Teaching Physician
Compliance
ALERT

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Physicians–STOP before you bill for an APRN or PA service

In May 2013, we published an article about billing for services rendered for the same patient on the same day of service by a mid-level practitioner and a physician. Specific guidelines allow a mid-level practitioner and a physician to combine their documentation and bill under the physician. We are repeating this article because this remains a challenging issue for Yale Medical Group (YMG) given the increase in the number of mid-level practitioners to our practice. YMG has had to pay insurers back more than $95,000 for services incorrectly billed.

In many areas of our practice, Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) work collaboratively with our physicians in the office, outpatient hospital, and inpatient hospital setting. **A physician may NOT use the documentation of an APRN or PA to determine the level of visit to bill unless the APRN or PA is employed or leased and credentialed by the Yale Medical Group.** The Yale Office of General Counsel has created a lease template that the clinical departments may use for this purpose. Unless the APRN/PA is leased and credentialed, billing cannot occur with insurers in order for shared documentation and billing guidelines to be met. In addition, APRNs need a **collaboration agreement** and PAs need a **delegation agreement** with their designated physician.

Unless all three of these components are in place –

- Mid-level employment or lease agreement
- Credentialing
- Collaboration or delegation agreement

we cannot use the documentation or bill for the services the APRN or PA provides in any setting. These rules also apply to any procedures that are performed by an unleased mid-level.

If you become aware that a non-leased mid-level practitioner is providing services collaboratively with you, please notify your practice manager right away so the proper paperwork can be put in place.

If you are not sure, check with your business office right away!

Consultations–Are you billing correctly?

The limitation of ten speed buttons in Epic Ambulatory has sometimes caused confusion with billing the new patient visit codes or a consultation. A "new patient" is a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. If the new patient visit CPT codes are not on your Epic speed buttons, you must go to the Charge Capture screen in the Visit Navigator and click in the "None" hyperlink found in the Additional E/M codes box to locate CPT codes 99201-99205. Finally, enter the selected code in the box above.

Consultation services require 3 things: (i) a request from an appropriate source; (ii) the consultation evaluation service; and, (iii) a written report. A written request and reason for a consultation must be included in the requesting practitioner's plan of care. The written request and reason for a consultation must be included in the consulting practitioner's plan of care. The statement "Thank you for referring" is not enough documentation to support the request. Your documentation should state the request, name of the provider requesting the consultation, and the reason for the consultation.

Examples of appropriate documentation are:

Request: "Mr. Jones is seen in consultation at the request of Dr. Kane for evaluation for abdominal pain…"
Advice: "Patient sent by Dr. Hoff for my advice about…"
Consult: "Patient seen in consultation at the request of Dr. Kane…"
Evaluation: "Dear Jim, thanks for asking me to evaluate Betsy for…"

In an office or outpatient setting, another consultation may be requested of the same consultant practitioner if the consultant has not been providing ongoing management of the patient for this condition after his/her initial consultation. A transfer of care occurs when a practitioner requests that another practitioner take over the responsibility for managing the patient's complete care for the condition and does not expect to continue treating or caring for the patient for that condition. A referring provider does not have to request a consult first. A consultation service may be based on time when the counseling/coordination of care constitutes **more than 50 percent of the face-to-face encounter** between the practitioner and the patient. Total time spent, counseling time, and the topics discussed must be documented. Payment may be made for a consultation if a practitioner in a group practice requests a consultation from another practitioner in the same group practice when the consulting practitioner has expertise in a specific medical area beyond the requesting professional's knowledge, and it is documented in the record.

Examples that meet the criteria for consultation:

Example 1: An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. He identifies a questionable skin lesion and asks a dermatologist to evaluate the lesion. The dermatologist examines the patient and decides the lesion is probably malignant and needs to be removed. He removes the lesion which is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his code in addition to the procedure code. He codes a consultation code (99241-99245) with Modifier 25 in addition to the procedure code. Modifier 25 is required to identify the consultation service as a significant, separately identifiable E/M service in addition to the procedure code reported for the removal of lesion. The internist resumes care of the patient and continues surveillance of the skin on the advice of the dermatologist.

Example 2: A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, which he schedules, and then sends a written report to the requesting physician; the general surgeon codes a consultation (99241-99245). Subsequently, the general surgeon performs the biopsy and arranges to see the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit (99212-99215) in the office or other outpatient setting, as appropriate. The family practice physician resumes the general medical care of the patient.

Examples that DO NOT meet the criteria for consultation

EXAMPLE 1: Standing orders in the medical record for consultations
EXAMPLE 2: No order for a consultation
EXAMPLE 3: No written report of a consultation
EXAMPLE 4: The emergency room physician treats the patient for a sprained ankle. The patient is discharged and instructed to visit the orthopedic clinic for follow-up. The physician in the orthopedic clinic shall not report a consultation service because advice or opinion is not required by the emergency room physician. The orthopedic physician shall report the appropriate office or other outpatient visit code.

The Compliance Department has recently created consultation E&M cards as illustrated below. Please contact Deborah Lyman at (203) 785-3438 or Deborah.Lyman@yale.edu to obtain a card.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

Chief Complaint (CC) is required for all codes **HPI** = History of Present Illness
ROS = Review of Systems **PFSH** = Past Medical, Family, Social History **MDM** = Medical Decision Making
If the patient is self-referred or is seeking a second opinion, bill the most appropriate E&M code, not a consult.

CPT Codes (need all 3 key components)	1. HISTORY	2. EXAM	3. MEDICAL DECISION MAKING	Time in Minutes
99241	Problem Focused HPI Brief (1-3)	Problem Focused 1 body area or organ system	Straightforward	15
99242	Expanded Problem Focused HPI Brief (1-3) ROS (1)	Expanded Problem Focused 2 - 5 body areas and/or organ systems	Straightforward	30
99243	Detailed HPI Extended (4) ROS (2-9), PFSH (1)	Detailed 6-7 body areas and/or organ systems	Low	40
99244	Comprehensive HPI Extended (4) ROS (10), PFSH (3)	Comprehensive 8 or more organ systems	Moderate	60
99245	Comprehensive HPI Extended (4) ROS (10), PFSH (3)	Comprehensive 8 or more organ systems	High	80

There are 3 requirements for consults: (1) another practitioner requests your advice/or opinion (2) request and medical necessity of the consult along with the evaluation is documented in the medical record (3) a written report of your advice/opinion to the requesting practitioner must be provided.
Continue to bill consults for Medicare patients, since the crosswalk takes place in the background via claim logic rules.

IMPORTANT: BILLING LEVEL SHOULD BE DRIVEN BY MDM ***2014.02.28***

INPATIENT CONSULTATIONS

Chief Complaint (CC) is required for all codes **HPI** = History of Present Illness
ROS = Review of Systems **PFSH** = Past Medical, Family, Social History **MDM** = Medical Decision Making
No distinction is made between new and established patients for consultations.

CPT Codes (need all 3 key components)	1. HISTORY	2. EXAM	3. MEDICAL DECISION MAKING	Time in Minutes
99251	Problem Focused HPI Brief (1-3)	Problem Focused 1 body area or organ system	Straightforward	20
99252	Expanded Problem Focused HPI Brief (1-3) ROS (1)	Expanded Problem Focused 2 - 5 body areas and/or organ systems	Straightforward	40
99253	Detailed HPI Extended (4) ROS (2-9), PFSH (1)	Detailed 6-7 body areas and/or organ systems	Low	55
99254	Comprehensive HPI Extended (4) ROS (10), PFSH (3)	Comprehensive 8 or more organ systems	Moderate	80
99255	Comprehensive HPI Extended (4) ROS (10), PFSH (3)	Comprehensive 8 or more organ systems	High	110

If you are coding an E&M service according to time spent counseling and/or coordinating care (CCOC), ***over 50%*** of the total visit time must have been spent on CCOC. The total time of the visit *and* the amount of time spent counseling needs to be documented in the medical record. Both times are required along with what you counseled the patient about.
Only the billing providers time can be counted toward the total E&M time.

IMPORTANT: BILLING LEVEL SHOULD BE DRIVEN BY MDM ***2014.02.28***

IN THE NEWS

Weston physical therapist indicted

Danielle Faux, 46, of Weston, was arrested on federal health care fraud charges after a federal grand jury returned an indictment charging Faux with 46 counts of health care fraud and one count of obstruction of a federal audit. According to the indictment, Faux owned and operated Danielle Faux PT, LLC, a physical therapy clinic in Norwalk, and was a part owner of Achieve Rehab and Fitness, a gym located at the same address in Norwalk. The indictment alleges that Faux engaged in a scheme to defraud Medicare and Anthem Blue Cross Blue Shield by referring some of her patients for personal training sessions at Achieve Rehab and Fitness and then billing the sessions as if they were physical therapy procedures. The indictment also alleges that Faux created and altered patient records when Medicare audited her practice in August 2009.

East Hartford doctor convicted of medical fraud

An East Hartford doctor pleaded no contest to billing the state's Medicaid program for an office visit during which he sexually assaulted a patient. Edwin Amobi Njoku, MD, of East Hartford, was convicted in Hartford Superior Court of one count of Larceny in the Second Degree By Defrauding A Public Community, a class C felony.

According to information presented in court, a female patient, who is a Medicaid recipient, went to Njoku's Burnside Avenue office for treatment of lower back pain. Instead, Njoku sexually assaulted her and then billed the state's Medicaid program $37.48 for medical treatment that was never given.

Njoku also faces mandatory federal exclusion by the U.S. Department of Health and Human Services. Excluded individuals are not allowed to receive payment for providing Medicare and Medicaid covered services in any capacity.

$9.9 million settlement with key defendants in Medicaid billing lawsuit

In the May 2013 Alert, we published an article about a potential $20 million Medicaid fraud conspiracy in Connecticut. The case has concluded with a $9.9 million settlement with Gary Anusavice of North Kingstown, R.I., and six of his management and consulting companies, settling the state's civil fraud claims stemming from an alleged illegal Medicaid billing scheme.

In addition to Gary Anusavice, the state's stipulated judgment covers E.G.A. Management, Inc.; Haven Consulting, Inc.; AMZ Consulting, Inc.; Electron Marketing, Inc.; Dental Care of Connecticut, Inc.; and, N.B. Dental, Inc.

Among the terms of the stipulation, Anusavice and the companies will pay the state $9.9 million, which represents treble damages under the Connecticut False Claims Act and restitution under the Connecticut Unfair Trade Practices Act. The agreement also bars Anusavice and the named companies from participating in any health care-related business in Connecticut, or engaging in any other business with state agencies for at least 10 years after Anusavice completes his incarceration under the federal plea agreement.

According to the state's civil complaint, in July, 1997, Gary Anusavice, a dentist at the time, was convicted in Massachusetts of a felony for submitting false health care claims. As a result of the conviction, he was permanently excluded by the U.S. Department of Health and Human Services from participation in Medicare and state health care programs, including Medicaid, after April 1998.

The state alleged that Anusavice violated his program exclusion by setting up, through a series of corporations, a number of dental practices around Connecticut that were operated by practicing dentists who were providers, or applied to become providers in the Connecticut Medical Assistance Program, and billed Medicaid for services. The state also alleged that Anusavice was able to implement a billing system that resulted in the state Medicaid program being double-billed for certain dental services, or billed for services that were not rendered.

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Compliance Programs—Preventative Medicine for Healthcare Providers

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