

**ALABAMA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITIES
MEDICAL DIRECTORS' ADVISORY COMMITTEE**

DATE: Saturday, February 25, 2006 7:30 a.m.

PLACE: Sheraton-Birmingham Hotel
Medical Forum, 2nd Floor
Birmingham, Alabama

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF
Louis Cottrell, Exec. Director, Alabama Nursing Home Association
Steve Furr, M.D., 2005-2006 ALMDA President
Robert Webb, M.D., Vice President, Program Chairman
David McRae, M.D., Board Chairman
Rick Harris, Director, Bureau of Health Provider Standards
Harrison Wallace, Dep. Dir., Bureau of Health Provider Standards
Jim Yates, M.D.
Malcolm Brown, M.D.
Charles T. Nevels, M.D.
Joe Downs, M.D.
Dick Owens, M.D.
Jimmy Davis, M.D.
Tom Geary, M.D.
Jerry Harrison, M.D.
Dick Rutland, M.D.
David Barthold, M.D.
Michael Reeves, M.D.
Thomas Stevens, M.D.
Kevin Jackson, M.D.
John Wagner, M.D.
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
Becky Hall, DHCF

Dr. Richard Esham welcomed attendees to the advisory meeting and thanked them for attending. He extended to the group regards from Dr. Searcy who was unable to attend due to a conflict. The Medicaid Report was not presented at this meeting. Dr. Esham thanked Mr. Cottrell of the Alabama Nursing Home Association (ANHA) for his attendance. Ms. Sadler introduced to the group a new member of the Division's staff, Mr. Harrison Wallace, Deputy Director, who brings a wealth of knowledge and experience to the Division. Previously, Mr. Wallace worked for Dr. Charles Woernle, Assistant State Health Officer for Disease Control and Prevention, and Director, Bureau of

Communicable Disease. The minutes from the July 23, 2005, Sandestin Golf and Beach Resort meeting were approved as written.

Dr. McRae addressed "New E & M Codes for Nursing Home Visits." As of January 1, 2006, physicians will be using the new E & M codes. Dennis Stone, M.D., AMDA's representative to the CPT Advisory Committee and Practice Expense Advisory Committee asked Dr. McRae to serve on this committee that had been researching E & M codes for a couple of years. The nursing codes that had been used for years will not cross walk with hospital codes. In other words, they were statutory. You were supposed to bill a 12 for a regular visit and a 13 if due to sickness, a new MDS was developed. It did not matter about your documentation or how sick the patient was except within limited criteria. 85% of physicians were billing wrong when they completed a review. The committee went through the process of CPT coding. Dennis Stone wrote several vignettes and went through the AMA RVS Committee and eventually to CMS and the new codes were established. Dr. McRae had a draft of what will probably be the final CPT Documentation. It is supposed to be on the AMA web site. It is exactly like all of the other CPT documentation code descriptions including vignettes and at what level expanded problem solving. Dr. McRae wanted to make sure that the membership understands that the new codes correlate with the hospital codes. The admission codes correlate with light care patients and with more complex patients. The decision making guidelines as to how to code correlate with the hospital codes. The new code numbers are (99304 – 306) for the initial assessment; four new codes for the subsequent visits (99307-99310); and a new code for the annual nursing facility assessment (99318). Domiciliary codes are (99341 – 99350). These codes have not changed. On the AMA site are CPT Documentation Guides. Dr. Harrison stated that he was told in another meeting that the CPT Documentation Guides were not on the site because the vignettes have not been completed. Dr. McRae stated that he disagreed with the vignettes that were written by Dr. Stone because they are written in such a way that the simplest patient, a typical nursing home patient, was not as simple as one could imagine. In other words, it was a patient with three problems and stable. One may have a patient with one problem and it doesn't fit very well. An example of a vignette (disagreement): 99307 - Subsequent nursing home visit of a 80 year old demented, non-diabetic patient, with a previously evaluated stage IV sacral pressure sore with peripheral localized inflammation. The patient was seen on a follow-up to evaluate the wound's response to the plan of care. This is supposed to be an example of a low level visit. That is the lowest level vignette, however; this is still a complicated patient. Dr. McRae strongly expressed his concerns about the vignettes in question, but they were not revised. The vignettes give guidance to the people who are conducting reviews. If you follow the problem focused history, the physical and decision making guidelines, you are completely covered. For example, if you have three problems and change one medication, you can bill an upper level code. Dr. Harrison stated that in subsequent visits, you can get a 07 with just two. Dr. McRae responded that the code goes up to 010. The codes now make more sense than before especially since most physicians were coding wrong. Dr. Esham asked if software was available. Dr. McRae stated that there is commercially available software. At the AGS meeting last year a PDA was being marketed. Dr. McRae did not know of any vendor who had a software program perhaps because the nursing home market is smaller. Dr. McRae has seen PDA parts that will allow you to document and tells you where you are

in the documentation process. He has not seen any programs for the new codes. Dr. Esham stated that in his company currently there is software that will do Evaluation and Management (E&M) Code calculation in the office environment. The next project is the hospital environment. Dr. Esham encouraged Dr. Yates, a customer, and other customers to urge his company, by letters and phone calls to develop software for the nursing home sector. In the strategic plans of his company, long term care is in the top three. Dr. Esham stated that they want to change and improve software to be user friendly. Dr. McRae stated that you can't rely on common sense anymore to code appropriately. Dr. Esham further stated that physicians under code because of their fear of being audited for over coding. The fines are shockingly high. A good software program would count what questions are asked. Dr. Harrison stated that there is another downside to under coding. Due to quality indicators, if you under code, you will fall out as poor quality of care because of not delivering appropriate care. It would be a marker for poor quality of care. Dr. McRae offered the group to review the draft. The new codes went into effect January 1, 2006, so if you are not using them correctly, they will get kicked back. If you are not using these new codes, you will not get paid. Again, domiciliary codes have not changed and the rate of reimbursement is less than a home visit. Dr. Harrison stated that in the meeting he attended, it was stated that assisted living visits had increased substantially to \$196 for an initial visit. The reason given was to keep patients out of the nursing home. The source of this information was Malcolm Frazier, who gave a primarily Medicare lecture, sponsored by Forest Pharmaceuticals. Previously he had given this lecture in Georgia and would soon be lecturing at Harvard. Dr. McRae stated that perhaps there are new assisted living codes that are different than domiciliary codes. Dr. Harrison stated that it was a very interesting session and took notes.

Additional references:

http://www.caltcm.org/press_releases/New_NH_Codes_and_Fees_111505_3.pdf

“AMDA Efforts Result in New and Revised Nursing Home Codes AMA Releases New Family of NF Codes through the CPT”

According to this information, AMDA's revised CPT Coding Booklet was available on-line in December, 2005. The revised booklet will update the NF vignettes and frequently asked questions on physician visits, the use of non-physician practitioners, hospice services, and domiciliary care.

“Affirming the Uniqueness of Long Term Care, AMDA Speaks Out on E/M Guidelines”

“AMDA Efforts in New and Revised Nursing Home Codes”

“Articles on Compliance Strategies” – Medicare Watchdogs Intensify E/M Coding Scrutiny; New Audit Sources Available

Dr. Esham directed the group to agenda item, Status Report DNR (Do Not Resuscitate), by Rick Harris. Mr. Harris first provided a historical review about DNAR concerns. For a long time there has been a concern that if a nursing home resident with a DNAR order, goes to the hospital, that the DNAR (Do Not Attempt Resuscitation) order does not follow the resident or if the order accompanies the resident, the hospital does not honor the order. The hospital physician executes another DNAR order using the hospital DNAR form. The resident returns to the nursing home or to another facility and by this time, several DNAR orders have been executed which creates confusion and is

burdensome. A meeting was held with major industry players; however, no members of the medical directors association attended. The hospital association, nursing home association, and assisted living association participated. There was resistance from attendees about having a mandatory form. The only way this particular concept can work is with a single, mandatory form which follows the patient. The hospital association had a significant objection to this concept. Mr. Harris volunteered to convene another meeting. He encouraged this group to attend and advocate this idea especially to the hospitals. Mr. Harris explained the resistance as follows. The patient goes to the hospital with paper work from the nursing home. The hospital is obligated to review the paper work. The hospital looks for a DNAR form and places the DNAR form in the patient's chart in the place where the hospital determines. When the patient leaves the hospital, the DNAR form is pulled from the chart and returns with the patient to the nursing home. The hospital views this process as an administrative burden. There was a discussion about if a copy would suffice. With this discussion, Mr. Harris again stated that it would be beneficial for this group to attend the meeting. Usually at these meetings are professional trade association people which are not hospital administrators. These attendees discuss what they think will be the objections by the hospital and by their boards. Mr. Harris stated that this is not a lost cause; it can be worked out, but we need to have the right people at the meeting. Dr. Harrison volunteered to attend if available. Dr. Geary stated that he had FAXED a copy of the Washington state DNR form that is a pink form that travels with the patient from hospital to nursing home to rehab hospital and back. Dr. Harrison said that in Winston county, a DNR form is in place and is utilized as an official document. Mr. Harris responded that it is legal for the hospital to honor a DNAR form that is completed in a nursing home. The resistance is placing another regulatory requirement on hospitals. Dr. Reeves commented that he didn't understand why hospitals would be resistant, because ER physicians are upset when they don't know if a patient from a nursing home has a DNAR order. Dr. McRae stated from the hospital perspective, boards have spent a lot of time developing hospital specific DNAR forms, some of which are very complex and give patients a variety of choices as to what DNAR means. The problem will be that hospitals are attached to these forms since it took a lot of time and committee work to develop them. Once you get a DNAR order from a nursing home, trying to crosswalk that into hospital bylaws with the hospital DNAR form would be impossible and would require a new conversation to translate. Dr. Harrison asked if the hospital forms are DNR or DNAR. Dr. Harrison understood that there was a difference at one time. Additional reference (National Ethics Teleconference What Does 'DNR' Really Mean? June 28, 2005):

<http://www1.va.gov/vhaethics/download/Transcripts/NET.6.28.05.doc>. Dr. McRae responded that in his two hospitals, there are two different forms. One is a two-page form that requires that you describe the conversation you had with the patient and/or family in detail which is five paragraphs in length. It also includes a laundry list of procedures that a patient may or may not want implemented, including starting IVs, shock, insertion of tubes, etc. The patient checks which ones they might want even if there is a lack of understanding. At the other hospital, it is a single form that has the same type of laundry list but different items that a patient may want done. At the bottom there is hospice and palliative care and therapeutic measures until death. Both have worked well at these hospitals. Dr. McRae would be resistant to a universal form that only states DNR for

patients due to not knowing what that means. His patients have been educated for years to know which items in these laundry lists they want. This is not a simple subject. Mr. Harris responded that some of these issues were discussed at the meeting. Another issue is the need to update the living will statute in Alabama. There are serious problems with this statute. When enacted, it was quite modern, but with time, needs to be updated. An example is the statute does not address pediatric living wills. Dr. McRae added that it does not address DNR status. It only addresses if two physicians state that a patient is about to die. Dr. Esham asked about the movers or key players of living will legislation. Mr. Harris responded that it was mostly lawyers. Specifically in attendance were: Greg Everett, Hospital Association; Richard Brockman, Alabama Nursing Home Association; Wendel Morgan, Medical Association; Dean Korless; Susan Doutan; a number of private lawyers who have numerous medical clients; and Rick Harris. Dr. Esham commented that this seems to be the logical group to take a re-look at DNR and DNAR subject matter. Dr. Esham stated that his vision would be that a DNR/DNAR universal form would be adopted as statute that would be required by all medical facilities and providers. It would not be just a paper form, but would also be in an electronic format. It should be retrievable in a data base. Dr. Stevens added that the only way the current system can change is for the hospital association to review all the different forms and comes to consensus about one form. Mr. Harris said there is an opportunity for a position of leadership especially from physicians. When physicians in a hospital come together and tell hospital administrators what they need to make things work better, Mr. Harris believes administration will listen. Dr. Webb stated at ECM there is a standardized form, which is very simple, that is used by the hospital and nursing home. The emergency room is very pleased with the form. Another thing that has been done is changing terminology such as natural death so people are not frightened. Dr. Esham commented that AMDA (American Medical Directors Association) and this group can take the leadership in this movement. There is influence, not only in long term care, but also in the medical association. This would be a perfect opportunity for Dr. Furr and Dr. Harrison to discuss these concerns with the medical association for a win – win outcome. This is a cause that serves the needs of our patients. Dr. Harrison stated that if this board and ALMDA (Alabama Medical Directors Association) should join in this initiative to construct a resolution for MASA (The Medical Association of the State of Alabama). Dr. Esham clarified that MASA along with ALMDA will create a resolution to the AMA (American Medical Association). The resolution must first be presented at the state level and then at the national level. Mr. Harris stated that the health department as the administrative arm of the Board of Health can set up a meeting and invite stakeholders. Typically when a meeting is set up invitations are extended to Mr. Cottrell and his staff at the Alabama Nursing Home Association, hospital association, hospice, and all of the different groups to participate. The health department, itself, is not in a position to provide the leadership about this issue. Physicians, especially those on this advisory committee, are the ones with the expertise and experience, who have the patients and who deal daily with these very difficult and complicated issues. Dr. Esham again stated this would be an initiative that would benefit patients. Dr. Furr added that someone would have to draft some legislation. Mr. Harris responded that if all of the associations met at the table and people could agree in principle and approach, a committee could be formed of physicians, hospital administrators, nursing home administrators, and lawyers to develop legislation

and some forms. The one group that the health department has heard from about the natural death act issue in the past is the pro life people. The health department has been careful to include this group in discussions. This group is open to these discussions and does not totally disagree about situations involving natural death and living wills. Most people do not want to be kept alive artificially. Dr. Reeves commented that the ER physicians should be included in these discussions. These are the doctors that are faced with critical decisions. Dr. Esham urged that the MASA organization is the one to take the leadership in this initiative because they represent all segments of the physician community and this group needs to create the spark. The Board of Censors and the Medical Association needs to pull the physician community together on this issue. This issue could be a positive initiative for the association. Others agreed and added that this would give the association some recognition. Mr. Cottrell added that ANHA is interested in this initiative. ANHA attorneys are ready to participate; however, Mr. Cottrell believes that physicians should take the lead role. Dr. Geary commented that there are not two nursing homes in Alabama that use the same forms and have the same philosophy about DNR. It would be helpful if all of the nursing homes came together and developed a universal form for nursing homes in conjunction with MASA. Dr. Esham stated that MASA needs to pull all of the various groups together; however, the nursing home association needs to independently review different forms and develop a universal form that can be supported. This form can then be presented to the medical association. Dr. Geary stated this would be a good place to start with the nursing home association and AMDA and then to MASA. Dr. Harrison suggested that those physicians attending the medical association meeting in May get together with Mr. Cottrell and the association's attorney and Mr. Harris and construct a resolution to submit to MASA. We need consensus and need to initiate a leadership position. Dr. Furr commented that members solicit support of the caucuses prior to the meeting. Each physician in attendance should promote the initiative in their caucuses. Dr. Esham commented that the resolution should articulate the general concepts. Dr. Esham asked Mr. Harris to develop a first draft and circulate to the physicians in attendance for comment. Dr. Esham thanked Mr. Harris for his assistance in the development of the resolution.

Dr. Esham asked Dr. Yates to discuss the final agenda item: Joint 501 Training. Dr. Yates stated that last year subjects of interest for joint training were determined to present to the nursing home association, DHCF (Division of Health Care Facilities), and ALMDA. The purpose was to assure that participants are interpreting information in the same way. As of this date, presentations have been conducted with the nursing home association and DHCF. During this conference, the presentation will be conducted with medical directors. The presentations have been well received. Legal, medical and regulatory groups were represented in the presentation. Mr. Cottrell commented that the presentation for ANHA conducted in the fall was done very well. Mr. Harris added that F 501 has not been cited as of this date. There was one possible case where a nursing home did not inform the physicians about residents not receiving prescribed medications. There was a drug supply issue. There was no conclusive, solid evidence that the medical director was notified of the problem. F 501 is about the Medical Director, not about attending physicians. If the nursing home fails to inform a medical director and involve the medical director in important resident care issues, that is a deficient practice for the nursing home. Dr. Yates stated that F 501 is citing when the nursing home is not

interacting, employing, and utilizing the medical director appropriately. It is not citing the medical director. Dr. Esham stated that there were about 300 participants at the nursing home association F 501 training in Birmingham in October. The same program will be provided at the conference for medical directors. Ms. Sadler stated that the program presented to surveyors was well received and appreciated. Ms. Sadler stated that she was appreciative of their time to develop and present this program. There were numerous positive comments. It was a very useful presentation for the survey staff.

Dr. Harrison asked about the legislation to allow physicians to call in Class II Controlled Substances to nursing homes. There was a discussion about opposition and a move from pharmacist to extend it beyond 72 hours. Mr. Cottrell stated that he has not heard of any opposition. It is out of committee and is on the calendar.

Dr. Reeves commented that he has a number of homes serviced by Nursing Solutions Incontinence Group. These are nurse practitioners who assess incontinent patients. They are using estrogen rings and other treatments that have been very successful in helping a lot of patients. In their practice, they use a cystourethrogram study. Reference: http://www.webmd.com/hw/blood_disorders/hw210845.asp About twenty-two states pay for this service. The group told Dr. Reeves that Dr. Fred Robertson, Medical Director (Alabama Medicare) will not pay for this service in Alabama. Those in attendance were asked if they were familiar with this group and/or test. Dr. McRae stated that they use a bladder ultrasound which is relatively inexpensive, effective and easy, but is not reimbursable. Dr. McRae would like to see these tests reimbursed in Alabama. Dr. Reeves volunteered to research the facts, pros and cons, to present to Dr. Robertson for consideration of reimbursement. Dr. Esham stated that he would like to invite Dr. Robertson to attend a meeting to explain the interactions, regulatory actions, and payment aspects of his role with respect to the role of medical directors. Dr. Geary commented that Pat Rice and Dr. Robertson previously presented in Montgomery about the overall policy of their roles as the fiscal intermediary for Medicare in Alabama. Dr. Esham commented that perhaps Dr. Robertson could be a presenter at the July conference.

There was a brief discussion about nurse practitioners signing orders. Nursing home policy development is a responsibility of the medical director in each home. The policy requirement for co-signatures by mid-level practitioners in each individual home should be developed and followed. If it is not required, the mid-level practitioners may write orders for anything except control substances. There will be a continuing education series about mid-level providers conducted by Cheryl Thomas throughout the state. These would be excellent questions to ask during this training.

The meeting was adjourned. Dr. Esham thanked everyone for their attendance and participation. The next meeting is July 22, 2006, San Destin, Florida.

****** CALL ME IF YOU HAVE ANY QUESTIONS ******

