TEACHING PHYSICIAN COMPLIANCE

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Medical Billing Compliance Hotline 1-800-351-2831

ALERT

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To Bill or Not to Bill Hospital Discharge Codes

The hospital discharge codes (99238-99239) can be billed in place of the subsequent visit codes (99231-99233) if you have provided and documented the following services as appropriate:

- final exam of the patient
- discussion of the hospital stay
- instructions for continuing care to all relevant caregivers
- preparation of discharge records, prescriptions and referral forms.

The hospital discharge codes are time based codes. They are used to report the total duration of time spent by a physician for a final hospital discharge of a patient. Since the codes are time-based, the amount of time spent should be documented in the medical record note. CPT code 99238 is for discharges services, 30 minutes or less and 99239 is for more than 30 minutes. The discharge codes are generally reimbursed at a higher rate than the subsequent hospital visit codes since the services require additional time.

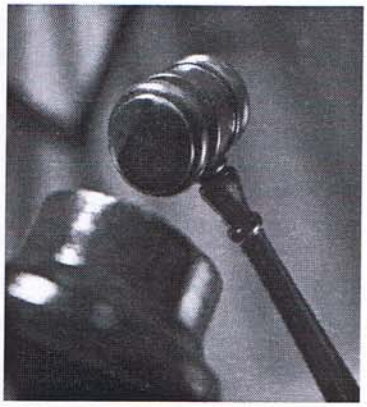
Chemo Demo Bombs

On January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) initiated a 1-year Medicare "Demonstration of Improved Quality of Care for Cancer Patients Undergoing Chemotherapy." According to CMS, the purpose of the demonstration was to " . . . assess and provide new support for the quality of care for cancer patients undergoing chemotherapy. . . . " CMS provided a $130 allowance each time a chemotherapy practitioner reported to Medicare, via the claims system, an assessment of a patient's levels of nausea and vomiting, pain, and fatigue—three conditions commonly experienced as symptoms of cancer or side effects of cancer treatment. The Office of the Inspector General conducted an audit of the demonstration project and identified several deficiencies including:

- Approximately 3 percent of demonstration payments were for services that did not meet program rules.
- Seven percent of the demonstration claims did not comply with program rules or were paid incorrectly resulting in a $17 million dollar overpayment.
- Participants administered the demonstration assessments inconsistently
- CMS was not collecting information on the interventions used to manage patients' symptoms.
- The demonstration allowance was disproportionate to the amount of effort involved on the part of the practitioners and that assessing these symptoms was already part of routine cancer care.

At the root of the problem was that CMS did not sufficiently define the parameters of the demonstration leading to inconsistent data collection and incomplete and unreliable data. The demonstration project is expected to spend approximately $275 million dollars and patients' will be liable for approximately $55 million dollars for the co-pay amount. That's quite a high price tag for American taxpayers for a study that is unreliable and unusable.

It's the Law!



Our practice is currently undergoing routine Medicaid audits of our documentation and billing. We are finding that our practice continues to have a problem when it comes to signing medical record documentation. Medical record entries require the provider's signature as specified in the Regulations of Connecticut State Agencies section 19a-14-40. Medical record entries that are not signed are considered non-documented services and cannot be billed.

Unsigned notes equal overpayments or no payments for your services.

Your signature must be evident for each entry in the medical record. In order to use an electronic signature, the physician must have a unique code that directs the computer to electronically generate the signature. Signature stamps should not be used. "Dictated but not read" does not count as a signature. It is not acceptable for anyone to sign someone else's name to a medical record document. The provider who furnishes the service must sign for the service. If billing for the services of ancillary personnel, the supervising physician must co-sign the ancillary personnel's note. Please contact the Compliance Department at 785-3868 if you have any questions regarding signature requirements.

OIG Outlines Standards For State False Claims Acts

Under section 1909 of the Social Security Act (the Act), 42 U.S.C. 1396h, the Inspector General (OIG) of the Department of Health and Human Services is required to determine, in consultation with the Attorney General, whether a State has in effect a law relating to false or fraudulent claims submitted to a State Medicaid program that meets certain enumerated requirements. If the Inspector General determines that a State law meets these requirements, the State medical assistance percentage, with respect to any amounts recovered under a State action brought under such a law, shall be increased by 10 percentage points. More states may soon pass false claims acts that provide for whistleblower protections, reward whistleblowers, and don't require proof of intent to defraud for prosecution to proceed.

In Connecticut, Senate Bill No. 938 "An Act Concerning False Claims" was introduced in the January 2005 session. The last action taken on this was a public hearing on 1/31/05. At this time, there are no plans to reintroduce the bill. More information may be obtained by going to http://oig.hhs.gov/authorities/docs/06/waisgate.pdf

The annual one hour of required medical billing compliance training deadline is December 31, 2006. To check your status, visit the TMS training web site: http://www.yale.edu/training/

In the News

Prison Sentence Imposed on Waterbury Physician

A Waterbury doctor, fifty-seven-year-old Juan Fica, pled guilty in March to conspiracy to commit health care fraud. He has been sentenced to 18 months in federal prison. He admitted that he hired an aide, Elie Nakouzi, who was not a licensed doctor, and billed insurance companies, Medicare and Medicaid for work Nakouzi did. Under a plea agreement, federal sentencing guidelines called for Fica to receive between 18 months and 24 months in prison and to pay Medicare and Medicaid and other insurers nearly $156,000.

Tenet Pays $900 Million Dollars

Tenet Healthcare Corporation which owns and operates approximately 70 acute care hospitals entered into a Corporate Integrity Agreement with the Office of the Inspector General in June of 2006. In June 2006, Tenet agreed to pay over $900 million to the United States to resolve its liability under the False Claims Act and related authorities. The allegations included:

- paying kickbacks to physicians
- Diagnosis Related Group (DRG) upcoding,
- improper outlier payments, and other fraudulent activities.

The CIA also includes unprecedented provisions requiring the Quality, Compliance, and Ethics Committee of Tenet's Board of Directors to undertake a review of the effectiveness of Tenet's compliance program and adopt resolutions with respect to this review. Tenet is required to submit annual reports to OIG, which will include certifications by Tenet officers that the company is in compliance with the requirements of the Federal health care programs

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