BEST PRACTICES MINUTES
March 7, 2016 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: Good morning. I want to welcome everyone to our Spring RIC/RAC meeting. I'm going to turn it over now to Karen Northcutt with Medical Management Plus for Best Practices.

MS. NORTHCUTT: Hello. I think that March madness, besides the basketball March Madness, is usually the madness from the beginning-of-the-year changes and looking ahead at what some of the initiatives are.

And what I was thinking about, when I was thinking about best practices, to look at some of the things and make sure that we have a clear understanding, coming from all different backgrounds, of some of the wording and some of the issues that are out there that are not necessarily in any order whatsoever, but, in my random head, as they came to me, things that bother me, things that I am seeing that are being audited, things that I've never thought about before until somebody brings it to my attention. So I did just kind of develop a list of things that were pertinent and important to me. And I really wanted to start with some definitions and some things that I think hospitals need to be very, very aware of as we talk about medical necessity.

Who has never heard of medical necessity? Okay. Just making sure. I think it's been crammed down our throats. And the polite thing, as I was reading in the government regs, on reconsideration processes for certain policies, in the beginning they used "fraudulent." Now they use "reasonable and necessary." So everything is reasonable and necessary. So I think that's definitely up to interpretation of who you are. I might think it's reasonable and necessary; somebody else might not think it's reasonable and necessary.

So the government, when they first started coverage for Medicare, they came into what's first called a "benefit category." And anything that they offered to pay for, it had to go into a benefit category. And once they had the benefits category, then they had to decide, what items and services can be in a benefit category. So that's where they start saying, okay, we're going to have national coverage determinations.

I'm saying this because we've got a question in there with Medicare about what is the determination process, how does that work. There are many, many, many NCDs out there on CMS's website. Lab has its own NCD manual. So if you ever thought that you could have something that was covered or noncovered, you really need to go to that manual.

But we have national coverage determinations that we have to follow. And what is important for that, as we will see, many of the auditors are now looking at the indications within that national coverage determination to see if your medical record supports what you are providing to the patient. And usually, in the past, we would have edits that said, I did this service and I have this diagnosis; therefore, if it passed the claim, everything is fine.

Well, all the votes were off on that. Every coverage determination usually has indications, and an indication is not always defined by a diagnosis code. So that's where the nitty-gritty wording is involved, and that's where I think some of the concurrent documentation programs, nurses that are actually having to look at this record prior to even the H&P, prior to scheduling procedures.

So the government had national coverage determinations. And then they said, well, from a local level, we might have other issues out there that somewhere in Alabama might be affected more than

California. So what they allowed since 2002 was what were originally called local medical review policies, LMRPs. And anybody old enough knows what those are. Those that are younger, bless you, you didn't have to know that.

That is how this committee started, just as an FYI from AlaHA, was actually talking to the payor, Cahaba, about their LMRPs. Medicaid did not have LMRPs, so they borrowed Cahaba's, which was not really good when you have a pediatric population trying to match a Medicare LMRP.

So CMS said, okay, LMRPs, now you're gone; we're going to call them local coverage determinations, LCDs. And anybody that has not gone to Cahaba's website that deals with medical necessity, deals with denials, and deals with a physician needs to know the LCDs well.

And I went back to look at some, because there are three specific ones that I really want to mention today. And the first one is being audited by the CERT. They're an auditor that actually looks at certain payors. And Cahaba is also looking at these procedures pre-payment. And those are Vertebroplasty and Kyphoplasty. And basically, you've got to have fractures and you've got to have conservative medical treatment. That is on our list of questions today: what does that mean, and how long does it have to last. And you also, for that particular population, have to have very good notes about how debilitating the pain is.

Right now, Cahaba says that we have a 50 percent error rate on 24 providers so far to date that they are denying those claims. So just to be clear, if you perform these procedures, you need to look at the policy, and you need to get with your physicians. And from a CERT policy, they're going to grade both Cahaba for paying you and you for performing it, so it's very vital to Cahaba that you get it right as well because they get graded by a CERT.

So that is the first policy. It has remained on their pre-payment list. They just made the next batch, so it's not going away. Obviously, we're not getting it right.

The second LCD that I wanted to go through is the urine drug testing policy.

We've got qualitative, which means I'm going to just run a cup, and I'm going to look for the most obvious drugs that should not be in your body. Okay? And that's usually when somebody comes with altered mental status in your ED or mawmaw is really not thinking clearly, I'm on opioids.

So at this point, what happened was many, many drug-testing facilities, and I'm not just saying hospitals, abused the system and for quantitative drug testing, had up to 50 to 70 drugs for which they were testing. Usually in pain centers, where the patient is on Lortab, I've seen them even test for two different types of testing for nicotine. Now what smoking and Lortab has to do with each other, I don't know. But they had where they were ordering a huge array of panels without the justification for doing that.

So after much payback, not just here but nationally, Cahaba has developed LCDs and has them on their website for drug testing. So if you do any pain management and you do toxicology and you do drug screens in your ED, you need to be very, very clear about what these local coverage determinations are for drug testing.

And the third one that has become very good, and I don't know if anybody has seen it, but Cahaba has come up with a brand new proposed LCD for anything that's cardiac-device related. And this is a very, very great thing. Because there has been conflict between CMS's national coverage determination of when you can have a pacemaker, when it's reasonable and necessary, and they gave billing instructions that nobody could follow.

So they said, you know what? Until we get this clear, we're going to put that on the MAC. So now, Cahaba, you get to make a reasonable and necessary policy based on pacemakers, defibrillators, and what's called cardiac resynchonization therapy (CRT) which is basically a third lead. For pacemakers, CMS was very strict and said you had to have sustained, symptomatic and nonreversible bradycardia.

I had several hospitals that reported the scenario where the patient has to have a pacemaker after an AV node ablation because you've killed the pacing, so something has got to pace them. Cahaba has included that in their policy. The policy is very long and arduous, but it is giving great coverage to a lot of questions that we had.

It came out probably about two weeks ago. They have until April 18th to get comments in on this proposed policy. So take that to your cardiology department, take it to your docs, and make sure that it's got everything that you want and need, because now is the time for comment period.

So at April 18th, they will then put out a final, if you will, and it will have 45 days notice on that, so probably looking somewhere around, I guess, June before we would actually have this policy, so we're kind of in limbo land still until that policy is out. But I think that most of the cardiologists will be very, very happy about this. And they have some layman's terms in there that is very simplistic, which I thought was good for those that, you know, aren't doing heart surgery, not doing cardiac devices, so I think it will be a really good learning experience for everyone.

And just as a side note on cardiac devices. So we've got national coverage, we've got local coverage. Now we have a meaningful one that we can go by. And I was talking the other day about cardiac devices, and here's something I didn't know. When a cardiologist is going to insert a device, lo and behold, a lot of hospitals will do a venogram prior to putting that in, to make sure your subclavian is not stopped up and I think it's a good thing , just to see if you're not clogged so we can go put that pacemaker in and be done. And that's called basically road mapping, and you're usually not being paid for that.

So I did not think any big deal about it except for the fact that the physician supervision requirements under the conditions of participation require that the physician be personally in the room in attendance when that is performed. And if you go to the physician RVU file, you'll see an indicator of '3' by CPT codes that require personal supervision. Those are not direct supervision where they can be around in the hospital; you've got somebody that can step in. Personal supervision means they need to be in the room.

I did not know really that techs were doing these without a physician in the room. I did not know that for the venography, that the techs were actually starting it and taking the picture. And it's not happening everywhere, but I know that this is an issue. And from a supervision and documentation, I think that it would be a good thing to go back to your cardiology department and check on your process. Not that I'm picking on cardiology today, but it would be a very wise thing to go back and look at that.

The main reason is it's time stamped. So if you see that a venogram is being performed at 10:15 and the cardiologist doesn't get there until 10:33, how did that happen? So just as an FYI to go back and look.

Not picking on cardiology again, but this is an old story, and it's got a new twist on it. And this is preoperative EKGs, preoperative EKGs prior to cardiac cath and whether or not it's reasonable and necessary. Okay? We're back to reasonable and necessary. And are we doing it as screening or because we're over 50 years old, we need an EKG before we have surgery or we have a cath?

I had always been on the side of, well, if they have a cardiac condition and they're going to have surgery and it's documented, yeah, I think that's wise. If they have a cardiac condition and they're going to have a cath, yeah, I think that's wise. I have had several that now have been audited by the OIG and they don't think that's wise. Okay?

In general, they have pointed back to the Correct Coding Initiative Manual. And it's in the general instructions of where they are formulating their response, if you will, to a preoperative EKG. I want to read this to you because I could fill it in with other things beside an EKG.

"When a diagnostic procedure precedes a surgical or nonsurgical therapeutic procedure and is the basis on which the decision to perform the surgical or nonsurgical therapeutic procedure is made, that diagnostic procedure may be considered to be separate and distinct from the procedure as long as it occurs before the therapeutic procedure and not interspersed with services that require therapeutic interventions."

Now, the day that an EKG diagnostic procedure is going to lead to the decision to do surgery, I'll eat my hat. Okay? So the context of an EKG has been inserted in this to determine if it's separate and distinct or it's not. This is the basis of how the OIG opinion is derived. And I can only imagine that a serial EKG of a chest pain patient coming to the ED that ends up in the cath lab with a stent is about the only time that it would ever have any formal rationale for going on to have that procedure. So I think we just have been shut down on any type of preoperative or pre-therapeutic EKG that does not lead on to the procedure following it. I think this is out of context, but I have actually seen it with my own eyes: that these are the responses that are coming down.

So cardiology I said I would not pick on, but I have. But I think we've gotten good news on devices; not so good news on EKGs. I do have to say, from the ED perspective for Medicare, those EKGs are basically going to be packaged for the most part, so, it's not like we're going to get paid a lot for them anyway.

I have just a couple more. And it's kind of leaning in from cardiology to interventional cardiology. And the CERT has now gotten into the audits on interventional radiology procedures. And that's a new twist. That's some different coding. And they're looking to make sure that the medical necessity for the intervention is dictated in the H&P. And usually these are very, very short diagnostic tests for the interventions for the balloons.

And for those who have kind of a very hollow H&P out there, they're looking for the rationale; in general, they're looking for the actual documentation rationale from the physician of why they're doing that procedure. Counterintuitive and crazy, but it is happening, and they are denying those services; and those can lead to some expensive denials.

Okay. If we have time later, I'll share a couple more things.