Teaching Physician
Compliance
ALERT
January 2015 Issue 99

Scribing medical record documentation

The following article is reprinted from a National Government Service (NGS) Policy Education Topics publication. NGS is the Medicare contractor for Yale Medical Group.

National Government Services recognizes an increasing trend in providers' use of scribes as assistants in medical record documentation. In these situations, a provider utilizes the services of staff to document work performed by the provider, in either an office or a facility setting.

In documenting any patient encounter, the scribe neither acts independently nor functions as a clinician, but simply records the provider's dictated notes during the visit. The provider who receives the payment for the service is expected to deliver the service and is responsible for the medical record; the scribe may simply enter information on the provider's behalf, all of which must be corroborated (i.e. approved) by the provider.

Some electronic medical record programs allow the provider to amend the scribe's entry before the provider signs and enters the note into the record; this is permissible. When a scribe enters on a paper medical record and correction is needed, the provider must add and sign an addendum to the scribe's note, rather than cross out or alter what the scribe has written.

During a patient encounter, the scribe may additionally perform standard medical assistant functions, as long as the scribe remains available to the provider and free to document the provider's verbal observations in real time. The act of scribing is intended to take place as the provider dictates his/her notes regarding the patient's history, exam and plan of care. The scribe is not permitted to record any independent notes, but only those specifically dictated by the provider.

Physicians using the services of a "scribe" must adhere to the following:

- Physician co-signs the note indicating the note is an accurate record of both his/her words and actions during that visit.
- Record entry notes the name of the person "acting as a scribe for Dr. _____."
- Documentation supports both the medical necessity of the level of service billed and the level of the key components required of the service. See Related Content for E&M guidelines.

In the office setting, a staff member may independently record the past, family and social history (PFSH) and the review of systems (ROS), and may act as the provider's scribe, by simply documenting the provider's words and activities during the visit. The provider may count that work toward the final level of service billed. However, the provider must document that he/she reviewed this information. In the same setting, an NPP accomplishing the entire visit should report those services under his or her own PTAN, unless "incident to" guidelines have been met (see Related Content for CMS IOM publication). Only when the "incident to" guidelines have been met, should the physician's name and NPI be used to bill Medicare for that service.

In a facility setting (hospital or skilled nursing home), when a NPP independently performs and documents an E&M service, the NPP is not functioning as a scribe, even if the documentation is later reviewed and/or co-signed by a physician. The service does not qualify as a split/shared visit, since the NPP performed the full service. "Incident to" concepts do not apply in the inpatient setting, and work performed exclusively by a NPP should be billed under the NPP's name and NPI.

Scribe usage may be appropriate and included in a Medicare provider's practice, when properly administered and documented. The Medicare provider must assume full responsibility for the performance, documentation, coding and billing of any scribed service.

Expanded CMS guidelines target billing for multiple procedures on a single patient, on the same day

The Center for Medicare and Medicaid Services (CMS) has established specific guidelines to ensure that providers are compensated properly when they perform multiple procedures on a single patient on the same day. The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together, either in all situations or in most situations.

For example, a bone marrow aspiration and biopsy are not typically payable on the same date of service for the same patient. However, if a patient has a bone marrow aspiration of the right posterior crest (38220) and a bone marrow biopsy of the left posterior crest (38221) during the same encounter, modifier 59 would be appropriate to indicate a separate distinct body structure.

The *CPT Manual* defines modifier 59 as follows:

"**Distinct Procedural Service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Effective this month, CMS has established four new modifiers to define subsets of modifier 59 as follows:

- XE Separate Encounter: a service that is distinct because it occurred during a separate encounter
- XS Separate Structure: a service that is distinct because it was performed on a separate organ/structure
- XP Separate Practitioner: a service that is distinct because it was performed by a different practitioner

- XU Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service

The new modifiers were established due to the high rate of incorrect usage of modifier 59. CMS hopes the new modifiers will help practitioners understand when use of the modifiers is appropriate.

Medicare and all of Yale Medical Group's major commercial carriers will accept/recognize the new modifiers on January 1, 2015. Therefore, practitioners should be using the new modifiers now. On or around January 20, billing staff will start to see Claim Scrubber edits on charges billed with modifier 59 that say: "Per CMS and AMA CPT, Modifier 59 should not be used when a more descriptive modifier is available, such as XE, XP, XS, and XU." The billing staff will be contacting practitioners to find out which new modifier should be used (XE, XP, XS or XU).

Preoperative testing: Do you know what is included?

Medicare covers the use of diagnostic testing as part of a preoperative examination when there is documentation of a diagnosis, or sign(s), or symptom(s) that indicate a medically necessary reason for the test. The existence of policies or protocols in hospitals or other providers requiring the routine use of these tests in and of themselves does not justify coverage.

Certain diagnostic tests often performed routinely prior to surgical procedures that do **not** meet the definition of reasonable and necessary include:

- Electrocardiograms performed preoperatively, when there are no indications for this test
- Radiologic examination of the chest performed preoperatively when there are no indications for this test
- Partial thromboplastin time (PTT) performed prior to medical intervention when there are no signs or symptoms of bleeding or thrombotic abnormality, or a personal history of bleeding; thrombosis conditions associated with coagulopathy
- Prothrombin Time (PT) performed prior to medical intervention when there are no signs or symptoms of bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis conditions associated with coagulopathy
- Serum iron studies performed as a preoperative test when there is no indication of anemia or recent autologous blood collections prior to surgery

Claims submitted for these tests performed solely as part of a preoperative examination **without additional diagnoses indicating medical necessity** will be denied as not reasonable and necessary.

Additionally, in regards to lipid profile/cholesterol tests, (VLDL (83719) and lipoprotein (a) (82172) claims will be denied as not medically necessary, since National Cholesterol Education Program (NCEP) recommendations do not include monitoring of VLDL or apolipoprotein levels for treatment of elevated cholesterol as risk factors for coronary and vascular atherosclerosis.

National clinical trial number instructions released

The Center for Medicare and Medicaid Services (CMS) has issued a FAQ to address questions related to submitting the National Clinical Trial (NCT) number on claim forms. The FAQ can be found at: http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Downloads/Mandatory-Clinical-Trial-Identifier-Number-QsAs.pdf and the Compliance Department website at: http://ycci.yale.edu/comply/insurance/index.aspx

In the News

OIG reviews YNHH claims

In a recent review of claims billed by Yale-New Haven Hospital (YNHH) to Medicare, the Office of Inspector General (OIG) concluded that YNHH complied with Medicare billing requirements in 79 of 192 inpatient and outpatient claims reviewed. The OIG estimated a potential overpayment for the remaining 113 claims of $1,708,552 for the 2010 and 2011 calendar years. Specifically, OIG cited 100 inpatient claims with billing errors that resulted in overpayments of $1,596,312, and 13 outpatient claims with billing errors resulting in overpayments of $112,240.

Some of the issues the OIG noted in its report included:

- Billing services as inpatient stays when they should have been billed either as outpatient or outpatient with observation services
- 20 claims for which YNHH did not adjust its inpatient claim billing to reduce payment after receiving reportable medical device credits from manufacturers for replaced devices.
- Four claims billed to Medicare separately for related discharges and readmissions within the same day
- Billing Medicare for incorrect DRG codes
- Billing Medicare for E&M services that did not meet Medicare requirements

The OIG recommended that YNHH refund the overpayments and strengthen controls to ensure full compliance with Medicare requirements. YNHH responded that it plans to file an appeal for approximately 50 percent of the claimed overpayments.

The entire report can be viewed at: http://oig.hhs.gov/oas/reports/region1/11300502.pdf

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Published by
Yale Medical Group