BEST PRACTICES MINUTES
March 19, 2018 RIC/RAC Meeting

Ms. Karen Northcutt
Ms. Becky Miller

MS. NORTHCUTT: What we're going to do is start with Palmetto, they have flown in. And Palmetto will be providing a presentation today. We don't know for sure if they will address all the questions that will be addressed at the meeting as you'll see on the minutes, whether that will all be in the presentation or not. If they're not, then we'll read the questions and try to get them to answer. We tried to allow them appropriate time because they did make the travel to be here. And this is our first time out of the chute. I'm very excited about meeting the new MAC. I think that they will be open to questions. And I think now we've got, what, six weeks under our belt, and hopefully it's been a decent experience in the transition.

So, I will be very brief today, but I do just have a couple of things that I did want to bring to people's attention, and especially hospitals, because sometimes Medicare kind of sneaks things in or it doesn't make a big deal out of it.

And for all of those hospitals that deal with cardiac defibrillators, they're back in motion again. As you know, ICD's have been under a National Coverage Determination since way back, but they have actually added since 2005 indications for primary prevention. For those that don't have to deal with ICD, basically it shocks you back to life. So, if you've already had a cardiac arrest and fell out, you're good to go. That's called a secondary provision. You've already come back to life and they let you have an ICD to kick start basically if it happens again.

There are other indications that are called primary prevention which means you're trying to prevent the fallout. You have congestive heart failure. You have ejection fraction that are of a nature that you are likely to fall out, either ischemic or non-ischemic, ischemia meaning the condition is most likely due to blood flow issues but that causes the tachycardia. Your heart just kind of flips out and, again, kick starts again. There are conditions for non-ischemic which means it's not related to the blood flow.

That's all the clinical nurse talk that I'll do on my nurse talk. But this policy was investigated in hospitals if you'll remember in the past by the Department of Justice because the indications for that primary prevention were not documented and/or they did not follow the National Coverage Determination. At the end of the day, over 500 hospitals across the U.S. had to pay back money to the tune of 200 million dollars. So they don't play with these. Their fees are very high cost items, and Medicare pays pretty good on those from about $22,000 to $24,000. It doesn't take a lot to add up to the -- you need the documentation and you need everything in that National Coverage Determination met as an indication to be covered.

So what CMS did was they looked at the National Coverage Determination because it has not really taken a good look at since 2005. And what they have come out with is a decision memo. And a decision memo is something that happens before you can change a National Coverage Determination. It goes out for comment. They get the comments back. It goes out for final comment again. And so the final comment period will be over March 31. And at that point you'll have 180 days for it to be revised in the National Coverage Determination. And I'll give briefly what the changes are, and most of it is for patient criteria.

Number one, they have added MRI as a mechanism to determine your left heart ejection fraction. And in the past it's echo. It was nuclear medicine or a cardiac angiography. So now those that

are using the MRIs, that will now be covered in September, 180 days from now. Okay. It will be covered but not now.

The other criteria is that non-ischemic patient, which means that it's most likely not due to a blood flow issue in the primary prevention, you have to have documented three months of optimal medical therapy, which most of the time the patients are on medication to try to prevent them from having a heart flip out and have to have a defibrillator. So optimal medical therapy -- and this is something that you need to share with your doctors, it needs to be in your record. That's why I'm giving you 180 days ahead of time because it's going to take a little while to get some of this in place in your record. But that optimal medical therapy, one of the comments was if the drug that I have them on isn't working, then they get the defibrillator. CMS says no, that is not optimal medical therapy. That is the incorrect drug for that patient. So, again, we need to have tried and made sure that this patient is going to get the maximum benefit out of their medical therapy. If they cannot, then they would be a candidate for that ICD.

Here's my favorite one, and it's called shared decision making. Prior to the implementation, implant of that ICD, for anything for primary prevention the doctor has to have a discussion, or a nurse practitioner or qualified health professional has to have a face-to-face meeting with that patient to discuss the benefits and the down side of having that ICD. And you have to use what's called evidence based decision making tool. So if you go out to CMS and go to the decision memos, it's going to lead you to what these tools look like. And this tool has to be completed before the patient can have the ICD.

Now, who is going to do the tool? One of them was very interesting. It shows the statistics of how many people really benefit from an ICD. And it has two paths. One path is that the patient is sick but they still want to move forward. There's still life they want to live. There's things they want to do. The other half is same -- different patient, same sickness, but they've had a good life and they don't really know if they want to go on. So that's going to be your decision you have. I am not kidding. Okay. When you get out there and start looking at these pathways, to have that conversation with the patient prior to that ICD is going to be very interesting. That is going to be the most important part of the documentation in that medical record.

And I do think that the last -- there is going to be an exception. If the patient has to have a pacemaker and a defibrillator, there are going to be some exceptions to basically the carve-out because in general, you can't have an ICD until after your forty days of your MI. So you have an MI, you've got to wait 40 days. If you have a stent or a CABG, you've got to wait 90 days. And you hope you don't fall out between the two. But there are some exceptions now that if you have to be paced and you have an ICD, then they will exclude that from the 40-day and the 90-day wait period.

And one of the final things, and whoever does your registry and usually in the EP lab or the cath lab, wherever they're putting this ICD in, the registry data we now have to put in on every patient that's primary prevention. That will go away, and that requirement will no longer be required. There comes a billing part of that because right now when you bill an ICD, you have what's called Q0 modifier on that claim. And that says that I have the ICD in the registry and it also says that I know it's medically necessary that I put this in. So in tandem, in 180 days when you have your optimal medical therapy and you have your shared medical decision making all documented in your records, you will no longer be required to put that in the registry and we won't be required to modify that CPT code at the end of the day. There's a lot of steps to this, and I encourage you to go out and read the decision memo. And go ahead and start this process in place so that you will be ready. Because the other side of this is if

documentation is not there, then we're all back over on the DOJ and who's putting in what. I just wanted you to be very clear on that. Does anybody have any questions on that?

Okay. That's great. I'm glad everybody got it. I had to read it a couple of times. But the NCD number just for what is the current NCD is 20.4. And that's going to be your NCD for the implantable defibrillator. I guess I'll be kind of barking that in July again to see if everybody has got this under control at that point.

And there's two things I did want to bring up as well with Palmetto. For those that do a lot of the genetic testing, the facilities, what they have is basically a registry that is required which means that for those that do molecular diagnostic testing, you will have to have a Z code, Z as in zebra, in the narrative section on the UB. Your lab should already have signed up with Palmetto and started to give them the panels for the actual testing that they are doing so that they can go ahead and obtain that Z code in order to bill that for molecular diagnostics. And all you have to do is call the lab and say you do molecular diagnostics and then lead them to the page on Palmetto because there is a whole section of what they need to be doing by June 1 to have those codes in place. After June 1, those claims will deny with those CPT codes without the appropriate code in the narrative section.

And my last one, I think that if you have looked, there is a lot of new treatment for obstructive sleep apnea (OSA) besides a CPAP. And my husband won't wear one either, so I get it. But that's why I sleep in the other room now because he won't wear one and I don't get any sleep at night. So that leads to new ways of treating OSA as we're called. And the newest way -- and there's a lot of vendors out there, and that's why I just wanted to say -- and it's called a hypoglossal basically stimulation. They basically put a stimulator in, as long as you want it in. And it's supposed to correct the OSA. The problem is that Blue Cross does not cover it. They think it's investigational. So right off the bat, your Blue Cross patients can't have this performed.

Okay. The mechanism, the stimulator, what it's called is Inspire. So if you hear the word Inspire and your sleep docs and some of the pulmonologists are really into this, Inspire is not covered by Blue Cross. Inspire codes to the same CPT code that is for another type of stimulation for seizures. If you bill this to Medicare using the appropriate CPT code, it is going to edit against the National Coverage Determination and deny you because you don't have seizures. We've got one CPT code that covers two completely different things. When we bill that code, you'll get a denial. And the cost of these are around $9,000 to $11,000. I just wanted to be up front with you on that. You know, it may be other commercial payers might be into that, but the one thing I fear about Blue Cross is that because this is such a generic CPT code, I don't know if they're reading it or not. I don't know if they're paying you and they don't know that they're paying you, if that makes any sense.

AUDIENCE: Do you know the CPT code? What's the CPT code?

MS. NORTHCUTT: The CPT code is 64568. I have audited some denials now, and basically every one that I have seen from Medicare is denying because they don't have a seizure diagnosis, which they'll never have a seizure diagnosis because they have obstructive sleep apnea

And I think those are my two big ones as far as I don't want anybody to lose any money and I want the documentation to be appropriate in the medical record.

All right. Well, we'll go ahead and if you want to take a quick break, then we can get Palmetto in. And hopefully we won't get in the hail and the tornadoes this afternoon.