In this CNS e-News release, CNS consultants Susan Hansen, MD, and the undersigned, discuss some of the billing pitfalls of Medicare and Workers' Compensation.

With the strong support of CNS President, Robyn G. Young, MD, CNS is currently at work in Sacramento where we are trying to get providers proper reimbursement and relief from wrongful denial of care, known as Non-Authorization.

CNS has retained lobbying assistance at the state level from AdvoCal and offers support to AAN at the federal level. Also, in this release is Eric Denys, MD, Carrier Advisory Committee Report from the January CAC-Palmetto meeting. Dr. Denys is the CNS Northern CAC representative.

Robert L. Weinmann, MD
Chair, CNS Legislative Committee
CNS Consultant

BEWARE OF COVERT CHANGES AS RBRVS IS USED TO REPLACE THE OMFS

"In a recent article entitled "Experts Say Minor Tweaking Needed for RBRVS Fee Schedule" which appeared in Workcompcentral 17 January 2013, Greg Jones reported that Deborah Kuehn, Vice President of coding and reimbursement for USHW, said that "Medicare doesn't pay providers for consulting with patients or writing reports" and that "DWC needs to make sure there is reimbursement for these services." CNS is working on this issue through its Legislative Committee and professional legislative representation in Sacramento. We understand that this matter is vital to maintain access to care and so that our doctors can make their offices and services available to injured workers and managed care patients.

Kuehn also stated that there would be "a huge downturn for specialty orthopedists and specialty providers" if the RBRVS schedule were used to eliminate these services. Observers of the Affordable Care Act will easily understand how the Independent Payment Advisory Board (IPAB) could make similar arbitrary decisions.

An opposing point of view comes from Greg Krohm, formerly executive director of the International Association of Industrial Accident Boards and Commissions, who was quoted as saying he takes a "dim view" of deviations from RBRVS. Krohm reportedly also said that he thinks "Medicare has got it about as good as it's going to get."

These statements show why CNS will need to attend to this year's legislative process in Sacramento and to assist AAN in Washington.

Robert L. Weinmann, MD
Chair, CNS Legislative Committee
CNS Consultant
2013 CNS EVENTS

Mark your calendar!

- March 19 – 7:00 am – 9:00 am – CNS AAN Affiliate Breakfast Mtg. San Diego
- March 16 – March 23 – CNS Hospitality Suite, Hilton San Diego Bayfront
- One Day MS Conference, Saturday, May 4 – Wyndham Hotel, San Francisco
- “CSI Neurology” – Annual Meeting, October 4-6, Marriott, Monterey

Carrier Advisory Committee News

Committee report of the CAC Palmetto
16 Jan 2013

CAC Palmetto Notes
16 Jan 2013

Introduction: CERT Prepayment reviews

Medicare is now conducting pre-payment audits of CPT 99205 new patient visits for California cardiologists, family practitioners, internists, neurologists, podiatrists and oncologists as well as CPT 99204 new patient visits for California general practitioners, ENT, family practitioners, ob-gyns, physiatrists, podiatrists and rheumatologists.

According to the Thursday, January 10, 2013, Palmetto GBA Daily Newsletter:

“J1 Part B Service Specific Complex Pre-Payment Review Notice for CPT Code 99205: E/M Initial Office Visit Services for Provider Specialties 06, 08, 11, 13, 48 and 83 in Northern California and Southern California

J1 Part B Service Specific Complex Pre-Payment Review Notice for CPT Code 99204: E/M Initial Office Visit Services for Provider Specialties 01, 04, 08, 18, 25, 48 and 66 in Northern California and Southern California

This complex review is based on a data analysis that indicated significant incidence of … errors identified by Comprehensive Error Rate Testing (CERT) for these services for these specialties …. A percentage of claims billed for this service will be randomly selected daily from Northern California and Southern California for a minimum period of three months at the end of which edit effectiveness will be performed.”

This means that Medicare may probe a physician’s coding compliance by sending “Additional Documentation Requests” prior to paying for comprehensive care that the physician already has provided to a Medicare beneficiary. A participating physician will not be paid by Medicare (and a patient treated by
a nonparticipating physician will not be reimbursed) until after Medicare’s “prepayment” review is complete.

There is no right of due process/assumption of correctness: a physician is presumed to have failed to conduct a comprehensive new patient visit unless the physician proves otherwise. Take any notice from Medicare very seriously.

Unless a physician can prove adherence to coding requirements, the physician will be paid less than the CPT 99205 or CPT 99204 fees – or may not be paid anything. A physician who fails the first probe by Medicare of about 20 charts may be subjected to a year-long pre-payment review by Medicare. In order to educate the physician, the physician will have to send medical records to Medicare for any CPT Code 99205 or 99204 new patient visit selected for review.

CERT audits may financially devastate any physician who is not prepared. Remember, auditors, whether MACs (Medicare Administrative Contractors such as Palmetto GBA), CERTs, RACs (Recovery Auditors) or ZPICs (Zone Program Integrity Contractors), have incentives to find something wrong in order to justify their jobs; RACs “eat what they kill.” (RACs are paid a percentage of any “recovery” - nonpayment to the physician - and therefore have an enormous incentive to find any physician under scrutiny to be out of compliance.)

**How might a physician limit his or her exposure to an extensive audit or allegations of fraud?**

Know the rules. The number one cause of failing a Medicare audit is failure to reply. Alert your biller to expect letters from Medicare. There is a short turn-around time.

Here are two tips on coding:
- Review the sample coding template for a CPT 99205 neurology new patient visit that is at the end of this article. It can be modified for other specialties by using the specialty’s physical examination coding rules.
- Specialists have the option to use the general physical examination coding rules instead of specialty-specific rules.
- Download the general guidelines for Medicare documentation at [www.medicalhomeportal.org/link/301](http://www.medicalhomeportal.org/link/301)

Here are five hints to avoid instantly failing to meet Medicare’s documentation standards:
- Hint #1: Make sure the record lists a “chief complaint.”
- Hint #2: 99204 and 99205 Review of Systems (ROS) must contain ten or more elements.
- Hint #3: Make sure every page of documentation includes a signature. See [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf) for signature requirements. Failure to sign or initial any page may result in exclusion of this page from the accepted documentation, which may result in a denial of payment by Medicare as well as a ZPIC audit for fraud. A physician DOES NOT WANT this type of scrutiny. If a MAC, RAC or CERT reviewer identifies a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate ZPIC for further “development” of fraud allegations.
- Hint #4: When counseling or coordination of care comprises more than 50% of the visit or service rendered, time is the key factor. 60 minutes total time spent must be clearly documented for a 99205 and 45 minutes for a 99204; it must be clearly documented that more than 50% of the time was spent on counseling or coordination of care.
- Hint #5: Do not correct any medical record with white out or electronic deletions. *Any appearance of improper alteration of a record may trigger a ZPIC audit for fraud.* Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents containing amendments, corrections or addenda must:
  1. Clearly and permanently identify any amendment, correction or delayed entry as such, &
  2. Clearly indicate the date and author of any amendment, correction or delayed entry, &
  3. Not delete but instead clearly identify all original content

**How might physicians limit their risk?**

Physicians might want to limit their exposure to further risks. If Medicare decides documentation does not meet its coding requirements, a physician should not hesitate to ask for a redetermination. Such an appeal might reduce the risk of a more intense prepayment or post-payment reviews. Download the redetermination form at [http://www.wpsmedicare.com/part_b/forms/_files/redetermrqstform.pdf](http://www.wpsmedicare.com/part_b/forms/_files/redetermrqstform.pdf)

In the event that Medicare denies payment for a CPT 99205 or CPT 99204 service, the physician might consider asking the patient who received the service to appeal on behalf of the physician. Also, take advantage of every redetermination or appeal opportunity.

According to Medicare, the physician should be aware that inadequate medical record documentation can lead to a financial liability for the beneficiary (patient) and/or supplier (physician), should the reviewer determine that a claim is not supported. A nonparticipating physician who bills a CPT 99205 or CPT 99204 might ask a new Medicare beneficiary to sign an Advanced Beneficiary Notice (ABN), which can be downloaded at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html). If a patient completes an ABN and Medicare decides that the nonparticipating physician’s documentation does not justify a CPT 99205 payment for reasons such as “medical necessity,” the physician may be able to bill the patient the usual price instead of Medicare’s discounted price.

**Conclusion: be prepared and keep informed**

Be prepared for reduced cash flow if you are a participating physician. Consider becoming a nonparticipating Medicare physician: the patient who has already received medical care, not the nonparticipating physician, waits for Medicare to pay. (Further, a nonparticipating physician may charge about 9% more than a participating physician.) Consider “opting out” of Medicare (which means Medicare will not pay the physician or reimburse the patient). Consider disenrolling from Medicare: a physician who is not enrolled in Medicare bills patients mutually agreed upon fees; patients submit their own claims for reimbursement to Medicare. (However, Medicare asserts that every physician who treats a Medicare beneficiary for payment - rather than free of charge - must enroll.)

Contact Palmetto GBA with any questions at [administrator@webmail.palmettogba.com](mailto:administrator@webmail.palmettogba.com).


Susan Hansen, MD
CNS Consultant
**Medicare Comprehensive Error Rate Testing (CERT)**

*has triggered pre-payment audits of many comprehensive new patient visits CPT99205*

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**NEUROLOGY NEW OFFICE 99205**

**DATE:**

**NAME:**

**CHIEF COMPLAINT:**

**HPI (needs 4+ of modifying facts/adjectives: location, quality, severity, duration, timing, context, modifying factors, and associated symptoms):**

**PAST HX & MEDS:**

**SOCIAL HX:**

**FAMILY HX:**

**ROS (>9): check if normal, state any abnormality**

- **Constitutional (fever, weight)**
- **Cardiovascular**
- **Genitourinary**
- **Endocrine**
- **Neuro**
- **Ears, nose, throat**
- **Respiratory**
- **Musculoskeletal**
- **Skin, breast**
- **Hematological/lymphatic**
- **Psych**
- **Gastrointestinal**
- **Skin**
- **Allergic/immunologic**

**NEURO PX [Neuro exam requires all 23 elements]: check if normal, state any abnormality**

**VS (3): BP_______ HR_______ Wght_____ Resp_______**

- **General appearance**
- **Attention**
- **Fund of knowledge**
- **CN 3-4-6**
- **CN 8**
- **CN 12**
- **Tone**
- **Gait**
- **Cardiovascular**
- **Eye**
- **Skin**
- **Psych**
- **Orientation**
- **Memory**
- **Fundoscopy**
- **CN 2**
- **CN 5**
- **CN 9**
- **Coordination**
- **Musculoskeletal**
- **ENT**
- **GI**
- **Heme/lymph**

**GENERAL PX [General exam requires at least 8 elements]: check if normal, state any abnormality**

**VS (3): BP_______ HR_______ Wght_____ Resp_______**

- **Cardiovascular**
- **Eye**
- **Skin**
- **Psych**
- **Respiratory**
- **Neuro**
- **Musculoskeletal**
- **Neurological**
- **GI**
- **Heme/lymph**

**IMPRESSIONS and PLANS:**

**Level 5: Needs one of:**
- Chronic illness with severe exacerbation/progression/side effects
- Risk of mortality or serious morbidity
- Abrupt Neuro change
- Prescribe high risk medications

**And one of:**
- One new problem needing additional assessment/Two continuing problems inadequately controlled

**COUNSELING/CORDINATION OF CARE OPTION [may use in place of bulleted system if visit is long]:**

Greater than half of this _____ minute visit was spent face-to-face counseling the patient or coordinating care with other caregivers including (give some specifics): __test results__ __impressions__ __recommended tests__

- __pt & family education__
- __risks-benefits of treatment options__
- __instructions for treatment__
- __instructions for follow up__
- __risk factor reduction__
- __other:__________________________

**Signature of physician: ________________________________**
Renewed effort to implement Medicare’s RBRVS system

Attached below is the most recent blog from David DePaolo. It addresses the renewed effort to implement Medicare’s RBRVS system here in California as required by SB 863. David’s essay reinforces CNS long standing position that the RBRVS system is not suitable for use in the workers’ compensation system. However, if it is forced into use, it cannot be implemented unless its ground rules are thoroughly analyzed and modified everywhere necessary. Actual reimbursement is certainly a critical component of an successful fee schedule, but the accompanying billing and reimbursement ground rules must be rational for use in the system so that the healthcare services that are the right of every legitimately injured worker in California are delivered timely and efficiently. This analysis requires time and a willingness to assure that the next California OMFS is the best one possible. There is no margin for experimentation or simply an effort to "get close" to a workable system...not when the conversion costs and potential for new, unintended frictional costs to employers is so high...not when injured workers' health might be at risk as a result of poor implementation.

We urge the Division to start face-to-face, across-the-table meetings NOW so that those who deal with reimbursement issues everyday can bring their expertise to this critical project. Time and effort invested now will save everyone involved many times over.

CNS urges every member to participate in the current DWC Forum focused on the RBRVS conversion by clicking here. Forum closes February 8, 2013.

David DePaolo's blog can be reached directly at http://daviddepaolo.blogspot.com/2013/01/pay-docs-for-listening-and-caring.html?goback=.gde_50881_member_205464476&m=1

Pay Docs for Listening and Caring

Perhaps one of the more contentious issues in California's SB 863 reform bill, at least as far as medical providers are concerned, is the mandate that the medical fee schedule convert to the Medicare Resource Based Relative Value Scale (RVRBS) by Jan. 1, 2014.

California lags several other key states in adopting Medicare's schedule, and SB 863 authors and proponents see this as a significant method of controlling not only costs, but the variety of treatment options available to injured workers because reimbursement rates directly affect procedural motivations.

The California Division of Workers’ Compensation (DWC) has said its general approach will be to adopt the Medicare ground rules, and only make changes to the payment ground rules “where appropriate in light of special needs of the workers’ compensation system.”

Public comment thus far has identified several areas where the special needs of workers’ compensation require deviation from Medicare's system. DWC is taking public comments until Feb. 8 on possible changes to the ground rules that would be necessary to make RBRVS work as the basis for determining provider reimbursement in California.

For instance, according to Greg Krohm, former executive director of the International Association of Industrial Accident Boards and Commissions (IAIABC) and who remains a research consultant for IAIABC, when Texas adopted RBRVS in 2003, it also adopted a single conversion factor that paid all providers 125% of Medicare’s rates. A 2007 study by Dr. Steven E. Levine and Dr. Ronald N. Kent found that the single conversion factor drove neurologists away from workers’ compensation. In 2002, 63% of neurologists were willing to treat workers’ compensation patients. By 2007, the number fell to just 9%.
I agree with Krohm, who said using multiple conversion factors for different specialty providers is one area where it is appropriate to deviate from Medicare’s rules that use only a single conversion factor. If the DWC is interested in maintaining physician participation in the system then it can not alienate potential medical vendors and thus risk medical access issues.

Deborah E. Kuehn, vice president of coding and reimbursement for U.S. HealthWorks, identified another area of concern and that is Medicare's discount when services are provided by physicians’ assistants and nurse practitioners. These providers are reimbursed at 85% of what would be paid to a physician who provided the same service.

Kuehn argues that until access issues to primary care physicians have stabilized it would be inappropriate to reduce fees to physicians’ assistants and nurse practitioners.

I agree with this analysis too. Physicians’ assistants and nurse practitioners perform more routine medical functions that don't require the expertise of a Medical Doctor and consequently help to keep the medical provider's costs low, and ergo, the overall cost of medical treatment lower than if these professionals were not available.

If it is not profitable to employ physicians’ assistants and nurse practitioners then the routine care duties fall upon the M.D., and if there aren't enough M.D.s to provide such services access issues occur and the overall cost of a claim increases.

But the single most important recommendation in the public comments, in my opinion, is to provide for consulting with patients - the basic office visit. Medicare doesn't pay providers for consulting with patients.

In my opinion, much of the failure of the medical delivery system in workers' compensation, nay general health, is that medical doctors don't spend sufficient office visit time with the patients. Often medical patients just need someone to listen to them.

Workers' compensation is a volume medical business. Office visits with the professional are very time limited. The human and psychological components of medical treatment are virtually non-existent in work comp care.

Yet there are many studies suggesting that actual treatment costs and indemnity costs would be greatly reduced if injured workers felt their physicians were actually listening to their complaints.

It turns out that "bedside manner" is vitally important to the delivery of medical services.

Medical care is highly personal. Depersonalizing the delivery of care occurs when the professional lacks interest in the patient. This is communicated to the patient primarily by the allocation of time for each patient interaction. This allocation of time is directly affected by how and for what the professional is being paid.

If the professional is being paid to perform a particular procedure - surgery for instance - the professional is going to direct his or her services towards that reimbursement goal, even if the medical issue could be more appropriately dealt with by some other procedure that isn't reimbursed (i.e. the office visit with some good listening and counseling).

Bring back good medicine. Pay physicians for actually listening and caring for their patients rather than just performing some specific procedure. The system will benefit enormously when injured workers know that someone actually cares.
What is Sequestration?

When you hear about “sequestration” in the news today, it refers to the automatic budget cuts passed into law under the Budget Control Act (BCA) of 2011. The BCA contained agreements on federal spending levels and the debt ceiling, and it created the Joint Select Committee on Deficit Reduction. This bipartisan “Super Committee” made up of Members of the House and Senate, was instructed to reduce the federal deficits by an additional $1.2 trillion. The sequestration procedure was put in place as a backup in case the Super Committee did not reach its goal.

Because the Committee failed to achieve its goal, sequestration is scheduled to start in March 2013 and run through the year 2021 — unless Congress can reach an agreement about annual spending before then.

Why does it matter?
Across-the-board cuts will have a harmful impact on many government programs and activities important to the Parkinson’s community, including biomedical research and drug approvals.

For example, sequestration could result in a $2.5 billion reduction to the National Institutes of Health (NIH) budget and 33,000 jobs lost. NIH funding is a driver of local economies across the country. According to United for Medical Research (www.unitedformedicalresearch.com), in 2011, NIH investment supported 432,000 jobs and generated $62.13 billion in economic activity. Every state stands to lose jobs and crucial NIH biomedical research funding if these cuts go into effect. California alone stands to lose 4,930 research jobs and $275.8 million in research funding if sequestration goes into effect!

This would have a devastating impact on biomedical research to find better treatments and a cure for Parkinson’s and many other diseases. If NIH funding is cut, even for just one year, years of critical research on a cure for Parkinson’s and other diseases could be wiped out.

What can YOU do?
There is still time to act! PAN is organizing a National “Call-in” Day on February 27 and we need everyone in the Parkinson’s community to call their representatives that day to tell them "WE NEED CURES, NOT CUTS!" Visit www.parkinsonsaction.org today to learn more about how you can take action.
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