Teaching Physician Compliance

ALERT

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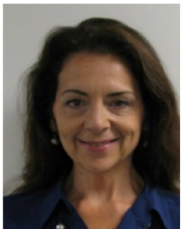
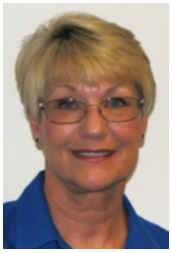
A warm welcome to two new compliance auditors

The Compliance Department welcomes two new staff members.



Brenda Dombkowski, RMA, CPC, CIMC, who has been responsible for compliance and education in the Department of Internal Medicine (IM) for the past 10 years, transitioned to the YMG Compliance Department as part of the department's centralization project. Brenda was an integral part of the IM's compliance and education activities and brings a wealth of experience. She is responsible for compliance activities in allergy, dermatology, endocrinology, geriatrics, occupational medicine, and surgery.



Kathleen Bartolotta, CPC, joined Yale Diagnostic Radiology in 2003. She left her manager position in 2010 when she transitioned to Patient Financial Services, where she made significant contributions to such projects as the research billing project and ICD.10 implementation. Kathy is responsible for compliance activities in the Yale Child Study Center, digestive diseases, pediatrics, and psychiatry.

Audit centralization should lead to better consistency, quality

With the growth of our clinical practice and the implementation of Epic, some departments have hired their own compliance billing auditors. While we applaud this effort at improving billing compliance, in keeping with the YMG Board's goal of standardization, the audit function will be centralized at the YMG level. By taking this step, we believe we can improve the consistency and quality of the audit service. This plan was approved by the YMG Operations Committee and the YMG Board, effective July 1, 2014.

The Compliance Department will continue to provide coverage for external audits for all departments. Currently there are four Medicaid audits in progress and over 60 Anthem reviews. In addition, Compliance will continue to provide annual medical billing compliance training, and assist Patient Financial Services (PFS) and the clinical departments with questions about documentation and billing compliance. Questions and issues resolved by the Compliance Department will be posted centrally and made available to all.

As a reminder, the Compliance Department is responsible for all materials provided to faculty for medical billing compliance training. This includes:

- Any training materials produced by the clinical departments
- Alterations of existing compliance training materials
- Contracts with outside entities to provide training

Documentation, coding, and billing requirements are extremely complex. The centralization of audits will allow YMG to provide our faculty with the most up-to-date education, and guarantee the best quality and consistency of the audits themselves. If you have any questions, please contact Judy Guay at 203-785-3868 or judy.guay@yale.edu.

There are risks to prepopulating notes

Recent compliance audits have shown some residents and fellows are pre-populating patients' progress notes prior to the date the patient is seen. While this practice may seem to take advantage of the efficiencies of Epic, the risks it creates far outweigh the benefits. Among the risks:

- Populating a note with outdated, conflicting, incomplete, or inaccurate information
- The inability to identify the original author if using the "share note" function in Epic
- Documenting an encounter for a patient who may be a "no show"
- Creating billing errors if the patient is admitted to the hospital on the same day as the scheduled outpatient encounter

Prepopulated notes also run the risk of "note bloat'" due to their length and their frequent clutter with "canned" text. As a result, important information coming from the actual visit may get lost, leading to poor communication, duplication of services, or delay in the patient receiving appropriate care. Furthermore, notes that are repetitive, inconsistent, or identical do not further the care of the patient; and, over time, are likely to be ignored by caregivers due to stagnant information. These types of notes may call into question the medical necessity of the care, and result in insurance payment denials, audits, or investigations.

Prepopulating notes is a practice that should be discouraged, and used only under unusual circumstances. Please remind faculty, fellows, and residents to document their care of the patient after the patient encounter occurs and to avoid using the "share note" feature in Epic.

Teaching physician attestation in the inpatient setting

Teaching physician attendings must add a personal attestation to Graduate Medical Education (GME) resident or fellow notes for evaluation and management (E&M) services. Prior to the upgrade to Epic 2014, the attending was required to addend the note with a personalized smart phrase. Epic 2014 now provides an "Attest" button to clearly separate the resident/fellow note from that of the attesting physician. The new button is in the toolbar. The old cosign option also remains. While a user may specify a default template for an attestation, all attestations must contain information that is personal and specific to the patient. It is not acceptable for the same verbiage to be used for each and every patient.

High denial rate for vascular studies

The National Government Services (NGS) Medicare Medical Review Department is conducting a prepayment review for Vascular Studies, CPT Codes 93880, 93882, 93970, 93971, 93925 and/or 93926, billed on the same day in six New England states and New York. The review was initiated after medical review data identified a large volume of claims billed for both arterial and vascular studies on the same day with questionable medical necessity. The results of the review follow:

- **April:** 995 total services were billed; 608 (60.2%) were reduced or denied in Connecticut and New York.
- **May:** 1,348 total services were billed; 857 (59.1%) were reduced or denied in Connecticut and New York.
- **June:** 1,279 total services were billed; 820 (57.4%) were reduced or denied in Connecticut, Massachusetts, Maine, New Hampshire, New York, Rhode Island, and Vermont.

Vascular study claims were reduced and/or denied for the following reasons:

- Minimal documentation without specific location or description of sign/symptom severity: "edema," "pain," "stenosis," or "claudication"
- Documentation of a provisional diagnosis instead of specific clinical indications: "R/O DVT," "R/O reflux," or "R/O stenosis." The diagnosis(es) must relate to known diseases or abnormal signs or symptoms to warrant appropriate testing
- Documentation of unilateral medical necessity indications accompanied by performance of bilateral noninvasive vascular studies: "calf pain," "swelling in limb"
- Failure to document prior noninvasive vascular studies history: postoperative complications, follow-up vascular study, or prior vascular surgery
- Submission of contradictory documentation: "history of bruit—yes; current bruit on physical examination—no"
- Lack of documentation submitted for review
- Missing or illegible provider signature

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NGS is also reviewing claims for prolonged services codes, CPT 99354-99357. The results follow:

- **April:** 1,570 total services were billed; 1,347 (86.2%) were reduced or denied.
- **May:** 1,521 total services were billed; 1,295 (88.1%) were reduced or denied.
- **June:** 1,269 total services were billed; 1,110 (90.6%) were reduced or denied.

Prolonged services claims were reduced and/or denied for the following reasons:

- 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 appropriate companion code (e.g., the E&M companion code for 99354 are the office or other outpatient visit codes of 99201-99205, 99212-99215)
- Diagnostic testing (e.g., ophthalmological testing, neuropsychiatric testing, EKGs) is done at time of visit, but time of the testing is not differentiated from the office visit and appears testing time is included in the reported prolonged time
- Codes are being reported for family meetings with no appropriate E&M and patient not in attendance

Proposed Medicare changes

Under the misvalued CPT code initiative, Medicare is proposing to transform all 10- and 90-day global surgery codes to 0-day global codes beginning in CY 2017. The Office of the Inspector General has identified a number of surgical procedures that include more visits in the global period than are being furnished. In order to address the potential for misevaluation of surgical services, beginning in CY 2017, Medicare is proposing to eliminate the payment included in the surgical code reimbursement for the pre- and post-operative visits and to pay separately for visits and services actually furnished after the day of the procedure.

Off-campus provider-based departments: *Medicare will* collect data on services furnished in these locations beginning in 2015 by requiring hospitals and physicians to report Modifer PB for those services furnished in an off-campus provider-based department on both hospital and physician claims.

In the News

Recent Connecticut arrests

Samantha Colbert, a Hartford woman, allegedly continued to work after her nursing license was suspended. She was arrested by inspectors from the Medicaid Fraud Control Unit and charged with one count of unlawfully practicing nursing and one count of second-degree forgery.

At the time of her suspension, Colbert was employed at Touchpoints at Chestnut, a skilled nursing facility in East Windsor that receives Medicaid funding. According to the warrant for her arrest, Colbert failed to notify her employer of her suspension and submitted a license with an altered expiration date. Forgery in the second degree and unlawfully practicing nursing are Class D felonies, each punishable by up to five years in prison and/or a $5,000 fine.

John Katsetos, M.D., 52, of Fairfield, was arrested on a charge that he exceeded the scope of his medical license to dispense controlled substances. As alleged in a criminal complaint, Dr. Katsetos has practiced medicine for more than 20 years, most recently in offices located at 90 Morgan St., Stamford, and 353 Bridgeport Ave., Milford. Dr. Katsetos operated as a general practitioner and was not licensed as a pain specialist. A long-term Drug Enforcement Administration investigation, which included the use of undercover law enforcement personnel, revealed that Dr. Katsetos was writing prescriptions for large quantities of Schedules II, III, IV, and V controlled substances outside the scope of legitimate medical practice. The complaint charges Dr. Katsetos with conspiracy to distribute and to possess with intent to distribute controlled substances, an offense that carries a maximum term of imprisonment of 20 years and a fine of up to $1 million.

In regards to both arrests, a complaint is considered only a charge and is not evidence of guilt. Charges are only allegations, and a defendant is presumed innocent unless and until proven guilty beyond a reasonable doubt.
Source: U.S. Attorney's Office