Medicare and Medicare Dis-Advantage

Ronald Hirsch, MD, FACP
Accretive Health
Learning Objectives:

• Understand the new short stay audit program and develop compliant processes to avoid denials
• Review the common audit risks of hospital-owned physician practices
• Prepare for increased scrutiny of outpatient service audits
It’s Going Public!

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>SAINT PETER’S UNIVERSITY HOSPITAL</td>
<td>NEW BRUNSWICK</td>
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<tr>
<td>ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL</td>
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<td>ST LUKE’S WARREN HOSPITAL</td>
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<td>CHRIST HOSPITAL, JERSEY CITY</td>
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<td>COOPER UNIVERSITY HOSPITAL</td>
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<td>JERSEY SHORE UNIVERSITY MEDICAL CENTER</td>
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<td>CLARA MAASS MEDICAL CENTER</td>
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<td>MONMOUTH MEDICAL CENTER, LONG BRANCH</td>
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<td>SOUTHERN OCEAN MEDICAL CENTER, MANAHAWSKIN</td>
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<td>JFK MEDICAL CTR - ANTHONY M. YELNICSICS COMMUNITY</td>
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<td>ST JOSEPH’S REGIONAL MEDICAL CENTER, PATerson</td>
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<td>VIRTUA WEST JERSEY HOSPITALS BERLIN, BERLIN</td>
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<td>HACKETTSTOWN REGIONAL MEDICAL CENTER, HACKETTSTOWN</td>
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<td>CAPITAL HEALTH SYSTEM - FULD CAMPUS, TRENTON</td>
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<td>CAPE REGIONAL MEDICAL CENTER INC, CAPE MAY COURT HOUSE</td>
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<td>HOBOKEN UNIVERSITY MEDICAL CENTER, HOBOKEN</td>
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<tr>
<td>SOMERSET MEDICAL CENTER, SOMERVILLE</td>
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</tbody>
</table>
**Doctor Data too!**

63 LACEY RD SUITE F, WHITING, NJ, 08759 | (732) 849-1075

GERIATRIC MEDICINE
See other providers with this specialty in N.J. »

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**How This Provider Compares**

Providers in this state and specialty were reimbursed, on average, $387 per patient in 2013. They performed about 6 services per patient. Here's how this provider compares:

<table>
<thead>
<tr>
<th><strong>NUMBER OF PATIENTS</strong></th>
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<tr>
<td>1,056</td>
<td>14,251</td>
<td>13.5</td>
<td>$933K</td>
<td>$883</td>
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This Provider is in the top 10%

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Medicare Audit Update

Two Midnight Rule adopted Oct 1, 2013

Two years of MAC probe and “educate” audits of short stays

Transitioned to the QIOs on Oct 1, 2015
Which Charts Are Eligible?

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Contractor Type(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through September 30, 2015</td>
<td>MACs conducting probe and educate.</td>
</tr>
<tr>
<td>October 1, 2015 through December 31, 2015</td>
<td>QIOs conducting reviews. MACs completing some remaining provider education.</td>
</tr>
<tr>
<td>January 1, 2016 and beyond</td>
<td>QIOs conducting initial reviews. RACs conducting further reviews upon referral by QIOs.</td>
</tr>
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</table>
### Which Charts Are Eligible?

<table>
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<tr>
<th>Summary of Inpatient Status Reviews</th>
<th>Contractor Type(s)</th>
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</thead>
<tbody>
<tr>
<td>Through September 30, 2015</td>
<td>MACs conducting probe and educate.</td>
</tr>
<tr>
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</tr>
<tr>
<td>January 1, 2016 and beyond</td>
<td>QIOs continue conducting initial reviews. RACs conducting further reviews upon referral by QIOs.</td>
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QIO Audits

10 – 25 Charts from May, 2015 to Oct, 2015 - short stays- 0 to 1 day inpatient admissions

Results due in 30 days, some taking over 90 days

Education required within 90 days, deadlines missed

If 3 or more of 10 denied on repeated audits, RAC referral possible. Wide latitude in referrals.
QIO Audits Halted May 3rd

CMS asked QIOs to stop audits for retraining to ensure the QIOs were applying the rules consistently
Audit Step #1

There must be an admission order authenticated prior to discharge.

Resident’s admission order must be cosigned before discharge on every inpatient admission.

Only exceptions are death and unexpected transfer.

No co-signature before discharge, no payment to hospital. Self-deny and rebill only ancillaries!
Step #2

Compliance with 2 MN Rule

Inpatient Only surgery excluded (but slip through)
Documented easy exceptions - death, AMA, intubated unexpectedly

Documented more difficult exceptions - transfers in or out, elect hospice, unexpected rapid recovery
Most common denial

One MN observation and one MN inpatient

“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.”

Did the patient have medical necessity for the second midnight or was it convenience?
Necessary or Convenient?

Necessary
Receiving necessary IV analgesia, IV Fluids, nebulizers, iv antibiotics
Frequent nursing checks, labs
Needs further diagnostic testing in hospital as the result of an abnormal test

Not necessary
No ride home
GI won’t come in to see patient
No stress test/MRI on weekend
No safe discharge plan
Why do you want to stay another day?

Beautiful private hospital room with cable TV and free internet, but…

Patient next door - C. diff

Patient across the hall - MRSA

Rarely used by doctors

5% chance wrong pills
What should you be doing?

Every zero to one MN inpatient admission screened pre-bill drop

- inpatient only surgery - check for medical necessity documentation and signed order
- look for exceptions - coded left AMA, died
- have CM/PA review others for adherence to 2 MN Rule

- if error, follow 42 CFR 482.30 and self-deny and rebill
Check your PEPPER

Will two day stays be a future target?
New APC for Observation 1-1-16

Previously APC 8009
- ED visit or direct admit plus 8 or more hrs
Observation = $1,234
- Eligible part B services billed separately
  - imaging, diagnostic and therapeutic procedures

New Comprehensive APC - 8011
- ED visit or direct admit plus 8 or more hrs
observation = $2,275 (adjusted for wage index)
No other services will be paid
The new Quirk of Observation

If a patient is placed in observation and underwent a status T procedure at any point, the Observation APC is not paid. You bill for the T procedure and all other services provided, but get no payment for bed and nursing services.

T procedures-
- cath without stent, colonoscopy, EGD, I&D abscess, nose packing

Find status indicators on Addendum B
What does this mean?

Patient with abd pain, placed obs, labs and ultrasound done, goes home next day- $2,275

Patient with abd pain, placed obs, labs ultrasound and EGD done, goes home next day- $1,200

Always do what is right for the patient, but realize the cost implications of what is being done.
And speaking of costs…

Observation cost for patient-
$166 part B deductible + 20% of $2,275 + meds = ~$800

Inpatient cost for patient-
$1,288 part A deductible

$800 is less than $1,288 so Observation stay is less expensive than Inpatient admission.
Don’t count courtesy days; it’s their choice to stay.
And you can waive self-admin med costs!
OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings

The purpose of this Policy Statement is to assure hospitals that they will not be subject to Office of Inspector General (OIG) administrative sanctions for discounting or waiving amounts Medicare beneficiaries may owe for self-administered drugs (SADs) they receive in outpatient settings when those drugs are not covered by Medicare Part B, subject to the conditions specified herein. This Policy Statement is designed to address the question whether various guidance documents issued by the Centers for Medicare & Medicaid Services (CMS), including a Program Memorandum outlining changes in the Outpatient Prospective Payment System (OPPS) for calendar year 2003, require hospitals to bill and collect (or make good faith efforts to collect) their usual and customary charges for SADs that are not covered by Medicare Part B (Noncovered SADs) to comply with OIG’s fraud and abuse authorities. That Program Memorandum stated that:

Full memo at www.ronaldhirsch.com
Too Much Observation?
The Hirsch Rule of Observation

If every patient is reviewed by CM for proper admission status, and every patient is placed in the right status, and observation is only ordered on the proper patients, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a second midnight is admitted as inpatient, then your observation rate is at your benchmark.
Outpatient Convenience Days/Stays

Patient presents on Sat with CP, needs stress test on Sunday but not offered so kept til Monday
Sat 2 pm-Sunday noon- obs with labs, EKG, tele
MD orders stress test Sun noon
Sunday noon-Monday 8 am- convenience obs
Monday 8-11 am stress test
Monday 11 am – 2 pm observation
Discharged at 2 pm

0762  G0378  25 units
0762  G0378  20 units  -GZ
Medicare Dis-Advantage

MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medicare Managed Care Manual, Ch 4
What’s your Case Manager’s Reality?

- Demand patients stay observation for days on end
- Rarely approve LTACH, acute rehab or even SNF
- 48-72-96 hrs to get approval for post-acute care
- Contracted home care agency has bad reputation
- DME supplier will not deliver supplies in a timely manner
- Bundling all readmissions within 30 days
It’s all in the Contract- Admissions

What criteria are used?

Coverage Statement: Hospital services (inpatient and outpatient) are covered when Medicare criteria are met.

For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant their need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. 

UHC Policy H-006
These changes to Aetna’s National Precertification List (NPL) will take effect on July 1, 2015:
Observation stays greater than 24 hours will require precertification. **Observation stays greater than 24 hours are considered an inpatient stay** and are subject to all inpatient policies, including the timely notification requirement.
How to Use Criteria

- Apply criteria on Episode day 2 of the appropriate subset

  **NOTE:** CMS requirements for “hospital based services” can be determined by applying criteria at the Observation, Acute, Intermediate, or Critical level of care. Patients who meet Observation criteria by demonstrating that they require hospital based services will satisfy CMS’s requirement for inpatient status.

  **For example:** A patient meeting partial responder criteria at the Observation level of care on episode day 2 would be considered an inpatient once they have crossed the second midnight of care.

- For complications of an ambulatory surgery or procedure, apply criteria on Post-op day 1 in the General Surgical subset
Inpatient admission required rather than observation care because of 1 or more of the following:

Significant finding or clinical condition judged too severe (eg, treatment intensity or expected duration requires inpatient admission) or too persistent (eg, insufficient improvement or worsening despite initial intervention or treatment for up to 24 hours) to be within scope of observation care, including 1 or more of the following:

- Vomiting that is severe or persistent
- Severe electrolyte abnormalities requiring inpatient care
- Hemodynamic instability that is severe or persistent
- Acute renal failure
- Other significant finding or clinical condition judged not to be within scope of observation care

Treatment or monitoring requiring inpatient admission (eg, due to intensity or expected duration) as indicated by need for 1 or more of the following:

- Continued inpatient IV hydration due to failure of rehydration treatment (eg, for greater than 24 hours) and expected improvement with further inpatient evaluation and treatment
Being Unready for discharge = Admit

Hospitalization

Return to top of Heart Failure: Rapid Review - ISC

Goal Length of Stay: Ambulatory or 2 days

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Discharge Readiness

Return to top of Heart Failure: Rapid Review - ISC

- Discharge readiness is indicated by patient meeting Recovery Milestones including ALL of the following (1)(12)(67)(68)(69)(70):
  - Ambulatory or appropriate activity level for age and condition
  - Oral hydration, medications, and diet
  - MI excluded
  - Hemodynamic stability
  - Tachypnea absent
  - Oxygenation at baseline or discharge oxygen regimen ordered
  - Cardiac rate and rhythm normal or documented appropriate for patient and discharge plan
  - Pulmonary edema resolved
  - Volume status acceptable on oral medication
  - Discharge plans and education understood
Readmissions- CMS Policy

When a patient is discharged/ transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.
Aetna Policy

Effective July 1, 2015, we’re changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we’re also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays.
Regence

Hospital readmission review (group and Individual plans)
All hospital readmissions for the same, similar or related condition which occur within 48 hours of the original discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.

The two hospital stays will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.
A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related. If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.

The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system.
Anthem Medicare Advantage considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment. Anthem Medicare Advantage defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.
Anthem Medicare Advantage will utilize clinical criteria and licensed clinical medical review for readmissions from day 2 to day 30 in order to determine if the second admission is for:

- The same or closely-related condition or procedure as the prior discharge
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- **An acute decompensation of a coexisting chronic disease**
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period
- An issue caused by a premature discharge from the same facility
The Money behind Medicare Readmissions

Estimated 2016 Readmissions—
21.5% rate, 0.07% penalty on all DRGs = $40,014

HF DRG - $8,000-$16,000 per admission
99 HF admits in 2014, drop 5% = $60,000 less revenue
+ cost of readmission prevention program
Do you really want to prevent readmissions?
MA Plan Contracts

Enlist CM to help review contract
Address criteria used for inpatient admission
Address criteria used for day reviews if per diem
Address MA plan delays – insist on extra per diem
Review contracted post-acute providers
Own a Physician Practice?

E&M coding audits mandatory

office- modifier-25, 99211, level 4 and 5

hospital- critical care, level 3 (and maybe 2)
A high lab utilizer - East Rutherford

How This Provider Compares

Providers in this state and specialty were reimbursed, on average, $345 per patient in 2013. They performed about 7 services per patient. Here's how this provider compares.

<table>
<thead>
<tr>
<th>NUMBER OF PATIENTS</th>
<th>SERVICES PERFORMED</th>
<th>AVG SERVICES PER PATIENT</th>
<th>TOTAL PAID BY MEDICARE</th>
<th>AVG PAID PER PATIENT</th>
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<tr>
<td>1,313</td>
<td>63,443</td>
<td>48.3</td>
<td>$1.57M</td>
<td>$1,194</td>
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</table>

This Provider

Rank: 18th out of 2,752 providers in this state & specialty

Rank: 3rd out of 2,752 providers in this state & specialty

This Provider is in the top 10%

Avg $345

This Provider is in the top 10%

Avg 6.6
A high E&M utilizer- Whiting

Office Visits

Medicare reimburses office visits using a five-point scale, with five being the most intensive and costly. The chart below shows what percentage of this provider's office visits were reimbursed at each level. A higher than average proportion of costly visits is not necessarily an indication of a problem, but it may be worth asking about.

This provider charged Medicare for a higher percentage of 5's than his peers.
A top Critical Care user - my hometown

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>Critical care delivery critically ill or injured patient...</td>
<td>5,191</td>
<td>53% of his services</td>
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<tr>
<td>99215</td>
<td>Established patient office or other outpatient, visit typ...</td>
<td>777</td>
<td>8% of his services</td>
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<td>90233</td>
<td>Subsequent hospital inpatient care, typically 35 minutes...</td>
<td>636</td>
<td>6% of his services</td>
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<tr>
<td>99232</td>
<td>Subsequent hospital inpatient care, typically 25 minutes...</td>
<td>480</td>
<td>5% of his services</td>
</tr>
<tr>
<td>99239</td>
<td>Subsequent nursing facility visit, typically 25 minutes...</td>
<td>455</td>
<td>5% of his services</td>
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Pre-op Testing - Medically Necessary?

1. CBC with Diff (within 30 days)
2. CMP
3. PT/INR, PTT (Z79.01: long term (current) use of anticoagulant)
4. UA – C&S (N39.0: UTI, site not specified, R82.99: Other abnormal findings in urine)
5. HbA1C - Diabetic patients only (disregard if already done 4x in past year. Obtain copy of most recent)
6. CXR (within 6 months) (J98.4: Other disorders of lung, Z77.22: Contact with and exposure to environmental tobacco smoke)
7. EKG (within 6 months if normal) (R07.9: chest pain, unspecified, I49.9: cardiac arrhythmia, unspecified)
8. MRSA screen (nares, axilla and groin)
9. Type and Screen
South Carolina Results
A total of 97 claims were reviewed, with 81 of the claims either completely or partially denied. The total dollars reviewed was $677,251.37 of which $431,708.53 was denied, resulting in a charge denial rate of 63.7%.

- There was no physician certified diagnosis submitted in the medical record that would substantiate the medical need for use of bevacizumab.
- For the diagnosis of non-squamous non-small cell lung cancer (unresectable, locally advanced, recurrent or metastatic), the recommended dose for bevacizumab of less than or equal to 15 mg/kg intravenously every 3 weeks in combination with carboplatin and paclitaxel was not ordered or followed.

http://goo.gl/KObpwM

Can you afford $5,000 per denial?
High Cost Drug Risks

For 1 of the 156 outpatient claims, the Hospital incorrectly billed Medicare for services that were not adequately documented. Specifically, the administration of the drug, Yervoy, was not sufficiently supplied in the medical record. The Hospital attributed this lack of support to two human errors: (1) a nurse did not document the treatment in the medical record and (2) pharmacy staff verbally confirmed treatment instead of verifying the documentation. As a result of these errors, the Hospital received an overpayment of $48,948.
Mean Monthly Spending for Orally Administered Anticancer Medications During the Year of Product Launch, 2000–2014 Spending estimates represent the amount paid to the pharmacy by the health plan and patient for a single fill of therapy (1-month supply) and does not include rebates or other price concessions negotiated between the health plan and manufacturer. Mean spending was estimated using generalized estimating equations with a log link and normal distribution by drug during the year in which the product was first launched. The dark blue line represents a two year moving average trendline. All prices were inflation adjusted to 2014 US dollars using the medical component of the Consumer Price Index.
We’ve tried everything; is it time to cut?

Per CERT Physician, disagree with the procedure of bilateral laminectomy, facetectomy and foraminotomy and thus admission as being reasonable and necessary. Beneficiary had "intractable low back and leg pain" and opted to proceed to surgery. There however was no documentation of conservative treatments or even any reports of radiologic imaging submitted. Without more data on how it affects his daily activities or what treatment have been tried, cannot approve the surgery option.
New Audit Tactic

MAC calls to schedule audit of spine/joints

Won’t give medical record numbers until they show up so no time to buff the charts

If you don’t have medical necessity documentation, don’t put it on the OR schedule, or schedule surgery and ask pt to come in to sign Pre-admission HINN
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 Stabilimax NZ Dynamic Spine Stabilization System);
- Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System;
- Endoscopic laser foraminoplasty, endoscopic foramotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation);
- Endoscopic transforaminal discectomy;
- 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 discectomy (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 and/or paravertebral 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 discectomy;
- Percutaneous endoscopic discectomy with or without laser (PELD) (also known as arthroscopic microdiscectomy 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.
<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
<th>Specific 'Granular' Error Findings</th>
<th>Number of Occurrences</th>
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<tr>
<td>5D164/5H164</td>
<td>Documentation Submitted Does Not Support Medical Necessity</td>
<td>No Evidence of Patient’s Best Corrected Snellen Visual Acuity (BCVA) Present in the Record.</td>
<td>187</td>
</tr>
<tr>
<td>5D164/5H164</td>
<td>Documentation Submitted Does Not Support Medical Necessity</td>
<td>No Evidence of Patient Reported Impairment of Visual Function Resulting in Restriction of Activities of Daily Living.</td>
<td>163</td>
</tr>
<tr>
<td>5D164/5H164</td>
<td>Documentation Submitted Does Not Support Medical Necessity</td>
<td>No Evidence/Documentation That Comprehensive Eye Examination and a Single Diagnostic A-Scan Was Done.</td>
<td>29</td>
</tr>
<tr>
<td>5D169/5H169</td>
<td>Services Not Documented</td>
<td>The Documentation Submitted Does Not Support Operative Eye Billed.</td>
<td>28</td>
</tr>
<tr>
<td>5D169/5H169</td>
<td>Services Not Documented</td>
<td>A Signed Operative Note/Report is Not Present.</td>
<td>26</td>
</tr>
</tbody>
</table>
Copy/Pasted/Cloned Progress Notes

However, there are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it’s illegal. These indications include potential “cloning” of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate “upcoding” of the intensity of care.

If you did not think it, ask it, examine it or review it, do not include it in your note.
Cloning of Progress Notes, Upcoding Lead To Fraud Settlement; Doctors Pay $422,000

February 22, 2016  Volume 25  Issue 7

The cloning of electronic medical records has led to a fraud settlement, possibly for the first time.

Somerset Cardiology Group, P.C., in Somerville, N.J., agreed to pay $422,741 in a civil money penalty (CMP) settlement stemming from allegations it submitted false or fraudulent claims. The six-physician cardiology group allegedly cloned patient progress notes and upcoded evaluation and management (E/M services, according to the HHS Office of Inspector General (OIG). The settlement was the end result of the

This provider charged Medicare for a higher percentage of 5’s than his peers.

SHIVANG TRIVEDI

AVERAGE FOR CARDIOVASCULAR DISEASE PROVIDERS IN NEW JERSEY
Careful study of the electronic medical record for automated errors can provide meaningful material for a fruitful cross. While simply pointing out the errors in the medical record may highlight the lack of care by a physician, the ultimate goal of the attack must be to undermine the entire record by focusing on those errors. Once the trial lawyer has undermined the record and established that it is not worthy of belief she can then argue that those errors in the record exemplify and define the lack of proper care and treatment rendered by the treating physicians.
Questions?

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