

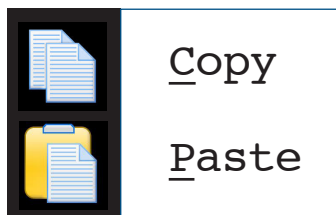


# Teaching Physician Compliance

**ALERT**

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## Fraud vulnerabilities in EHRs



Based on a report issued recently by the Office of the Inspector General (OIG), we can expect to see some guidance issued to practitioners for copy and paste and required audit trails in the electronic medical record. The OIG conducted a survey of the 864 hospitals that received Medicare incentive payments as of March 2012. The questionnaire examined the presence of features and capabilities in Certified Electronic Health Record (EHR) Technology related to RTI-recommended safeguards regarding audit functions, EHR user authorization and access, and EHR data transfer. The OIG also conducted on-site structured interviews with hospital staff and observed a demonstration of the hospitals' Certified EHR Technology in eight hospitals. Finally, the OIG conducted structured surveys with four EHR vendors and asked them the extent to which they had incorporated recommended fraud safeguards into their products.

The OIG's report "NOT ALL RECOMMENDED FRAUD SAFEGUARDS HAVE BEEN IMPLEMENTED IN HOSPITAL EHR TECHNOLOGY" found many safeguards lacking. The OIG recommended that audit logs be operational whenever EHR technology is available for updates or viewing. It also recommended that the Office of the National Coordinator for Health Information Technology (ONC) and the Center for Medicare and Medicaid Services (CMS) strengthen collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs. The OIG also recommended that CMS develop guidance on the use of the copy-paste feature in EHR technology. CMS and ONC concurred with all of the OIG recommendations.

## Practitioners must finalize their notes

A recent communication with Medicaid says that it is not acceptable for physicians, APRNs, or PAs (practitioners) to allow an **administrative assistant** to add words or edit a medical record note after the practitioner has documented the note. Typically, this arrangement has been used by practitioners to send out consultation letters. According to Medicaid, only the absolute, final copy of the letter should be electronically signed by the physician. In other words, the physician should only electronically sign the letter after the administrative assistant adds the final verbiage. That way the letter cannot be modified by the assistant either by accident or design, and the physician is wholly accountable for its final review and content.

While the communication with Medicaid focused on consultation letters, this guidance should be applied to all medical record notes. Please contact the Compliance Office for questions regarding this requirement at (203) 785-3868.

## OIG eyes clinicians with high cumulative payments

According to the OIG, clinicians generating high Medicare Part B payments represent a greater risk to Medicare if they bill incorrectly or commit fraud. The OIG identified 303 clinicians who each furnished more than \$3 million of Part B services during 2009 and 104 (34%) with potential improper payments. As of December 31, 2011, 80 of the 104 clinicians had been reviewed and \$34 million in overpayments was identified. In addition, three of the clinicians had medical licenses suspended and two were indicted.

Based on the results of these reviews, the OIG recommended that CMS:

- (1) Establish a cumulative payment threshold—taking into consideration costs and potential program integrity benefits—above which a clinician's claims would be selected for review; and,
- (2) Implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

OIG's report, Review of Clinicians Associated with High Cumulative Payments (A-01-11000511) can be found at <http://oig.hhs.gov/oas/reports/region1/11100511.pdf>

## Medicare prepayment audits of rhythm ECGs and noninvasive diagnostic tests

National Government Services (NGS), the Connecticut Medicare contractor, will be conducting service-specific prepayment audits on Rhythm ECGs, One to Three Leads; Interpretation and Report Only [current procedural terminology (CPT) code 93042] reported by cardiologists. Medical review data has recently identified a large volume of claims being billed for CPT 93042 reported in an in-patient place of service.

Multiple Noninvasive Diagnostic tests will also be reviewed on a prepayment basis. The CPT codes to be reviewed are as follows:

- 93880 (Duplex Scan of Extracranial Arteries; complete bilateral) or 93882 (Duplex Scan of Extracranial Arteries; limited or unilateral) when reported on the same day as:
  - (i) 93970 (Duplex scan of extremity veins including responses to compression and other maneuvers, complete bilateral study);
  - (ii) 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers, unilateral or limited study);
  - (iii) 93925 (Duplex scan of lower extremity arteries or arterial bypass grafts, complete bilateral study); and/or, 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts, unilateral or limited study)
- 93970 or 93971 when reported on the same day as 93880, 93882, 93925, and/or 93926
- 93925 or 93926 when reported on the same day as 93880, 93882, 93970, and/or 93971

The audits seek to better identify common billing errors, develop educational efforts, and prevent improper payments. Providers will be receiving letters asking for documentation to support the service billed.

## New Compliance Auditor



Nicole Shields, CPC, joined the Yale Medical Group compliance department in September 2013. She formerly worked for the Cardiology Associates of New Haven as the coding and compliance coordinator and has more than twelve years of experience in medical claims management. Nicole also worked as the Coding Compliance Auditor for Middlesex Cardiology Associates. Nicole is responsible for compliance activities in Cardiology, Laboratory Medicine, Ophthalmology, Pathology, Psychiatry, and Therapeutic Radiology. She can be reached at [Nicole.Shields@yale.edu](mailto:Nicole.Shields@yale.edu).

## IN THE NEWS

### Greenwich MD to pay \$300,000 to settle False Claims Act violations

Jun Xu, M.D., and his professional corporation, Rehabilitation Medicine and Acupuncture Center, LLC, of Riverside, CT, have entered into a civil settlement with the government in which they will pay \$300,000 to resolve allegations that Dr. Xu violated the False Claims Act.

The allegations against Dr. Xu involve fraudulent billing to Medicare for physical therapy services. The government alleges that Dr. Xu

submitted claims to Medicare for physical therapy services that were medically unnecessary and/or not performed in accordance with Medicare requirements. Specifically, the government alleges that Dr. Xu billed Medicare for one-on-one physical therapy services when the physical therapist was, in fact, providing group therapy, and that he submitted claims to Medicare for therapy services that were rendered by massage therapists.

Medicare regulations explicitly state that “the services of massage therapists may not be billed as therapy services.”

To resolve their liability under the False Claims Act, Dr. Xu and his professional corporation paid \$300,000 in order to reimburse the Medicare programs for conduct occurring between January 1, 2007, and December 31, 2009. Under the False Claims Act, the government can recover up to three times its actual damages, plus penalties of \$5,500 to \$11,000 for each false claim.



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