Medicare Update 3-25-09

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Questions following presentation

Q: I've always been told that the Medicare exam is a complaint driven system. What I am hearing you say is that the nature of the presenting problem after the exam is done is actually how we should code that.
A: Yeah. Sometimes all you are left with is a complaint. There are many times you get into that situation where you have somebody who comes in with shoulder pain, and by the time you finish evaluating them you still don't know what that shoulder pain is, use shoulder pain. But if you know then you should use the diagnosis.
Q: We are an Ophthalmology office so if a patient comes in and they just say they have blurred vision and they think they need new glasses and we find they may have a retinal detachment or something, then we can bill appropriate to what the exam findings are.
A: Absolutely, you bill to the diagnosis because a retinal detachment is certainly a worse thing than a dry eye and they both will cause blurred vision in different ways of course.

Q: We have heard recently that Trailblazer has been doing some targeted pre-payment audits in particular with 99245 and right now we have just heard it's basically in Colorado but we are wondering is that something that our providers should be expecting, pre-payment audits on any specific codes?
A: We are doing our service specific audits, but I was under the impression that we were not doing audits on E&M right now. I think we may have a few leftover audits where if people hit a certain threshold then we will audit them, but they are not widespread audits. They are very targeted. And should you be expecting one? You can always be expecting something from Medicare. We did tons of E&M audits over the last few years. E&M has dropped, we have a list of problems that we prioritize our medical review resources to and last year and this year, E&M had been at the top of the list for a long time, meaning we were still gathering information. But now E&M is about 5 on the list. For the most part we are doing educational letters and sending the CBRs and things like that for E&M rather than doing audits. I may be wrong, there may be still some audits going on but it's not the top of the list, so I would not be thinking you are going to get audited for E&M very soon.

Q: If E&M is not at the top of the list, what is 1 and 2?
A: Ambulance. We have had a rash or ambulance fraud in the Houston area. And I can tell you that the I-10 is kind of the axis of evil with respect to Medicare fraud. Almost, not all, surely fraud can pop up anywhere, but Houston has been the hotbed of Medicare fraud for as long as I have been in the program. First it was physical therapy. For a number of years we chased people who were not physical therapists, these were enterprising entrepreneurs who were totally fraudulent and none of them were physical therapists. Right now we have a problem with ambulance, in the Houston area primarily, not solely, but primarily; taking patients to and from dialysis. So that is our number one problem right now. Drugs and biologicals are the next problem, erythropoietin and darbepoetin were big. There are some chemotherapeutic agents that are also big, those are high dollars. Number three is a group of procedures. The way we choose these things are called BETOS (Berenson-Eggers Type of Service) groups

where like services are lumped together, and there are several procedure groups. If you do wound care or surgical debridement you might get audited. If you do a lot of epo depo or chemo you might get audited.

Q: El Paso – Ophthalmology provider: The Medicare administrative contract, Trailblazer is not covering visual field testing (92083) for monitoring age related macular degeneration. This is a unique position in the US, there are several peer reviewed medical publications demonstrating new techniques in visual field testing as the only clinically validated methods for early detection of neurovascular AMD. What is being done by Trailblazer to cover these clinically validated visual field testing methodologies for macular degeneration?
A: Visual field testing is subject to local coverage determination, and if I am not mistaken that local coverage determination, I may be getting these wrong because I don't write all of them, but some of them. I think that one was recently changed to actually remove visual fields for AMD. I'm pretty sure. I may be getting this wrong. If you will send me an email I will look it back up and make sure I am talking correctly. Whether it's the one we just changed or whether it was already like that, the way these policies are written, we look at the literature and vet these things in front of a group of specialists in 5 states. If we wrote and finalized it that way it means the specialists, the Ophthalmologists in 5 states were comfortable with it and that we got no comments to the contrary. Now that said, any local coverage determination, which this is the nice thing about LCDs compared to NCDs or statutes. Once something is in a law it takes another law to change it. Once something is in an NCD it takes CMS 3-4 years to change it. Once something is in an LCD, if it needs to me changed, all it takes is a submission of the literature to support the position of the change, sent to me or Dr. Haley. So if you will send me an email at Debra.patterson@trailblazerhealth.com
If you will send me the email about that question, I will look it up. If you have the literature you are referring to you can scan it in and attach it to an email it to me, or mail or fax it and I will be happy to look at it and if we need to change the policy we will. If in fact it is the one I am thinking it is, I heard from a number of Ophthalmologists including the AAO that said we were fine with that. So email me and I will get you more information. What I just said about policy is true of any policy. Any policy out there, if medicine changes, or if we got it wrong, then point it out to us. Send us the literature, point us to where we are wrong and we would be happy to look at it.

Q: El Paso – Orthopedic surgery: Can a resident bill for a full component for an x-ray without faculty involvement. What is the wording the faculty needs to document on the chart as to the x-ray findings.
A: The faculty needs to review the x-ray and write that he reviewed the film and write his findings or write that he agrees with the resident's findings if he does. The Radiologist needs to demonstrate that he provided a service for the patient. He looked at the x-ray and he came to a conclusion. Either he agreed with the resident's conclusion or he disagreed and he needs to write why.
MJ: Let me add one other thing to that. There is some misunderstanding about supervision. Some people believe the resident can supervise the tech and that is not true. For x-rays there is general supervision and that means the physician must be available by phone. It is the physician that supervises any kind of diagnostic service, not a resident.

Q: I have a question about consults in the ER. For the Ophthalmology department, the AAO has advised us that when you see a patient in the ER, that is a transfer of care not a consult. But I see other specialties billing that as a consult.
A: On my desk right now are a bunch of scenarios asking if these would be a consult and I am having a difficult time answering that because every situation is different, and I am really hesitant to say that would always be a consult or that would always not be a consult. I think that Ophthalmologists can bill consults in the ER, just like anybody else can but an Ophthalmologists consult like anybody else's consult has to be, it can't be a transfer of care it has to be a consult. How do I define a transfer of care? This is how it works for me and I think it might work for you too. This is what I'm looking for when I'm reviewing records. I get to review the ones that have internal disagreement about. If the referring/ER physician is going to use the information the Ophthalmologist gives to treat the patient himself or do MDM on that problem himself then it can be a consultation if all the other things are met. This is true inside or outside the ER. If the referring physician will use the consultants opinion to treat the patient or make decisions for the patient for that problem it can be a consult. If that referring physician is not going to use the information it is a transfer of care. Example: The one that I have used many times in presentations, the patient is going to the Orthopedist for their final post-op check-up on their knee surgery, and when they get there the nurse dutifully checks the blood pressure and it is 150/100. The Orthopedist tells the patient, go get your blood pressure checked and the patient says "Whom shall I see?" The Orthopedist says go see Dr. Jones who is right down the hall. Is the Orthopedist ever going to treat hypertension? No. Is that Orthopedist going to make some decision about this patient based on what Dr. Jones says? Not likely. That would be a transfer of care or just a new patient for Dr. Jones. On the other hand, let's say the patient coming in to see the Orthopedist and he is going to have his knew operated on next week and his blood pressure is 150/100. He tells the patient to go see Dr. Jones, find out about your blood pressure, get yourself cleared and have Dr. Jones call me. The patient goes and sees Dr. Jones who gets the blood pressure down, does the EKG, does the whole nine yards and he tells the Orthopedist that the patient is safe to operate on as far as blood pressure is well controlled. That could be a consultation from the Internist or Cardiologist's part. You have sort of the same scenario, but it is different because one is a transfer of care and one is not. In Ophthalmology you have a difficult situation, asked several times about what about when Ophthalmologists send someone to a retinal specialist. For that one, you know what is wrong with the patient, you know what needs to be done, but you don't do it the retinal specialist will do it. But you will be taking care of the patient afterwards. If your care is going to impinge on what the retinal specialist does then the retina doctor could be a consult. Probably more often it is not a consult because the other doctor is going to fix the problem. When you try to draw black and white lines there is always going to be a case where you just cannot decide. I've seen several over my career. If you truly can't decide and you just go with what you think is right and you can ague your case, then do it. If anyone questions it you can support your decision. Chances are you will win.

Q: Nursing Homes: Is there any exception where the resident can see a nursing home patient follow-up, lower level CPT, and the attending can just discuss the case with him, or are they always going to have to lay hands on them?
A: They have to see the patient.
Q: Like the primary care exception rule?

A: Nursing homes won't fall under the primary care exception rule. The only time the physician doesn't have to see the patient is what she was talking about the primary care exception rule. When a clinic has told us that they meet the PCE rule the attending has to be there and provide general supervision, they don't have to see every patient for the lower level E&M. For the higher level E&M they still have to see the patient. The nursing home doesn't fall under that, they have to see everyone.

Q: We have a Cardiologist who sees a lot of very sick patients, such as one who has a problem focused type history, a detailed exam, but on the MDM we have a slew of diagnosis: hypertension, diastolic dysfunction, hyperlipidemia, peripheral vascular disease, Alzheimer's disease, osteoporosis. But on the plan she says "continue current care".
A: Continue what? Here is the deal. If this patient has all these problems, and the physician really did deal with all these problems, how come the history is only problem focused? It makes me as a physician? He examined her and he made a lot of plans, but he didn't ask her any questions and he didn't get any information from her. So there is a little disconnect right there. Truly if someone has 3-4 problems and even if you just get the status of the chronic problems: are they getting better, are they stable, are they taking their medication or not; you have an extended right there. The problem focused history means they got only 1-2 elements out of the HPI, they don't have any review of systems, and they have no PFSH. Past history you have because you probably found out what drugs they were on, so that means you didn't get any ROS. It's a bad record, go teach them to write good records. I cannot believe he saw them and they were on those medicines and he didn't review them or mention them. That is what I mean by a good clinical record, it will meet all that stuff. The physician's work was not accurately reflected in that note. The typical Internal Medicine patient there who happens to have heart trouble too and you are probably treating them as an Internist. If you are doing the work document it and make the payor believe it. Don't leave money on the table or leave yourself open to question.

Q: I have two questions from the Trailblazer Pocket Coding Reference, which I believe is your work. One question that comes up over and over again from coders in particular and analysts is: in table A1 what is a plausible differential diagnosis co-morbidity or complication? What has to be in the record for you to be able to say "Okay, that is a plausible differential diagnosis.
A: That means it has to be plausible. It means the facts have to be believable. Typically what it means is that the physician has to have written that is the differential diagnosis. I don't expect a coder to have to run through and read a record and come up with a differential diagnosis that is not their job. It is the doctor's job to tell you what was on his mind. And what is plausible is somebody who … I will give you an example of what I think plausible is and I will give you one I think is not plausible. Someone comes in to the ER complaining of chest pain, sub-sternal, radiating to the jaw, but also has a swollen leg, has just gotten off an aircraft, and they are very short of breath. I think that angina or acute MI is plausible as a working diagnosis. DVT is a working diagnosis as well as heart failure. Their blood pressure is 76/50. Well then you have a whole list of things that are then plausible. And I think it is the doctor's job to list the things that he typically wants to rule out by all the tests he is going to do in the ER. So then he is going to get cardiac enzyme, EKG, spiral CT or a lung scan. He may get a venous Doppler, chest x-ray, b-naturatic protein, peptide, and all those things. Those are

plausible diagnoses. What is not plausible? Someone who comes in with right sided chest pain who has a typical rash running around the T-11 dermatome and has no history of risk factors for coronary disease and the diagnosis of "rule out angina" is on there. That is not plausible. Now that same patient who has the rash on C-6, has zoster obviously, also has a history of heart disease and says that they are waking up in the middle of the night with some other pain or they throw you one of those curves of atypical chest pain. You really believe in your mind you need to rule out unstable angina in this patient. It is still plausible but you have to have something in the record that would lead the reasonable clinician to think there was a likelihood that disease was present. That is what I mean by plausible.

Q: Question two is on table A2, management options. We have a list of management options that are listed and then there is Other as the last management option. What limitations are there on filling in Other and what is a reasonable way of deciding what point value should be? Example: One ER doctor said why don't we put "decision to activate trauma team" and call that a 2 point option. [A: One point.] Well, I don't know what are the criteria?
A: On the decision to activate the trauma team, I don't know enough about those decisions to comment, but I am betting that there is some criteria you go by, by which you would activate the trauma team. If it takes a physician to make that decision, then I would put that is the same category as consult and give it one point. Now if you personally call the head of the trauma team and you say "I have this and this." and you give him the whole run down then that could be two points, if you call him yourself. How you assign a point value? First of all there may be no limit on the number of things you could put under the Other category. It is anything that is not already there that you would call a treatment option could be on that list and everything would have a point value of 1 for the most part. I think you would be safe in saying everything should be 1 point. There are a couple of things that are 2 points but those are things that I think require a lot of physician work rather than a decision that someone else carries out. It is something you have to do. That gets more points. Most anything else is 1 point and the list can be unending.

Q: Amarillo: One of our physicians, Dr. Young, submitted a question through Dr. Brown and I was hoping we could get to it before the end of our time. It concerned the oversight of 4 residents being supervised by 1 teaching physician. [A: Are you talking about Anesthesia?] It is in primary care.
A: I cannot quote the primary care exception. Does it specifically say how many residents?
MJ: The primary care exception says no more than 4 residents can be supervised by an attending physician and the attending physician can have no other duties while they are supervising. And I will point out there is written documentation from CMS. You will probably remember this, in 1996 or 1998, addressing the fact: what if 1 of the 4 residents had less than 6 months training. CMS said that in that case as long as it didn't distract from the attending physician's ability to supervise the other 3 residents, they could supervise a resident with less than 6 months but they had to personally go see the patients of that resident and supervise the others. [Q: Did they put that in the manual or is that just in a Q&A?] It is a written letter specifically from CMS. I can't remember. I can send you a copy. That was right when they came out with the new teaching physician rules.

A: I am thinking they never put that in the manual.
MJ: No, but it is being utilized. People are relying upon it at other academic institutions. The only problem is that in the past 10 years that it has been out there and other institutions have used it, most of them have not because of the difficulty in being able to go see the patients for that resident and address questions from the other residents who are seeing patients at the same time. What is the question the physician is posing with respect to supervision of residents in a primary care exception?

Q: One of the issues was that our teaching physicians were being assigned 4 specific residents. Now if we had 6 residents then we had to have two teaching physicians and if one of those 4 residents assigned to teaching physician A was available to check out with teaching physician B if his teaching physician A was not available to him.
[A: The manual certainly does not address that.] Do they actually have to be assigned to one specific teaching physician? [A: I don't think so.] Or can, say the example being 6 residents, can be assigned to both teaching physicians.
A: I think it is the latter. I think most everybody here is nodding in agreement. I know for a fact that the CMS manual's instructions to contractors on teaching physicians does not go into that degree of detail. I think it would be very reasonable to say that as long as there are enough physicians to cover the number of residents that it doesn't matter who supervises whom. When CMS is silent on an issue then we can make things up as we go.

Q: One more question on the consultation for some clarification. We will take a scenario of a patient coming into the ER, kid has fallen off the bicycle, injured their arm, the ER physician sees them and calls the Orthopedic physician. They treat the patient in the ER and the ER tells them to follow-up in 6 weeks. If you are going by the scenario you used earlier, since that care is not really being handed over to the ER physician to be actually treating that patient as far as that is concerned. Is that transfer of care at that point, and if it is, then what code would the Orthopedic physician use? If he used an ER code, the 9928 codes. [A: He doesn't.] What does the ER physician use?
A: The ER doctor uses the ER codes. The Orthopedist uses, if it is a new patient to him, one of the new patient out-patient codes. If it is one of his established patients he would have to use an established out-patient code. He would then use the ER place of service code.