2011 Medicare Review of Cardiology Office Visits

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The Jurisdiction 1 Part B Medicare contractor, Palmetto GBA (Augusta, GA), announced that a prospective review of Current Procedural Terminology (CPT) visit code 99214 was initiated April 1, 2011, for all cardiologists, internists, and family practitioners in California. It is crucial that physicians understand the potential impact of this audit.

Medicare's analysis of office visit coding revealed that California cardiologists bill the moderate complexity code (99214) more often than do cardiologists elsewhere. Typically, such a prepayment service review is undertaken when a code "overutilization" is 2 standard deviations beyond the norm. We can thus assume that CPT code 99213 is more frequently used in most other states, but the higher level 99214 code is used more frequently in California. If your practice typically uses billing code 99214, a random review of your charts will likely be forthcoming.

Prior audits of a small number of charts indicate that most reviewed records (in one audit, up to 95%) are deficient in some aspect; Palmetto GBA is required to recoup the difference in payments when such charts are "down-coded" to the auditor's recommended level. The most common deficiencies are technical omissions, such as failure of the chart to indicate the beneficiary name or the date of service, an illegible chart entry, or an inadequate provider signature. Another common problem is inadequate documentation to support the intensity of the billed service, either due to a seemingly cursory physical examination or lack of data to indicate that medical decision making was complex enough to warrant the chosen CPT code. If routinely deficient documentation is found, then extrapolation to the entire Medicare billings of that provider might ensue; as such, there could be demands for large retroactive repayments to Medicare, as well as ongoing prepayment review of that provider.

There are ways to legitimately support a CPT 99214 service code. Charts must be technically complete and legibly signed by the provider. A signature card or other means to support the identity of the provider can be submitted if necessary. A detailed history and examination should be documented on the date of service. Adequate detail must be provided to support that medical decision making was at least "moderately complex" on the date of service—this can be supported by submission of diagnostic test results, imaging reports, letters to referring physicians, an expanded problem list, and the like. These simple steps could protect against major repayments to Medicare. ■

Appropriate Use Criteria: The Gold Standard, or a Mechanism for the Derogation of Clinical Judgment?

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Appropriate Use Criteria (AUC) have been carefully developed over the past several years within our cardiology community to provide general guidelines for the use of many procedures and our care of patients. They are based on studies that demonstrate, for example, in whom, and with what timing, automatic implantable cardioverter defibrillators (AICDs) should be placed in patients with congestive heart failure and reduced ejection fractions. Recent study results published in the *Journal of the American Medical Association* that showed that approximately 20% of AICDs implanted were placed outside of these guidelines, prompting much uproar in the lay press.[1] This, in turn, stimulated an exceptionally thoughtful interchange on the American College of Cardiology Board of Governors' list server, which is our method of communication with one another.

The focus of many of these comments was the fact that there are clearly patients who do not fit into the particular recommendations of AUC. Some patients will fall outside of these guidelines; if they do, it does not mean they received inappropriate care. It may reflect the fact that at times we are guided by the entity each of us knows has great value: clinical judgment. Clinical judgment has to guide therapy in the context of AUC recommendations. In other words, just because a patient had a defibrillator placed at 30 rather than 40 days does not mean it was inappropriate. That said, it was also noted that some centers had a zero rate of "inappropriate placement," whereas others had a rate as high as 40%. This discrepancy is puzzling and requires further scrutiny. One particularly thoughtful comment from our incoming Ontario Governor (Rob S.B. Beanlands, MD, who is head of a large electrophysiology division) was that the rate of so-called inappropriate placement of AICDs in Canada was approximately 20%. It is essential that we educate the public, through the political process and the lay press, that more than administrative claims data be used to say whether we are doing "good work."

A flip side of AUC, however, is shown by recent Senate hearings conducted by Senator Jay Rockefeller (D-WV) regarding the case of a patient in Delaware whose stress test was denied by a Radiology Benefits Manager (RBM). The patient had a major cardiac event and nearly died. The RBM denied the request in spite of the fact that it fell within the AUC. It was determined that a primary motivation of the RBM was to decrease costs by denying procedures, whether they fell within AUC or not. They also found, however, that some requests fell within guidelines, and some did not.

The positive publicity of our advocacy for patients in this instance was a good thing. It highlights the fact that there must be a pathway for us to be able to use good clinical judgment for a particular patient, and that such a course should not be used by Centers for Medicare and Medicaid Services or insurance companies to impugn our judgment. One idea is for Electronic Medical Records to have embedded within them a method to "override" a decision made outside of AUC, using reasons that could be agreed on by the same people at National Cardiovascular Data Registry who wrote the AUC.

In California, there is a push to start a voluntary reporting of percutaneous coronary intervention (PCI) data, which would include the reporting of our adherence to AUC criteria. We in California will be participating in a project in which some of us will be voluntarily reporting our adherence to AUC criteria and our results of PCI in the public domain. Stay tuned to see how this project is progressing. We will plan an update in our segment of *Reviews in Cardiovascular Medicine* next year.

We have a great opportunity to use AUCs, as they are well-crafted and thought-out criteria for therapies in the care of our patients. We cannot, however, become slaves of administrative claims data, and we must be careful about the laws of unintended consequences as we move forward in our caring for patients. ■

Reference

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Our Shared Cardiology History

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It may seem surprising but the American College of Cardiology (ACC) and the British Cardiovascular Society (BCS) both owe their origin, in part, to the influence of one man, the great Scottish physician Sir James Mackenzie. The ACC developed from the Sir James Mackenzie Cardiological Society, founded in New York in 1926, and the BCS is descended from the Cardiac Club, founded in Oxford in 1922.

James Mackenzie (1853-1925), who did all his research while a general practitioner, inspired a generation of young physicians to study heart disease; in 1912 he suggested to Dr. A.R. Cushny that a club be formed to discuss cardiac problems. World War I then intervened, but in 1922 the Cardiac Club was founded by 15 physicians with Mackenzie as an honorary member. It met once a year and topics included the heart in influenza, quinidine, infective endocarditis, angina pectoris, and the heart and athletics.[1] By 1937 there was need for a larger organization, and the Cardiac Society of Great Britain and Ireland was born. A journal was needed for their research, and in 1939 the Society founded the *British Heart Journal*, which changed its name to *Heart* in 1995.

During World War II the BCS welcomed members of the US Armed Forces at its meetings. By 1948, cardiac surgery was becoming established, and the Society elected its first surgical members (eight in all), including Dr. Russell Brock, pioneer in 1948 of mitral valvotomy, and Dr. Thomas Holmes Sellors, who performed the first pulmonary valvotomy in 1947. The BCS had already elected its first women members in 1940, at a time when some British medical schools were still closed to women.[2]

At first, every scientific meeting was a plenary session. There was a strict rule that papers must be spoken, not read from a script, and members were referred to only by their surnames, including women members. During the discussion of a paper the honorary secretary had the unwelcome task of writing the names of the questioners, maybe up to six of them, on the blackboard. The secretary was expected to recognize the members even if they did not state their names!

By 1952 the growth of cardiology was reflected in an increase of membership from 105 to 250, and by then the name had changed to the *British Cardiac Society*. A valuable addition to the meetings came in 1963 when Dr. Samuel Levine endowed a lecture in memory of Sir Thomas Lewis, who helped American physicians during World War I; since then another five nominated lectureships have been established. The BCS was conscious of the need for international collaboration, and joint meetings with European societies were held in Helsinki, Paris, Prague, Amsterdam, and Stockholm until 1981. The BCS became fully involved with the European Society of Cardiology after its formation in 1952, at which time Sir John Parkinson was elected as the first president.

An important event for the BCS was the purchase in 1994 of its first home, a fine 1798 house in London built by the famous Adam brothers. It contains offices, meeting rooms, and a historical library and museum, details of which can be found on the BCS Web site (http://www.bcs.com).[3]

The BCS now has 2100 members, 17 affiliated groups, and an attendance of over 3000 delegates at its annual meetings, where the participation of visitors from the United States (who have become valued friends over the years) is greatly appreciated. ■

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