

When a Payer Retires a Coverage Policy: Implications for Physicians

Coverage policies are not set in stone. But when a Medicare carrier or commercial payer changes or retires a coverage policy, it is reasonable for your practice to expect uninterrupted, appropriate, and timely reimbursement for your services.

However, the rationales for retirement of coverage policies—and the effects on physicians—can vary, so it's important for physicians to contact the payer to try to discern the reasons for the decision and whether the retirement might delay claims processing or if new coverage restrictions will be imposed.

If it was a Medicare policy, you can ask your state carrier advisory committee (CAC) representative to inquire with the Medicare administrative contractor (MAC) about why the policy was retired. Or, check with the AAN or your state medical society.

Changes, Retirements Due to Many Factors

“Coverage policies” or “medical policies,” as they are termed in the commercial insurance world, and “local coverage determinations” (LCDs) or “national coverage determinations” (NCDs) on the Medicare side, should not be viewed as permanent documents. They are a means to clarify a coverage or payment issue that exists in a specific provider community and to set parameters for dealing with that issue. When a policy is “retired” it no longer exists, meaning that, for a variety of reasons, the payer no longer feels that the policy document is needed. Importantly, that does not nullify the possibility of reactivating that policy. A payer may decide in the future that there is a need to reinstate either the same or a similar policy.

For example, Novitas Solutions—the Part B Medicare administrative contractor for several states¹—announced in July that it had retired its coverage policy on botulinum toxins (LCD27476-retired), retroactively effective to January 18, 2013.² In response to a query from the AAN about the change, a medical director at Novitas responded that it no longer felt a policy was warranted because the edits were effective with the previous LCD and it felt providers were billing appropriately for these services.

Major changes to policy also may occur as a result of convincing scientific demonstration of inefficiency of or harm from a treatment or technology, availability of superior technology that supersedes existing practices, a change in coding, or a change in law or regulation.

Reasons a payer might retire a coverage policy include if the existing LCD or policy—capturing payer-specific instructions for reporting the service(s)—is effective and the providers show an understanding of how to bill appropriately; it would not be unusual for that policy or LCD to be retired. Or, retirement may be in anticipation of a major change that impacts the scope of the LCD, although typically—if the intention of the payer is to have a policy in place on the topic—there is a seamless transition between retirement of a policy and implementation of an updated policy.

There are numerous examples where policy was retired as circumstances changed:

- Pallidotomy went out once deep brain stimulation took hold.
- SPECT scans were seldom needed once CT angioplasty and MRA gained wide acceptability.
- Loss of effectiveness demonstration, as in TENS for chronic low back pain. There was a great reduction in use once more effective therapies came in, such as when verteporfin injection was replaced by bevacizumab for AMD.

Additional Resources

Learn more about the Medicare coverage determination process at: www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html.

Access commercial payer coverage policy databases at www.aan.com/practice/payer-relations/payer-specific-information.

References

- ¹ The jurisdiction of Novitas includes Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas; the counties of Arlington and Fairfax in Virginia; and the city of Alexandria, Virginia.
- ² Novitas J-H announcement: www.novitas-solutions.com/policy/history-jh.html
Novitas J-12 (future J-L) announcement: www.novitas-solutions.com/policy/illustrator

Tips for Billing Where No Coverage Policy Exists

- Even if an LCD is no longer in effect, the “reasonable and necessary” threshold would still need to be clearly evident in the documentation, as was the case when a policy was active. Good documentation is the best defense if a claim were to be audited.
- Providers should know well the labeled and unlabeled use of any drug they use.
- Off-label use of drugs may prove to be problematic without a policy in effect—it is more important than ever to document medical necessity in these circumstances.
- Consider whether under certain circumstances it may be appropriate to ask your patients to sign an advance beneficiary notice (ABN) (e.g., when up-front drug costs are high and there is uncertainty about whether or not the service will be reimbursed in the absence of a stated coverage policy).

Power Your Practice: What You Need to Know About Comprehensive Care Payments

This article is the second in a series discussing new payment and delivery models that neurology practices will need to know about and evaluate. The October issue of AANnews covered bundled payments, where physicians are paid a lump sum for all services provided during a defined episode of care. This issue focuses on comprehensive payments, where physicians are paid a lump sum for all services provided across many episodes of care.

While bundled payments are effective in reducing cost per episode of care, they do not provide a good incentive to limit the number of episodes and so the overall cost of care may remain high. Comprehensive payments, on the other hand, provide an incentive to reduce the overall cost of a patient's care, including the number of episodes.

For example, in the Per Member Per Month (PMPM) comprehensive payment model, physicians receive payment every month a patient is enrolled in the plan whether or not any services are provided. The objective of the monthly payment is to facilitate care coordination and preventative care that will keep patients healthy. Consequently, healthy patients will require fewer health care services.

Low health care service utilization leads to reduced health care costs. Studies show that there has been some slowing in health care costs when capitation payments—a less sophisticated form of comprehensive payments—were widely used by the health maintenance organizations (HMOs) of the 1990s. But this managed care form of comprehensive payments was highly criticized by both patients and providers as it penalized doctors for providing additional care when patients got sicker.¹

The more recent comprehensive payments are condition-adjusted. This means that the PMPM payment should reflect

patient's actual health status and take into account the need for additional services. In this way, it is hoped that comprehensive payments will reduce health care cost while the quality of care will not suffer.²

Tips for comprehensive payments:

- Predict the extent to which your patient population will use identified services
- Review your comprehensive contract to ensure that it does not allow the health plan to add more services without your consent
- Evaluate the risk adjustments to be sure that payments will realistically cover the costs of caring for a sicker patient

For more information, refer to these AAN resources:

- Comprehensive payments: www.aan.com/practice/new-payment-and-delivery-models/comprehensive-and-global-payments
- New payment models: www.aan.com/practice/new-payment-and-delivery-models
- *Neurology® Clinical Practice*, “Payment reform and the changing landscape in medical practice,” tinyurl.com/pn32cda
- *Neurology: Clinical Practice*, “The neurologist as a medical home neighbor,” tinyurl.com/ogrobku

¹ Fuchs V.R., The Gross Domestic Product and Health Care Spending. *NEJM*. 2013; 369:107-109. Available at: www.nejm.org/doi/pdf/10.1056/NEJMp1305298.

² Miller H., From Volume To Value: Better Ways To Pay For Health Care. *Health Affairs*. 2009; 28: 1418-1428. Available at: content.healthaffairs.org/content/28/5/1418.full.

Be Aware of How the Sunshine Act Affects You

On August 1, 2013, pharmaceutical companies and device manufacturers began tracking transfers of value to physicians under the Physician Payments Transparency Act (PPSA), a sub-section of the Affordable Care Act, and now known as the “Open Payments” program. The program is intended to provide greater transparency on manufacturers' relationships with physicians.

Manufacturers are generally required to report payments of \$10 or more given to physicians and teaching hospitals to the Centers for Medicare & Medicaid

Services (CMS), who will collect the data annually (by March 31, 2014) and publish it on a public website (by September 30, 2014). The reports will include the physician's name, address, NPI number, and other identifying information. The AAN urges members to learn about the Open Payments program and retain their own records of items of value received from pharmaceutical companies and device manufacturers in order to evaluate and challenge (if needed) the accuracy of submitted reports.

The Council of Medical Specialty Societies (of which the AAN is a

member) recently convened a task force led by the CMSS General Counsels Group (including AAN counsel), and including the CME directors and membership directors groups, to review the effect of the Open Payments program on societies and their members. The task force developed a series of responses to frequently asked questions, which were approved by the CMSS Board of Directors for dissemination to CMSS member societies.

For more information and to read the FAQ, visit www.aan.com/practice/practice-management-resources.