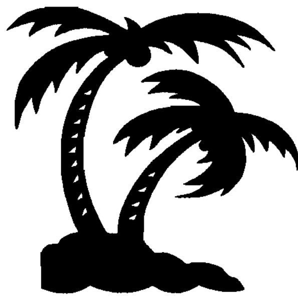


FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

May 11, 2007
JW Marriott Buckhead, Atlanta, GA
8 – 9:30 pm
MINUTES

Present: Presiding: Venerando Batas, MD, President, Duby Avila MD, Treasurer, Robert Christopher MD, Robert Dehgan MD, Vice President, Anthony Dorto MD, Craig Lichtblau MD, Arthur Pasach MD, Eddie Sassoon MD, assorted spouses/guests, Executive Director Lorry S Davis MEd and assistant, Catherine Groh-Tamasi. (Dr John Muenz who was supposed to attend, became unable to travel at the last moment – we wish him well in his recovery.)

Old Business:

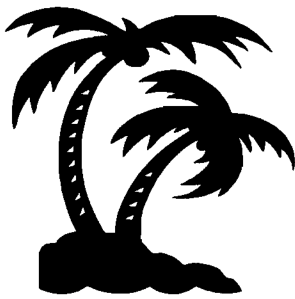
1. Minutes of the April 30, 2006, Miami Meeting were accepted.
2. Membership Report – Tony Dorto MD

We currently have 121 members, 12 of whom are retired, hence 109 dues paying members. We again employed AAPMR to send FSPMR member apps, along with AAPMR dues notices, to those AAPMR members in FL who are not yet FSPMR members. From this, we netted 8 new member applications. The cost was $169.17. We will engage in this process again for 2008. We netted 3 applications from referrals and 2 from the website.
Today we consider 12 candidates for membership:

Michael Frey MD	Ft Myers	needs member recommendation
Carol Krause MD	Daytona Beach	needs member recommendation
Jimmy Lockhart MD	Vero Beach	Craig Lichtblau MD
Kerry Maher MD	Jacksonville	Deborah Stewart MD
Trevor Paris MD	Jacksonville	Anthony Dorto MD
Carlos Placer MD	Kissimmee	Duby Avila MD
Christopher Rayher MD	Hudson	needs member recommendation
Franz Richter MD	Orlando	Lance Cassell MD
Stuart Rubin MD	Boynton Beach	needs member recommendation
Eddie Sassoon MD	Lauderhill	Anthony Dorto MD
Ronald Snyder MD	W Palm Beach	Mark Rubenstein MD
Hongying XI MD	Tampa	Venerando Batas MD

Those that have recommending members were voted into membership.
Additionally:
David Berkower DO, recommended by Dr Dehgan, has not responded to the invitation
Pierre Louis MD, recommended by Dr Avila, has not responded to the invitation
Ann Schutt, MD, retired, has incomplete application, and has not responded to further inquiry – Dr Christopher will follow up with Dr Schutt.
Asma Syed MD, Leesburg, has incomplete application, has not responded to further inquiry

PO Box 330298, Atlantic Beach, FL 32233-0298
Phone: (904)270-8886 Fax: (904)246-9233
E-mail: Lorry4@earthlink.net
www.fspmr.org



Florida Society of Physical Medicine and Rehabilitation

3. Treasury Report – Duby Avila MD, Treasurer

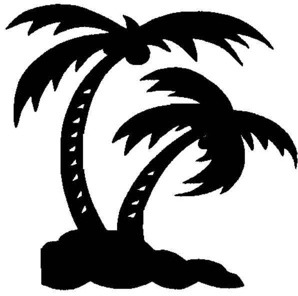
FSPMR is in good financial shape. We currently have $14,609.45 in our account. After the first and second dues invoices, there are still 18 members who have not yet paid 2006 dues. They are Drs R Amar, L Brown, R Cuevas, G DeBlasio, R Gruber, M Gulati, J Merritt, J Olsson, C Oteyza, Z Parrilla, P Reddy, M Romano, J Tan, J Toledo, B Vasquez, Y Wassaf, J Wright. Third and final notices will go out after this meeting. Potential additional income: $2,250.00.

Other Anticipated Expenses This Year:

Executive Director:	$5,250.00 ($9000/yr)
This Meeting:	1,000.00
Administrative:	
Phone/Fax	150.00
Printing/Mailing	100.00
Banking	25.00
Office Supplies	100.00
Postage	150.00
Website	300.00
Total Anticipated Expenses:	$7,075.00

New Business:

1. 2007 Florida Legislative Session
   a. FMA's latest report. – Dr Batas – attached. The FMA successfully stopped an assessment on FL physicians who carry medical liability insurance (to bolster the state's hurricane catastrophe fund). Dr Batas stated that each physician in this category will save $811 - $17,000 and this will be a 3 year exemption.
   Regarding the Medicaid item: Per Dr Batas, Dr Hutton, FMA President, says the whole idea is to increase patient access to care.
   b. PIP Position Paper. http://fspmr.org/fspmr%20pip%20position%20paper.pdf and attached.
   c. Did not pass. Sandra Mortham, FMA EVP, states that PIP will be considered at July's Special Session. – Dr Batas led a discussion where there was also opinion that it might be best to let this bill sunset due to fraud and abuse factors. Only 7 states have PIP.
   d. Lorry Davis mentioned the FL Controlled Substances bill passed. People referred to it as FLASPER. This was necessary legislation to enact the federal legislation, National All Schedule Prescription Electronic Record – passed by US Congress 2 yrs ago with no dissenting votes. The Governor could veto it, but it is not viewed as likely.
   The FMA advocated for this legislation.
   e. voterVOICe.net – Lorry Davis explained the concept behind this electronic method of giving your legislators your opinions – quickly and easily. Both the FL Academy of Pain Medicine and the FL Society of Interventional Pain Physicians have this service. It is the same service that the FMA uses. There was not any interest voiced in this service.



Florida Society of Physical Medicine and Rehabilitation

2. AAPMR – The Preserving Patient Access to Inpatient Rehabilitation Hospitals Act Introduced – see attached. Craig Lichtblau MD stated he resigned due to the 75% rule. There is a proposal that the figured be moved to 60%. Small rehab units will not remain viable. Dr Batas stated that he screens all potential rehab hospital patients for polyneuropathy and documents this on the consultation and the Electrodiagnostics.. some of the historic mainstays of rehab units, strokes and hip replacements – now require co-morbidities that require close medical supervision in order to fit the criteria.
3. EDX Scope of Practice Resolution – Robert Dehgan MD, VP – Attached.
   a. Medicare CAC Representation
   a. FMA Specialty Section Participation
   b. FMA Annual Meeting Representation
   c. Unity with FL Neurology Society

Dr Lichtblau stated he is willing to testify against physical therapists or other healthcare providers wh EDX mistakes.

Good and Welfare:

1. For those physiatrists interested in interventional procedures, as well as noninterventional pain topics, the Florida Academy of Pain Medicine will hold its annual meeting July 27 - 29, 2007, at The Gaylord Palms, Kissimmee. The FL Society of Interventional Pain Physicians will also be meeting with this event. Information will be sent to you regarding this meeting.

2. Annual Meeting 2008 – the decision was made to meet with the Florida Academy of Pain Medicine at The Gaylord Palms in July rather than with the FL Work Comp Conference at The Orlando World Marriott in August, or the SSPMR in May.

3. Dr Michael Frey MD, one of today's member candidates, writes in, "I would like to become an integral part in the future. Are there any positions that will be unfilled next year that you need help with as far as 'governmental positions?' I am definitely eager to work more in helping perfect our way of doing procedures and treating patients with painful disorders."

3. This new letterhead – Thank You to Ann Crutchfield, Practice Administrator for Dr Batas' group

Respectfully submitted, Lorry S. Davis, M.Ed., Executive Director

PO Box 330298, Atlantic Beach, FL 32233-0298
Phone: (904)270-8886 Fax: (904)246-9233
E-mail: Lorry4@earthlink.net
www.fspmr.org

Lorry Davis

From: Sandra Mortham, FMA EVP/CEO [FMA_Communications@informz.net]
Sent: Friday, May 04, 2007 6:07 PM
To: lorry4@earthlink.net
Subject: A Message from FMA Executive Vice President Sandra Mortham - May 4, 2007

Physicians Who Care

a message from
FMA Executive Vice President Sandra Mortham

With the 2007 Legislative Session ending within the last hour, I want to take the opportunity to thank each of you for your support. This is a difficult process but one you can't avoid. Even though you don't always get everything you want, you must be on the field and willing to fight the fight. Sometimes I hear that it isn't worth even being involved but that is truly not the case. If you are not there to protect your profession, you can be assured there will be those that will be ready to take your livelihood away from you.

Governor Crist will be calling a Special Session in June and my prediction is that PIP will be included in the call along with Property Tax Reform. Once we hear specifically on this issue, we will let you know. Any time the legislature is in Session, you must be ready for any issue that may arise. You can be sure we stand ready for the challenge.

Your legislative staff headed by Francie Plendl did a phenomenal job working for each one of you. Please consider sending Francie, John Knight, Jeff Scott, Fred Whitson and Michelle Jacquis kudos for their many long nights over the last two weeks at the Capital. Their knowledge of the issues are second to none and always willing to go the extra mile for you. Sarah Rothell did a wonderful job coordinating our program with ACP. They were wonderful advocates on many of our important issues particularly during committee hearings. The entire FMA staff pitches in during this time even though they have their own jobs to accomplish. Thanks to all.

End of Session Summary

The 2007 session ended on Friday, May 4 at 4:10 p.m. Thanks to the hard work of FMA members, county medical societies, specialty societies, the Alliance and the support of key legislators, we stopped a multitude of bills targeting physicians and also passed some key legislation. Unfortunately, we were not able to obtain an increase in Medicaid funding for physician reimbursements due to an unprecedented budget shortfall. Following is a summary of some of the issues we worked on this session. A full report will be available in June. If you have any questions, please contact the legislative staff via email at fplendl@medone.org or by calling 850-224-6496.

ASSESSMENT OF PHYSICIANS

In the last bill taken up by the legislature, the FMA successfully stopped a new assessment on Florida physicians by extending an exemption in current law that was set to expire this month. Had the FMA not successfully acted, ALL physicians in Florida who carry medical liability insurance would have been susceptible to huge assessments to bolster the statei¦s hurricane catastrophe fund.

SCOPE OF PRACTICE BILLS KILLED
The FMA was able to stop a multitude of scope of practice bills that were filed this year including:

- ARNPs prescribing controlled substances
- ARNPs certifying cause of death and signing death certificates
- Physical therapists expanding their scope of practice
- Psychologists ordering lab tests
- Creation of expansive scope of practice for Clinical Nurse Specialists

Unfortunately, legislation allowing pharmacists to administer flu shots passed after a long, hard fought battle. Governor Crist has said he will sign the bill. Fortunately, the FMA was able to reduce the bill from: administration of all vaccines/ immunizations to: flu shots for adults, pursuant to a protocol with a physician.

TORT REFORM
The FMA successfully fought off the trial lawyers in their attempt to strip physicians of their ability to adequately defend themselves in medical liability cases (Fabre doctrine).

The FMA also stopped language that would have made it more difficult for a medical liability insurer to provide their insured physicians with an adequate defense.

In addition the FMA stopped language in a late-in-session amendment that created two new causes of action against physicians

MEDICAID
Despite intensive lobbying by FMA staff and our physician leadership, due to a budget shortfall there was no increase given to physicians for Medicaid reimbursements. However, we did get the point across that an increase is long overdue, and we expect both House and Senate leadership to work on this issue next year.

CERTIFICATE OF EXEMPTION FOR PHYSICIANi¦S OFFICES
The FMA successfully killed a proposal that would have required doctors offices to pay a fee and obtain a certificate of exemption from medical clinic licensure laws.

PIP
The FMA successfully killed a fee schedule that the auto insurers were attempting to force on physicians as well as a hospital proposal to force all PIP patients into emergency rooms.

BOARD OF MEDICINE
The FMA opposed a bill that would have changed the makeup of the Board of Medicine by reducing the number of doctors on the board and increasing the number of lay persons. We also assisted FOMA and the Board of Osteopathic Medicine in passing legislation regarding licensure of DOs.

PHYSICIAN WORKFORCE DATA COLLECTION
The FMA worked to pass legislation requiring the collection of physician workforce data by the Department of Health. This data is necessary to assess the negative impact on Floridai¦s physician workforce due to the medical liability crisis and inadequate reimbursement levels. The data will also be used for medical education planning. The FMA worked hard to ensure that the new data collection requirement does not present an increased burden on physicians.

ELECTRONIC PRESCRIBING
The FMA worked to pass language that waives the licensure renewal fee (a savings of about $400) to up to 10,000 MDs and DOs who implement electronic prescribing systems.

OTHER BILLS

- Stopped legislation prohibiting certain types of psychiatric treatment for children
- Supported passage of a new law that requires fiscal intermediaries to comply with current prompt pay laws.
- Supported language that allows a doctor to control the type of drugs given to transplant patients.
- Stopped legislation that would have increased the cost and burden on physicians who treat deaf/hearing impaired patients.

This is only a small sampling of the issues the FMA worked on this session. We monitored over 400 bills and reviewed thousands of amendments. A full update will be coming to you soon.

Sincerely,
Sandra Mortham, EVP/CEO

Be sure to visit the FMA Web site at www.fmaonline.org for the latest news updates.

Florida Medical Association | 123 S. Adams Street | Tallahassee, FL 32301 | Privacy Policy

To unsubscribe from future emails, click here.

BACKGROUND & ISSUE OVERVIEW

The Florida Society of Physical Medicine and Rehabilitation is one of the 47 member societies of the American Academy of Physical Medicine and Rehabilitation. Physical Medicine and Rehabilitation (PMR) is one of the recognized specialties of the American Board of Medical Specialties. PMR specialists are well trained in the evaluation and management of musculoskeletal injuries.

Personal Injury Protection or PIP provides medical expense coverage if the driver or another individual covered under the policy is injured in an automobile accident. It is often called no-fault coverage because it pays medical expenses no matter who has caused the accident. PIP coverage pays hospitals, doctors, trauma centers and other medical providers directly for treatment of injuries from automobile accidents. In 2003, the Legislature repealed Florida's Motor Vehicle No-Fault law to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session. However the reenactment did not take place. The implication of letting the PIP no fault law disappear is that legitimately injured individuals may not have health insurance whatsoever preventing access to medical care. It is apparent that there has been a great deal of abuse in the current PIP system, and anti fraud measures must be put in place.

CURRENT STATUS

The legislature could still save the no-fault system (PIP) in the session which has just begun. If proposals are rejected, then the No-Fault law will sunset by October 1, 2007, and PIP will no longer be a mandatory coverage.

ORGANIZATIONS THAT SUPPORT THE CHANGE

The driving force behind this issue appears to be State Farm and a few large auto insurers.

ORGANIZATIONS THAT OPPOSE THE CHANGE

Florida Medical Association

Florida Orthopedic and ER Physicians

POSITION

The majority of injuries sustained in automobile accidents is mostly non surgical trauma. Current PIP coverage for these types of injuries is adequate and meets the needs of the majority. The FSPMR supports continuing mandatory PIP coverage.

The society is very much aware that fraud and abuse is prevalent in PIP cases. It is our recommendation that a system be put in place to minimize fraud and abuse. We strongly urge that only appropriate health care professionals provide treatment to these types of patients.

Inpatient Rehabilitation Hospital/Unit 75 Percent Rule: Diagnostic-Based Quota System Trumps Medical Judgment

- **The Rule's "quota system" is not medically appropriate**. By requiring rehabilitation hospitals and units to treat specific percentages of patients with certain diagnoses, it fails to recognize medical characteristics, circumstances, and needs of individual patients.

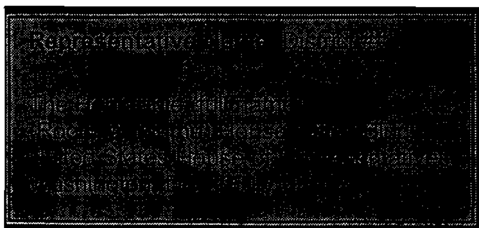
- **The Rule has not kept pace with clinical advancements** in physical medicine and rehabilitation over the past two decades. Patients with cancer, cardiac, pulmonary and other conditions who can be effectively treated by inpatient rehabilitation face a roadblock because they count against rehabilitation hospitals trying to comply with the Rule.

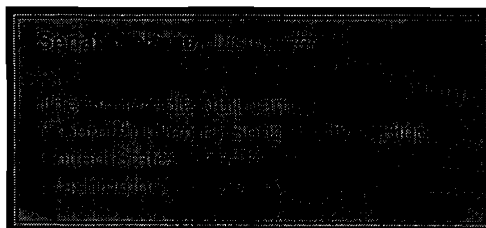
- **The Rule relies on black and white criteria, ignoring the medical judgment of physicians** and undermining their reasonable autonomy as care providers. For example, consider a surgeon who recommends the services of an inpatient rehabilitation hospital after joint replacement surgery for a patient who is 84 years old, morbidly obese (body mass index of 40), has diabetes and a history of poor wound healing. Regardless of the surgeon's medical concerns, unless the patient were 85 or had a BMI of 50 (far above 40, the already-strict definition of morbid obesity), admitting the patient adds to a rehab hospital's risk of being decertified under the Rule.

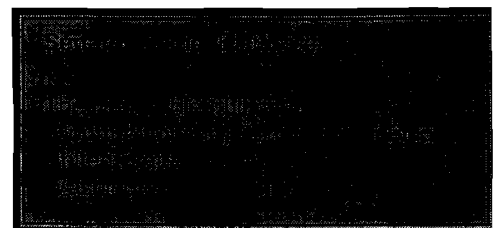
- **The Rule is ethically unacceptable**. Patients are disadvantaged without being informed of the Rule's existence or effect. Normally physicians would stand up for patients' rights, but referring physicians may not be fully aware of the Rule's impact upon their patients and, if aware, must still wait for a regulatory or legislative solution. There is a general lack of transparency with the Rule's policies that can effectively make access to inpatient rehabilitation a "luck of the draw" process, relegating the unlucky to services at facilities where progress is slower, readmission rates to acute hospitals are higher, and mortality rates are significantly increased.

- **The Rule is harming patients**, hamstringing physicians, and helping to funnel patients who need intensive rehabilitative care (that can be provided only by rehabilitation hospitals or units) into nursing homes.

- **Legislation in both the U.S. House and Senate will help promote quality of life for people who have serious rehabilitation needs by preserving access to safe and effective care in America's rehabilitation hospitals and units.**
  - H.R. 1459 and S. 543, the "Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007,"protects from further erosion of patient access to inpatient rehabilitation care and services by maintaining the current threshold at 60 percent. **BUT**, unless Congress acts fast, the Rule's compliance threshold jumps to 65 percent starting July 1, 2007, and then to the full 75 percent in 2008 — so we must act ***NOW*** to keep the Rule as inclusive as possible!







Lorry Davis

From: Robert Dehgan [robdehgan@msn.com]
Sent: Sunday, May 06, 2007 9:38 PM
To: lorry4@earthlink.net
Subject: Response to letter sent to Dr. Stolp ; original letter to Dr. Stolp/Resolution
Attachments: FirstCoastArticle102306.pdf; December2006PracticeTopics.pdf; resolution 2007.wps; March 28 dr stalp.doc

Hi Lorry, enclosed please find, letter to Dr. Stolp re EMG/NVC studies and the resolution I have written. Thanks, Rob Dehgan

---

From: *"Megan Fogelson" <mfogelson@aanem.org>*
To: *<Robdehgan@msn.com>*
CC: *<stolp.kathryn@mayo.edu>*
Subject: *Response to letter sent to Dr. Stolp 4/9/07*
Date: *Thu, 12 Apr 2007 09:12:51 -0500*

Dear Dr. Dehgan:

As the Director of Health Policy and Advocacy for the AANEM, Dr. Stolp forwarded your letter to me. The concerns you raise are well founded and your statements are strongly supported by your colleagues in the field of electrodiagnostic medicine. Your communication to Ms. Avera at First Coast is very much appreciated. I communicated with her multiple times concerning the recent draft EDX policy and provided relevant AANEM resources. I am including First Coast's current coding article concerning automated devices, which was summarized in the December issues of the AANEM Practice Topics newsletter. I included a copy of the newsletter as well. Presently, users of automated devices, such as the NC-stat, are required to bill using CPT code 95900. Physicians billing 95900 will be paid on an individual basis.

In February I attended the Florida Board of Medicine's monthly meeting. During that meeting the rule defining what qualifications a physical therapist must have in order to perform EMGs was discussed. The qualifications themselves where not the issue, rather the rule section discussing the qualification was mistakenly placed in the physical therapist rule section, rather than the board of medicine's rule section. The reason this is a mistake is that the board of medicine has the authority under statute to define the qualifications required of a physical therapist to perform needle EMG. Initially, the AANEM was interested in trying to change the qualifications, but was advised via the Florida Medical Society and the Board of Medicine that we needed to delay our involvement until the rule section was within the domain of the Board of Medicine. Did you receive any of this information from the AANEM or the Florida PM&R society? I am currently in a holding pattern as to approaching the Florida Board of Medicine about changing the rule language concerning PT. Realistically, the only way to entirely exclude PTs from performing needle EMGs is to bring legislation, which is very costly and time consuming. I would like to try to persuade the Board of Medicine to change the rules in such a way that it makes it virtually impossible for a physical therapists to meet the required qualifications to perform needle EMG in Florida. When we do approach the Florida Board of Medicine we will need physicians to attend the meeting in support and to communicate with the board via letters and phone calls. I hope you will assist us when the time is right!

The AANEM has been very activing in educating payors and legislators about the importance of providing quality electrodiagnostic medicine to patients. Please give me a call sometime and we can discuss further strategies to address poor quality studies being performed. I am currently working on developing a advocacy training program that would provide AANEM members the resources and skills to effectively advocate in their state. There will also be an advocacy focus event at the AANEM's fall meeting in October.

Regards,

Megan Fogelson, JD, MHA
Director of Health Policy and Advocacy
(507) 288-0100
Fax (507) 288-1225
2621 Superior Dr. NW

Resolution: 07-

Title of Resolution: Performance of Electrodiagnostic Studies (NCV, EMG)

Sponsor: Florida Society of Physical Medicine and Rehabilitation

Whereas, Electrodiagnostic studies (NCV and EMG) provide an clinically effective means to evaluate injury or disease of muscle, nerve roots, and peripheral nerves when patients complain of pain, weakness, numbness and tingling.

Whereas, Florida Medicare states (*Part B News 10/31/06*) that "nerve conduction studies should only be performed by physicians with training and expertise in the evaluation and treatment of peripheral nerve disorders. Such expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty that diagnoses and treats patients with never conduction problems (e.g., physical medicine and rehabilitation or neurology)." ; and

Whereas, legislation has been proposed that would allow non-qualified physicians and healthcare providers to perform NCV and EMG studies; and

Whereas, NCV and EMG studies performed by non-qualified physicians and healthcare providers is harmful to patients, can lead to inappropriate treatment or unnecessary surgery, and generate waste when studies have to be repeated; therefore be it

RESOLVED, that the Florida Medical Association oppose any legislation that would allow non-qualified physicians or healthcare providers to perform and be reimbursed for NCV and EMG studies; and be it further

RESOLVED, that strict and proper credentialing for NCV and EMG should be promoted with all private and public payers to prevent the need to promote patient safety and quality outcomes.

March 28, 2007

Kathryn A Stalp MD MS
President of AANEM

Dear Dr. Stalp:

The purpose of this letter is to ask for guidance and suggestion. I am a board certified physiatrist, fellowship trained in neurology & electrodiagnosis. I serve as the vice president of Florida society of PM & R, delegate to Florida medical association and a member of the Medicare advisory committee.

We have a big problem in Florida with podiatrist, chiropractors, physical therapist and fami physicians performing nerve conduction studies. I have campaigned and made presentatior to Florida Medical association annual assembly, Medicare Committee and Specialty Societ section. I am enclosing my letter.

I am very passionate about this mission and actually planning to take the Board examinatio in spring of 2008.

I am working with the Florida Society of neurology and would appreciate any help or suggestions.

Sincerely,

Robert B. Dehgan MD

Practice Topics
Your Primary Practice Issues
December 2006

Two Medicare Policies Require NC-Stat® Users to Bill CPT 95999

Trailblazer
Medicare Carrier for the District of Columbia (D.C.), Delaware, Maryland, Texas, and Virginia

Trailblazer released a new Local Coverage Determination (LCD) that will be effective January 1, 2007. The Trailblazer policy states that "performing more than 25% of nerve conduction studies in the absence of concurrent electromyography may result in medical review by Medicare." A coding article drafted in conjunction with the LCD states that "raw measurement data obtained and transmitted telephonically or over the Internet does not qualify for the payment of the neurodiagnostic codes included in this policy." The article further states, "when billing for initial identification of the presence of peripheral neuropathy accomplished with discriminatory devices that use fixed anatomic templates and computer generated reports, use the Not Otherwise Classified (NOC) code 95999. Indicate [sic] use is for the initial identification of the presence of peripheral neuropathy by including the name of the device used, such as NC-stat, in item 19 of the CMS-1500 form." The AANEM believes that physicians performing NCSs using the NC-stat will be required to bill 95999 under the LCD.

The new LCD also stresses the value of neurodiagnostic studies as an extension of the history and physical examination and the face-to-face interaction between the physician and patient.

The Trailblazer LCD states that, "billing of sensory perception or other testing by simple handheld devices (Neurometer and current perception testing) as NCS (CPT 95900, 95903, 95904) is not allowed. Trailblazer will not reimburse for surface EMG, simple hand-held devices or pressure-sensitive devices (Neurometer and current perception threshold testing)

Please share this information with your peers and referral sources. Failure to appropriately bill may result in Medicare fraud.

First Coast Service Options, Inc.
Medicare Carrier for Connecticut and Florida

On October 18th, First Coast released an article discussing coding guidelines for nerve conduction studies performed using the NC-stat® by Neurometrix. According to the article, "nerve conduction studies performed with this device should not be billed to Medicare with current CPT codes 95900, 95903, and 95904." The article further articulates, "until a specific code for this service is established by CPT that describes automated testing, this procedure must be billed with procedure code 95999 (unlisted neurological or neuromuscular diagnostic procedure)." The First Coast article states that they will administer claims on an "individual consideration basis." Physicians billing 95999 for studies performed using the NC-stat will be required to provide 1) a description of the test, 2) indications for the test, 3) a copy of the test results with interpretation, 4) an outline of how the results are used for specific patient decision making, and 5) peer-reviewed literature that supports the use of this modality in lieu of established testing for the specific patient's condition. First Coast notes that nerve conduction studies should be "performed by physicians with training and expertise in the evaluation and treating of peripheral nerve disorders," and recognizes that this type of training is included in programs for physicians training in physiatry and neurology.

All articles and payor policies are available at aanem.org on the Payor Policies section.

Donate to the Advocacy Fund today.
Visit www.aanem.org and contribute using the hotlink on the homepage

Congress Prevents 5% Medicare Cut

The Tax Relief and Health Care Act of 2006 which became law this month included provisions that prevent a 5% cut in Medicare physician payments for 2007. However, this is a temporary victory, as the legislation does not change the base payment rates beyond 2007. In 2008, physicians will once again face cuts in reimbursement as a result of the flawed sustainable growth rate formula.

In addition, the bill extends the 1.0 floor on work Geographic Practice Cost Index for 1 year, extends for 1 year the exception process allowing therapy caps to be exceeded for certain patients, and creates bonus payments for physicians who report quality measures.

CIGNA Draft Supports EMG and NCSs Being Performed Together

CIGNA Government Services
Medicare Carrier for Idaho, North Carolina, and Tennessee

CIGNA's draft LCD states that "appropriate neurodiagnosis usually demands both Nerve Conduction Studies (NCSs) and EMG." "Medicare expects that NCSs will not be routinely be performed without concomitant EMG." Further, NCSs performed without an EMG will be seen only in the "setting of limited follow-up studies of neuromuscular structures that have undergone previous electrodiagnostic evaluation."

This draft LCD is similar to the Trailblazer LCD (see page 1) in emphasizing the importance of neurodiagnostic studies as an extension of the history and physical examination, the face-to-face encounter between the physician and the patient, and the value of real-time data and interpretation.

Under the draft LCD, sensory perception and other testing by simple hand-held devices (Neurometer and current perception threshold testing), quantitative sensory testing and sensory nerve conduction threshold should not be billed as NCSs.

The LCD lists conditions that do not qualify for payment. including: 1) diagnostic studies that provide delayed interpretation as substitutes for nerve conduction; or 2) raw measurement data obtained and transmitted via telephone or over the Internet.

The AANEM submitted comments supporting the LCD, highlighting the importance of trained physicians interpreting EDX studies and the clinical value of performing NCSs and EMG together.

AANEM Educates Payors about Quality Electrodiagnostic Studies

The AANEM continues to educate insurance companies about quality electrodiagnostic medicine. The rapid increase in the number of NCSs performed over the last 2 years has caused insurance companies to examine their reimbursement policies for electrodiagnostic procedures. To assure that changes to polices adequately balance the need to provide quality care while eliminating possible abuse, in December the AANEM mailed an educational resource packet to over 1400 insurance companies. The mailing stressed the importance of qualified EDX physicians performing NCSs and EMG together in the majority of cases.

In the past, information provided by the AANEM to insurance companies has been well received, and has resulted in wide-spread adoption of the language contained in the AANEM's *Recommended Policy*. All insurance companies who received the mailing were advised that AANEM staff will assist with any revisions or questions related to their EDX policy. If you are interested in educating insurance companies in your state about quality electrodiagnostic medicine, please contact the Policy Department.

Single-Fiber EMG Physician Work Value Increased for 2007

The AANEM, in collaboration with the AAN and AAPMR, surveyed the physician work values for single-fiber EMG during the Relative Value Update Committee (RUC) 5-Year Review in 2005. Surveys and presentation to the RUC produced a RUC recommendation of 3.0 physician work units, up from the existing 1.5. The Centers for Medicare & Medicaid Services (CMS) initially proposed a value of 2.0 despite the RUC recommendation in June of 2006. However, written comments and a presentation by the AANEM's RUC Advisor, Dr. Andrea Boon, before a CMS Refinement Panel in September succeeded in securing 2.88 physician work units for this procedure. Representatives from AAN and AAPMR also participated in the refinement panel in support of the increased value. This increase will take effect January 1, 2007.

Medicare 101

What Is a National Coverage Determination (NCD)?

NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure, or device. NCDs generally outline the conditions for which a service is considered to be covered or not covered. Once published in a CMS program instruction, an NCD is binding on all Medicare carriers.

What is Medicare Local Coverage Determination (LCD)?

LCDs are decisions by local carriers that apply to a particular region of the U.S. to cover a particular service. Carriers specify clinical circumstances under which a service is considered reasonable and necessary. The LCDs are administrative and educational tools to assist providers in submitting claims for payment. Carriers develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community.

What is a Medicare Article?

Articles are written by local carriers to provide coding guidelines that are not included in LCDs.

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Emerging Diagnostic Technology – NC - stat System, NeuroMetrix®

NC-stat by NeuroMetrix® is an automated nerve conduction testing system marketed as an alternative to conventional nerve conduction testing. The NC-stat system is marketed as hand held and offers rapid turn around of test results, to perform non-invasive point of service testing for the assessment of nerves in the upper and lower extremities.

Nerve conduction studies performed with this device should not be billed to Medicare with the current *CPT* codes *95900*, *95903*, or *95904*. The procedure code descriptor must precisely describe the service billed. Therefore, until a specific code for this service is established by *CPT* that describes automated testing, this procedure must be billed with procedure code *95999* (*Unlisted neurological or neuromuscular diagnostic procedure*).

Currently, First Coast Service Options, Inc. (FCSO) does not have a local coverage determination that addresses when this automated diagnostic test is covered, and if covered, the criteria for coverage; so claims will be administered on an individual consideration basis.

As with any diagnostic test, the test should only be considered for patients with signs and symptoms and used in clinical decision-making when current established diagnostic tests are not indicated. There is no Medicare screening benefit for this type of automated nerve conduction study. The test should only be performed by physicians with training and expertise in the evaluation and treatment of peripheral nerve disorders. This expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty that diagnoses and treats patients with nerve conduction problems. This type of training is generally included in the residency or fellowship programs of physicians who specialize in physical medicine and rehabilitation (physiatrists) or neurology (neurologists).

If a claim is submitted to Medicare, a letter will be sent to the performing provider requesting records that document a description of the test, indications for the test (patient specific signs or symptoms) as outlined in a prior E&M evaluation), a copy of the test results with interpretation and an outline of how the results are used for specific patient decision making. Also, the physician should submit peer-reviewed literature that supports the use of this modality in lieu of established testing for the specific patient's condition.

More often than not, new services or technologies do not meet all the standards for coverage by Medicare. Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed *CPT* codes (*95999* in this situation). For further details about the Centers for Medicare & Medicaid Services (CMS) Beneficiary Notices Initiative (BNI), please point your browser to this link: http://www.cms.hhs.gov/BNI/.

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