



Documentation later than 30 days may result in financial take backs



Medicaid has issued a Provider Bulletin 2014-23 that states that medical records must be completed (including authentication by the provider) in as timely a manner as possible but **no later than 30 days** after a billable inpatient or out-patient visit or procedure. Failure to complete the medical record within 30 days may result in a financial adjustment based upon post payment review of claims.

Source: 42 CFR 482(c)(4)(B)(viii), Section 19-13-D3(d)(7) & Section 19-13-D4a(d)(5) Regulations of Connecticut State Agencies

Collaboration agreement for APRNs

The Connecticut State House and Senate recently voted to let nurse practitioners work independently without collaborating with doctors. Governor's Bill 36 states: (3) An advanced practice registered nurse having been issued a license pursuant to section 20-94a and having maintained such license for a period of not less than three years in accordance with the provisions of subdivision (2) of this subsection may thereafter, alone or in collaboration with a physician or another health care provider licensed to practice in this state: (A) Perform the acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section; and (B) prescribe, dispense and administer medical therapeutics and corrective measures and dispense drugs in the form of professional samples as described in subdivision (2) of this subsection in all settings. The bill passed April 28.

APRNs are still required to follow the collaboration requirements that were previously in effect for the first three years after they are issued a license. For a checklist of what is required to be in the APRN collaboration agreement, please contact Judy Guay at 785-3868 or judy.guay@yale.edu

Source: Hartford Courant

CMS releases Medicare physician payment data

In an effort to combat health care fraud, the Center for Medicare and Medicaid Services (CMS) released the payment amounts made to hundreds of thousands of doctors and medical facilities in 2012. In Connecticut, more than \$1 billion was billed to Medicare Part B, which excludes payments to hospitals and other institutions. The top biller in Connecticut was Quest Laboratory in Wallingford, which billed \$24.5 million to provide services to nearly 160,000 patients. The doctor with the most billings was Hamden ophthalmologist Nauman Chaudhry, M.D., who received more than \$5 million from Medicare. Nine of the 10 top Connecticut doctors were ophthalmologists. Nationally, the doctor who received the most money from Medicare was a Florida ophthalmologist who received \$21 million.

CMS officials said they released the data despite opposition from the American Medical Association (AMA) and many other organizations in the hope that reporters and lawyers will help them ferret out fraud.

Last year, James Ralabate, a Stratford-based general practitioner, agreed to pay back \$700,000 to settle Department of Justice allegations that he had billed for providing nursing home visits to patients who had been transferred to a hospital. Richard Sokoloff, M.D., a Guilford podiatrist, pled guilty to charges of billing Medicare for the removal of ingrown toenails that he did not perform.

Source: Record Journal

Yale Medical Group Hotline

Yale Medical Group implemented a confidential hotline in October 1998 as part of its commitment to medical billing compliance. The toll-free number is 1-877-360-YALE, and it's available to Yale employees 24/7.

- Calls are answered by a third-party vendor, not by a Yale employee.
- Callers may provide their name and contact information, or choose to remain anonymous.
- To ensure confidentiality, calls are not recorded or traced.

The hotline is a simple way for employees to report potential violations of medical billing regulations. All employees, both faculty and staff, may use the hotline. This includes all employees in the clinical departments, Patient Financial Services, and off-site practice locations.

The hotline is an avenue of reporting for employees who:

- Do not feel comfortable bringing concerns to their supervisor
- Have brought their concerns to their supervisor and were not satisfied with the action or lack of action taken.

Examples of medical billing compliance issues may include recurring or intentional situations involving:

- Billing patients for amounts that they are not responsible for
- Identifying a system problem that may result in incorrect bills
- Improper allocation of credit balances
- Billing for services under the wrong patient's account
- Billing for a service that is not documented
- Medical record cloning
- Up-coding or billing for a procedure using an incorrect procedure or diagnosis code
- Services intentionally billed under the wrong physician

Any employee who brings an issue to the university's attention through the hotline or otherwise should be aware that university policy prohibits retaliation against employees who report possible compliance issues in good faith. You can learn more about the hotline at: <http://www.yale.edu/resources/faq.html>.

OIG 2014 Work Plan

The 2014 Office of Inspector General (OIG) Work Plan has been released by the U.S. Department of Health and Human Services (HHS). Items of interest to physicians include:

Anesthesia services: The OIG will review Medicare Part B claims for personally performed (Modifier AA) anesthesia services to determine whether Medicare payments for anesthesiologist services were personally performed. Services provided by CRNAs or

residents under medical direction only are billed with Modifier QK, which limits payment to 50 percent of the Medicare-allowed amount for personally performed services.

Diagnostic radiology: The OIG will review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which utilization has increased for these tests.

Electrodiagnostic testing: The OIG will review Medicare claims data to identify questionable billing for electro-diagnostic testing and determine the extent to which Medicare utilization rates differ by provider specialty, diagnosis, and geographic area for these services.

Evaluation and management services: The OIG will review multiple E/M services associated with the same providers and patients to determine the extent to which electronic or paper medical records had documentation vulnerabilities. Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

Imaging services: The OIG will review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, the OIG will focus on the practice expense components, including the equipment utilization rate.

Laboratory tests: The OIG will review billing characteristics for Part B clinical laboratory (lab) tests and identify questionable billing. Medicare is the largest payer of clinical lab services in the nation. Medicare's payments for lab services in 2008 represented an increase of 92 percent over payments in 1998. In 2010, Medicare paid about \$8.2 billion for lab tests, accounting for three percent of all Medicare Part B payments. Much of the growth in lab spending has resulted from the increased volume of ordered services.

Ophthalmologists: The OIG will review Medicare claims data to identify inappropriate payments and/or questionable billing for ophthalmological services during 2012. The OIG will also determine the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2012.

IN THE NEWS

Trumbull anesthesiologist fined \$7,500

A Trumbull anesthesiologist who mistakenly administered a fatal dose of Lidocaine to a patient during surgery in May 2013 was reprimanded and fined \$7,500 Tuesday by the state Medical Examining Board.

Sandra Congdon, M.D., made the mistake while the patient was undergoing surgery at the Surgery Center of Fairfield County in Trumbull, according to State Department of Public Health records. When the patient's blood pressure dropped during the procedure, Congdon inadvertently administered the anesthetic Lidocaine instead of Hespan, which is used to expand blood plasma when a patient goes into shock.

The patient showed no pulse and received cardiac life support before being transferred to the emergency department at St. Vincent's Medical Center in Bridgeport. The patient died, and a medical examiner ruled the cause of death was acute Lidocaine toxicity.

Duke agrees to pay \$1 million for alleged false claims submitted to federal health care programs

Duke University Health System, Inc. has agreed to pay \$1 million to resolve allegations under the U.S. and North Carolina False Claims Acts that it made false claims in conjunction with certain services provided to beneficiaries of federal health care programs (Medicare, Medicaid, and TRICARE).

Duke allegedly made false claims to Medicare, Medicaid, and TRICARE by:

1. Billing the government for services provided by physician assistants (PAs) during coronary artery bypass surgeries when the PAs were acting as surgical assistants (along with graduate medical trainees), which is not allowed under government regulations
2. Increasing billing by unbundling claims when the unbundling was not appropriate, specifically in connection with cardiac and anesthesia services.

The allegations resolved by this settlement arose from a whistleblower lawsuit filed under the False Claims Act by Leslie Johnson, a former employee of Duke PRMO, LLC d/b/a Patient Revenue Management Organization. Duke PRMO is controlled by Duke University Hospital System, and provides billing, collection, and administrative services to Duke University Health System.

Ridgefield osteopath arrested

David Lester Johnson, D.O., was arrested on federal health care fraud charges stemming from an indictment charging him with 14 counts of health care fraud and 14 counts of making false statements relating to health care matters.

Johnston, who owns and operates Osteopathic Wellness Center, LLC, 158 Danbury Road, Ridgefield, is alleged to have engaged in a scheme to defraud Medicare and several private health insurance companies by billing for osteopathic and physical therapy services that he did not perform, and by misrepresenting the nature of the services that were performed.

If convicted, Johnston faces a maximum term of imprisonment of 10 years and a fine of up to \$250,000 on each of the health care fraud counts. He faces a maximum term of imprisonment of five years and a fine of \$250,000 on the false statements counts.

UCLA pays surgeon \$10 million in whistleblower-retaliation case

University of California regents agreed to pay \$10 million to the former chairman of UCLA's orthopedic surgery department, who had alleged that the medical school allowed doctors to take industry payments that may have compromised patient care.

In 2012, the surgeon sued UCLA, the UC regents, fellow surgeons, and senior university officials, alleging they failed to act on his complaints about widespread conflicts of interest and later retaliated against him for speaking up.

As department chairman, Robert Pedowitz, M.D., testified he became concerned about colleagues who had financial ties to medical-device makers or other companies that could unduly influence their care of patients or taint important medical research.

He also alleged that UCLA looked the other way because the university stood to benefit financially from the success of medical products or drugs developed by its doctors.

One of the orthopedic surgeons that Pedowitz complained about testified at trial about receiving \$250,000 in consulting fees in 2008 from device-maker Medtronic. In memos to university officials, Pedowitz raised concerns about the financial dealings of other doctors as well.

Source: LA Times



Compliance Programs—Preventative Medicine
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