Teaching Physician
Compliance
ALERT
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Reminder - The University Has a Gift Policy

Yale University policy places restrictions on the use of University assets to make gifts to individuals or other organizations. Policy 3303.1 allows modest occasional gifts to be made to students, employees or immediate family members in expression of sympathy, and to employees for professional achievement in a limited number of situations. Exceptions to this policy can only be approved by an Officer of the Corporation or authorized designee.

In addition to the University policy, the Anti-Kickback Statute, 42 USC 1320a-7b prohibits the offer or receipt of certain remuneration in return for referrals or for recommending the purchase of supplies and services reimbursable under federally-funded health care programs. Thus, the offer of gifts in return for referrals may not be made from University funds, and violates the Anti-Kickback Statute. Remuneration is basically anything of value. Violations of the Anti-Kickback Statute can result in prison sentences and fines and penalties of up to $50,000 per kickback plus three times the amount of the remuneration.The University gift policy can be found at http://www.yale.edu/ppdev/policy/3303/3303.pdf

Timed Entries in the Medical Record – Correction

In May 2007, an article in the Alert was published stating that all inpatient medical record documentation notes must be legible, dated, timed, and authenticated in written or electronic form by the person responsible for providing the service. This requirement also applies to medical record notes documented for outpatient hospital services. Outpatient hospital services are services provided in space that the University does not own or lease.

Hospital Discharge Day Management Codes

CPT codes 99238 and 99239 are time-based codes used to report the physician's total duration of time preparing for the patient's final hospital discharge. The services under these CPT codes are:

- final examination of the patient
- "discussion of the hospital stay" which may be performed with the patient and/or family
- instructions for continuing care to all relevant caregivers, and
- preparation of discharge records, prescriptions, and referral forms

The preparation of discharge records would include a summary of events that occurred during the hospital stay. CPT code 99238 is for "30 minutes or less," and 99239 is for "more than 30 minutes." The time spent by the physician performing the above activities should be documented in the medical record. Physicians working in collaboration with a resident must be present for the entire period for which the claim is made.

Scribe Requirements

The Joint Commission has published their position on the use of scribes and the key points from the Q & A follow:

Q. What is a scribe and how are they used?

A. A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or licensed independent practitioner (LIP). It is the Joint Commission's stand that the scribe does not and may not act independently but documents the physician's or LIP's dictation and/or activities.

Q. Do the Joint Commission's standards allow organizations to utilize scribes?

A. The Joint Commission neither endorses nor prohibits the use of scribes. However, if one chooses to allow the use of scribes, some of the controls the surveyors will expect to see include:

- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities
- Orientation and training specific to the organization and role
- Competency assessment and performance evaluations

Both the scribe and physician/LIP must sign, date and time the note. The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or LIP.

- Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry.

Q. If the unlicensed scribe enters orders into the medical record, are they considered verbal orders?

A. No. If the scribe enters orders into the medical record, they are not considered verbal orders. Verbal orders can never be given by scribes, nor given to scribes.

For more information on the use of scribes, please see the September 2010 issue of Alert.

"Physical Exam" for E&M Services Revised

For dates of service effective August 1, 2011, when selecting the level of "Physical Exam" by using the 1995 Evaluation & Management (E&M) guidelines, the following numerical qualifiers should be used. These guidelines were recently published by our Connecticut Medicare contractor, National Government Services (NGS), who will use them when conducting reviews of E&M services. The changes are:

Expanded Problem Focused Exam (EPF) Exam:

From: 2 -4 To: 2 -5
body areas and/or organ systems

Detailed Exam:

From: 5 -7 To: 6 -7
body areas and/or organ systems

ICD-10-CM Update

The US Department of Health and Human Services (HHS) has mandated the replacement of the International Classification of Diseases ICD-9-CM code sets to report health care diagnoses with ICD-10-CM code sets by October 1, 2013. This article explains why this change is necessary and how ICD-10-CM is different from ICD-9-CM. Future articles in the Alert newsletter will focus on how our practice will implement the new code set.

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Ann Marie DeMaio, LPN, CPC New Compliance Auditor

Please welcome Ann Marie DeMaio, LPN, CPC, who joins the Compliance Department as the newest Compliance Auditor. Ann Marie's focus will be auditing the departments of Diagnostic Radiology, Laboratory Medicine, Pathology, Therapeutic Radiology, and Psychiatry. Ann Marie was employed at Health Net for approximately 16 years as Medical Claims Review Nurse.

She can be reached at (203) 737-5536 or via email at annmarie.demaio@yale.edu.

CMS Proposes to Rescind Lab Requisition Signature Requirement

CMS is proposing to rescind a new requirement that the ordering physician or qualified non-physician practitioner (NPP) sign requisitions for all clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). The requirement for signatures on lab requisitions was mainly an effort on the part of CMS to continue to reduce fraud and improper payments. Opponents raised concerns that the signature requirement would impose unnecessary burdens and could result in delayed services and patient harm.

CMS recognized that it underestimated the effects of the signature requirement and proposed to reinstate the prior policy that the signature of the physician or NPP is not required on a requisition for a clinical diagnostic laboratory test paid under the CLFS for Medicare purposes.

CMS goes on to say that this proposed rule does not preclude an individual laboratory from requiring a physician's or NPP's signature on the requisition. A lab may develop its own compliance procedures to ensure that it only furnishes services in response to a physician or NPP order.

The proposed rule with a comment period was published in the June 30 Federal Register: http://www.gpo.gov/fdsys/pkg/FR-2011-06-30/pdf/2011-16366.pdf

ICD-10-CM Update

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The ICD-9-CM code set is 30 years old and has outdated and obsolete codes that produce inaccurate and limited data. ICD-10 implementation will radically change the way coding is currently done and will require a significant effort for Yale Medical Group (YMG) to implement.

The number of diagnosis codes will increase from 17,000 codes in ICD-9 to 68,000 codes in ICD-10-CM codes. The ICD-9 codes are mostly 3-5 digit numeric codes, whereas ICD-10 codes are 3-7 alphanumeric digits. There is no one-to-one match between ICD-9-CM and ICD-10-CM. There may be multiple ICD-9-CM codes for a single ICD-10 code, and there may be multiple ICD-10 codes for a singe ICD-9-CM code. CMS created the national version of the General Equivalence Mappings (GEMS) to ensure that consistency in national data is maintained.

Some of the major modifications include:

- requiring the identification of laterality (right vs. left designations, bilateral)
- restructuring the reporting of obstetric diagnoses
- revising diabetes mellitus codes
- adding code extensions for injuries and grouping them by anatomical sites vs. type of injury, and
- expanding codes for postoperative complications

The following is an example of how ICD-10-CM increases specificity:

Diagnosis – Hematuria (blood in urine)

- ICD-9-CM : 599.7 – Hematuria
- ICD-10-CM: R31.0 – Gross hematuria

R31.1 – Benign essential microscopic hematuria

R31.2 – Other microscopic hematuria

R31.9 – Hematuria, unspecified

Fully implementing this major code change will require significant education and training for coders, billers, auditors, practice managers, administrators, physicians, non-physician practitioners, and other health care personnel. Medical record documentation will become critical, as it needs to support the new level of specificity in ICD-10. Improvement in clinical documentation may be required. The ICD-10-CM codes are available at no charge on the CMS website at www.cms.hhs.gov/ICD-10

In the News

Dr. Mark W. Izard, a physician who specialized in nephrology and treatment of kidney disorders, has agreed to pay $2.2 million to settle allegations that he violated the False Claims Act. Dr. Izard allegedly provided services at various nursing homes in the Hartford area when the patients had been transferred to local hospitals for treatment.

He was also accused of billing Medicare and Medicaid for services provided by hospital Advanced Practice Registered Nurses (APRNs) or Hartford Hospital medical residents. Dr. Izard will also be excluded from Medicare, Medicaid, and all other federal health care programs for seven years.

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