

# FSIPP NEWSLETTER

DECEMBER, 2007

VOLUME I, ISSUE 4  
EDITOR-IN-CHIEF: DEBORAH H. TRACY, MD



**Lora Brown, MD**



## *President's Message*



## *Greetings to All*



As we enter the holiday season, I look back over the previous year and realize that all FSIPP members have a lot of which to be proud. Thanks to efforts of many, our little group has transcended into a legitimate state professional organization. FSIPP garners audiences and respect from Medicare payers, State Legislators, the Florida Medical Association, and many others. *Our voices are being heard.*

I am also reminded how lucky we are. We, as interventional pain physicians, are privileged to care for so many patients who would otherwise have no hope other than to live with debilitating chronic pain. We should be reminded during this season to reflect on how important we are to so many people...our staff, our referring physicians, and mostly our patients. It is OUR RESPONSIBILITY to do everything in our power to ensure the continued access of our patients to the interventional pain therapies that help them so much.

As we leave 2007 and enter 2008, do not become complacent. There is no time to relax. We must continue to provide financial support to allies who endorse the enforcement of just medical and public health policy. We must continue educating ourselves and write letters to our political leaders, educating them. Flood their in-boxes with your letters, your staffs' letters and your patients' letters. Send them weekly. Engage a staff member to collect patient names that support preserving Medicare access to pain management and forward their letters directly or complete their submissions for them. Take the time to explain the importance of stopping physician Medicare fee cuts as soon as possible. Make sure they understand the importance of preserving Medicare reimbursement for outpatient ambulatory surgery centers.

Most political leaders mean well. They are pulled in many directions by various interests. Unfortunately, politicians hear the "fattest wallet" or the "most votes." As interventional pain physicians we have a small voice, BUT, as the interventional pain community (physicians and patients) ...HEAR US ROAR.

I challenge each and every FSIPP member to commit financial support to our political allies in 2008. I have personally made financial sacrifices, in contributions, to support our efforts this year. This is a small price to pay in relation to how I benefit each and every day from my profession. As you know; we face continual cuts with consistent increases in expenses. I also challenge you to engage your practice in a letter writing campaign (it has never been easier with CAPWIZ and VOTER VOICE). Every patient that enters your practice should be engaged and they should be encouraged to engage their family and friends.

We must be involved in the political process in every possible way. We cannot turn a blind eye any longer. ***It is a matter of preserving your profession!***

***Happy Holidays!***  
**Lorrie**

### *Inside this issue:*

***DEA Policy Statement  
Regarding Dispensing  
Controlled Substances***

***Help Hints About  
Medicare***

*Medicare, Local  
Coverage Determinations  
(LCDs)  
Comparative Billing  
Reports*

***Pay for Performance  
(P4P) Update***

***NASPER, Dr. Trescot's  
Testimony to  
Congress***

***Gayle Harrell, House of  
Representatives,  
Support Letter***

***NEW PROCEDURE  
Sacroiliac Neurotomy  
using Cooled-RF***

***Doctors Need to Make  
Your Practices  
Prosper***

***Vaughn Reading  
Room: OIG Audits,  
Discograms, Coding.  
Summary of Changes  
for Chronic Pain in  
2008***

***FPIC, Malpractice Case  
Study and Legal FAQs***

## *DEA Announces Final Rule For Issuance Of Multiple Schedule II Prescriptions*

Notice regarding the Multiple Schedule II Rule has now been prepared and is to be published in the Federal Register. The rule entitled, "Issuance of Multiple prescriptions for Schedule II Controlled Substance," took effect on Dec. 9, 2007.

The final rule amends the DEA's previous regulation to allow practitioners to provide individual patients with multiple prescriptions for a specific Schedule II controlled substance, written on the same date, to be filled sequentially. The new rule allows physicians to write three separate prescriptions with staggered fill dates. Patients can still be given the equivalent of a 90-day prescription for Schedule II controlled substances when medically appropriate.

### *Help Hints About Medicare*

#### **1. Medicare, Local Coverage Determinations (LCDs)**

Medicare LCDs are published to provide notice as to what the Contractor considers medically necessary and reasonable, and therefore covered by Medicare. LCDs are guidelines and not treatment protocols, but have serious impact on physician documentation in determining reimbursement. All draft and final LCDs are posted on the First Coast Service Options (FCSO) website. It is crucial that physicians follow this website and respond during comment periods to ensure patient access and physician compliance. Please see link below to Medicare: [www.floridamedicare.com/Part\\_B/Local\\_Medical\\_Coverage/Final\\_LCDs/index.asp](http://www.floridamedicare.com/Part_B/Local_Medical_Coverage/Final_LCDs/index.asp)

#### **2. Requesting A Comparative Billing Report**

A comparative billing report is available to providers from Medicare, First Coast Service Options by request. The purpose of these reports is to show the type of comparable data that Medicare considers when determining how the provider's business practice differs from other providers in the same specialty payment area or locality. A provider specific report can be helpful for providers when conducting self-audits and illustrate the utilization of a service by a physician, in the State of Florida, and compared to the nation. To find out more about requesting a Comparative Billing Report use the link: [www.floridamedicare.com/Part\\_B/Billing\\_and\\_Coverage/107721.pdf](http://www.floridamedicare.com/Part_B/Billing_and_Coverage/107721.pdf)



### *Pay For Performance P4P*

#### *Is Significant And Here Whether We Like It Or Not!*

Deborah H. Tracy, MD, MBA  
Editor-in-Chief



If you've been thinking that ignoring Pay for Performance (P4P) will make it go away, think again, because development of the measures was spearheaded by the AMA. If you've been apprehensive that P4P is too complicated to integrate, relax. With a few helpful hints, you will be able to incorporate P4P into your super bill; however, you will have to take some time to understand its construction for implementation. Finally, recognize that you might increase your **total** Medicare charges by 1.5%, by reporting up to 3 measures. Yes, total! Medicare is not stupid and they know that 1.5% may not be good incentive; therefore, if the program flies, this rate may increase to 10% or as high as 20% over the next few years.

P4P is part of "The Physician Quality Reporting Initiative" (PQRI) implemented by CMS in July 2007 as a result of the Tax Relief and Health Care Act of 2006 (TRHCA). It includes bonus payments for satisfactory submission of data on the quality of covered professional services furnished to Medicare beneficiaries. CMS final rule for 2008 identifies 119 measures (increased from the initial 74 measures in 2007).

In general, the quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or outcome. The denominator population is defined by certain ICD-9 and CPT Category 1 codes specified in the measure. These codes are submitted as part of a claim for covered services under the Medicare Physician Fee Schedule (MPFS). The numerator is defined by an applicable CPT Category 11 code (or temporary G-code). When a patient falls in the denominator population but specifications define circumstances in which a patient may be excluded from the measure's denominator population,

then a modifier is appended. CPT Category 11 code modifiers such as 1P, 2P, 3P or 8P are available to describe the reason for exclusion.

The measure specifications provide the following information:

- Measure title
- Measure description
- Instructions on reporting (frequency, timeframes applicability)
- Numerator coding
- Definitions of terms
- Coding instructions
- CPT Category 11 exclusion modifiers
- Denominator coding Rationale statement
- Supporting Criteria for the measure

For a list of the measures and their specifications go to the following website:

<http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf>.

Please note, at this website, a list of approximately 134 measures (# of measures changes). Of the 134 measures only about a dozen are applicable to the specialty of pain management, to a lesser or greater degree depending on your practice style. For example, if you provide procedures with an indication for preoperative antibiotics then measure number 20, *Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician*, would be a reportable measure. Other measures that might be applicable to our profession are numbers: 21, 30, 40, 41, 114, 124, 125, 130, and 132. Interesting measure numbers 131, *Pain Assessment Prior to Initiation of Patient Treatment*, is proposed only if a standardized tool is utilized and intended for a multidisciplinary approach. Measures 133 and 134 require behavioral tools.

The 2008 percent bonus is 1.5% of **total charges**; therefore at the 2008 rate of 1.5% a physician who is reimbursed \$400,000 from Medicare could receive a potential bonus of \$6000. There is however, a bonus cap; the individual's instances of reporting quality data multiplied by (300%) multiplied by the national average per measure payment. In the long run this could be serious reimbursement.

The final Measure Specifications are still in development and changing daily. They are expected to be ready by January 1, 2008. Please stay tuned for further updates and review of this material.

**PLEASE SEND COMMENTS REGARDING THIS ARTICLE OR ANY OTHER FEATURE IN THE NEWSLETTER TO:**  
[info@fsipp.org](mailto:info@fsipp.org)



### NASPER

Dr. Trescot's Testimony to Congress  
President ASIPP, Past President, FSIPP

The following excerpts from Dr. Trescot's testimony to Congress on October 24, 2007, in support of the National All Schedules Prescription Electronic Reporting (NASPER), exemplifies the fortitude with which ASIPP is leading the cause to protect our Society, Patients and Physicians from the hazards of prescription drug abuse.

"...Opioid or narcotic use and misuse is a huge and growing problem in the United States. Americans make up only 4.6% of the world's population, but they consume 80% of the global supply of pain medicines, 99% of the global supply of Hydrocodone (one of the most abused of our readily available pain medicines) and 2/3rds of the world's illegal drugs. Despite the billions of dollars thrown at this problem, we have not been able to reduce the nation's substance abuse and addiction. The number of illegal drug users is rising. The number of teen illegal drug users has more than doubled, and the number of Americans abusing controlled prescription drugs has jumped from 6.2 to 15.2 million in the last ten years. Among the patients suffering with chronic pain and receiving opioids, 1 in 5 are abusing those prescription-controlled medications and approximately the same number of patients are also using illicit drugs.

"The National Drug Control Strategy from the White House spent over 10 billion dollars a year since its enactment in 1988 with no demonstrable results in curbing drug abuse or addiction. And, specifically, there has been no

(Continued from page 3)

change in prescription controlled substance abuse. Yet, almost a quarter of a trillion dollars of the nation's yearly healthcare bill is attributed to substance abuse and addiction. Some of the increase in opioid abuse is occurring with teenagers, who view prescription medications as not only "safer," but also the "cool" drugs to use. Prescription medications are the most commonly used drugs to get high among teenagers, and teenagers represent almost a third of the prescription drugs abused in the country. These medicines have come from friends, from stealing the medications from their family members, and occasionally from the internet. Over 90% of drugs were obtained by legitimate prescriptions. In addition, the highest use of pain relievers nonmedically was in the 18-25 year group.

"I was struck by an undercover surveillance video I viewed last week, which showed nearly a hundred people standing in a doctor's waiting room as they waited their turn to pickup their narcotic prescriptions. I was stunned by how much it looked like a "bar scene" and then realized it was because virtually every person in the waiting room was under the age of 30. This pill mill was catering to the young. Unfortunately the elderly are also at risk, because of their multiple medications (and potential drug interactions), and their multiple degenerative joint changes (such as hip, knees and back). And yet, though this population may have significant and legitimate opioid needs, they are at risk for diversion of their medications, either actively (selling them for income supplementation) or passively (with their medications stolen by caregivers and family members).

"Approximately 75-90% of drug abusers have obtained their medications legally, and most likely through a prescription. Doctor shopping is one of the most common methods of obtaining prescription drugs for personal and illegal use. We feel therefore strongly that the most effective way of controlling this epidemic is to control the "end of the pen" or, in other words, the way the medications are prescribed..."

"...Why has NASPER Not Been Implemented? Because it enacts legislation, most of which is inadequately funded, and not designed to share information. By identifying those patients who are doctor shopping, legitimate physicians will be able to identify and intervene early with patients who are misusing and abusing their medications. In addition, the ability to identify legitimate pain patients will increase the access to care for those patients who truly need the medication and shut down the most obvious avenue for obtaining fraudulent prescriptions."

"...NASPER would allow communication among states....Please help us in this battle by providing funding for NASPER, one of the major tools we have in this crucial battle."

### *Florida House of Representatives*

*Gayle B. Harrell*

State Representative, 81<sup>st</sup> District

Re: Funding for NASPER  
To Whom It May Concern:

Diversion of prescription drugs for illegal purposes has become a major problem in Florida – one that clearly threatens the health and well being of our citizens. More people die from prescription drug abuse in Florida than from the abuse of cocaine and heroine combined. In an attempt to address this epidemic, the Legislature in Florida has debated the establishment of an electronic prescription drug registry for the past six years. As the sponsor of this legislation for the past five years, I have encountered great difficulty in passing a drug registry program for a variety of reasons, not the least of which is funding for such a system. The National All Schedules Prescription Electronic Act (NASPER) could provide a major weapon against prescription drug abuse. It has great potential to limit prescription drug abuse not only within states, but across state lines. Although the bill was signed into law, it has yet to be funded. The lack of funding for NASPER directly impacts the ability of states to address this problem. Had there been federal funding for such an electronic drug registry in Florida, one of the major hurdles that we have had to address would have been overcome. Hence, I would urge the US Congress to allocate funds for this program.

*Gayle Harrell*

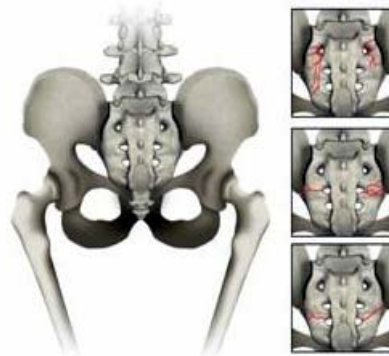
Gayle Harrell, Rep. District 81

*New Procedure*  
**Sacroiliac Neurotomy**  
 Dr. Nilesh Patel

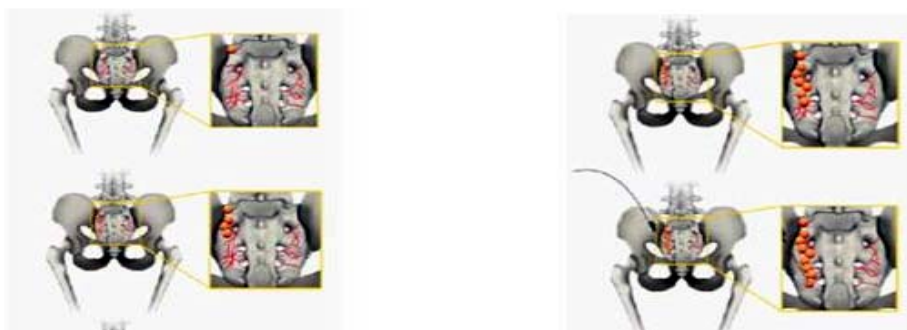
It is estimated that 1 in 5 patients with persistent, chronic low back pain suffer from pain originating in the sacroiliac joint complex. This condition has been defined in the literature as sacroiliac joint (SIJ) syndrome and it can have a significant impact on patient well-being. Once conservative options for treating SIJ syndrome have been exhausted, there exists no 'gold standard' for the treatment of chronic SIJ pain. Sacroiliac neurotomy is a minimally invasive procedure that provides long-term pain relief in the treatment of SIJ syndrome. Sacroiliac Neurotomy is intended for patients who experience chronic sacroiliac pain (>6 months) and have failed to achieve improvement with non-operative treatment. Positive diagnosis is indicated by > 80% pain relief from two separate intra-articular blocks. The patient must be 18 years of age, and all other sources of low back pain must be ruled out. These criteria must all be reviewed by the treating physician to ensure likelihood of a successful treatment.

**Description of Sacroiliac Neurotomy using Cooled-RF**

It is important to note that there is no consistency with regard to the lateral branch number, location, or path to the joint, either between patients, or between the right side and left side on the same patients (see Figure 1). This variability presents a challenge to physicians who wish to target these afferent nociceptive fibers in an attempt to provide relief from chronic SIJ pain. Sacroiliac RF neurotomy using the SInergy™ cooled RF probe overcomes the challenge of variable nerve location by creating ablative lesions that are eight (8) times the size of a standard RF lesion. During a procedure, RF energy is focused around the electrode in order to generate heat in the surrounding tissue. The electrode is internally cooled to moderate temperatures near the tip and achieves the appropriate temperature distribution in the target tissue. Successive lesions are created by repositioning the electrode in a step-wise manner, until all lateral branches between the sacral foramina and the SIJ have been ablated. It typically takes nine lesions to cover the area (see Figure 2). The thermal coagulation of lateral branch nerves prevents them from communicating afferent pain signals to the central nervous system.



**Figure 1: Example of one patient's Innervation of the Sacroiliac Joint Spinal levels S1, S2, and S3**



**Figure 2: Sacroiliac Neurotomy using the SInergy™ cooled RF probe. A line of block is created. Orange spheres represent the cooled RF lesions.**

(Continued Next Page)

(Continued from page 5)

### Summary of Evidence

The evidence supporting sacroiliac neurotomy using the SInergy™ System includes a randomized trial (RCT), and a prospective case series. The RCT, conducted by Dr. Steven Cohen at Johns Hopkins in Baltimore, assessed the long-term benefit of sacroiliac neurotomy using the SInergy system compared to placebo. Major findings include this study, which has been submitted for publication, clearly demonstrating the long-term benefit of this procedure. A prospective case series conducted at Denver Pain Management, has also demonstrated efficacy of sacroiliac neurotomy for properly selected patients. This study has been presented at the 15<sup>th</sup> annual scientific meeting of the International Spine Intervention Society, and is pending submission to a peer reviewed journal.

### *Doctors Need to Make Your Practices Prosper To Better Serve Your Patients*



Dr. McKalip is a member of the FMA board representing Hernando, Pasco, Pinellas and Hillsborough Counties (District C). He is the President-Elect of the Florida Neurosurgical Association and a Delegate from the FMA to the AMA House of Delegates. He currently serves as the Vice President of the Pinellas County Medical Association and the Chair of the FMA Council on Medical Economics. Dr. McKalip currently practices neurosurgery in St. Petersburg, Florida.

It is hard being a Doctor these days, in Florida and everywhere else in the country. After years of training, taking on student debt and dedication to our patients, doctors are facing decreased revenue and increased expense. We face increased government regulation and impediments from insurance companies – both of these third party payers have formed the equivalent of a Berlin Wall in between patients and doctors. A recent trip I made to Hawaii for the AMA meeting drove home the point when the President of the Hawaiian Medical Association told how doctors in her state were leaving. Trauma centers couldn't find specialists to cover hospitals and the primary care base had to see higher volumes – with less time on each patient- just to keep their doors open. This was a direct result of a de facto "single payer" system in Hawaii where only Blue Cross Blue Shield writes health insurance since they are exempt from state taxes. This monopoly has driven payment down as all the other pressures drive expenses up. As was learned when Nixon fixed prices on gasoline in the early '70's – price fixing leads to shortages. This well know economic law is happening in Hawaii and everywhere else as price fixing by Medicare, and growing insurance company monopolies, drive doctors into slavery or out of business.

The next few years will perhaps be the last chance for doctors to stand up for themselves if we are to keep our doors open and ensure that patients have access to caring, experienced professional doctors. Doctors will need to look hard at the contracts they sign and insist on fair payment (not reimbursement...payment!). They may need to insist that onerous burdens such as mandatory reporting of practice data or mandatory electronic medical records are not parts of their contracts since this drives up costs. They will need to unite together through their medical staffs to ensure that bylaws are not created that close the doors to economic competition, interfere with a physician's due process or increase the physician workload. They will need to join and work within organized medicine to ensure that officials friendly to medicine and patients are elected and others are driven out; keep up the fight against abuse plaintiff lawyers; and insist on minimal government interference in their practices.

Physicians are caring and want to serve their patients. But the economic reality is that no one, physicians included, will pay to work. We must remember the words of Adam Smith, who in the 18<sup>th</sup> century described the fundamental concepts of capitalism...the same capitalism that lead to the fall of the Berlin Wall. He wrote, in *Wealth of Nations*, "It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest." Doctors can't serve their patients if they can't keep their doors open to practice. That is why it is time for doctors to work together - through medical associations, medical staffs and by forming group practices if needed – to protect their self-interests.

A concrete example of how this can work would be in the simple contracting between patient and doctor for the routine costs of their annual medical care. Patients who have Health Savings Accounts demand (and deserve) more time with their doctors, they will ask why they need a test or visit instead of assuming that seeing a doctors only costs \$10, an MRI \$25 or surgery \$100. In this arrangement, doctors will see an increase in their cash flow and will bolster their economic security and autonomy. Catastrophes will be covered by high deductible insurance at 100% of the cost. This will result in lower premiums for insurance (increasing affordability), lower costs and increased access to high quality care for all Americans. The third parties of the government and insurance companies have had their chance to ensure access to high quality health care for all. Politicians, special interests and huge corporations want to continue to tinker and build a better system. They have failed. Let's get back to what works in 84% of the remainder of the American Economy: Capitalism. When physicians have prosperous practices and enjoy the economic freedom that all others have in our country, then patients will truly win.

VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

## *-Reading Room- OIG Audits*

Thursday, October 11, 2007

News Flash! The OIG is currently sending out form letters to chronic pain physicians across the country seeking to audit various interventional pain physicians. So far, 6 of my clients have received these letters (4 in Texas, 1 in Idaho, and 1 in New Mexico). The letters are on DHHS/OIG letterhead, from the Regional Inspector General, and so far, all records are being sent to Michele Brown, Medical Records Manager, in Richmond, VA. If you receive one of these letters, this is not a practice wide audit, but a very limited audit, typically of 1 patient over a 5-month period.

Upon further investigation, this appears to be part of the OIG's 2008 Work Plan, recently published, in which the OIG states that it will investigate interventional pain management in 2008, as follows:

### **"Medicare Payments for Interventional Pain Management Procedures**

We will review Medicare payments for interventional pain management procedures. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will pay for services only if they are medically necessary. Interventional pain management procedures consist of minimally invasive procedures, such as needle placement of drugs in targeted areas, ablation of targeted nerves, and some surgical techniques. Many clinicians believe that these procedures are useful in diagnosing and treating chronic, localized pain that does not respond well to other treatments. Interventional pain management is a relatively new and growing medical specialty. In 2005, Medicare paid nearly \$2 billion for these procedures. We will determine the appropriateness of Medicare payments for interventional pain management procedures and assess the oversight of these procedures.

(OEI; 05-07-00200; expected issue date: FY 2008; work in progress)."

These are medical necessity audits. As I have been explaining to those of you I have audited recently, Medicare's new "push" is on medical necessity for pain procedures. Now, it looks as if Medicare is going to audit a number of you to determine whether your procedures are medically necessary. Typically, in these types of audits, deficiencies are addressed by a refund demand of only the patient involved, and in most instances, the audit does not result in extrapolation or further audits. We will just have to and see if these audits are true to form.

In each of the letters my clients have received so far, 1-3 patients are selected for audit, and all dates of service within a 5-month period are being reviewed for that patient.

My recommendation is that if you receive one of these letters that you send to me a copy of the letter together with the records you send to the OIG

### *Discogram Bundled with IDET*

VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

The AMA, in its September 2007 edition of the CPT Assistant, has opined that because the code descriptor for IDET (CPT 22526) includes fluoroscopy, that is also an indication that IDET bundles a discogram. "Therefore, it is not appropriate to report separately the performance of a discography at the level of the IDET procedure."

### *Coding for Ganglion Impar Sympathetic Block*

VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

In the September 2007 edition of the CPT Assistant, the AMA issued a formal opinion that there is no specific code for a ganglion impar sympathetic block, and therefore, the unlisted code 64999 must be reported for that procedure.

The AMA had previously issued a letter to me over a year ago stating the same thing, and has now formalized that ruling in the CPT Assistant.

VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

### *Summary of Changes for Chronic Pain in 2008*

(Continued Next Page)

## Summary of Changes for Chronic Pain in 2008 (continued)

### Overview.

The good news for chronic pain in 2008 is that the CPT Code descriptors for the primary codes that pain practices typically bill remain unchanged, including epidurals, facets, pumps, stims, SI joint injections, and TPI's. Moreover, there are no new, significant pain procedure CPT codes adopted for 2008. The bad news is that reimbursement from Medicare will drop both as to the conversion factor ("CF") for professional fees and in the ASC facility fee arena.

### Smoking and Substance Abuse Counseling.

For an explanation of the new E&M codes for smoking counseling and the new G codes for substance abuse counseling, I will incorporate and expand upon my comments in the anesthesia changes article that I posted yesterday. Smoking cessation counseling and substance abuse counseling codes have been added for 2008. The smoking cessation codes are 99406 (4-10 minutes/\$12) and 99407 (> 10 minutes/\$24). The aforementioned reimbursement is Medicare. These codes have a status code of "A" which means that Medicare will pay for them, unless otherwise excluded. In my opinion, the billing practitioner would need to have some formal training in smoking counseling in order to bill these codes, such as attending a smoking cessation training course and obtaining a certificate; otherwise, Medicare will contend the service was not performed by qualified personnel. In addition to the smoking cessation counseling, there are two addiction counseling codes, 99408 and 99409, which were also added to the E&M section of the CPT Code, but they are not payable by Medicare because they use the term "screening." So, Medicare adopted two G codes to take their place which are payable, i.e., G0396 (15-30 minutes/\$29) and G0397 (> 30 minutes/\$57). The G codes use the word "structured assessment (e.g., AUDIT, DAST)" and "intervention" rather than "screening", and thus, they are listed with an active status, i.e., payable. These codes apply to substance abuse counseling for substances other than tobacco, i.e., alcohol and narcotics. CMS gives a warning that "We will instruct Medicare contractors to pay for these codes only when considered reasonable and necessary." So, it sounds like there would have to be some pre-existing symptoms warranting the counseling and intervention. Since both the smoking/substance abuse counseling services are evaluation and management services, I do not believe that one would be able to bill both an E&M code for an office visit and the counseling codes on the same date of service, as Medicare bundles multiple E&M codes on the same date of service.

### Modifiers.

Insofar as modifiers are concerned, the 22 modifier was amended to change its title from "unusual services" to "increased services." Additionally, the 2007 threshold criteria to use the 22 modifier, i.e., "when the service provided is greater than typically required" is changed in 2008 to "substantially greater than typically required." Documentation will now be required for (a) the reason for the additional work, and (b) the nature of the substantially increased work. Regarding modifiers 25, 51, and 59, clarifications were added to emphasize that the 25 modifier is only appended to E&M codes, not procedure codes, and the 59 and 51 modifiers are only appended to procedure codes, not E&M codes.

### 2008 OIG Work Plan Targets Interventional Pain.

Unfortunately, the OIG added the entire field of interventional pain management to the 2008 Work Plan. The OIG stated, "We will review Medicare payments for interventional pain management procedures. . . . In 2005, Medicare paid nearly \$2 billion for these procedures. We will determine the appropriateness of Medicare payments for interventional pain management procedures and assess the oversight of these procedures." Message: get ready to be audited. These are not E&M audits; these are procedure audits, and the focus will be on whether the procedure was medically necessary, i.e., are you adequately documenting your clinical indications, or, have you administered more injections than the allotted number allowed under the LCD. Many of you have already been the subject of recent audits, and I suspect that we are seeing only the tip of the iceberg. Make sure that you keep up with your external audits in chronic pain; now is the time to get your house in order.

### 2008 OIG Work Plan Targets Incident to Billing.

In addition, the 2008 Work Plan targets incident to billing, with a special emphasis on whether the staff for whom the physician is billing in the physician's name is qualified to render the services billed in the physician's name. Some of you have already been audited for this. If you have received an audit request where you have to go on-line and fill out an electronic form attesting to whether you personally rendered each of the services for which you billed on a given

(Continued Next Page)

(Continued from page 8)

date of service, and if not, who personally provided that service and their qualifications, that is an incident to audit. Make sure that all your staff's credentials are in proper order, and that whoever is providing any service in your office is qualified by proper education and training to administer the services provided. Keep all documentation of certifications, training courses, etc. attended by nurses and ancillary staff to prove their competence.

### **2008 OIG Work Plan Targets E&M Visits During Global Period.**

The 2008 Work Plan also targets the billing of E&M visits during the global period. Make sure that for pumps and stims, which have 90-day globals, that your software has some type of flag that prompts the data entry personnel to question whether the visit should be billed. If the visit is related to the pump or stim implant, and is within 90 days of the implantation, it is a related visit and is bundled. You may want to consider adding to each procedure on the charge sheet/ Superbill the global period of each procedure which has a 10-day or 90-day global period, so your physicians can see which procedures they have to be careful of when seeing a patient in follow-up to a procedure. RF codes and lysis of adhesion codes have 10-day globals. The global period of each procedure can be found in the 2008 Physician's Fee Schedule Excel file on CMS's website.

### **2008 OIG Work Plan Targets Psychiatric Services.**

Finally, for those practices which employ psychiatrists or psychologists, the 2008 Work Plan targets these services to see if (1) they were medically necessary, and (2) if they followed the documentation guidelines of the LCD's required by each state's Medicare carrier.



## *Case Study* *Inappropriate documentation constitutes fraudulent record*

*(Editor's Note: This case study analysis reflects an actual First Professionals' case.)*

### **Case Analysis**

During surgery this patient experienced cardiac arrest without successful recovery. Timing factors in the anesthesia record were inconsistent with the Code Blue documentation. According to the times recorded in the nurse's record on the Code sheet, anesthesia monitoring would have stopped 10 minutes before resuscitation began. The anesthesiologist, being certain that there was no time lapse in the monitoring of the patient, assumed his time documentation in the anesthesia record was wrong—and adjusted the record to coordinate the times with the Code sheet in an effort for clarification. At trial it was discovered that the anesthesiologist had altered the record. Consequently the medical record was deemed fraudulent and the case rendered indefensible. During the criminal investigation that was initiated against the anesthesiologist for the record alteration, it was determined that there was indeed a 10-minute time difference—between the anesthesiologist's wristwatch and that of the clock on the operating room wall.

### **Risk Management Discussion**

- Document with specificity.
- Never alter the medical record.
- Corrections to records should be dated contemporaneously with the correction and initialed.
- Never use "White Out" or otherwise attempt to cover original record entries – line through an erroneous entry, and initial and date the change made.
- Provide an explanation for inconsistencies in the record.
- Document your medical rationale.
- Ensure the same integrity of documentation made on paper is made electronically.
- Entries should be legible, and contain sufficient detail to clearly demonstrate why the course of treatment was or was not undertaken.
- Documentation should support the diagnosis, justify the treatment, and be accurately dated and timed.
- Ascertain if timing inconsistencies exist and determine the etiology.
- All OR staff should synchronize timing devices prior to every procedure.

---



**Legal FAQs**

**What is a 'tort'?** A civil wrong or injury for which the court will provide a remedy in the form of an action for damages.

**What are 'compensatory damages'?** Generally, damages designed to compensate the injured party. Compensatory damages include past, present and future medical bills, lost wages, and other expenses attributed to the negligent act or injury.

**What is meant by 'discovery'?** Pre-trial devices that are used by one party to obtain information about the case. Forms of discovery include depositions, written interrogatories, production of documents or things including medical records and personal records. Discovery could also include physical and mental examinations, requests for admission and information necessary to support a claim for damages.

**What is meant by the term 'negligence'?** Generally, the failure to use such care as a reasonably prudent and careful person would use under similar circumstances, or the doing of some act which a person of ordinary prudence would not have done under similar circumstances.

**Must a physician sign all progress notes made?** Although state law does not specifically require a signature, Medicare, Medicaid and most HMOs require such documentation.

**What is arbitration and what benefit does it provide?** Arbitration is the submission of a dispute to one or more impartial persons for a final and binding decision. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. It is also believed that arbitration panels will help to avoid unreasonable jury awards, thereby further lowering costs. These cost savings would positively impact professional liability rates and the cost and availability of health care services.

**May a Physician Assistant (PA) sign the Baker Act forms to involuntarily admit a patient for psychiatric evaluation?** Yes, providing that such authority is within the scope of practice of the PA's supervising physician per Florida Statute 394.451(21). •

---



---

**We're on the Web!**

**[flsipp.org](http://flsipp.org)**

---

**FSIPP NEWSLETTER**

To Contact Us: [info@flsipp.org](mailto:info@flsipp.org)