Teaching Physician
Compliance
ALERT
May 2015 Issue 101

Can an MD use documentation by an APRN or PA for billing?

Advanced practice registered nurses (APRNs) and physician assistants (PAs) work collaboratively with physicians throughout our practice in office, hospital outpatient, and hospital inpatient settings. It is important that physicians document their work with APRNs and PAs correctly for billing. In order to meet "shared visit" rules, the physician must include a personal note recording all services he/she provided to the patient on the date of service in order to bill under the physician's name. Physicians may not add an attestation as they would when working with a resident or fellow.

This is because APRNs and PAs are independent billing providers. They can be credentialed and bill independently for all services they provide. If a physician wishes to bill under the shared visit rules, **the physician's documentation must support that he/she provided a substantive portion of the service.**

Remember also that physicians may not use the documentation of an APRN or PA to determine the level of visit to bill unless the APRN or PA is employed or leased and credentialed by Yale Medical Group (YMG). We have been working to ensure that all APRNs and PAs who you work with are properly covered under the Shared Services Agreement with Yale New Haven Hospital.

Shared visit rules do not apply to procedures or testing. If an APRN or PA performs and documents a procedure or a test, the APRN/PA must bill under his/her own billing number. Please contact the Compliance Department at 203-785-3868 if your department would like additional educational literature or training in this area.

Reminders and recommendations based on chart audit reviews

As many of you know, the Compliance Department routinely audits charts from throughout YMG. Based on recent experience, here are some common issues that come up:

- When bringing forward the History of Present Illness from a prior visit, please remember to update the information with data relevant to today's visit.
- Physicians must add a complete note describing in detail the services provided to a patient when working collaboratively with an APRN or PA.
- Physicians must append the modifier GC to the charge when working collaboratively with a GME resident or fellow.
- Physicians must include a personalized statement when working with a GME resident that supports that they saw and evaluated the patient, and that describes their role in the plan. The note must be personalized for each patient. It's okay to start from a template, but the note has to be personalized to the patient.
- If billing E&Ms by time, the provider must document the time spent counseling and coordinating care, and the total time of the visit. The only time that can be counted is the billing practitioner's face-to-face time with the patient.
- Do not copy or forward documentation from another practitioner's note without proper attribution.
- Please bill using medically relevant diagnosis codes for your services as well as for orders for diagnostic testing.
- Bill using the actual date of service if you are documenting your note the next day. The date of service can be noted in Epic even for notes written later.
- Remember to include the time in your note for such time-based codes as critical care and hospital discharge codes.
- Document the critical care intervention when billing critical care.
- Individuals not employed or leased by YMG can document the patient's vitals; review of systems; and past, family, and social history. It must be evident that the MD reviewed these components to consider them in the level of E&M to bill.

Complete your requirement with specialty-specific training

Thirty-nine percent of faculty members have completed their annual medical billing training requirement as of April 2015. The due date for the requirement is December 31. The Compliance Department can provide specialty-specific training seminars, and we encourage all departments to consider this option, because it is the most personalized. For information on specialty-specific training sessions, please contact Judy Guay, Director, Medical Billing Compliance, at 203-785-3868.

General audience seminars are currently scheduled in The Anlyan Center, Room N207, from 5-6 p.m., on the following dates: Oct. 21, Nov. 4 and 18, Dec. 4 and 18.

Seminars are sometimes canceled due to low registration, therefore, please register in advance by contacting Debbie Lyman at 203-785-3438 or by e-mail at deborah.lyman@yale.edu.

You can complete training through a seminar or online module if you are an advanced practice registered nurse, certified nurse midwife, certified nurse specialist, certified registered nurse anesthetist, clinical psychologist, licensed clinical social worker, physician assistant, registered dietitian, or speech pathologist. Register online at http://comply.yale.edu/about/app/index.aspx. Faculty can complete their annual online training (The Teaching Physician Tutorial) at http://learn.med.yale.edu/cms/caslogin.asp.

Fraud and abuse control program recovered $3.3 billion in 2014

More than $27.8 billion has been returned to the Medicare Trust Fund since the Health Care Fraud and Abuse Control Program was launched in 1997, announced U.S. Attorney General Eric Holder and Department of

Health and Human Services Secretary Sylvia M. Burwell in March.

"The government's health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in fiscal year 2014 alone from individuals and companies that attempted to defraud federal health programs, including programs that serve seniors, persons with disabilities, and those with low incomes. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered $7.70.

Medicare Fraud Strike Force Teams harness data analytics and the combined resources of federal, state, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. "Since its inception, Strike Force prosecutors filed more than 963 cases charging more than 2,097 defendants who collectively billed the Medicare program more than $6.5 billion; 1,443 defendants pleaded guilty and 191 others were convicted in jury trials; and 1,197 defendants were sentenced to imprisonment for an average term of approximately 47 months. Through the Strike Force and other efforts, in fiscal year 2014 alone, the Justice Department opened 924 new criminal health care fraud investigations. Federal prosecutors filed criminal charges in 496 cases involving 805 defendants. A total of 734 defendants were convicted of health care fraud related crimes during the year." The full report can be viewed at http://oig.hhs.gov/reports-and-publications/hcfac/index.asp.

In the News

Dentist pleads guilty to health care fraud

Mehran Zamani, DDS, pled guilty in federal court in Hartford to a federal health care fraud offense that was part of a multimillion dollar Medicaid fraud scheme. As a result of this fraud, the Connecticut Medicaid program improperly reimbursed the dental practice nearly $21 million.

In the fall of 2008, Gary Anusavice hired Zamani to work as a dentist at Landmark Dental, a dental practice in West Haven that Anusavice had opened earlier in the year. At the time, Anusavice was a convicted felon, and former dentist who had been excluded from Medicaid. Although Anusavice remained the primary decision maker for the business, Zamani became the dentist whose name and license were used as the front for the practice.

In or around January 2009, Zamani applied for his own Medicaid provider number for Landmark Dental. His application for the provider number failed to disclose that Anusavice had an ownership interest in Landmark Dental. Even though Zamani was aware of Anusavice's disciplinary history, Zamani subsequently signed Medicaid provider applications for two other dental practices operated by Anusavice, Dental Group of Stamford and Dental Group of Connecticut in Trumbull. Both applications also failed to disclose Anusavice's background and involvement in the practices.

In March 2015, Zamani signed a settlement agreement; he agreed to pay $200,000, forfeit a dental office he owned at 18 Madison Street in Hartford, and give up all rights to approximately $1.9 million in Medicaid dollars that had been suspended by the Connecticut Department of Social Services. Zamani also agreed to be excluded from all federal healthcare programs for a period of 10 years.

Anusavice was sentenced to 97 months of imprisonment and ordered to pay restitution of more than $5.2 million, in addition to back taxes of more than $1.8 million, plus applicable interest and penalties. He also forfeited his Rhode Island residence, a 33-foot yacht, a Mercedes-Benz automobile, and approximately $91,700 in cash. Anusavice will pay the state $9.9 million, which represents treble damages under the Connecticut False Claims Act and restitution under the Connecticut Unfair Trade Practices Act.

Physician pleads guilty in $13 million no-show MD scheme

Okon Umana, MD, of West Haven, pled guilty to conspiracy charges that he was a no-show medical director of a clinic that fraudulently billed Medicare and Medicaid more than $13 million. The clinic, Cropsey Medical Care LLC, was located in Brooklyn, New York. Umana was charged with allowing the clinic to use his name and provider number to bill for medically unnecessary or non-existent physical therapy, diagnostic tests, and other services provided by a physician assistant acting without supervision. Umana faces a maximum penalty of five years in prison, a fine of more than $250,000, restitution of up to $6.4 million, and forfeiture of nearly $6.6 million.

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Compliance Programs—Preventive Medicine for Healthcare Providers

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If you have concerns about medical billing compliance that you are unable to report to your supervisor or to the Compliance Officer, please call the hotline number above.

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