Teaching Physician
Compliance
ALERT
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What's under the Medicare Microscope?

National Government Services (NGS), our Medicare contractor, has announced that they will be conducting pre-payment audits of the following CPT evaluation and management (E&M) codes billed by the indicated specialty. NGS will request the medical record documentation before making a payment determination for CPT:

- 99205--Initial patient office or other outpatient visit billed by **Internal Medicine**
- 99215--Established patient office or other outpatient visit billed by **Hematology/Oncology**
- 99223--Initial hospital inpatient billed by **Surgeons**
- 99233--Subsequent hospital inpatient visit billed by **Cardiology** and **Gastroenterology**
- 99354-99357--Prolonged services requiring direct patient contact beyond the usual service **(all specialties)**

The primary focus of the audits will be to better identify common billing errors, develop educational efforts, and prevent improper payments by the Medicare program. Additional physician specialties may be added based on E&M utilization data Medicare obtains in the future.

A widespread prepayment audit on 99205 was conducted by Medicare in the spring of 2010 in Connecticut and New York which revealed a 69% error rate. Most of the errors occurred because services were billed at a higher level than could be substantiated by the documentation.

A second review of 99205 conducted by Medicare in the spring of 2013 showed a 78% denial or recoding error rate.

The majority of 99205s were recoded to a lower E&M level because the record lacked documentation supporting the three key components:

- A comprehensive interval history
- A comprehensive examination
- Medical decision making of high complexity

99205s were also reduced or denied due to:

- Insufficient or missing documentation
- Failure to respond to development requests
- Missing or illegible provider signature
- Incomplete or missing patient information

The same review was performed by Medicare for the prolonged service codes for claims billed in the spring of 2013 and a 80% denial/recoded rate was determined.

Prolonged office and inpatient claims were reduced/denied because of the following documentation insufficiencies:

- Lacks start and end times of prolonged service
- Direct face-to-face is not supported
- Lacks content of prolonged service needed beyond the usual service of the E&M
- Prolonged service with over 50% of the total time of the face-to-face encounter is not being reported with the highest code level in the family of E&M companion codes
- Diagnostic testing (ophthalmological testing, neuropsychiatric testing, EKGs) is done at time of visit, but time of the testing is not differentiated from the office visit and testing time appears to be included in the reported prolonged time.

Prolonged inpatient services claims were also reduced/denied for family meetings without the patient in attendance.

EPIC Corner

If you are documenting a patient visit on a day other than the day the services were provided to the patient, you need to indicate the actual date of service in your note. The note should contain the date you are writing the note and the date you saw the patient.

Tips for documenting a quality inpatient progress note

Is "note bloat" making you head for a bottle of antacids? Try or share these best practice tips for documenting a quality inpatient progress note:

1. The note header should include the name of the service, author, and training level of the author
2. The subjective/interval history is newly documented
3. The vital sign section is uncluttered
4. Only include selected relevant medications or put med list at the end of the note
5. The I/O section is uncluttered
6. The exam is newly documented and not copied in its entirety from the previous note
7. The lab section is uncluttered with only pertinent labs
8. The imaging section is uncluttered with only pertinent imaging results
9. The assessment is newly documented
10. The plan is newly documented or partially copied with new information added
11. Abnormal lab values have an accompanying diagnosis
12. The author's name and contact information (pager, cell) is included at the bottom of the note

These tips can be found in the Best Practices for Inpatient Progress Notes Audit Tool created by the University of Wisconsin.

Observation services

Observation is a "set of services" and must be ordered by a physician. They are short-term outpatient services with ongoing treatment, assessment and reassessment of the patient. The purpose is to provide decision-making time to determine if the patient needs to be admitted to the inpatient setting or if they can be safely discharged home.

Observation can be used for a patient who:

- Requires further testing to determine the need for admission (or possible discharge)
- Has had an adverse reaction or complication from a procedure and requires additional length of stay/monitoring and need for admission is unknown
- Is stable, yet the cause of the presenting signs/symptoms are unknown and further short-term treatment/testing is required

Observation cannot be used for:

- Routine postoperative or post-procedure care
- Active monitoring which is an inherent part of the service, e.g., chemotherapy, blood transfusions, endoscopic procedures, etc.
- A patient who is acutely unstable and requires inpatient level of care
- A patient waiting for an available inpatient, skilled nursing facility, or other type of bed or transfer
- A patient who is stable but for whom outpatient tests/procedures may not be available for several days, i.e., weekend/holiday/scheduling issues
- Family convenience/lack of social support
- Lack of ride or discharge destination

Source: NGS Medicare CERT Observation Tip Sheet

IN THE NEWS

State Medical Examining Board Actions

The state Medical Examining Board recently took the following actions:

Dr. Ljudmil Kljusev, a Milford psychiatrist, was fined $15,000 for sending personal texts to a patient. In addition to the fine, Dr. Kljusev, was reprimanded for inviting the female patient in 2007 to meet him at a restaurant, for sending her personal texts, and for calling her "Sweety".

The board imposed a 20-year suspension and a $5,000 fine on Dr. Mary Jane Brackett, 77 of Watertown, for failing to comply with a 2012 order from the board. State records show she failed to pay a $1,000 fine, provide a physician to monitor her practice, or take a course on medical record documentation.

The board also reprimanded Brackett for having a loud argument and a physical struggle with the mother of a patient in 2011. Brackett was arrested in connection with that incident and was charged with breach of peace but later pleaded guilty to creating a public disturbance.

Brackett also received probation for one year for failing to take enough continuing medical education courses and a reprimand for failing to have malpractice insurance for six months in 2012. In 2012, sanctions were imposed on Brackett for making a false accusation against a patient's father to state child protection officials.

Dr. Louis Telesford of Hamden was fined $5,000 and his license was placed on probation for five years for using the name of another doctor to prescribe drugs during 2009 and 2010. He is also required to have a physician monitor his patient records.

The board fined Dr. Naimetulla Syed, of Glastonbury, $5,000 for billing insurance for patient visits in 2010 that never took place, records show. The board also reprimanded him, placed his license on a six-month probation, and ordered him to take a course in chart documentation. It fined him another $500 for failing to take enough continuing medical education courses.

Dr. Jeffrey Schorr of Greenwich was fined $3,000 and reprimanded for prescribing painkillers such as oxycodone to two friends between 2010 and 2012 without keeping adequate medical records on the patients. Schorr was also found to have improperly stored old patient records in a garage in New York State to which a neighbor had access. Under a consent order with Schorr, the board placed his license on probation for a year and ordered him to take coursework on patient privacy and record keeping.

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Compliance Programs—Preventative Medicine for Healthcare Providers

Chief Medical Officer: Ronald Vender, MD
Compliance Medical Director Joshua Copel, MD
Director of Medical Billing Compliance: Judy L. Guay
judy.guay@yale.edu | (203) 785-3868

P.O. Box 9805 • New Haven, CT 06536
1 (877) 360-YALE hotline
http://comply.yale.edu/medicalbilling