverage Determinations (LCDs) and administrative policies and not issues and policies related to private insurance business. The CAC is not a forum for peer review, discussion of individual cases or individual providers. While the CAC shall review all draft LCDs, the final implementation decision about LCDs rests with the Carrier Medical Director.

What is CMS?

- Centers for Medicare and Medicaid Services
    - Formerly HCFA
    - Under the Department of Health and Human Services
    - Created in 1977
    - Administers the Medicare program and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards

- CMS Function
    - Assures Medicare and Medicaid are properly administered by its contractors
    - Establishes policies for reimbursement of health care providers
    - Conducts research on effectiveness of various methods of health care management, treatment and financing
    - Assesses the quality of health care facilities and services

- CMS Role in Health Care Policy
    - The United States Congress generates statutes that set guidelines regarding covered and non-covered services
    - The United States Congress determines the aggregate amount of funds available to provide and administer those services
    - CMS then generates policies to provide appropriate services with the funds available

Federal Law (Statutes)

- MCM 2323
    - Foot care and supportive devices for feet
- Foot care policies
    - Excludes:
        - Treatment of flat foot
        - Treatment of subluxation of foot
        - Routine foot care (covered with systemic conditions, etc.)
        - Supportive devices (except therapeutic shoes)
- MCM 4120
    - Application of Foot Care Exclusions to Physician's services
        - Instructions to the carriers on payments
            - Routine care requirements included here
- MCM 2323 & 4120
    - Medicare Benefit Policy Manual. Chapter 15, Section 290 "Foot Care"
- 42 U.S.C. 1876(c) (2) (a)
    - Requires Medicare/Medicaid managed care plans to provide their enrollees with services available/covered under Medicare Parts A and B
        - It does not stipulate who provides the services

CMS Criteria

- Demonstrated effectiveness
- Appropriateness
- Comparison with similar technologies

CMS

- Influences policy by selecting and overseeing the Medicare Carriers for the states
- Makes National Coverage Determinations and interpretations, which are binding on all Medicare contractors
    - They are **not** subject to public notice and comment prior to implementation

Membership on the CAC

- Doctors of Medicine
- Doctors of Osteopathy
- Doctors of Dental Surgery
- Doctors of Podiatry
- Doctors of Optometry
- Chiropractors

CAC Structure

- Each specialty shall have only one member and a designated alternate with approval of committee co-chairs.
- Consider a 2-3 year term
- The CAC is co-chaired by the contractor medical director and one physician on the committee.

Role of the CAC Member

- Serve to improve the relations and communication between Medicare and the physician community
- Disseminate proposed LCDs to colleagues in their respective State and specialty societies to solicit comments
- Disseminate information about the Medicare program obtained at CAC meetings to their respective State and specialty societies
- Discuss inconsistent/conflicting LCDs

If a CAC representative feels that he/she has exhausted remedies within the structure of their local carrier, he/she can appeal to the CMS Regional Reimbursement Policy Specialist.

Always check with APMA before you contact the regional specialist

Absence of a National Coverage Determination

- In the absence of a national decision or policy for particular services, local contractors have the discretion to issue a local coverage determination (LMRPILCD)
    - About 70% of policies are LCDs
    - About 30% of policies are National Coverage Determinations (NCDs)

Local Medical Review Policy (LMRP) = Local Coverage Determination (LCD)

- About 70% of policies
- Program integrity tool
- Address and identify potential abuse
- Specify criteria that describes whether an item or service is covered and under what circumstances it is considered reasonable, necessary, and appropriate

Content of an LCD

- Clear, concise and properly formatted
- Does not restrict or conflict with NCDs or coverage provisions in interpretive manuals

When to Develop New/Revised LCDs?

- Claims are paid or denied without a provider having a full understanding of the basis for payment and denial
- Contractors identified a service that is never covered under certain circumstances and wish to establish automated review in the absence of a National Coverage Determination or coverage provision in an interpretive manual that supports automated review
- A validated widespread problem demonstrates a significant risk to the Medicare trust funds
- A LCD is needed to assure beneficiary access to care
- Uniform LCDs across all of a contractor's jurisdiction is required
- Frequent denials are issued (following routine or complex review) or frequent denials are anticipated

Developing a LCD

- Is there a Benefit category?
- Do you have jurisdiction?
- Is the item/service statutorily excluded?
- Is the item/service reasonable and necessary*?
- Is the item/service limited by a national coverage determination?

*In order to be covered under Medicare, a service shall be reasonable and necessary, as defined in the Social Security Act§1862(a)(l)(A). Contractors will consider the following factors in determining whether a service is reasonable and necessary:

- Safe and effective
- Not experimental or investigational
- Appropriate in terms of the duration and frequency of the service, compliance with medical practice standard, medically necessary, and service provided by qualified personnel and in a setting appropriate to the patient's medical needs and condition

Techniques for writing LCDs

- Provide extensive and high quality of evidence to support LCDs. In order of preference, LCDs should be based on:
    - Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies
    - General acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:
        - Scientific data or research studies published in peer-review medical journals
        - Consensus of expert medical opinion (i.e., recognized authorities in the field)
        - Medical opinion derived from consultation with medical associations or other health care experts

LCDs That Require a Comment and Notice Period

- Contractors shall provide for both a comment period and a notice period in the following situation
    - All **New LCDs**
    - Revised LCDs that **Restrict** Existing LCDs
    - Revised LCDs that make a Substantive Correction
- Contractors shall solicit comments on the draft LCD from:
    - Groups of health professionals and provider organizations that may be affected by the LCD
    - Representatives of relevant specialty societies
    - Other intermediaries/carriers
    - Quality Improvement Organizations within the region
    - Other CMDs within the region
    - General public
    - The Regional Office, associate regional administrator, for distribution to the appropriate regional staff.
    - The appropriate Advisory process:
        - The CAC, for carriers
        - The DMERC Advisory Process (DAP), for DMERCs

Comment period for LMRP/LCD

- Minimum comment period of 45 calendar days on the draft of LCD; and
- Minimum comment period of 45 calendar days on the final LCD
- Starts when the LCD is distributed to the CAC

Draft LCD Open Meetings

- Contractors shall provide open meetings for discussing the draft LCDs prior to presenting the policy to the CAC
- Members of CAC may attend these open meetings
- Interested parties, including providers, physicians, vendors, manufacturers, beneficiaries, laboratories, home care, nursing facilities, hospice, and caregivers, can also participate in these open meetings

LCD Notice Process

- Final LCDs
    - Must be made public via publication on the web site, or in a news bulletin
    - Effective date follows a minimum notice period of 45 days
        - DMERC notice is 45 days

Application of LCD

- Applied to claims on either a repayment or a post payment basis.
- Should **not** be applied retroactively to claims processed prior to the effective date.

Communication Plan for the Review of Local Coverage Determinations (LCDs)

This plan is intended to allow for better coordination of the activities of the LCD Subcommittee, but does not represent official APMA policy

1. When a CAC representative contacts APMA requesting assistance with the review of a new or revised LCD, the CAC representative will be advised that:
    - Three weeks lead-time is required to evaluate the LCD
    - Additionally, the CAC representative will be instructed:
        a. To release the policy on the CAC listserve inviting feedback from other CAC representatives. (The exact website link to the policy must be provided.)
        b. To send a separate e-mail to the other CAC representatives that share the same carrier (APMA will provide the names and contact information of the other CAC representatives that should be contacted) asking for input and identification of any concerns related to the policy.
2. If the CAC representative is satisfied with the responses from the list serve and the other CAC representatives that share the same carrier, THEN *no further action is required*. If the CAC representative is not satisfied with the responses from the listserve and the other CAC representatives that share the same carrier, THEN *he/she may request assistance from the LCD Subcommittee.*
3. The APMA will communicate the request for assistance to the LCD Subcommittee.
4. APMA will notify the other CAC representatives that share the same carrier that the LCD Subcommittee is reviewing the policy and invite their input/concerns.
5. The LCD Subcommittee will communicate about the policy via e-mail or conference call. All responses will be communicated to APMA.
6. APMA will formulate a draft response based on the comments and recommendations of the LCD Subcommittee.
7. The draft response will be shared with the LCD Subcommittee and revisions will be made if necessary.
8. Once the LCD Subcommittee finalizes the response, the recommendations and comments will be communicated to the HPC Chair.
9. Any final recommendations and comments formally made by APMA must be approved in advance of their release by the HPC Chair and, if deemed appropriate, by the HPC Chair and the APMA BOT.
10. The recommendations and comments should then be shared with the original CAC representative requestor or with the CAC representatives that share the same carrier.
11. If necessary, APMA will submit written comments to the carrier, which will reflect the opinions and recommendations of the LCD Subcommittee. (This step will be dependent upon the response of the carrier.)

PRIVATE INSURANCE ADVISORY COMMITTEE STRUCTURE
OUTLINE FOR COMPONENT ORGANIZATIONS

The current managed care environment of Private Payers is placing an extraordinary burden on the podiatric physician to keep pace with changes in policies. These policies are in a constant state of flux and include changes in fee schedules, claims processing guidelines, coding, drug formularies and member benefits. There is no consistency from one payer to another, making it difficult for the individual provider to keep up with these changes. Therefore, it is crucial for each state component to identify a Private Insurance Advisory Committee (PIAC) representative to better serve members.

I. PIAC BASICS

A. Each component organization should have a designated PIAC representative. In many states, this will be a different person than the one assigned to the CAC process. However, some states may find it necessary to have the CAC representative serve as the PIAC representative as well.

B. All members of the state component organization should know the PIAC representative. Members should be advised to contact their PIAC representative for guidance on how to handle private insurance issues.

II. PIAC REPRESENTATIVE

A. This individual should be someone who is familiar with private insurance issues such as coding and claims processing.

B. The PIAC representative should become familiar with their individual state insurances laws as they apply to private carriers. Particular attention must be given to statutes (if present) that apply to:
   1. Timely payment
   2. Fee discrimination (if applicable)
   3. Retroactive payment
   4. Fee schedules and contractual information

III. PIAC RESPONSIBILITIES

A. The PIAC representative should receive information from members and determine what type of issue it is:
   1. Claims processing
   2. Payment/reimbursement
   3. Policy/contractual
   4. Other

B. The PIAC representative should then recommend the appropriate action to the member:

1. Give advice to the member on the process for the member to take appropriate action.
2. Collect more information from the member that may be necessary for the PIAC representative to assist the member. This may include: correspondence between the payer and the member, EOBs, etc.
3. Enable the member to be more effective by providing guidance such as form letters for appeals, contact information, statute information, etc.
4. All correspondence to the payer/insurance carrier should be documented. Confirm all telephone conversations with a follow- up letter as needed and send letters via certified mail.

IV. Establish an effective communication network to disseminate regional issues to members. Examples of communication tools include:

1. List Serves
2. E-mail Blasts
3. Newsletters
4. Membership meetings
5. Phone Trees

V. Establish personal contacts at insurance carriers in your state.

VI. APMA should be informed of patterns or issues developing within your state or region so that APMA can be more effective in dealing with issues that have the potential for further spread or are issues with large national carriers.

PIAC Algorithm

When a Private Insurance Advisory Committee (PIAC) representative receives a complaint from a member regarding a private insurance issue, the representative is responsible for directing the member as to how to solve the issue. This step-by-step procedural guild was developed as a tool to aid the PIAC representative in addressing these issues.

Step 1: Determine the type of complaint or issue

Group A: Claim Denial and/or Claim Delay

- Denial preauthorization
- Denial of payment after preauthorization
- Denial of procedure or service
- Denial of CPT modifier
- Automatic denial of code(s)
- Late payment of claim

Group B: Coding and Reimbursement Issues

- Payment below contract fee schedule
- Inappropriate bundling of services/procedures
- Inappropriate down-coding of originally submitted CPT code
- Incorrect application of CPT modifier
- Failure to follow general CPT guidelines
- Inappropriate modification of originally submitted CPT code

Group C: Policy and Contract Related Issues

- Plan has set limits for services performed by DPMs but not for MDs and DOs
- Coordination of benefits issue
- Request for retrospective audit or review
- Request for extensive documentation
- Adjustment of global period
- Medical necessity review

Group D: Other

Step 2: Once a determination has been made as to the type of complaint, the following approaches should be taken by the PIAC representative to address the issue:

Claim Denial and/or Claim Delay Issues

When the PIAC representative is contacted by a member who has identified an inappropriate claim denial or claim delay by an insurance carrier, the representative should instruct the member to first attempt to resolve the matter by contacting the insurance carrier's provider representative or claims manager. The member should be advised to obtain the name, title, and contact telephone number of the person they speak with and to write this information down in their notes.

If the phone call to correct the issue is unsuccessful, the member should be advised to:

1. Become familiar with:
    a. The insurance carrier's claim appeals process, as some carriers may require specific forms for submitting claim appeals
    b. The insurance carrier's claim adjudication procedures
    c. The insurance carrier's rates and reimbursement methodology

2. Prepare an appeal letter that includes the patient's name, subscriber's name, insurance carrier identification and plan numbers, date of service, and the reason the physician is challenging the denial or delay.

3. Be sure to thoroughly explain the rationale for challenging the denial or delay in the appeal letter.

4. Gather and include the appropriate documentation to support the claim appeal. Useful supporting documentation may include:
    a. The insurance carrier's contract or medical payment policy that supports the procedure listed
    b. CPT guidelines that can be referenced
    c. Operative notes that explain the separate and identifiable services reported
    d. CMS guidelines that can be referenced
    e. State prompt payment laws that can be referenced

5. Be sure to address the appeal letter to the appropriate provider representative so someone will be responsible for a reply. If a contact person is unknown, call the carrier and request the name and address of the appropriate provider representative or the appropriate department to which the appeal letter should be addressed.

6. Make a copy of the letter and supporting documentation for your records.

7. Send the letter and supporting documentation by certified mail, return receipt requested.

8. When sending a letter regarding a claim delay issue, send a copy of the letter to the state insurance commissioner for their records. Also, be sure to reference this at the bottom of the letter.

9. Consistently follow up with the carrier's provider representative on the status of the review of the claim appeal.

Coding and Reimbursement Issues

When the PIAC representative is contacted by a member who has identified a coding or reimbursement problem, the representative should instruct the member to first attempt to resolve the matter by contacting the insurance carrier's provider representative or claims manager. The member should be advised to obtain the name, title, and contact telephone number of the person they speak with and to write this information down in their notes.

If the phone call to correct the issue is unsuccessful, the member should be advised to:

1. Become familiar with:
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    b. CPT guidelines that can be referenced
    c. Operative notes that explain the separate and identifiable services reported
    d. CMS guidelines that can be referenced, State laws regarding fee discrimination or fee schedule changes without notification, etc., that can be referenced

5. Be sure to address the appeal letter to the appropriate provider representative so someone will be responsible for a reply. If a contact person is unknown, call the carrier and request the name and address of the appropriate provider representative or the appropriate department to which the appeal letter should be addressed.

6. Make a copy of the letter and supporting documentation for your records.

7. Send the letter and supporting documentation by certified mail, return receipt requested.

8. Consistently follow up with the carrier's provider representative on the status of the review of the claim appeal.

Policy and Contract Related Issues

When the PIAC representative is contacted by a member who has identified an insurance carrier policy or contract related problem, the representative should instruct the member to first attempt to resolve the matter by contacting the insurance carrier's provider representative or claims manager. The member should be advised to obtain the name, title, and contact telephone number of the person they speak with and to write this information down in their notes.

If the phone call to correct the issue is unsuccessful, the member should be advised to:

1. Become familiar with:
    a. The insurance carrier's claim appeals process, as some carriers may require specific forms for submitting claim appeals
    b. The insurance carrier's claim adjudication procedures
    c. The insurance carrier's rates and reimbursement methodology

2. Prepare an appeal letter that includes the patient's name, subscriber's name, insurance carrier identification and plan numbers, date of service, and the reason the physician is challenging the denial or delay.

3. Be sure to thoroughly explain the rationale for challenging the insurance carrier's policy or contract provision in the appeal letter.

4. Gather and include the appropriate documentation to support the claim appeal. Useful supporting documentation may include:
    a. The insurance carrier's contract or medical payment policy that supports the procedure listed
    b. CPT guidelines that can be referenced
    c. Operative notes that explain the separate and identifiable services reported
    d. CMS guidelines that can be referenced
    e. State laws regarding fee discrimination, equal pay for equal work, regulating procedures for recoupment, timeframes for audits, statutes of limitation, etc., that can be referenced.

5. Be sure to address the appeal letter to the appropriate provider representative so someone will be responsible for a reply. If a contact person is unknown, call the carrier and request the name and address of the appropriate provider representative or the appropriate department to which the appeal letter should be addressed.

6. Make a copy of the letter and supporting documentation for your records.

7. Send the letter and supporting documentation by certified mail, return receipt requested.

8. Consistently follow up with the carrier's provider representative on the status of the review of the claim appeal.

<u>Step 3</u>: If a PIAC representative is contacted by a member who has completed Step 2 but the problem has not been resolved, the representative should instruct the member to:

1. Send copies of all documentation (including personal notes) related to the problem to the PIAC representative.
2. The PIAC representative should share this information with his/her state component president or executive director to enlist their help in addressing the issue.
3. The PIAC representative should also share the information with APMA to inform them of the issue.

<u>Step 4</u>: If the state component society is unable to resolve the issue, the PIAC representative should contact APMA to assist in addressing the issue.

Acronyms Used by APMA

revised 6/14

AAAHC	American Association of Ambulatory Health Centers
AACPM	American Association of Colleges of Podiatric Medicine
AADE	American Association of Diabetes Educators
AAFS	Academy of Ambulatory Foot Surgery
AAHP	American Association of Hospital & Healthcare Podiatrists
AAPA	American Academy of Physician Assistants
AAPC	American Academy of Professional Coders
AAPPM	American Academy of Podiatric Practice Management
AARP	American Association of Retired Persons
AAWP	American Association for Women Podiatrists
ABN	advanced beneficiary notice
ABPO	American Board of Podiatric Orthopedics
ABPOPPM	American Board of Podiatric Orthopedics & Primary Podiatric Medicine
ABPPH	American Board of Podiatric Public Health
ABPS	American Board of Podiatric Surgery
ABQAUR	American Board of Quality Assurance & Utilization Review
AC	Accreditation Committee
ACC	American College of Cardiology
ACFAOM	American College of Foot and Ankle Orthopedics and Medicine
ACFAS	American College of Foot & Ankle Surgeons
ADA	American Diabetes Association
AFO	ankle-foot orthoses
AHIP	America's Health Insurance Plans
AHP	association health plan
AMA	American Medical Association
AMC	Annual Meeting Committee
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Podiatry Association
APC	ambulatory payment classification
APG	ambulatory payment grouping
APHA	American Public Health Association
APMAPAC	APMA Political Action Committee
APMSA	American Podiatric Medical Students' Association
ARC	Awards & Recognition Committee
ASC	Ambulatory surgical center
ASO	Arteriosclerosis Obliterans
ASPA	Association of Specialized & Professional Accreditors
ASPE	American Society of Podiatric Executives
ASPMA	American Society of Podiatric Medical Assistants
ASPS	American Society of Podiatric Surgeons
AWP	average wholesale price
AZPod	Arizona Podiatric Medicine Program at Midwestern University
BCBS	Blue Cross Blue Shield

BCBSA	Blue Cross Blue Shield Association
BMAD	Medicare Part B Data
BNI	Beneficiary Notices Initiative
BOT	Board of Trustees
BUSPM	Barry University School of Podiatric Medicine
C&C	Corns & Calluses
CAC	Carrier Advisory Committee
CASPR	Centralized Application Service for Podiatric Residencies
CB	Consolidated billing
CC	Coding Committee
CCI	Correct Coding Initiative
CCPC	Correct Coding Policy Committee
CEC	Continuing Education Committee
CERT	Comprehensive Error Report Testing
CEU	Continuing education unit
CHAMP US	Civilian Health and Medical Program of the United States
CHEA	Council for Higher Education Accreditation
CLIA	Clinical Laboratory Improvement Amendments
CMD	Carrier Medical Director
CME	Continuing medical education
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of benefits
COC	Certificate of Coverage
COPs	conditions of participation
COTH	Council of Teaching Hospitals
CPAC	Clinical Practice Advisory Committee
CPed	Certified Pedorthist
CPME	Council on Podiatric Medical Education
CPMS	College of Podiatric Medicine & Surgery- Des Moines University
CPT	current procedural terminology
CRC	Coding Resource Center
CRIP	Centralized Regional Interview Process
CSPM	California School of Podiatric Medicine at Samuel Merritt College
cv	curriculum vitae
DAC	Diabetes Advisory Committee
DAP	DMERC Advisory Process
DC	Development Committee
DEA	Drug Enforcement Agency
DGs	Diagnostic groups
DHHS	Department of Health & Human Services
DIPJ	Distal Interphalangeal Joint
DME	durable medical equipment
DMEPOS	durable medical equipment prosthetics, orthotics, & supplies
DMERC	durable medical equipment regional carrier
DOA	dead on arrival
DOE	Department of Education
DOJ	Department of Justice

DPM	Doctor of Podiatric Medicine
DRG	diagnosis related group
EC	economic credentialing
E&M	evaluation & management
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMG	Electromyography
EOB	Explanation of benefits
EOMB	explanation of medical benefits
EPF	Endoscopic Plantar Fasciotomy
EPHI	Electronic Protected Health Information
ERISA	Employee Retirement Income Security Act
ESWT	Extracorporeal Shockwave Therapy
FACA	Federal Advisory Committee Act
FAQ	frequently asked questions
FDA	Food and Drug Administration
FEC	Federal Election Commission
FFS	Fee for Service
FI	fiscal intermediary
FIP	Federation Internationale des Podologues
FM	financial management
FMR	focused medical review
FOIA	Freedom of Information Act
FPMB	Federation of Podiatric Medical Boards
FPMP	Family Practice Management Plan
FQHC	Federal Qualified Health Center
GAO	Government Accountability Office
GME	graduate medical education
GPCI	Geographic Practice Cost Index
GSSR	Global Surgical Services Report
H&P	history & physical
HAY	Hallux Abducto Valgus
HBO	Hyperbaric Oxygen
HCPAC	Health Care Professionals Advisory Committee
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data & Information Set
HHA	Horne Health Agency
HHS	Health & Human Services
HICN	Health Insurance Claim Number
HIO	Health Insurance Organization
HIPAA	Health Insurance Portability & Accountability Act
HMO	Health Maintenance Organization
HOD	House of Delegates
HOPD	Hospital Outpatient Department
HPA	Health Policy Alternatives
HPPC	Health Policy and Practice Committee
HPI	History of present illness

HSC	Health Systems Committee
ICD	International Classification of Diseases
ICD-9-CM	International Classification of Diseases- 9th revision- Clinical Modification
ICD-10-CM	International Classification of Diseases- l0th revision- Clinical Modification
IG	Inspector General
IOV -	Initial office visit
IPA	Independent Physicians Association
IPN	Independent Practitioner Network
IPO	Independent Practitioner Organization
JAPMA	Journal of the American Podiatric Medical Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCRSB	Joint Committee on Recognition of Specialty Boards
JRRC	Joint Residency Review Committee
LC	Legislative Committee
LCD	local coverage determination
LEP	limited English proficiency
LMRP	local medical review policy
LOPS	loss of protective sensation
LT	left
MCDC	Marketing & Career Development Committee
MCM	Medicare Carriers Manual
MCM2323	Medicare Carriers Manual Section 2323
MCM4120	Medicare Carriers Manual Section 4120
MCO	Managed care organization
MDM	medical decision making
MedPAC	Medicare Payment Advisory Committee
MGMA	Medical Group Management Association
MSLC	Membership & Student Liaison Committee
MSP	Medicare Secondary Payer
MTP	Metatarsal Phalangeal
NAC	National Association of Chiropodists
NAIC	National Association of Insurance Commissions
NATA	National Athletic Trainers Association
NBPME	National Board of Podiatric Medical Examiners
NCA	national coverage analyses
NCCJ	National Correct Coding Initiative
NCD	national coverage determination/decision
NCLR	National Council of La Raza
NCQA	National Committee on Quality Assurance
NDEP	National Diabetes Education Program
NEMB	notices of exclusion from Medicare benefits
NHIC	National Health Information Center
NHLBI	National Heart, Lung & Blood Institute
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NMHCC	National Managed Health Care Congress
NOC	Not otherwise classified
NPI	National Provider Identifier

NPRM	notice of proposed rule making
NSC	National Supplier Clearinghouse
NUCC	National Uniform Claim Committee
NYCPM	New York College of Podiatric Medicine
OCPM	Ohio College of Podiatric Medicine
OCR	Office of Civil Rights
OCSQ	Office of Clinical Standards and Quality
OIG	Office of the Inspector General
OOP	out-of-pocket
OPEIU	Office of Professional Employees International Union
OT	occupational therapy
OTC	over the counter
PAC	Political Action Committee
PAD	peripheral arterial disease
PAOC	Program Advisory & Oversight Committee
PAS	Periodic Acid Schiffs Stain
PC	professional component
PCA	progressive corrective action
PCP	primary care provider
PEAC	Practice Expense Advisory Committee
PECOS	Provider Enrollment Claim and Ownership System
PE&I	Public Education & Information Committee
PFP	pay for performance
PHO	physician and hospital organization
PHPPMC	Public Health & Preventive Podiatric Medicine Committee
PIAC	Private Insurance Advisory Committee
PICA	Podiatry Insurance Company of America
PIPJ	Proximal Interphalangeal Joint
PM&S	Podiatric Medicine & Surgery
PMPM	per member per month
PMPY	per member per year
PMSR	podiatric medicine and surgery residency
PN with LOPS	peripheral neuropathy with loss of protective sensation
POORA	Podiatrist's Recognition Award
POR	podiatric orthopedic residency
POS	point of service
POVs	power operated vehicles/post- operative visits
PPAC	Podiatry Political Action Committee
PPAC	Practicing Physician Advisory Committee
PPMR	primary podiatric medical residency
PPO	preferred provider organization
PPS	prospective payment system
PRIT	Physician Regulatory Issues Team
PRN	Physicians' Recovery Network
PRO	Peer Review Organization
PSA	Public service announcement
PSC	program safeguard contractor

PSR	Podiatric Surgical Residency
PT	Physical therapy
PVD	peripheral vascular disease
QIO	Quality Improvement Organization
RA	rheumatoid arthritis
RBRVS	resource-based relative value system
RFC	routine foot care
RFP	request for proposal
RICO	Racketeer Influenced Corrupt Organization
RMT	Requirements Management Team
RO	regional office
ROM	range of motion
ROS	review of systems
RPR	rotating podiatric residency
RT	right
RUC	RBRVS Update Committee
RVS	relative value scale
RVU	relative value unit
SAC	State Advocacy Committee
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAM	Science and Management Symposium
SCF	single conversion factor
SCP	specialty care physician
SCPM	Scholl College of Podiatric Medicine at Rosalind Franklin University
SGR	Sustainable growth rate
SNF	skilled nursing facility
SNPMA	Student National Podiatric Medical Association
SOCAP	Society of Chiropodists & Podiatrists
SOI	statement of intent
SSA	Social Security Administration
SVS	Society of Vascular Surgery
TC	technical component
TCS	Transactions & codes set
TENS	Transcutaneous Electric Nerve Stimulator
TPA	third party administrator
TPP	third party payer
TSD	therapeutic shoes & inserts for individuals w/diabetes
TUSPM	Temple University School of Podiatric Medicine
UPIN	universal provider identification number
UR	utilization review
V2015	Vision 2015
VA	Veterans Administration
VAC	vacuum assisted closure
VNR	video news release
WPS	Wisconsin Physician Service
YMC	Young Members Committee

Managed Care Glossary

Ambulatory Surgery Center (ASC): Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Antitrust laws: Laws that prohibit institutional mergers and acquisitions, exclusive contracts, joint ventures, and other business dealings in areas that may substantially reduce competition or have a tendency to produce a monopoly, and consequently have a detrimental effect on consumer welfare.

Any Willing Provider Laws: state laws that require health plan permits providers to apply for and participate in the health plan's network, provided that the provider is willing to accept the managed care organization's terms and conditions of participation.

Assignment of benefits: A procedure whereby the subscriber authorizes the insurance carrier to make payment of allowable benefits directly to the provider.

Balance Billing: Billing the patient or beneficiary for any fee in excess of the amount allowed by the insurance carrier.

Beneficiary: A person designated by an insuring organization as eligible to receive insurance benefits.

Benefit levels: The limit or degree of services a person is entitled to receive based on his/her contract with a health plan or insurer.

Billed claims: The fees or costs of health care services provided by a covered person submitted by a health care provider.

Bundling: The use of a single payment for a group of related procedures or services.

Capitation: A census driven reimbursement system wherein a fixed amount is paid per patient enrolled monthly to the physician to cover services.

Carrier: The insurance company which writes and administers the health insurance policy.

Carve-out plan: Coverage for specific health care services available for purchase separate from the basic plan.

Claim: Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.

Closed access: A type of health plan in which covered persons are required to select a primary care physician from the plan's participating providers. The patient is required to see the selected primary care physician for care and referrals to other health care providers within the plan. Typically found in a staff, group or network model HMO. Also called closed panel or gatekeeper model.

Co-insurance: The portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often, co-insurance applies after first meeting a deductible requirement.

Co-payment: A cost-sharing arrangement in which a plan member pays a specified charge for a specified service, such as $10 for an office visit. The member is usually responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some co-payments are referred to as co-insurance with the distinguishing characteristics that co-payments are a flat or variable dollar amount and co-insurance is a defined percentage of the charges for service rendered. Also called co-pay.

Coverage decision: A decision made by a health plan or insurer whether to pay for or provide a medical service or technology for particular clinical indications.

Capitation: Under a capitation arrangement, the provider receives from the managed care organization a flat payment per enrollee per month. Under this arrangement, the provider agrees to provide all of certain specified covered medical services to managed care organization's enrollees. Thus, the number of the enrollees, rather than the utilization of services, controls the provider's revenues.

Date of service: The date on which health care services were provided to the covered person.

Deductible: The stipulated amounts which a covered person must pay each year toward the costs of medical treatment before the benefits of the program go into effect.

Downcoding: A process used by insurance carriers to reduce the value of billed procedures by changing the codes submitted to ones of lower value.

Duplication of benefits: Overlapping or identical coverage of an insured person under two or more health plans, usually the result of contracts with different service organizations, insurance companies or prepayment plans.

E/M: Evaluation and Management

Economic Profiling/Credentialing: the process of determining a physician's qualifications to participate in a health plan network or [to receive] privilege[s] by a hospital, based in whole or in part on utilization of health care services and lower cost of care, without regard to the appropriateness of the care furnished.

Effective date: The date a contract becomes in force.

ERISA: Employee Retirement Income Security Act of 1974.

Enrollee: An individual who is enrolled for coverage under a health plan contract who is eligible on his/her own behalf (not by virtue or by being an eligible dependent) to receive the health services provided under the contract.

Explanation of Benefits (EOB): A form included with a check from the insurance carrier which explains the benefits that were paid and/or charges that were rejected.

Exclusion: Specific services or conditions which the policy will not cover or which are covered at a limited rate.

Fee-for-service (FFS): Refers to paying medical providers for individual services rendered.

Fee Schedule: A list of predetermined payments for medical services.

Global service: A group of clinically related services that are treated as a single unit for the purpose of coding, billing and payment.

Health Maintenance Organization (HMO): A type of managed care plan that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Health Plan: An organization that acts as an insurer for an enrolled

population. Individual Practice Association (IPA): A HMO that contracts with

individual
physicians to provide services to HMO members in a negotiated per capita or fee-for-
service rate. Physicians maintain their own offices and can contract with other HMOs and see other fee-for-service patients.

Insured: The person who represents the family unit in relation to the insurance program. Usually the employee whose employment makes the coverage possible.

Managed care: A system of health care delivery that influences utilization of services, cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost effective health care.

Modifiers: Codes used to supplement CPT or HCPCS codes that permit payment to differ for a subset of services billed. They may indicate that the service has been changed in some way.

Nondiscrimination Laws: state law that prohibits managed care organization from barring certain type of providers from their networks based upon the type of licensure or degree held by the provider.

Non-participating provider (non-par): A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care.

Out-of-pocket costs: The portion of payments for health services required to be paid by the enrollee, including co-payments, coinsurance and deductibles.

Participating provider: A provider who has contracted with the health plan to provide medical services to covered persons. The provider may be a hospital, pharmacy, other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.

Per contract per month (PC/PM): The amount of dollars related to each effective contract holder, subscriber or member for each month (PS/PM-per subscriber per month) (PM/PM-per member per month)

Per member per month: Unit of measure that applies to costs or revenues for each enrolled plan member each month.

Point-of-service plan: A managed care plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network or non-network providers at the time care is needed and usually are charged sizable co-payments for selecting the latter.

Preferred provider organization (PPO): A managed care health plan that contracts with networks or panels of providers to furnish services and be paid on a negotiated schedule.

Prior authorization: The process of obtaining coverage approval for a service or medication.

Prompt Payment Laws: state laws that regulate claims payment process.

Prospective reimbursement: Any method of paying hospitals or other health care providers for a defined period (usually one year) according to amounts or rates of payment established in advance.

Provider: the person in relation to the insurance program who provided covered services and supplies to the beneficiary.

Physician-Hospital Organizations (PHO): an integrated delivery system in which doctors and hospitals bind themselves together to negotiate better contractual terms and bear the financial risk of capitation arrangements.

Reasonable and customary: A term used to refer to the commonly charged or prevailing fees for health services within a geographic area.

Schedule of allowance: A list of specific amounts which the carrier will pay toward the cost of medical services provided.

Self-insured health plan: Employer provided health insurance in which the employer, not the insurer, is at risk for its employees' medical expenses.

Third party administrator (TPA): An administrative organization other than the insurance company or health care provider that collects insurance premiums, pays claims, and provides administrative services.

Unbundling: The process of coding, billing, and requesting payment for services that are generally included in a global charge.

Upcoding: The process of selecting a code for service that is more intense, extensive, or has a higher charge, than the service actually provided.

Utilization Review (UR): The process of reviewing services provided to determine if those services were medically necessary and appropriate.