

MEDICARE COMPLIANCE

Documentation Is Best Defense as Feds Turn Up Heat on Pricy Cardiac Procedures

As the Department of Justice's investigation of hospital billing for implantable cardioverter defibrillators (ICDs) picks up steam, beware a potential assault on pacemakers and cardiac stents, because Medicare sets forth coverage guidelines for all three high-dollar cardiac procedures.

"Auditors have not previously examined them with the kind of detail they expect today," says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia. "Today's standard of documentation is probably here to stay, and doctors and hospitals have to be far more detailed in documentation of all procedures."

In particular, though, claims for cardiac procedures are under the glare of a powerful spotlight. DOJ is investigating whether claims for ICD implantation failed to meet the relevant Medicare national coverage decision (NCD 20.4). The government's concerns about NCD noncompliance were reinforced by a study published in the Jan. 12 issue of the *Journal of the American Medical Association (JAMA)*. Researchers led by Sana Al-Khatib, M.D., of Duke University Medical Center reviewed 111,707 ICD cases from the National Cardiovascular Data Registry-ICD Registry. Their findings: 22.5% "did not meet evidence-based criteria for this implantation"; these patients "had a significantly higher risk of in-hospital death" compared with patients who received evidence-based ICDs.

DOJ is not the only agency scrutinizing cardiac procedures. "I expect recovery audit contractors and Medicare administrative contractors to follow the same pattern with other high-dollar cardiac procedures, such as pacemakers and stents, because they also are associated with NCDs," Taylor says. That means Medicare does not cover pacemaker, stent or ICD implantation for cases that fail to satisfy the NCD. CMS clearly encourages this scrutiny. Its Program for Evaluating Payment Patterns Electronic Report (PEPPER) is tackling at least 28 new targets in late February, including stents, one-day stays for cardiac arrhythmias, and two-day stays for heart failure and shock (RMC 12/13/10, p. 1).

Taylor says DOJ has been focused on patients receiving ICDs for "primary prevention" of sudden death who don't qualify for the device according to Medicare coverage guidelines. For example, the NCD says that

Medicare usually won't pay for ICD implantation for some patients who have suffered a myocardial infarction within 40 days of the procedure.

Even if patients didn't suffer a myocardial infarction within 40 days of ICD implantation, RACs and MACs may deny claims because patients didn't meet other criteria. That's why hospitals should be attuned to all nine "covered indications" of the NCD and ensure physicians document all of them in a way that satisfies Medicare auditors, he says.

There are many potential pitfalls to documenting medical necessity for ICDs. For example, physicians may not adequately explain the severity of the patient's cardiomyopathy or the type of cardiomyopathy (ischemic versus nonischemic), Taylor says. Physicians also "don't always go into detail about arrhythmias the patient has experienced," he says. "We rarely see in the medical record the physician stating which of the nine coverage indications the physician feels justified the recommendation for ICD implantation," Taylor says. As a result, auditors often can't tell why physicians performed the procedures.

Examples of Pacemaker, Stent Errors

In particular, physicians fail to sufficiently document patients' previous myocardial infarctions, which is a recipe for claims vulnerability. "The NCD has a very specific definition of what constitutes a previous myocardial infarction," he says. "If the doctor merely says 'in the past, the patient had an MI,' it's not clear that that statement alone is sufficient to completely fulfill documentation requirements. The doctor has to go into more detail." Physicians could document a pattern of troponin scores that meet the definition of myocardial infarction and note a specific ejection fraction number and New York Heart Association classification to more thoroughly indicate the need for ICD implantation.

In fact, Taylor, who recently reviewed hundreds of ICD implantation cases, harbors some suspicion that the *JAMA* findings may have been affected by poor registry documentation. "It is possible, and in my experience even likely, that poor documentation may account for a significant number of supposedly unnecessary ICD placements," he says. "Hospitals should take action to make sure that physicians practicing at their facilities are well versed in the Medicare

coverage guidelines — not just for ICDs, but also for pacemakers, stents and other procedures.”

Medicare has spelled out coverage requirements for pacemakers in NCD 20.8 and for percutaneous transluminal angioplasty with or without carotid stent placement in NCD 20.7. That makes the procedures potential RAC and MAC medical-necessity targets because failing to meet and/or document the defined condition justifying the procedure is grounds for denial. Taylor cites examples of documentation weaknesses with the two procedures:

◆ **Pacemakers:** “Physicians often don’t document why they feel patients need a dual-chamber pacemaker rather than a single-chamber device,” he says. Dual-chamber devices are used frequently, but physicians have to justify why they’re inserting the higher-cost devices. For example, a single-chamber pacemaker may not be adequate to support an active patient’s lifestyle, but that won’t necessarily be apparent from the medical records unless the physician writes it down. Physicians should also describe the symptoms that justify pacemaker placement. For instance, it’s

incomplete to document a patient’s low heart rate, but fail to indicate whether the patient experienced dizziness or fainting.

◆ **Stents:** While the NCD for stents may not seem as complex as the NCDs for pacemakers and ICDs, physicians should still document pertinent facts such as whether the patient’s angina is refractory to medical management, whether there is objective evidence of myocardial ischemia, and whether the lesion is amenable to angioplasty.

Because CMS has published coverage criteria for many procedures, Taylor predicts that hospitals will start proactively taking steps to more thoroughly check the medical-necessity documentation against the NCDs in advance of procedures to determine whether they meet coverage criteria. “Hospitals will have to be more diligent in having case managers check whether documentation fulfills Medicare requirements to prevent the risk of denial on the back end,” Taylor says. “The days when hospitals can afford to lose a \$25,000 payment are behind us.”

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