Teaching Physician Compliance

ALERT

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Coding Compliance - Recent clarifications from CMS

The following information points were noted in recent transmittals sent by the Center for Medicare and Medicaid Services and can be relied upon for coding and documentation compliance. Questions or requests for the source documents can be sent to judy.harris@yale.edu.

Critical Care

- When a patient receives an E/M service, then crashes on the same day, both an E/M code and a critical care code can be billed.

- No two providers can combine their critical care time units to meet the 30-minute threshold for 99291.

- Two physicians of different specialties in the same group practice can't both bill 99291 on the same date of service unless they perform different services unique to their specialty. Physicians of the same specialty from the same practice must bill as one physician.

- The physician's progress note in the medical record should indicate the time involved in the performance of separately billable procedures was not counted toward critical care time.

- Examples of critical care billing that may require further review could include: claims from several physicians submitting multiple units of critical care for a single patient, and submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date. Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a 'per shift" basis.

- Critical Care time may not be billed for these services: time spent off of the hospital floor or away from where the patient is located; time for procedures that are not critical care services as enumerated by CPT; updates/reports to or counseling with the family; or teaching sessions with house staff or students that are not involved in direct patient critical care

Examples of patients who may not satisfy Medicare medical necessity criteria include:

(i) Patients admitted to a critical care unit because no other hospital beds were available;

(ii) Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and

(iii) Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

The clarification included the following example of acceptable teaching physician documentation. Patient developed hypotension and hypoxia; "I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care." *Source: Transmittal 1530*

Hospital Discharge codes

In the unwelcome event that one of your patients dies in the hospital, the physician who performs the death pronouncement can bill for the service with the discharge day management codes (99238 or 99239). The actual pronouncement date should be used as the date of service even if the paperwork is delayed to a later date. Many physicians had previously wondered how to report a death pronouncement, since the discharge day management codes require a "face to face" evaluation and management of the patient. *Transmittal 1460*

Prolonged Services

In order to bill the prolonged service code, the time of the visit must go 30 minutes over the typical time for the specific E&M. For example, 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). In order to bill 99354 and 99355 (each additional 30 minutes in addition to 99204, 120 minutes with face to face contact must be made. 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.

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and

continued

2008 Compliance Award Winners

Sukru Emre, M.D.

Each year, the Compliance Office presents an award to individuals who demonstrate diligence in their medical billing compliance efforts. The recipients for 2008 are **Sukru Emre, M.D.**, Professor (Surgery - Transplant) and **Brenda Fisser,** Manager (Pediatrics).

Brenda Fisser

Dr Emre has played a lead role in revising the section's documentation templates and in facilitating medical billing training for faculty members. He has been a leader in championing correct inpatient and outpatient documentation and coding for the Yale New Haven Transplant Center. In Pediatrics, **Brenda Fisser** has faced many unique documentation and coding challenges which she has partnered with the Compliance Department to resolve. Brenda smoothly transitioned to a department with multiple subspecialties and works collaboratively with faculty to come up with the most compliant solution. Brenda is also assisting our practice with the beta testing of the Patient Protocol Manager, a software solution for billing clinical care services in a research study. Both recipients received a gift certificate to a popular local restaurant.

Prolonged services continued

management code) and should not be "rounded" to the next higher level. In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

As an example, a physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must 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 for billing prolonged services. *Transmittal 1490*

Intra-operative consults

We are including intra-operative consults in this Coding Compliance article because of several questions that have been received recently by the Compliance Department. While there is no specific code for an intra-operative consult, a consultation code can be billed if the criteria are met. Either the inpatient or outpatient consultation codes can be used, depending on patient status at the time of the operation.

A consultation requires the following:

1) The consulting physician's opinion or advice in the treatment of the patient must be requested.

2) The request, visit, and findings and recommendations must be documented by the consulting physician.

3) The findings and recommendations must be communicated to the requesting physician in writing.

The operative patient often will have a shared medical record, in which case documentation of the request should be noted in the shared record as well as the findings and recommendations of the consultant physician. The standard rules regarding history, physical examination, and medical decision making or time apply to determine what level of service is reported. If you are being called in as an assistant surgeon or to perform co-surgery, the consultation codes should not be used. The CPT code for the procedure(s) that you are performing should be utilized along with the appropriate modifier for either assistant at surgery (modifier 82) or co-surgery (modifier 62). Keep in mind that Medicare will not pay for an assistant at surgery unless there is no qualified resident available to assist.

IN THE NEWS

Fourth CT Hospital Fined

Hartford Hospital became the fourth hospital in Connecticut to settle with the U.S. Department of Justice to resolve allegations of incorrect billings for chemotherapy services. The amount of the settlement was $788,960. The other institutions that have settled are:

Yale New Haven Hospital -$3.78 Million
UCONN -$475,278
Greenwich Hospital - $605,274

Dentist Sentenced

A Fairfield dentist, Paul Dengelegi, has been sentenced to three years in prison on nine counts of illegally prescribing and obtaining narcotics for friends, family members and addicts. Prosecutors say Dengelegi issued between $128,000 and $136,000 worth of illegal prescriptions for oxycodone, OxyContin, Percocet and other painkillers.

New Compliance Auditor

Michelle Morgan-Herb, R.N., B.S.N., E.J.D.

has been selected as the new compliance auditor for the departments of Cardiology, Diagnostic Radiology, Laboratory Medicine, Pathology and Therapeutic Radiology. Michelle's previous employer was the Boys & Girls Village and she has worked at Yale University and the former Yale Psychiatric Institute in the past. Michelle can be reached at 737-5536 or michelle.morganherb@yale.edu.

Westport Case Settled

Dr Igal Staw who owned and operated Respiratory Associates and Health Extenders has been sentenced to two years probation and paid more than $421,000 in restitution to resolve allegations of health care fraud. The allegations against Dr Staw included submitting claims to insurance companies for physical therapy sessions, nutritional counseling sessions, and massage therapy sessions, which were rendered by non-physician providers at his medical practices. In order to obtain reimbursement for these services, Staw falsely represented that these services were physician office visits. Physical therapy services were actually provided by exercise physiologists and massage therapists (not by licensed physical therapists), as well as claims for services provided by an individual who had previously been excluded from Medicare and Medicaid.

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