Teaching Physician Compliance

ALERT

Published by the Yale Medical Group

January 2010 Issue 69

Consultation Update

In December, we sent an email to the faculty about Medicare's decision to eliminate payment for consultation codes and to reimburse consultations under other E & M codes. We instructed you not to make any changes to current coding practices, because YMG was able to implement an internal procedure to accommodate this change. This article gives the background about Medicare's expectations for billing, how your consultation services are being paid, and situations that might require your input.

Medicare expects the following codes to be used in place of the consultation codes.

99221 – 99223, Initial Hospital Care, New or Established patient

99201 – 99205 New patient office or outpatient visit

99211 – 99215 Established patient office or outpatient visit

Modifier AI – inpatient hospital admission by attending

The Initial Hospital Care codes (99221-99223) have been traditionally used exclusively by the admitting physician. As of 1/1/10, the admitting physician will still utilize 99221-99223 for the inpatient admission code but will append a modifier AI. Modifier AI indicates that this is the attending physician's admission H&P charge. The reason that modifier AI is necessary is because specialty physician consultations will now also use the same set of codes (99221-99223) in place of the inpatient consult codes (99251-99255). The good news is that the billing system will automatically crosswalk the inpatient consult codes and no action is required on the part of the physician.

"The bottom line is that you should continue to report the consultation codes when your advice and opinion is requested"

The office or outpatient visit codes (99201-99215) are to be used in place of the consult codes 99241-99245. If the patient is a new patient to the physician, the billing system will automatically crosswalk the consult code to the new patient visit code. If the patient is an established patient, an automatic crosswalk is in place for 2 of the 5 consult codes. For the remaining 3 codes (99242-99244), physician input will be needed to recode these claims to an established patient visit code.

The chart below indicates the codes that can be crosswalked by the GE-IDX system and those that cannot be automatically coded. The documentation requirements for each code is also indicated. It is important to note that the documentation requirements for CPT codes 99201 – 99215 and 99221 – 99223 have long been in existence and have not changed.

The bottom line is that you should continue to report the consultation codes when your advice and opinion is requested in consultation for all patients regardless of payer. At this time, all of our private carriers are recognizing the consultation codes. Preliminary financial models indicate an anticipated decrease in Medicare reimbursement. Any questions regarding documentation and billing of E&M codes may be directed to Judy Harris, Director Medical Billing Compliance at 785-3868 or judy.harris@yale.edu.

Connecticut Now Has a False Claims Act

On October 5, 2009, Governor Rell signed a civil False Claims Act into law. Connecticut's False Claims Act ("CFCA") is modeled after the federal False Claims Act, a Civil War era statute originally enacted to prosecute profiteers engaged in fraud against the Union Army. The False Claims Act is the federal government's primary and powerful statutory tool to combat fraud, waste and abuse, particularly in the Medicare and Medicaid programs.

The new Connecticut statute has the potential to become an equally potent tool for state authorities to

continued page 2

Office or Outpatient Hospital Place of Service		
Consultation Code	**New Patient Visits - Crosswalk Codes**	**Return Patient Visits - Crosswalk Codes**
99241	99201 Problem Focused Hx & exam, straightforward MDM	99212 Problem focused Hx & exam, straightforward MDM
99242	99202 Expanded Problem Focused Hx & exam, straightforward MDM	physician to re-code based on documentation.
99243	99203 Detailed Hx & exam, Low MDM	physician to re-code based on documentation.
99244	99204 Comprehensive Hx & exam, moderate MDM	physician to re-code based on documentation.
99245	99205 Comprehensive Hx & exam, high MDM	99215 Comprehensive Hx & exam, high MDM

Inpatient Hospital Place of Service	
Consultation Code	**Crosswalk Code**
99251	99231 problem focused Hx & exam, low MDM
99252	99231 problem focused Hx & exam, low MDM
99253	99221 Detailed or comprehensive Hx & exam, Straightforward or low MDM
99254	99222 Comprehensive Hx & exam, moderate MDM
99255	99223 Comprehensive Hx & exam, high MDM

Emergency Department Place of Service	
Consultation Code	**ED Visit**
99241	99281 Problem focused Hx & exam, straigntforward MDM
99242	physician to re-code based on documentation.
99243	physician to re-code based on documentation.
99244	physician to re-code based on documentation.
99245	99285 Comprehensive Hx & exam, high MDM

Green = Automatic CFL code updates - no intervention required.
Yellow = Biller can change code based on approved crosswalks
Red = Biller must consult physician and review documentation to re-code the service.

HX = History

HPI = History of Present Illness

MDM = Medical Decision Making

Assistant at Surgery – Is there a resident available?

Medicare will not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service. However, Medicare will pay for an assistant at surgery at a teaching hospital if there are no qualified residents available.

The unavailability of a qualified resident needs to be documented in the patient's medical record. In addition, the claim submitted to Medicare for the assistant at surgery charge must be billed with a modifier 82. Modifier 82 acts as a certification which states:

> *"I understand that §1842(b)(7)(D) of the Act generally prohibits. Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier."*

Medicare retains claims billed with modifier 82 and will conduct post-payment reviews as necessary. For example, Medicare will investigate situations in which it is always certified that there are no qualified residents available, and undertake recovery if warranted.

In the News

CT Physician Settles for $100,000

Dr. Thomas Greco of Waterbury voluntarily self-disclosed billing violations and has agreed to pay the federal government nearly $100,000 to settle claims that his practice improperly billed Medicare for infusion therapy services that were not rendered. Greco was paid $66,591 by Medicare for the improperly billed claims between April 2006 and November 2008. The False Claims Act provides for treble damages and penalties however if the person or entity who violates the act promptly discloses the violation and fully cooperates with the government, the government can only recover up to double damages. Greco agreed to pay a multiplier of 1.5 times damages. Source: Health Care Fraud Report

Plastic surgery center closes

Following an investigation by the Department of Public Health (DPH), a plastic surgeon had her license suspended and has voluntarily shut down her Ridgefield office. Dr. Teresita Mascardo had been running the Connecticut Plastic Surgery Center in Ridgefield. DPH inspectors found nine violations during a scheduled inspection, including an unlicensed anesthesiologist, animal droppings on equipment and single-use supplies resealed with blood and other fluids on them. Attorney General Richard Blumenthal assisted in the investigation. Dr. Mascardo also has a practice in New York where she pled guilty to filing a false tax return and as a result, had her license suspended in 2008 in New York. Source: Channel 8 News

Connecticut's False Claims Act continued

combat fraud and abuse. While the federal False Claims Act applies to any false claim submitted to the federal government, the Connecticut law only applies to the medical assistance programs administered by the Department of Social Services (DSS) including Medicaid; State-Administered General Assistance (SAGA); HUSKY B; and Charter Oak.

The CFCA's penalties can range from $5,000 up to $10,000 per violation. The CFCA also authorizes recovery of up to three times the damages sustained by the state as a result of the false claim. The CFCA rewards self-policing, self-reporting and cooperation with state investigations by authorizing a reduction to the treble damages provision to "not less than" double damages, provided certain conditions are met. One of these conditions is the timely notification of the erroneous billings to state officials responsible for investigating false claims violations.

Like the federal False Claims Act, the CFCA permits private individuals to initiate civil actions under the Act. These individuals are known as "whistleblowers" or "qui tam realtors". If the Attorney General decides to proceed with the whistleblower's case and the case is successful, the whistleblower may receive up to 15% to 25% of the state's recovery. The Act protects whistleblowers from workplace retaliation.

For more information on the CFCA go to: http://www.cga.ct.gov/2009/ACT/PA/2009PA-00005-R00HB-07005SS3-PA.htm

Teaching Physician Compliance ALERT

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