Teaching Physician Compliance

ALERT

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EMR News Flash

This month the Yale New Haven Health System and the Yale School of Medicine entered into a multi-year agreement with Epic for an electronic health record (EHR). While the EPIC EHR will enhance our practice in many ways, there are some pitfalls is the EHR is not used correctly. The following article addresses some important do's and don'ts of EHR documentation.

What you don't want to see in an EMR

The attending note in the EMR read "d/w attending". Huh??? This is a case where the attending copied the fellow's note verbatim into his own note including the plan to "d/w attending". This type of error casts suspicion on the credibility of the attending note and may lead to questions about what their actual involvement was. EMRs may actually increase your risk of an audit unless you use the system's documentation features properly. The following items are also ill advised as entries in the EMR.

•Rote notes that go on for pages and pages

These notes are not reader-friendly and contain long copied lists of facts that don't necessarily call out pertinent positives. As a result, referring physicians often complain about getting "canned" EMR chart notes from consulting specialists. Because the note has so much extraneous material, the referring physician may skip to the bottom and skip something important.

•Inaccurate description of patients' reports or physicians' actions

Pulling forward of a note suggests that the author completed the same components as the last time. Did you really do all this work again?

•A copy forward of a history of present illness (HPI) without review and update by the provider.

Each record must stand on its own in an audit and cloned documentation will likely not be reimbursed for subsequent visits.

For example, consider a three-pack-a-day spine patient who enters into a nonsmoking agreement prior to a laminectomy. If the patient sticks with it and the orthopaedic surgeon doesn't review and update the social history while the patient is being managed conservatively in preparation for spinal surgery, the note will 'pull forward' as if the patient is still smoking three packs a day, thus creating inconsistencies in the current HPI and the review of systems (ROS). It could also affect the decision to proceed with surgery.

What you do want to see in an EMR

•EMR notes should essentially mirror handwritten documentation except that it is legible. Normal documentation into the paper chart is about a half-page long, the documentation in the EMR system should be about the same length.

•E&M templates that are customized by specialty; The exam template used by a spine surgeon bears little resemblance to one that can be used by a foot and ankle surgeon, which in turn is different from one a sports medicine specialist requires. During template creation, input is needed from the physicians who will be using the template.

•Updated information for the history of present illness, exam, and plan, which are areas likely to change

At a recent Association of American Medical Colleges (AAMC) conference, Dr. Debra Patterson, Medicare Contractor Medical Director for Trailblazer had the following comments in regards to EMRs.

•If a teaching physician expects payment from Medicare for services in which residents are involved, there needs to be a personal note from the teaching physician to demonstrate the teaching physician's contribution to the service. The copy and pasting of a resident's note does not support their contribution.

•It is foolish to think you can come up with the magic words to use over and over to meet teaching physician rules and establish medical necessity for teaching physician involvement. The EMR needs to contain more than just an attestation by the teaching physician.

In order to meet the teaching physician documentation rules, the teaching physician must document a personal note that supports that they saw and evaluated the patient and what their role was in the plan. For more information about teaching physician rules, please visit the Yale Medical Group Compliance Website. http://comply.yale.edu/medicalbilling/

How to bill for Prolonged Service Codes correctly

There are two sets of rules for billing the prolonged service codes. The first rule is based on the documented level of E&M and that the visit went 30 minutes or more over the time listed in the CPT book for that particular E&M. The second rule applies to those E&M visits where counseling and coordination of care account for more than 50% of the visit. In both cases, the E&M and prolonged service code would be billed and direct patient contact (face to face) by the physician is required. We will address rule one first.

Rule one - A new patient visit, CPT 99204 has a typical time of 45 minutes assigned per CPT. The total visit time would need to be 75 minutes in order to bill 99354 (prolonged services). Both 99204 and 99354 may be billed in this example. The documentation must meet the requirements of CPT 99204.

Rule two - In E&M services in which the code level is selected based on counseling time, you may only report prolonged services with the highest code level in that family of codes as the companion code. This means you can only bill for prolonged services in the office if you meet and exceed the time for a level 5 E&M.

If a physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient, the physician should bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time (30 minutes) for billing prolonged services. In this case only the 99215 code can be billed.

The start and end times should be documented when billing prolonged services. In order to bill for prolonged services, the time spent must always be the billing provider's face to face time even in the inpatient setting.

Medicare recently conducted a review of prolonged service code billings and identified the following errors.

•Missing or illegible provider signature – Documentation must be legible and include a provider's signature.

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In the News

West Haven woman gets 28 months for idenity theft

Angelique Mullings of West Haven, was sentenced 28 months of imprisonment, followed by three years of supervised release, for stealing the identities of approximately 40 health care professionals that she used to order cell phones on the internet.

Mullings had access to the names, dates of birth, SSNs and home addresses of certain individuals through her employer WellPoint, Inc., a licensee of Anthem Blue Cross and Blue Shield. These individuals included doctors, psychologists, nurses, and dieticians. Mullings used their personal information to open numerous fictitious e-mail accounts, bank accounts and credit card accounts. She then used the stolen information to place online orders for cell phones in the names of some of the victims, and had the phones delivered to her home on Stevens Avenue in West Haven, or to another address in New Haven. Mullings was also ordered to pay restitution in the amount of $2,914.95.

Second pediatric practice settles government claim

Milford Pediatric Group, P.C. has entered into a civil settlement with the government and will pay $65,378 to resolve fraudulent billing accusations. It was alleged that the Milford Pediatric Group improperly billed for after-hours services when the practice was open. The practice is located at 20 Commerce Park in Milford. In the May Alert, we reported that Fairfield County Health Care Associates paid $76,444 for the same issue.

It was alleged that Milford Pediatric Group routinely billed Medicaid for the special add-on code and received additional payments, above and beyond the usual payments for the services in question, when the practice was not closed, but instead was open for business and regularly scheduling patients for same day sick visits. The Federal Bureau of Investigation and the U.S. Department of Health and Human Services, Office of Inspector General conducted the investigation.
Source: USAO 5/27/10

Senior Medicare Patrol

The Senior Medicare Patrol Project recruits retired professionals to serve as educators and resources in helping patients to detect and report fraud, waste, and abuse in the Medicare program. At least 1 project is located in each of the 50 States, as well as in the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

In 2009, the 55 projects had a total of 4,444 active volunteers. These volunteers educated Medicare beneficiaries in 7,177 group sessions and held 33,855 one-on-one counseling sessions. In addition, the projects conducted 311,377 media outreach activities and 5,684 community outreach education events. The total savings to Medicare, Medicaid, beneficiaries, and others were over three times higher in 2009 as compared to 2008. However, a true measure of the program's success is unable to be tracked since much of it can be attributable a sentinel effect whereby fraud and errors are reduced in light of Medicare beneficiaries' scrutiny of their bills.

Source: OEI http://www.oig.hhs.gov/oei/reports/oei-02-10-00100.pdf

Prolonged Service Codes -Continued

- Incomplete or missing patient information – A patient's medical record must include a legible patient name for identification. Also, the medical record should be clearly dated and correspond to the date of service billed.
- Lack of documentation of total visit duration - Documentation is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.
- Lack of documentation to establish face to face contact by the provider- The documentation must support that the billing provider personally provided this direct face-to-face service.
- Lack of an Evaluation and Management (E&M) companion code - Prolonged service codes 99354-99357 are not paid unless they are accompanied by an appropriate E&M companion code.

This Chart indicates how to bill the prolonged service codes

Duration of Prolonged Services	Codes
Less than 30 minutes	Not reported separately
30 to 74 minutes (30 mins to 1 hour 14 mins)	99354 x 1
75 to 104 minutes (1 hour 15 mins to 1 hour 44 mins)	99354 x 1 and 99355 x 1
105 or more minutes (1 hour 45 mins or more)	99354 x 1 and 99355 x 2 or more for each additional 30 minutes

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Published by the Yale Medical Group
Compliance Programs—Preventative Medicine for Healthcare Providers
P.O. Box 9805
New Haven, CT 06536
1 (877) 360-YALE hotline
http://comply.yale.edu/medicalbilling
Chief Medical Officer: Ronald Vender, MD
Compliance Medical Director Joshua Copel, MD
Director of Medical Billing Compliance: Judy L. Harris
judy.harris@yale.edu | (203) 785-3868