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physician advisory services

What about the transferring hospital?

Wow this guy is sick, we need to get him to MGH ASAP. I have called them already. Stick him in the ICU until they call with a bed--> **Observation** since leaving in less than 2 MN (unless you intubate). If he ends up not going, then the hospital can admit at any time.

Wow this guy is sick, get him to the ICU and if he does not get better, we may need to transfer him to MGH in the next day or two--> **Inpatient** since they expect him to stay and can still bill inpatient even if he gets worse and leaves for MGH prior to the second midnight.

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This means that the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written.

The potential increase in very short (less than 2 midnights) observation stays should be balanced by a significant decrease in long (2 midnights or more) observation stays. Because we expect that this revision should virtually eliminate the use of extended observation, we also anticipate it will concurrently limit beneficiary cost-sharing for outpatient services.

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Inpatient Only surgery admissions must all be certified

But the admission order and the H&P satisfy the requirements for certification. They are certifying that the admission meets the 2014 IPPS Rules for admission.

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Disclaimers

What we say is true today; it may all change tomorrow

Doctors are all called “he,” but they really aren’t

Nurses, CM’s and SW’s are all called “she,” but they really aren’t

All doctors are liars, cheaters, have huge egos and do it just for money, but most really aren’t

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Question #1

A 67 year old female presents with an MI, confirmed by EKG and troponin and goes to cath lab from ED where an LAD stent is placed. She is admitted and monitored. She has a 40 second run of VT that self-terminates. The cardiologist calls the EP doc who sees patient and schedules ICD. Do you…

- Allow procedure to proceed because you never question your doctor’s medical decisions?
- Stop the procedure from being scheduled?
- Discuss with the doctor and if insists then present an ABN?
- Discuss with the doctor and I insists then present a HINN 11?

Why Are We In this Situation?

"If we don't do it ourselves, Congress will make a law forcing us to do it." – Ian Jones, MD, VPMA, Sherman Hospital, Elgin, IL

We have not been good guardians of the Medicare Trust Fund so they had to mandate…

- Core measures
- Joint Commission Patient Safety Goals
- Never Events
- And now the RAC, Prepayment reviews, OIG audits, VBP

Why audits? --Doctors behaving badly

Florida dermatologist fined $26 million

The dermatologist had a pass-through billing arrangement with the pathology lab

- He sends slides
- They read slides
- He signs interpretations
- He bills Medicare

Also performed unnecessary Moh's surgery and flap surgery to bill higher amount

Whistleblower- employed pathologist at lab- $4 mil reward

Look who is watching you!

EMH Regional Medical Center And North Ohio Heart Center To Pay $4.4 Million To Resolve False Claims Act Allegations

-the United States alleged that EMH and NOHC performed angioplasty and stent placement procedures on patients who had heart disease but whose blood vessels were not sufficiently occluded to require the particular procedures at issue= unnecessary

The whistleblower in this matter, Kenny Loughner, was the former manager of EMH's catheterization and electrophysiology laboratory. As a result of today's settlement, Mr. Loughner will receive $660,859 of the United States' recovery

http://www.justice.gov/usao/ohn/news/2013/04janemh.html

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SPINE SURGEON ARRESTED ON CHARGES HE PERFORMED UNNECESSARY SURGERIES AND BILLED HEALTH INSURANCE PROGRAMS

The indictment alleges that Durrani would tell the patient the medical situation was urgent and that back surgery was needed right away. He would also falsely tell the patient that he/she was at risk of grave injuries without the surgery. For cervical spine patients, **Durrani would often tell a patient that there was a risk of paralysis or their head would fall off if the patient was in a car accident because there was almost nothing attaching the head to the patient's body.** www.justice.gov/usao/ohs/news/08-07-13.html

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HOME QUICK NEWS OPINION MARKET DATA PERSONAL FINANCE TECH POLIT

Chicago Hospital Accused of Cutting Throats for $160,000

- Physician kickbacks- rent, employee salaries, student supervision
- Direct admit SNF patients from distant SNF, bypass closer hospitals
- Admit patients without acute medical needs
- Pulmonologist oversedates patients so unnecessary trach needed and hospital gets DRG 003- weight- 17.8 (joint replacement- 2.87) and MD gets more visits
  - http://www.justice.gov/usao/iln/pr/chicago/2013/pr0416_01a.pdf

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Rockford Physician Arrested on Charge of Health Care Fraud

U.S. Attorney's Office
January 25, 2014

Northern District of Illinois
(312) 353-5300

Law enforcement interviewed M.H., and M.H. stated that M.H. had sex with DEHAAN numerous times in approximately 2010 because DEHAAN agreed to prescribe her controlled substances, including Ritalin and Norco. In exchange for the prescribed medications, M.H. had sex with DEHAAN approximately two to three times a month for approximately six months. M.H. stated that on one occasion, DEHAAN performed a breast exam on M.H, but he did not perform any other medical services. According to Medicare billing data, DEHAAN billed, and was paid by Medicare, for the following services for M.H.

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Medical Necessity

Two types of medical necessity

Medically necessary to be in the hospital- why does the patient need to be in the hospital?

Medical necessity to provide the care itself- why does the patient need what is being done to them?

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The New Medical Necessity

2014 IPPS Rule - medical necessity of level of care

"The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services **or** reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care."

2014 IPPS Final Rule, p. 50945

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Is it medically necessary for the patient to remain in the hospital for their evaluation or treatment?

Is their needed treatment only safely provided in the hospital? Ventilator, initiation of IV antibiotics with active infection, iv Dilaudid

Is there a high short-term risk that warrants keeping them in the hospital for testing that could be done as outpatient? TIA, Chest pain

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Medical Necessity for the Procedure

MS-DRG 470 -- Major joint replacement or reattachment of lower extremity w/o MCC

- **Applicable NCD/LCD:** LCD L32078

FCSO CERT error findings:

In 92 percent of these cases, the documentation did not support that the procedure was reasonable and necessary

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How dare they tell me what is necessary!

Section 1862(a)(1)(A) of the Social Security Act states that Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Medicare is a "defined benefit" health plan. It only pays for certain things as defined by the SSA, not for everything that a patient wants or doctor orders.

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Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

Safe and effective

Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:

Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member

- Furnished in a setting appropriate to the patient's medical needs and condition
- Ordered and furnished by qualified personnel
- One that meets, but does not exceed, the patient's medical need
- At least as beneficial as an existing and available medically appropriate alternative

Reasonable and Necessary?

NCD- National Coverage Determination
- Applies to all CMS jurisdictions

LCD- Local Coverage Determination
- Issued by MAC's

OIG thinks CMS needs to standardize LCD's across MAC's

But Really Now?

"Was the procedure truly not medically necessary or was the procedure appropriately done and it was the documentation that did not support medical necessity?"
- My question to FCSO Medical Director, July 18, 2012 Webinar on Pre-payment reviews

"We believe the care was appropriate in the majority of cases but strongly believe that good documentation is necessary for good care to be provided."
- Citation: ***Outstanding medical records create superior patient outcomes*** from: http://medicare.fcso.com/CERT/237256.asp

The Medical Record

"Physicians have been taught throughout their training that the medical record is their best insurance policy to communicate the quality of their analytical skills, problem-solving ability, and as a controlling guide for the complexity of patient care." – FCSO Medical Director

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The Medical Record

Evidence emerging from increasing use of electronic health records confirms that, when properly applied, the medical record will,

- Reduce patient care errors,
- Reduce rates of missing clinical information,
- Advance evidence-based clinical decision-making,
- Reduce costs by preventing duplicative and contraindicated services,
- Provide for care coordination across the spectrum of providers, and
- Enhance the quality of patient outcomes

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The Medical Record

When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), the results were dramatic: *substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained*

- Dunlay SM, et al. Medical records and Quality of Care in Acute Coronary Syndromes Results from CRUSADE**FREE**. *Arch Intern Med.* 2008; 168(15):1692-1698.

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NCD's

The NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under §1862(a)(1) of the Act …NCDs are usually issued as a program instruction. Once published in a CMS program instruction, an NCD is binding on all Medicare carriers/DMERCS, FIs, QIOs, Program Safeguard Contractors (PSCs) and Medicare+Choice organizations.

- Chapter 13.1.1 Program Integrity Manual

Can They Be Ignored?

An NCD is binding on fiscal intermediaries, carriers, QIOs, QICs, ALJs, and the MAC.

Review by an ALJ.

- (1) An ALJ may not disregard, set aside, or otherwise review an NCD.
- (2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD was applied correctly to the claim.
  - 42 CFR§ 405.1060

And an LCD?

An LCD is a decision by a Medicare administrative contractor (MAC), fiscal intermediary or carrier whether to cover a particular service on a MAC-wide, intermediary wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

- Chapter 13.1.3 Program Integrity Manual

LCD

The LCDs specify under what clinical circumstances a service is considered to be reasonable and necessary. They are administrative and educational tools to assist providers in submitting correct claims for payment. Contractors publish LCDs to provide guidance to the public and medical community within their jurisdictions.

Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community.

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Case Study

Your hospital has a busy urology service. The urologists perform TURP's regularly. Post-op CBI is continued for two days on all patients and patients go home after 2 midnights on POD #3.

Do you...

- Advise the doctor to admit the patient pre-op since the stay will surpass 2 midnights?
- Advise the doctor to perform the surgery as outpatient and admit them prior to the second midnight?
- Advise the doctor to perform the surgery as outpatient and place them on observation if they need a third midnight?
- Advise the doctor to perform the surgery as outpatient and admit them only if they need a third midnight?
- Let them do what they want; they bring in lots of patients?

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LCD (cont.)

Acceptance by individual health care providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with interest in the outcome, are not sufficient evidence of general acceptance by the medical community.

The broad range of available evidence must be considered and its quality shall be evaluated before a conclusion is reached.

- Chapter 13.7.1 Program Integrity Manual

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Acceptable Standards of Practice

Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts

- Medicare Claims Processing Manual, Chapter 30, 40.1.3

Consensus of Expert Medical Opinion

By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.

Medicare Claims Processing Manual, Chapter 30, 40.1.3

What Is Not Included?

I've always done it this way.

But the patient insists I do it.

The device rep said that it works well for this.

But I have to do something.

I am a Harvard doctor- no one tells me what to do!

Our case- TURP and the Literature

A study on the use of a rapid catheter removal protocol in 64 patients who had TURP found that 98% were discharged within 23 hours of the procedure.

Analysis of 250 men who had TURP found that 78% were discharged within 23 hours of the procedure.

A study of 307 patients undergoing TURP under spinal anesthesia found that 92% were discharged the same day.

A study examining more than 400 admitted patients who underwent TURP found that 77% were discharged on the first postoperative day.

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Outpatient Surgery

If it is not on the Inpatient Only list, the routine recovery is less than 2 midnights.

Particular patients with unique circumstances may warrant admission pre-op if documented expectation is greater than 2 MN recovery.

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Are LCD's Binding Like NCD's?

(a) ALJs and the MAC are not bound by LCDs, LMRPs, or CMS program guidance, such as program memoranda and manual instructions, but will give substantial deference to these policies if they are applicable to a particular case.

(b) If an ALJ or MAC declines to follow a policy in a particular case, the ALJ or MAC decision must explain the reasons why the policy was not followed. An ALJ or MAC decision to disregard such policy applies only to the specific claim being considered and does not have precedential effect.

- 42 CFR§ 405.1062

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One Big, Big, Big Caveat

Medicare coverage and FDA approval are not the same!!!

FDA approval = required for medication/device to be used in US- specifies FDA-approved indications

Medicare coverage = Medicare will pay for use if fits their accepted NCD/LCD

Pilot project- Joint FDA/CMS evaluation of new technology

- Parallel Review of Medical Products, 75 Fed. Reg. 57045 (Sept. 17, 2010)

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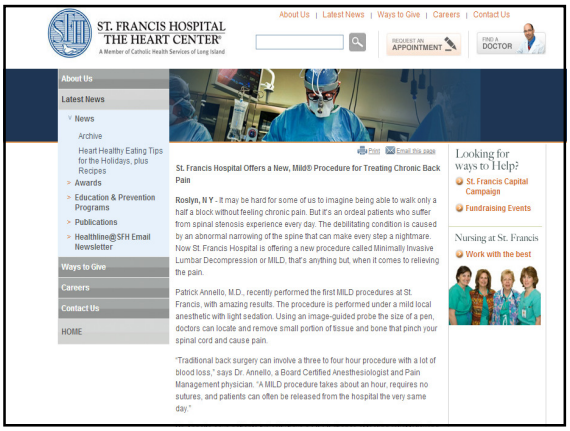
For Example…

DEVICE: VERTOS MEDICAL MILD® DEVICE KIT

510(k) NO: K093062 (TRADITIONAL)
DECISION MADE: 04-FEB-10

http://www.accessdata.fda.gov/cdrh_docs/pdf9/K093062.pdf



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What did the MAC's say?

NGS- not covered
NHIC- covered
Palmetto- covered
CGS- covered
Novitas- not covered
WPS- covered
FCSO- not covered
Noridian- not covered

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NGS June 2012

Percutaneous Laminotomy/Laminectomy (Intralaminar Approach) (CPT-0275T) – Related to LCD L25275

The *mild®* procedure is performed percutaneously with image guidance. The literature is interesting and summarized above for this procedure performed with a device that has received a 501k clearance from the Federal Drug Administration (FDA). However, the literature thus far is not considered sufficiently mature or robust to establish efficacy and coverage. Further patient outcome studies with blinding, controls and randomization with larger numbers of patients followed over a longer period time to determine efficacy are felt to be needed prior to allowing coverage.

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CMS has spoken

Decision Memorandum for CAG #00433N

Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

Date: January 9, 2014

I. Decision

A. The Centers for Medicare & Medicaid Services (CMS) has determined that percutaneous image guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.

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What does commercial insurers say?

Image-guided minimally invasive lumbar decompression is considered investigational for all applications. BCBSNC does not provide coverage for investigational services or procedures.

UHC- The following spinal procedures are unproven:

B. Spinal Decompression

1. Interspinous process decompression (IPD) systems, such as the X-STOP for the treatment of spinal stenosis

2. Minimally invasive lumbar decompression (MILD)

Cigna does not cover a percutaneous or endoscopic laminectomy or disc decompression procedure, including but not limited to the following, because it is considered experimental, investigational or unproven

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Aetna's list of non-covered treatment for back pain

BacFast HD for isolated facet fusion;
Coccygeal ganglion (ganglion impar) block for coccydynia, pelvic pain, and all other indications;
Devices for annular repair (e.g., Inclose Surgical Mesh System);
Dynamic stabilization (e.g., Dynesys Spinal System, Graf ligamentoplasty/Graf artificial ligament, and the StabilimaxNZ Dynamic Spine Stabilization System);
Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System;
Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation);
Endoscopic transforaminal diskectomy;
Epidural fat grafting during lumbar decompression laminectomy/discectomy;
Epidural injections of lytic agents (e.g., hyaluronidase, hypertonic saline) or mechanical lysis in the treatment of adhesive arachnoiditis, epidural fibrosis, failed back syndrome, or other indications;
Epiduroscopy (also known as epidural myeloscopy, epidural spinal endoscopy, myeloscopy, and spinal endoscopy) for the diagnosis and treatment of intractable LBP or other indications;
Facet chemodenervation/chemical facet neurolysis;
Facet joint implantation;
Far lateral microendoscopic diskectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications;
Intercostal nerve blocks for intercostal neuritis;
Interlaminar lumbar instrumented fusion (ILIF);
Inter-spinous and interlaminar distraction (e.g., the Aspen spinous process fixation system, the Coflex interlaminar stabilization spinal implant, the Coflex-F implant for minimally invasive lumbar fusion, Eclipse inter-spinous distraction device, ExtenSure bone allograft inter-spinous spacer, X-Stop device, and the TOPS System) for spinal stenosis or other indications;
Intradiscal and/or paravertebral oxygen/ozone injection;
Intradiscal steroid injections;
Khan kinetic treatment (KKT);
Laser facet denervation;
Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications;
Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications;
Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications;
Minimally invasive lumbar decompression (MILD) procedure (percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements under indirect image guidance) for lumbar canal stenosis or other indications;
Minimally invasive (endoscopic) transforaminal lumbar interbody fusion (MITLIF) for lumbar disc degeneration and instability or other indications;
NuFix facet fusion;
OptiMesh grafting system;
Percutaneous cervical diskectomy;
Percutaneous endoscopic diskectomy with or without laser (PELD) (also known as arthroscopic microdiskectomy or Yeung Endoscopic Spinal Surgery System [Y.E.S.S.]);
Piriformis muscle resection and other surgery for piriformis syndrome;
Psoas compartment block for lumbar radiculopathy or myositis ossification;
Racz procedure (epidural adhesiolysis with the Racz catheter) for the treatment of members with adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications;
Radiofrequency denervation for sacroiliac joint pain;
Radiofrequency lesioning of dorsal root ganglia for back pain;
Radiofrequency lesioning of terminal (peripheral) nerve endings for back pain;
Radiofrequency/pulsed radiofrequency ablation of trigger point pain;
Sacroiliac fusion or pinning for the treatment of LBP due to sacroiliac joint syndrome; Note: Sacroiliac fusion may be medically necessary for sacroiliac pain due to severe traumatic injury, where a trial of an external fixator is successful in providing pain relief;
Sacroiliac joint fusion (e.g., by means of the iFuse System and the SImmetry Sacroiliac Joint Fusion System);
Sacroplasty for osteoporotic sacral insufficiency fractures and other indications;
TruFuse facet fusion;
Vesselplasty (e.g., Vessel-X);
Xclose Tissue Repair System.

Aetna Policy 0016-Invasive treatment of back pain, updated 8-2013

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Gaming the system

So how does a doctor avoid a non-coverage rule?
"Stretch the truth"

The bait and switch for mild® procedure

- Doctor schedules as 63030- traditional diskectomy
- Vertos rep shows up in OR with mild® equipment
- Doctor performs 0275T
- Doctor bills 63030, gets paid
- Hospital must bill actual procedure- 0275T, gets denied
- Vertos still sends bill to hospital for hardware

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What is your hospital's new service evaluation procedure?

Do you look at…

- FDA/CMS/Insurance approvals?
- Medical Necessity Guidelines?
- Equipment costs- fixed and per procedure?
- Staff training?
- Reimbursement- DRG / APC?
- Precertification requirements?
- Expertise of physicians?

Just because you can offer a new service does not mean that you have to offer it. (Gotta wonder…who is going to be patient #1 and do they know it?)

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A 67 yr old patient is hospitalized with COPD exacerbation. The patient has a CBC and the Hb is noted to be 11.8. No bleeding or symptoms of anemia. No past cancer screening. Hospitalist calls GI to eval and do colonoscopy.

Do you…

-allow it to proceed without question?

-allow it to proceed and bill part B as screening test?

-give a HINN 11?

-give an ABN?

-talk to doctor to defer to outpatient?

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When does CMS care about coverage?

When they pay for it!

-Was stay medically necessary? If yes, pay DRG, hospital may do "anything" to patient they feel is indicated for patient

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-Did any service change the DRG? If yes, evaluate medical necessity of that service

MS-DRG 981, Extensive OR procedure unrelated to principal diagnosis with MCC: Weight 5.0389

MS-DRG 982, Extensive OR procedure unrelated to principal diagnosis with CC: Weight 2.8954

MS-DRG 983, Extensive OR procedure unrelated to principal diagnosis without CC/MCC: Weight 1.8072

MS-DRG 987, Nonextensive OR procedure unrelated to principal diagnosis with MCC: Weight 3.4020

MS-DRG 988, Nonextensive OR procedure unrelated to principal diagnosis with CC: Weight 1.7836

MS-DRG 989, Nonextensive OR procedure unrelated to principal diagnosis without CC/MCC: Weight 1.0358

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Add-On payments

-Were any services billed separately? If yes, evaluate each service for medical necessity- New technology add-on payments, blood clotting elements, outlier payments

- Dificid for C difficile diarrhea- $868
- Zenith Aortic Graft- $8,171.50
- Voraxaze- MTX toxicity- $45,000 (acquisition cost $26,000 per 1,000 units- 150 lb person= $88,000)
- Argus- artificial retina- $72,028.75
- Kcentra- reversal of warfarin bleeding- $1,587.50
- Zilver- peripheral stent- $1,705.25

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Inpatient Claims for Blood Clotting Factor Drugs

- OIG review- the Hospital submitted a claim to Medicare with incorrect charges, that resulted in an incorrect outlier payment. Specifically, the Hospital billed for off-label use of medication that was not covered by Medicare.
- NovoSeven $10,000 per vial- indicated for hemophilia only; off label not paid
  - OIG report A-07-11-05009, May 22, 2012

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Outlier Payment

Outlier Payment = (.80) x [(charges x cost/charge ratio) - (DRG + IME + DSH + threshold)]

Where:

Charges = Hospital's actual charges for services provided to the patient

Cost/Charge ratio = Cost-to-charge ratio derived from most recent settled Medicare cost report

DRG = Standard DRG payment

IME = Indirect medical education payment

DSH = Disproportionate share payment

Threshold = Annual threshold set by CMS- $21,748 in 2014

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Since We Are Talking About Drugs…

Effective January 1, 1994, off-label, medically accepted indications of Food and Drug Administration-(FDA) approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen are identified under the conditions described below.

Off-label, medically accepted indications are supported in either one or more of the compendia (4) or in peer-reviewed medical literature (26 journals).

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The Approved Compedia

American Hospital Formulary Service-Drug Information (AHFS-DI)

National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical Pharmacology

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The Approved Journals

American Journal of Medicine;
Annals of Internal Medicine;
Annals of Oncology;
Annals of Surgical Oncology;
Biology of Blood and Marrow Transplantation;
Blood;
Bone Marrow Transplantation;
British Journal of Cancer;
British Journal of Hematology;
British Medical Journal;
Cancer;
Clinical Cancer Research;
Drugs;
European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
Gynecologic Oncology;
International Journal of Radiation, Oncology, Biology, and Physics;
The Journal of the American Medical Association;
Journal of Clinical Oncology;
Journal of the National Cancer Institute;
Journal of the National Comprehensive Cancer Network (NCCN);
Journal of Urology;
Lancet;
Lancet Oncology;
Leukemia;
The New England Journal of Medicine; or
Radiation Oncology

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Use medications in order!

Kyprolis™ (carfilzomib) is approved for the treatment of patients with multiple myeloma who have received at least two prior therapies, including bortezomib and an immunomodulatory agent, and have demonstrated disease progression on or within 60 days of completion of the last therapy.

The medical record must clearly document the patient's prior chemotherapy regimens, disease progression and body surface area.

Documentation must include verification of the administration of dexamethasone 4 mg orally or intravenously prior to all doses of during Cycle 1 and prior to all doses during the first cycle of dose escalation to reduce the incidence and severity of infusion reactions.

$9,550 for a typical cycle of six vials, cycle every 28 days

Currently, no data are available that demonstrate an improvement in progression-free survival or overall survival.

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Provenge- prostate cancer

$33,000 per dose, 3 doses 2 weeks apart

Documentation regarding means of castration (e.g., surgically by bilateral orchiectomy or documentation of 3 or more months of chemical castration and agent used or the medical documentation from the treating physician includes a clear statement of failure of chemical castration)

Medical records should specifically address evidence of progressive disease after surgical or chemical castration (examples may include: changes in size of lymph nodes or parenchymal masses on physical examination or radiographic studies, bone scan progression, PSA progression, etc.)

Evidence that the patient is asymptomatic or minimally symptomatic (should include a note about the patient's level of activity)

Each claim must stand alone, meaning the documentation in the submitted record must support the medical necessity of the service(s) billed on each individual claim.

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Is this all about the money?

Adherence to NCCN guidelines for treatment of ovarian cancer is correlated with overall survival and may be a useful process measure of quality cancer care. High-volume providers are significantly more likely to provide NCCN guideline-adherent care and are associated with improved survival outcomes. Ovarian cancer case volume may be a useful structural measure of quality cancer care. Increased efforts to concentrate ovarian cancer care are warranted.

- Abstract 45, The Society of Gynecologic Oncology 44th Annual Meeting, March, 2103

Anyone at your hospital looking at outpatient chemo?

- Can't ask for the drug back when claim is denied.

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The Other Caveat

Just because it is not covered does not mean it cannot be offered to the patient

ABN for outpatient services

HINN 11- Non-covered item in covered stay

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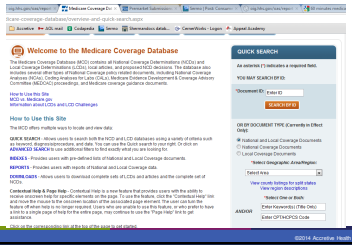
Where do I find NCD/LCD's?

www.cms.gov/mcd

- (Medicare Coverage decisions)



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Total Joints- Target Number 1

LCD 32081- Total Joint Replacements

- First Coast Services

Unsuccessful history of appropriate conservative therapy (non-surgical medical management) that is clearly addressed in the pre procedure medical record. Non surgical medical management is usually implemented for 3 months or more to assess effectiveness.

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But …

If certain conservative measures are not necessary for a given patient, it should be directly noted in the pre-procedure documentation. The clinical judgment of the treating physician is always a consideration if clearly addressed in the pre-procedure record and if consistent with the episode of care for the patient as documented in patient records and claim history.

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Who Did They Consult?

InterQual® 2011 Procedures Adult Criteria, Total Joint Replacement, Knee and Hip & Removal and Replacement, Total Joint Replacement Knee and Hip. McKesson Corporation.

Milliman Care Guidelines® 2011. Inpatient and Surgical Care 15th Edition. Knee Arthroplasty and Hip Arthroplasty. Milliman Care Guidelines LLC.

National Guideline Clearinghouse. Osteoarthritis. The care and management of osteoarthritis in adults. Retrieved from https://www.guideline.gov

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A denied claim

Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain and pain meds do not work. Therefore, she needs a total right knee replacement.

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An acceptable History

Mrs. Smith is a 70-year-old female who is suffering from end-stage Osteoarthritis (OA) of her right knee, worsening gradually over the past 10 years. Treatment has included NSAIDs which have not effectively relieved her pain/inflammation and which have recently begun to cause her gastric distress. She has also participated in an exercise program/physical therapy for the past 3 months without functional improvement. Sometimes the pain keeps her awake at night. She is using a cane and is no longer able to climb the five steps to her front door. Personal safety is compromised as she had falls x 3 in attempting the stairs to her home entrance. Her knee pain and stiffness limit her ability to perform ADLs. She cannot walk from her bedroom to her kitchen without stopping to rest.

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Physical Examination:

Vital Signs: 140/90, Heart rate 78, RR 18.

Physical exam: Bilateral varus knee deformity consistent with severe osteoarthritis. Right knee extension reduced to minus 15 degrees and flexion to less than 100 degrees. Unable to rise from chair unassisted. Full motion of the right hip, no calf tenderness or ankle edema. Antalgic gait noted.

X-ray (7/2/11): right knee shows joint space narrowing along with marginal osteophytes.

Impression:

Total Knee Arthroplasty (TKA) indicated.

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FCSO taking back surgeon's money!

Re: OVERPAYMENT RECOUPMENT ACTION
Beneficiary Name: [redacted]
HIC: [redacted]
ICN: [redacted]
Date(s) of Service: [redacted]

Dear Provider:

First Coast Service Options, Inc. (FCSO) serves as the Medicare Administrative Contractor (MAC) for Jurisdiction 9 (J9) which includes Florida, Puerto Rico and U.S. Virgin Islands. One of the primary responsibilities of the MAC is to prevent improper payments. The Centers for Medicare and Medicaid Services utilize the Comprehensive Error Rate Testing (CERT) program to measure improper payments made by the Medicare Fee-for-Service program. For more information regarding the CERT program, you can go to the following FCSO link: http://medicare.fcso.com/Landing/203608.asp.

One of the primary drivers of CERT payment errors nationally and in J9 involves inpatient hospital services where the patient was admitted for an inpatient procedure or required a procedure during hospitalization and documentation submitted by the hospital (e.g., physician H&P, progress notes, operative reports, etc.) failed to support medical necessity for the procedure. In some cases, the procedure(s) in question is subject to medical necessity requirements defined in national coverage determinations (NCD) and/or local coverage determinations (LCD). For more information on this issue go to http://medicare.fcso.com/CERT/index.asp and click on the link for "Improper Payments and Inpatient Prepayment Medical Review."

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 180 states that services "related to" noncovered services, including services that are not covered because they are determined to be not reasonable and necessary, are not covered services under Medicare. Therefore, FCSO has initiated overpayment recoupment of the Part B services performed by the surgeon, co-surgeon and assistant surgeon (as applicable) for the patient on the above identified date of service based on a medical necessity denial of the corresponding inpatient DRG claim.

This letter serves to notify you of the intent to recoup Part B payment. This is not an overpayment demand letter. You will receive the overpayment demand letter which includes your appeal rights in a future correspondence.

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CMS publication MLN Matters SE 1236

Documenting Medical Necessity for Major Joint Replacement (Hip and Knee)

CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments. To avoid denial of claims for major joint replacement surgery, the medical records should contain enough **detailed** information to support the determination that major joint replacement surgery was reasonable and necessary for the patient. **Progress notes consisting of only conclusive statements should be avoided.**

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Why are they not listening?

The J15 Part A Medical Review department performed a service-specific probe review on claims submitted for Major Joint Replacement (DRG 470) in Ohio **from March through May 2013**. Based on the results summarized below, the probe edit review will be advanced to a complex edit review in Ohio.

Reviewed	$1,421,327.76	123
Denied	$459,511.03	41
Charge Denial Rate	32.3%	

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Can You See Me Now?

Palmetto – CERT review of Cataract Extraction
- 88% deemed not medically necessary!

Established LCD 30889- Cataract surgery in Adults
- Defines indications for surgery and documentation requirements

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Indications

Cataract causing symptomatic impairment of vision not correctable by a change in glasses or contact lenses resulting in activity limitations

Retinopathy that cannot be monitored due to presence of cataract

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Documentation

A statement indicating that specific symptomatic impairment of visual function resulting in specific activity limitations.

A statement or measurements indicating that the patient's impairment of visual function is believed not to be correctable with a tolerable change in glasses or contact lenses.

An appropriate preop ophthalmologic examination

Ancillary testing as appropriate to establish medical necessity, such as Snellen testing, Glare testing

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Cardiac Catheterization

WPS LCD L30719, NGS L26880

Cardiac catheterization/coronary angiography is considered the standard for evaluating ventricular function, assessing valvular heart disease and coronary artery anatomy for patient management. While other methods are available, and are important in the overall evaluation, cardiac catheterization combined with coronary angiography is typically considered the key in clinical decision-making in the surgical or percutaneous candidates.

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Approved Indications

Patients without symptoms or with atypical symptoms, who have had *documented evidence* of CAD on specified noninvasive cardiac testing

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Approved Indications (cont.)

Rest or exercise-induced electrocardiography (ECG) abnormalities suggesting myocardial *ischemia associated with other risk factors*. Abnormal exercise ECG including ST segment depression, exercise-induced ST elevation in leads other than aVr, blunted systolic blood pressure response during progressive exercise, or exercise-induced ventricular tachycardia.

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Approved Indications (cont.)

Abnormal myocardial perfusion scintigraphy includes radiopharmaceutical distribution that is compatible with coronary ischemia

Approved indications (cont.)

Abnormal radionuclide ventriculography where the left ventricular ejection fraction falls during exercise or rest, and the findings are suggestive of CAD

After successful resuscitation from cardiac arrest when a reasonable suspicion of coronary artery disease exists

Prior to a high risk surgery

Angina that has proven inadequately responsive to medical treatment or prior intervention

Acute Coronary Syndrome

Approved Indications (cont.)

Angina associated with ***abnormal*** ***results*** of non-invasive cardiac testing that are suggestive of CAD

Approved Indications (cont.)

When the presence of atypical chest pain due to coronary spasm is suspected, or there are signs and symptoms of abnormal left ventricular function.

Complicated MI

Complicated myocardial infarction

- The patient experiences an episode(s) of ischemic chest pain, particularly when accompanied with ECG changes.
- Mitral regurgitation or ruptured interventricular septum is suspected, particularly when accompanied with heart failure or shock.
- Sub acute cardiac rupture (pseudo aneurysm) is suspected.
- Hemodynamic compromise or clinical heart failure exists.
- After non-Q-wave myocardial infarction, particularly when there is suspicion of ischemia post-MI.

More Complicated MI Indications

- Recurrent, potentially malignant ventricular arrhythmias.
- Evidence of myocardial ischemia (e.g., abnormal blood pressure response or ventricular tachycardia on predischarge exercise stress testing, abnormal laboratory testing or non-invasive cardiac tests).
- Heart failure or left ventricular ejection fraction is significantly decreased and is associated with manifestations of recurrent myocardial ischemia, or is associated with significant ventricular arrhythmias.
- Evaluation for multivessel disease for prognosis and management.
- ***No note about uncomplicated MI- like the old days.***

And Finally

- The presence of left ventricular failure without obvious cause.
- Pre-valve surgery
- A bunch of rare indications like congenital disease

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What Does That All Mean?

"Chest pain, take to cath lab" may not get paid

Unclear if high risk patients without documented ischemia will be covered, even with a good note

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What About Intervention?

WPS LCD 32791- Percutaneous Coronary Intervention

Patients with acute coronary syndrome (eg acute myocardial infarction, unstable angina)

Patients with a history of significant obstructive atherosclerotic disease

Patients with restenosis of a coronary artery previously treated with intracoronary stent or other revascularization procedure

Patients with chronic angina

Patients with silent ischemia

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Stents- The Double Edged Sword

"Performance of a diagnostic cardiac catheterization and interventional procedure on the same day is increasingly the standard of practice. While there may be reasons for delaying the interventional procedure (e.g., transfer from a community hospital to a tertiary center, excessive dye load, further treatment planning or evaluation of angiography, etc.), it is recommended that both procedures be performed during the same encounter when medically appropriate. Separation of these procedures for the purpose of circumventing the multiple surgery pricing, or for the convenience of physician or hospital scheduling, is considered an inappropriate practice and may subject the services to review and denial for medical necessity."

- LCD L32791 – WPS Medicare

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On the Other Hand

Putting Ad Hoc PCI on Pause

- Brahmajee K. Nallamothu, MD, MPH; Harlan M. Krumholz, MD, SM *JAMA*. 2010;304(18):2059-2060.

"At the other extreme are ongoing concerns about how frequently PCI is performed when medical therapy appears suitable. Part of this results from the well-described "oculo-stenotic" reflex, i.e. the tendency to treat blockages, even when clinically silent, based on benefits attributed to PCI that are not supported by the literature."

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"Stenting belongs to one of the bleakest chapters in the history of Western medicine," Nortin Hadler, a professor of medicine at the University of North Carolina at Chapel Hill, told Bloomberg. Cardiologists he said, continue to conduct these procedures because the "interventional cardiology industry has a cash flow comparable to the GDP [gross domestic product] of many countries" and doesn't want to lose it.

http://www.fiercehealthcare.com/story/half-cardiac-stent-procedures-overused-unnecessary/2013-09-27

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Ad Hoc PCI 5

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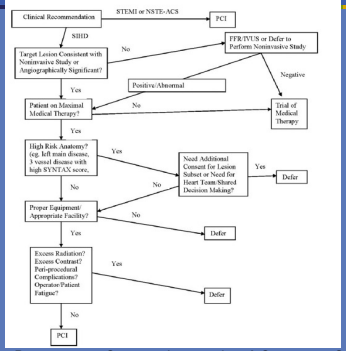

Ad Hoc Percutaneous Coronary Intervention: A Consensus Statement From the Society for Cardiovascular Angiography and Interventions; CCI Journal November 29, 2012

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Stenting non-culprit lesions in ACS

Previous thinking- stent culprit, stage non-culprit

New study- stent all > 50%

After a mean follow-up of 23 months, the primary end point, defined as death from cardiac causes, nonfatal MI, or refractory angina, occurred in 21 patients treated with preventive PCI and 53 patients treated with PCI of the culprit lesion only. This translated into a 65% relative reduction in risk and 14% absolute reduction in the primary end point. There was also an observed 68% relative reduction in the risk of nonfatal MI and a 65% reduction in the risk of refractory angina.

PRAMI- http://www.theheart.org/article/1575917.do

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Non-Coronary Stenting

Renal Artery

- Uncontrolled malignant hypertension despite multidrug therapy who have been found to have unilateral or bilateral renal artery stenosis equal to or greater than 50%
- Progressive renal insufficiency due to atherosclerotic stenosis of > 70%
- Recurrent congestive heart failure, pulmonary edema, or coronary ischemia in the setting of stenosis of the renal artery(s) of > 60%.
- Renal artery stenosis of > 50% in a transplanted kidney

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Lower Extremity

- Lifestyle limiting claudication, ischemic rest pain, nonhealing tissue ulceration, focal gangrene, dissection, impending failure of a lower extremity bypass graft.

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ICD's

NCD 20.4

Well established criteria

Consistent with HRS recommendations

Primary prevention- patient must be able to sign own informed consent- no surrogate!

Use a checklist- too expensive to mess around

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32,000 ICD's placed per year in US

Nationally, 22.5% for non-evidence-based indications (hospital range 0-60%)

$250,000,000 spent per year in US for ineffective device

- **Non–Evidence-Based ICD Implantations in the United States** Sana M. Al-Khatib, MD et al. *JAMA*. 2011;305(1):43-49

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ICD indication #2

Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (within 40 days) and not due to a transient or reversible cause.

Our case- HINN-11- non-covered service during a covered inpatient stay

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BiV pacers

- New York Heart Association (NYHA) classification of heart failure III or IV; *and*
- Sinus rhythm, or chronic atrial fibrillation (AF), or frequent dependence on ventricular pacing; *and*
- left ventricular ejection fraction (LVEF) less than or equal to 35 %; *and*
- QRS duration greater than or equal to 120 msec; *and*
- beneficiary is on a stable pharmacologic regimen before implantation, which may include any of the following, unless contraindicated: angiotensin-converting enzyme inhibitor, angiotensin receptor blocker, beta blocker, digoxin, or diuretics

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or

- NYHA classification of heart failure II; *and*
- sinus rhythm; *and*
- no evidence of atrial arrhythmia; *and*
- left ventricular ejection fraction (LVEF) less than or equal to 30%; *and*
- left bundle branch block with QRS duration greater than or equal to 130 msec; *and*
- beneficiary is on a stable pharmacologic regimen before implantation, which may include any of the following, unless contraindicated: angiotensin-converting enzyme inhibitor, angiotensin receptor blocker; beta blocker; digoxin, or diuretics

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Cardiac-Resynchronization Therapy in Heart Failure with a Narrow QRS Complex

New England Journal of Medicine, Sept. 3, 2013

In patients with systolic heart failure and a QRS duration of less than 130 msec, CRT does not reduce the rate of death or hospitalization for heart failure and may increase mortality.

Pacemakers

NCD 20.8

Aug. 13, 2013- NCD changed- single and dual covered equally

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.

2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree AV block.

No retroactive effective date; denials will continue for 3 years based on …

Dual Chamber Pacer- for "old" pacers

Patients in whom single-chamber (ventricular pacing) at the time of pacemaker insertion elicits a definite drop in blood pressure, retrograde conduction, or discomfort.

Patients in whom the pacemaker syndrome (atrial ventricular asynchrony), with significant symptoms, has already been experienced with a pacemaker that is being replaced.

Patients in whom even a relatively small increase in cardiac efficiency will importantly improve the quality of life, e.g., patients with congestive heart failure despite adequate other medical measures.

Patients in whom the pacemaker syndrome can be anticipated, e.g., in young and active people, etc.

Old NCD Caveat

Dual-chamber pacemakers may also be covered for the conditions (defined as Group I.A. in the Medicare NCD Manual), if the medical necessity is sufficiently justified through adequate claims development. Expert physicians differ in their judgments about what constitutes appropriate criteria for dual-chamber pacemaker use. The judgment is that such a pacemaker is warranted in the patient meeting accepted criteria must be based upon the individual needs and characteristics of that patient, weighing the magnitude and likelihood of anticipated benefits against the magnitude and likelihood of disadvantages to the patient.

If denied, get letter from cardiologist explaining why dual chamber was indicated for this patient; also point out that studies in new NCD date from pre-2010 so standard of care has been dual chamber.

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Getting answers from a MAC

A patient is scheduled for elective a dual chamber pacemaker replacement as outpatient. The notes indicate “dual chamber pacer originally placed 1987 after syncopal episode. No old records available.” Do you…

- Allow the placement to proceed?
- Present an ABN?
- Tell the doctor to turn off the pacer and wait until she has another qualifying episode?

This could also apply to replacement ICD’s where EF has improved.

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What about replacement devices?

In this instance I don't believe the NCD would apply. The NCD applies when making the initial determination to insert a permanent cardiac pacemaker. In this situation the decision has already been made. The patient has, and has had, a pacemaker for 5 years.

The replacement dual chamber pacemaker must meet the NCD requirements as indicated in the CMS Pub. 100-03, Chapter 1, Part 1, section 20.8.

The critical question is whether the patient’s current clinical needs are best addressed by use of a dual chamber pacemaker or alternatively some other therapy. While certain events (e.g. syncope) may support the need for a pacemaker, the NCD does not require all beneficiaries to experience an event. There is also no NCD requirement to turn off the pacemaker and await some event.

Given all this information, the bottom line is that reasonable clinicians should make reasonable decisions. If there is a replacement need, then some supporting documentation (to the extent of practical expectations) should be available to support the ongoing need for dual pacing at the time of replacement. The concept of reasonable & nececessary is not a one-time, "static" event, but a long-term perspective for managing all Medicare beneficiaries.

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Nuclear Stress tests

NGS LCD 26859

Diagnostic evaluation of patients with chest pain and uninterpretable or equivocal ECG changes caused by drugs, bundle branch block, or left ventricular hypertrophy

Preoperative assessment for non-cardiac surgery, when used to determine risk for surgery and/or perioperative management in:

- patients with minor or intermediate clinical risk predictors and poor functional capacity or patients with intermediate or high likelihood of coronary heart disease, or patients with poor functional capacity undergoing high risk non-cardiac surgery: aortic and peripheral vascular surgery

MAC ADR received by Hospital

ADR was for 35 non-emergent stress tests with SPECT. Again the reason for good cause was a "significant increase in 2012 for billing and payment". The ADR requests;

Copy of claim/bill

Physician order

Test report

Documentation of diagnosis/ indication for test

"All documentation that supports payment of this claim"

Question

The patient is a 52 yr old female (on Medicare) with 3-4 months of back pain, and had difficulty walking and a limp. She had a MRI which was reported as "abnormal." She had a history of two previous back surgeries of unknown type. Her exam showed the following: "she can walk upright, does not have to bend as much as previously, is having less pain, and does not limp." There was no documentation of any conservative measures in the record. The surgeon has scheduled the patient for outpatient spinal fusion. Do you…

- Allow the surgery to proceed?
- Discuss with surgeon then present a pre-admission HINN?
- Discuss with surgeon then present an ABN?
- Don't do anything because your hospital does not review cases pre-op?

Spinal Fusion for Lumbar Stenosis

LCD 32074 First Coast Services

Lumbar instability

Spinal Stenosis, failed 3 months conservative treatment

Spondylolysis, failed 3 months therapy

Degenerative Disc disease, failed 6 months therapy

This hospital allowed surgery to proceed and was denied.

"Per CERT Physician Specialist, disagree with procedure of lumbar laminectomy and admission as being reasonable and necessary. She had multiple post-operative complications including hypotension and respiratory failure which would have been avoided if she had not had surgery."

Another case

65 yr old female sees surgeon for gastric bypass. BMI 34, no comorbid conditions. Agrees with surgeon to pay for surgery. No discussion with hospital. Surgery performed.

Patient ends up in ICU with complications; on vent, husband brings in patient's Medicare card, presents to hospital staff.

Who pays the bill?

The hospital is stuck with the bill

Services "related to" noncovered services (e.g., cosmetic surgery, noncovered organ transplants, noncovered artificial organ implants, etc.), including services related to follow-up care and complications of noncovered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare." -MBPM, Chapter 1, Section 120

Patient should have been screened and asked to sign a HINN for surgery. No HINN, no bill patient.

I&D

NGS LCD L28490

Use of incision and drainage of abscess codes (CPT codes 10060, 10061) is limited to lesions with documented abscess and/or pus collection. Use of these codes is not appropriate for treatment of blisters, cysts (including sebaceous cyst), or other fluid collections without the documented presence of discrete abscess, pus collection, pain, infection or inflammation.

Stretta Procedure CPT 43257

NGS LCD L26863

The Stretta procedure delivers radiofrequency thermal energy to the lower esophagus as a treatment for gastroesophageal reflux disease (GERD). National Government Services considers the Stretta procedure to be investigational and therefore non-covered.

- efficacy based on objective physiologic measurements has not been shown;
- a clear mechanism of action has not been determined, and;
- significant long-term studies confirming efficacy and safety have not been carried out.

Question

You are a general internist. Your long time patient, a healthy 70 year old female, is sent to you for medical clearance for cataract extraction. The ophthalmologist sends a form and requests you "clear the patient" and perform an EKG, CXR, CBC, CMP, PT/PTT, HCG and UA with culture. Do you…

- Clear the patient and do everything requested?
- Clear the patient and do none of the tests?
- Evaluate the patient's suitability for surgery and indicate that there is no medical indication for the tests?
- Send the patient to another ophthalmologist?

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Pre-op tests

WPS LCD 32779- Non-covered Preoperative services

- The use of diagnostic testing as part of a pre-operative examination, where there is an absence of signs or symptoms indicating a need for the test, is not covered under the Medicare benefit.
- Electrocardiograms performed pre-operatively, when there are no indications for this test;
- Radiologic examination of the chest performed pre-operatively, when there are no indications for this test;
- PT and/or PTT performed prior to medical intervention when there are no signs or symptoms of bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis conditions associated with coagulopathy.

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Want to get your anesthesiologists up in arms?

Novitas LCD DL27489- Monitored Anesthesia Care (MAC)

- The anesthesia procedures listed in the "CPT/HCPCS Codes" section of this policy are usually provided by the attending surgeon, are included in the global fee, and are not usually separately reimbursable. However, in certain instances, MAC provided by anesthesia personnel may be necessary for these procedures, if the patients' diagnosis or pertinent medical history is reflective of one or more of the conditions found in the "ICD-9 Codes That Support Medical Necessity"

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- The MAC service rendered must be reasonable, appropriate and medically necessary. The presence of an underlying condition alone, as reported by an ICD-9 code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact on the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition in and of itself is not necessarily sufficient.

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So What?

Current trend is to do colonoscopies with propofol and MAC

Pros:

- Faster recovery
- Less work for GI doc- can concentrate on scope
- Easy work for anesthesiologist
- Really a doctor payment issue so does not affect hospital

Cons:

- Adds costs- insurer, Medicare, patient
  - Patient can't pick anesthesiologist- out of network nightmares
- GI doc fee includes payment for sedation

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Impacted cerumen

LCD L31861- CGS

Payment is made for impacted cerumen removal requiring a physician's skill when personally performed by a physician.

Payment may be made only for: a) medically necessary removal of symptomatic impacted cerumen; b) medically necessary removal of impacted cerumen impeding the physician's ability to properly evaluate or manage other signs, symptoms or conditions (e.g., examination of the tympanic membrane in cases of otitis media); or c) medically necessary removal of impacted cerumen impeding a physician's or audiologist's ability to perform covered, medically necessary audiometry.

Payment may be made for both removal of impacted cerumen and an E/M service only if the E/M service represents a medically necessary, significant and separately identifiable service that is supported by medical record documentation.

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Virtual Colonoscopy

LCD L31833- CGS

CT colonography, also known as virtual colonoscopy, utilizes helical computed tomography of the abdomen and pelvis along with 2D or 3D reconstruction to visualize the colon lumen. The test requires colonic preparation similar to that required for instrument (fiberoptic, video) colonoscopy, as well as air insufflation to achieve colonic distention.

Virtual colonoscopy is only indicated in those patients in whom a diagnostic or surveillance instrument colonoscopy of the entire colon is incomplete due to an inability to fully pass the colonoscope proximally, and a repeat attempt is not indicated. Virtual colonoscopy is intended for use in pre-operative planning only when imaging of the non-visualized colon proximal to the obstruction is medically necessary in making decisions involving the approach to the patient.

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Incomplete colonoscopy must be due to one of the following:

1. An obstructing neoplasm,
2. Intrinsic scarring, stricture, aberrant anatomy, or obstruction from prior surgery, radiation, or diverticular disease.
3. Extrinsic compression.
4. Patient safety. There are few absolute contraindications to instrument colonoscopy. Relative contraindications do not create medical necessity for using virtual colonoscopy as a screening procedure, and the above indications must still be met.

The following relative contraindications to instrument colonoscopy may be indications for virtual colonoscopy if well documented in the medical record and the patient's primary physician and the colonoscopist agree on the increased risk to the patient: Severe coagulopathy, Long-term anticoagulation,Increased sedation risk (such as from severe COPD or previous anesthesia adverse reaction)

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An example of a lab NCD

190.31 PSA testing

PSA is of proven value in differentiating benign from malignant disease in men with lower urinary tract signs and symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia and incontinence) as well as with patients with palpably abnormal prostate glands on physician exam, and in patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. PSA is also a marker used to follow the progress of prostate cancer once a diagnosis has been established, such as in detecting metastatic or persistent disease in patients who may require additional treatment. PSA testing may also be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease.

Generally, for patients with lower urinary tract signs or symptoms, the test is performed only once per year unless there is a change in the patient's medical condition.

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Another one

201.2- Pap smear

A screening pap smear and related medically necessary services provided to a woman for the early detection of cervical cancer (including collection of the sample of cells and a physician's interpretation of the test results) and pelvic examination (including clinical breast examination) are covered under Medicare Part B when ordered by a physician (or authorized practitioner) under one of the following conditions:

She has not had such a test during the preceding two years or is a woman of childbearing age (§1861(nn) of the Act).

There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than every two years.

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Looking to the Future- Potential NCD Topics

CMS invited the public's input concerning any items and services that may be inappropriately used (i.e., underused, overused, or misused) or provide minimal benefit in hospitals, clinics, emergency departments, doctors' offices, or in other healthcare settings.[1] CMS also expressed interest in public input on items or services that might improve health outcomes and are not currently covered.

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Abdominal CT
Back surgery for recurring low back pain
Knee MRI for likely arthritic condition
Misuse and overuse of the hospital outpatient settings for IV infusions and injectables
Neuroimaging for headaches
Nonemergent percutaneous transluminal coronary angioplasty (PTCA) and stents
Nuclear stress tests for cardiac related symptoms
Intraaortic balloon pump and percutaneous ventricular assist device for cardiogenic shock, high risk PCI and acute MI
Proton beam therapy for prostate cancer
Surgery for low risk prostate cancers
Underuse of physical therapy and other non-invasive therapy for back pain
Vertebroplasty and kyphoplasty
Wound center debridement vs. active wound management and frequent non-medically necessary debridement for very small wounds

– http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

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Do they listen to comments?

Comment: Request received to allow coverage for antibody mediated (humoral) heart transplant rejection and complications of transplanted heart, as well as, treatment of allosensitization in the pre-transplant candidate.
Response: LCD updated to allow coverage for kidney, heart, lung, liver, bone marrow, and stem cell transplants.

Comment: A provider (that's me!) and a few hospital managers found disrespectful the statement that said "Subsequent information may support a physician's "hunch" that the patient needed inpatient care."
Response: WPS Medicare never intended any disrespect and extends our sincere apologies to our provider community, along with a thank you to those who brought this to our attention. We have amended the sentence to state; "Subsequent information may support a physician's decision that the patient needed inpatient care"

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But that's not our MAC!

Contractors may review claims on either a prepayment or postpayment basis regardless of whether a NCD, coverage provision in an interpretive manual, or LCD exists for that *item or* service. However, automated denials can be made only when clear policy or certain other conditions (see chapter 3, §3.5.1) exist. When making individual claim determinations, the contractor shall determine whether the *item or* service in question is covered based on an LCD or the clinical judgment of the medical reviewer.

--Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, section 13.3

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CMS retained Performant Recovery, Inc. to carry out the Recovery Audit (RA) program in Region A, which includes all states located in the Northeast region of the United States.

Medical indications for the coverage of Blepharoplasty – eyelid lifts are outlined in 42 CFR 405.926, 42 CFR 405.980, 42 CFR 405.982, 42 CFR 405.984; 42 CFR 405.986, the Medicare Claims Processing Manual, CMS Pub. 100·04, Chapter 34, Sections 10.6.1 and 10.11, and Medicare Program Integrity Manual, CMS Pub 100-08, Chapter 3, Section 3.5.1;· Novitas Local Coverage Determination L27474 and National Government Services Local Coverage Determination L26448.

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What Can You Do?

Procedure

- Educate your doctors
- Create check off forms
- Get office records
- Educate your doctor's office staff
- Provide resources
- If it is elective, review it before it happens

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What is your hospital's new service evaluation procedure?

Do you look at…

- FDA/CMS/Insurance approvals?
- Medical Necessity Guidelines?
- Equipment costs- fixed and per procedure?
- Staff training?
- Reimbursement- DRG / APC?
- Precertification requirements?
- Expertise of physicians?

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Hospital pays $178M for false advertising, inexperienced doc

A jury ordered the hospital to pay plaintiff Clay Chandler $168 million in damages for brain damage he suffered as a result of uncorrected leakage in his abdomen after a weight loss procedure in 2007 performed by surgeon John DePeri.

Although pamphlets and other advertising materials claimed the Memorial Hospital program was accredited with the American Society of Bariatric Surgery's Center of Excellence seal, a jury found the hospital allowed a surgeon who did not meet the ASB's standards to perform surgery.

In accredited programs, providers must have performed at least 50 bariatric surgeries and completed at least 20 hours of bariatric education courses. However, DePeri performed only 21 bariatric surgeries and took one class prior to operating on Chandler

www.fiercehealthcare.com/story/hospital-pays-178m-false-advertising-inexperienced-doc/2012-02-15#ixzz2ebqMY91C

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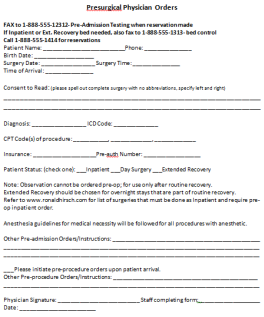
www.ronaldhirsch.com



Presurgical Physician Orders

FAX to 1-888-555-12312- Pre-Admission Testing when reservation made
If Inpatient or Ext. Recovery bed needed, also fax to 1-888-555-1313- bed control
Call 1-888-555-1414 for reservations

Patient Name: _____Phone: _____
Birth Date: _____
Surgery Date:_____ Surgery Time:_____
Time of Arrival: _____

Consent to Read: (please spell out complete surgery with no abbreviations, specify left and right)
_____
_____

Diagnosis: _____ ICD Code: _____

CPT Code(s) of procedure: _____, _____, _____

Insurance: _____Pre-auth Number: _____

Patient Status: (check one): ___Inpatient ___Day Surgery ___Extended Recovery

Note: Observation cannot be ordered pre-op; for use only after routine recovery.
Extended Recovery should be chosen for overnight stays that are part of routine recovery.
Refer to www.ronaldhirsch.com for list of surgeries that must be done as Inpatient and require pre-op Inpatient order.

Anesthesia guidelines for medical necessity will be followed for all procedures with anesthetic.

Other Pre-admission Orders/Instructions: _____
_____
_____

___Please initiate pre-procedure orders upon patient arrival.
Other Pre-procedure Orders/Instructions: _____
_____

Physician Signature: _____Staff completing form:_____
Date: _____

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Questions?

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