

**Dr. Srivastava's Response to  
TriCenturion's Post-Pay Medical Review Summary**

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### Introduction

Dr. Srivastava is a highly regarded interventional cardiologist in the community where he works. He has been licensed to practice medicine in Maryland since 1990. He is board certified in interventional cardiology, cardiovascular disease, electrophysiology and internal medicine. He is the only physician board certified in all these specialties at the hospitals where he has medical staff privileges. He has held numerous fellowships and academic appointments. In 2003, he was awarded the Governor's citation for "Excellency in Cardiology" for providing pro bono care to the residents of Maryland. He is always among the leaders in the amount of pro bono care that he provides to the indigent of Prince George's County, Maryland.

Through counsel, Dr. Srivastava sought the assistance of the coding experts at Coding Compliance Solutions, LLC ("CCS") and of the cardiology expertise of Mehrdad Rezaee, MD, PhD, a board certified practicing interventional cardiologist who is also a Clinical Assistant Professor of Medicine (Cardiology) at the Stanford University School of Medicine. The analysis that CCS conducted of TriCenturion's allegations is attached to this Response as Exhibit A. Dr. Rezaee's opinions are referred to in the course of the Response and his Declaration concerning the particular criticism that was made of Dr. Srivastava's care of Thelma Parker is attached as Exhibit B. The pertinent portion of another Declaration from Dr. Rezaee addressing the procedures that Dr. Srivastava performed during a left heart

catheterization and his used of CPT code 93526 is also attached along with his CV as Exhibit C.

CCS is prepared to handle all the coding for Dr. Srivastava's procedures. CCS would review all pertinent medical documentation and apply the appropriate codes that can then be used by Dr. Srivastava's office for billing purposes.

### Response

TriCenturion's Post-Pay Medical Review Summary ("the Summary") is confusing, illogical and incorrect. The spreadsheet attached to the summary does not adequately explain the basis for the "Denial Reasons" provided and it offers no explanation at all of the numbers that are listed under the "Rationale Notes" column. In the "Review Findings" section of the Summary, the reviewer maintains that "unbundling is demonstrated throughout this review" but not a single one of the line items in the attached spreadsheet indicate that "unbundling" is the basis for the denial. The allegations of the narrative portion of the Summary are hard to follow and no concrete examples are provided of the nature of the issues that it attempts to identify.

### CPT Code 93526

The Summary begins with a discussion of the use of CPT code 93526, combined right and left right catheterization. The reviewer alleges that for almost all catheterizations, the service is billed inappropriately under CPT code 93526 because the cath lab reports do not support the performance of a right heart cath. But the reviewer hedges her bets by challenging the medical necessity for the right

heart caths that she contends were not performed, and she always lists lack of medical necessity in the spreadsheet as the reason for denying payment for 93526 services. She does not claim that Dr. Srivastava failed to perform the right heart cath. Rather, she disingenuously takes him to task for actually performing a procedure that was not medically necessary thereby “plac[ing] an unsuspecting patient population at risk”. This allegation is false.

Had the reviewer been careful in her examination of the entire medical records of Dr. Srivastava’s patients including the film maintained at the hospitals where the procedures were performed, she would have seen that Dr. Srivastava performed two procedures when he did a left heart catheterization. He documented exactly what he did in the medical records. Whenever he did a left heart catheterization, he also opened a line into the venous system and inserted a catheter to the entrance of the right heart so that in the event of complications he could inject medications or insert a catheter. This is the prudent practice of medicine and it is followed by many other cardiologists. Dr. Rezaee addresses this practice in his Declaration attached as Exhibit C. Dr. Srivastava saved lives by using this precaution. Nowhere in the cath lab reports that he completed does Dr. Srivastava ever misrepresent what he was doing. He never indicates that he recorded any right heart hemodynamic pressures when he opened the venous line. He was not performing an unnecessary procedure.

The reviewer challenges Dr. Srivastava’s office’s use of CPT code 93526 because he did not measure the right heart hemodynamic pressures. Dr.

Srivastava's office used that code to bill for both the insertion of a catheter to the entrance of the right heart and his performance of a left heart catheterization. The reviewer ignores the propriety of opening a line into the venous system and the fact that this is a separate and distinct procedure from the left heart catheterization.

The CPT code does not provide any clear cut answers for the optimal billing approach for the procedures that Dr. Srivastava performed. Dr. Rezaee believes that it was acceptable for Dr. Srivastava to bill these procedures under 93526. See Exhibit C. He does not think there is really any one code or combination of codes that adequately captures the nature of the procedures that Dr. Srivastava performed.

The expert coders at CCS who are often used by the government to evaluate coding issues, agree with Dr. Rezaee that there is no optimal way to bill for what Dr. Srivastava did. In their attached Analysis, they express the opinion that it would have been appropriate for Dr. Srivastava to use CPT code 93510 for the left heart cath and either CPT code 36010 or 36013 for the insertion of the venous catheter. See Exhibit A. They correctly note that the reimbursement that Dr. Srivastava would have received if he billed in this way would have been higher than what he did receive by using 93526. As they explain, instead of over billing, Dr. Srivastava under billed his services. The experts at CCS also note that payers frown on the use of multiple codes when a more comprehensive one will do. Dr. Srivastava's use of the single 93526 instead of 93510 and 36010 is in line with that preference and resulted in lower reimbursement for him. The CCS experts say that

the use of 93526 could have been further explained by appending modifier 52 to indicate that less than all of the services had been performed. They also point out that the reimbursement with or without modifier 52 would have been identical.

### “Unbundling”

The TriCenturion reviewer’s allegations of what she calls “unbundling” are unsupported. She claims that “Unbundling of services are demonstrated throughout this review”, but she fails to give any example of this practice and there is not a single reimbursement denial for “unbundling” anywhere in her spreadsheet. She alleges that “Of those lines of service reviewed constituting lack of medical necessity, unbundling was the leading reason for denial, as evidenced by the spreadsheet”. There is no reference to unbundling in the spreadsheet. There is a denial code for “Service not medically reasonable & necessary” but lack of medical necessity and unbundling are two completely different things. It is impossible to know what she is talking about.

Mr. Corcoran’s May 18, 2005 letter that accompanied the TriCenturion Summary does contain specific examples of what he describes as unbundling in his “Second” category of alleged violations of the False Claims Act. His use of the “unbundling” description is incorrect for the reasons set forth in CSS’ attached analysis, but, more to the point, there is nothing inappropriate, let alone false, about the billing patterns that are described. Every code that Dr. Srivastava used accurately describes the procedure that he performed.

Apparently in 2000 when Dr. Srivastava's office used these codes, they were the subject of Medicare Correct Coding Initiative ("CCI") edits. Under these edits, Medicare implemented a system to deny payment for certain combinations of codes but never informed Dr. Srivastava of this prior to the time covered in the TriCenturion sample. He did not receive any guidance until a Local Medical Review Policy bulletin was issued in November 2003. Generally, Dr. Srivastava was not reimbursed for the services that he provided because the Medicare software edits denied him payment, but there was nothing false in his coding description of each service that he performed.

Dividing Patient Procedures Into Separate DOS And Treatment Episodes Instead Of Performing And Billing For All Treatment At One Time

This convoluted allegation by the TriCenturion reviewer is particularly offensive. Dr. Srivastava is known in the medical community at the hospitals where he works as a particularly skilled physician. Dr. Srivastava often immediately proceeds with an angioplasty after a diagnostic cath has revealed the need for one. This saves the patient from having to undergo two separate procedures on two separate occasions. It also saves the payer from paying the significant costs associated with the use of the cath lab on two separate occasions. Many other cardiologists who practice at the hospitals where Dr. Srivastava performs his procedures will do a diagnostic cath one day and an angioplasty on another. Dr. Srivastava will try to perform both at the same time.

In this section of the Summary, the reviewer again conflates issues and makes illogical accusations. She states that this "*practice* is where the greatest

abuse of 93526 manifests itself”. First, it is hard to tell what she means by the *practice*. She never explains it. Then in the same section of the Summary, she revisits 93526 and alleges that “This *billing* practice . . . places an unsuspecting patient population at risk”. How a *billing* practice can put patients at risk is never explained. It appears from Mr. Corcoran’s letter adopting her allegations that Dr. Srivastava’s treatment of Thelma Parker gave rise to the reviewer’s claims.

As both Dr. Rezaee and CSS note, Dr. Srivastava saved Thelma Parker’s life. There is nothing in his treatment of Thelma Parker that Dr. Srivastava would have done differently in hindsight. If the *practice* that the reviewer claims Dr. Srivastava engaged in is manifested by the Thelma Parker case then more cardiologists ought to adopt that practice. The TriCenturion reviewer’s allegation that Dr. Srivastava purposely chose to perform procedures on five different dates of service for a 76 year old woman when he should have performed them all on the first day is reckless. Every procedure that Dr. Srivastava performed for Thelma Parker was based upon the clinical indications at the time it was performed, and Ms. Parker’s clinical condition changed significantly over the span of Dr. Srivastava’s treatment. Dr. Rezaee’s opinion about Dr. Srivastava’s handling of the Thelma Parker case is attached.

#### Interventions Into Branch Vessels

The TriCenturion’s reviewer’s allegations are not clear but the issue seems to be whether Dr. Srivastava’s billing claims were false when he billed for multiple catheterizations and stent placements in branch vessels of a parent vessel. It

should be noted that Dr. Srivastava's office followed the CPT code instructions and used CPT code 92980 ("Transcatheter placement of intracoronary stent(s) . . . single vessel") for the first stent placement and CPT code 92981 ("each additional vessel") for stent placements in additional vessels. Reimbursement is reduced for CPT code 92981.

When Dr. Srivastava inserted a catheter and placed a stent in a branch vessel of a coronary artery and then used another catheter to place another stent into another branch vessel of the same coronary artery, his office billed for both interventions although it used the reduced reimbursement CPT code 92981 for the second and subsequent stent placements. The TriCenturion reviewer apparently took exception to this in reliance on a Local Medical Review Policy ("LMRP") issued by Trailblazers, the Medicare carrier for Dr. Srivastava's region. LMRPs are issued periodically by Medicare carriers for different regions of the country. They, along with Correct Coding Initiative edits, are additional guidance to the CPT code itself that providers must master and coordinate in order to satisfy Medicare's ever changing reimbursement regime. Although not fully set forth and misstated in the TriCenturion Summary, the pertinent language from the LMRP is as follows:

When a single interventional modality is utilized in more than one of these three vessels [the three coronary arteries], the first vessel is to be identified using the respective 'single vessel' code. Each additional major coronary instrumented is to be identified using the 'each additional vessel' code. Branch vessels are considered an integral part of and included with intervention in the named parent vessel.

An issue presented by this language is whether the placement of three stents in three branch vessels of one coronary artery by the use of three separate

catheterizations through the artery should be billed under a single use of CPT code 92980, or one use of that code and two uses of the “additional vessel” lower reimbursement CPT code 92981. The language “Branch vessels are considered part of and included with intervention in the named parent vessel” does not mean that a provider cannot bill for each intervention into a branch vessel where that intervention coincides with a separate intervention through the parent. When Dr. Srivastava placed stents in two or three branches of a parent vessel, he intervened anew through the parent vessel for each such placement. Stents cannot be placed in multiple branches by inserting a catheter only once into the parent vessel and using that single catheter to do the work for all three placements. There is a separate catheter intervention into the parent vessel each time that a stent is placed in a branch vessel.

This is unlike the use of an angioplasty balloon to repair multiple branch lesions after a single intervention into the parent artery. In that circumstance, the language of the LMRP might be construed to prohibit multiple billing for the use of one balloon on one catheter during one parent vessel intervention to repair multiple lesions. But the plain meaning of the language does not prohibit billing for each intervention into a parent vessel even if those interventions are for stent placements in multiple branches of that single parent vessel. Dr. Srivastava’s billing was also consistent with the CPT code’s admonition to use 92981 for “additional vessels”. Branch vessels *are* additional vessels. Dr. Srivastava’s billing

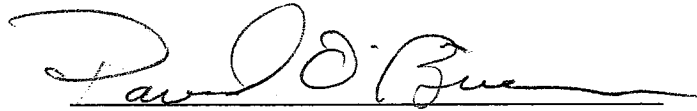
for stent placement in multiple branch vessels was not false, nor was it frequent. Its incidence in the TriCenturion sample is very low.

Finally, it is worth noting that Medicare reimburses hospitals for each stent used and for the cath lab time that it takes for separate branch placement regardless of whether those branches are part of a single parent vessel.

Conclusion

Dr. Srivastava did not submit false claims for reimbursement and the allegations contained in the TriCenturion Summary are incorrect.

Respectfully submitted,



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