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Medical Billing Compliance
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PRIT Eases Documentation Burden

The Physicians Regulatory Issues Team (PRIT) is a group of subject matter experts with the Center for Medicare and Medicaid Services (CMS) who work to reduce the regulatory burden on physicians who participate with the Medicare Program. PRIT's mission can be described by a quote from the Director, William Rogers, M.D., of PRIT posted on their website.

"It is my goal to simplify the lives of physicians by the elimination of unnecessary regulation, and help make Medicare participation a pleasure rather then a burden."

As part of attaining that goal, PRIT has modified the teaching physician documentation requirements for physicians using an electronic medical record. The new guidance states:

In the context of an electronic medical record, the term 'macro' means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physiciar must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only

The new guidance demonstrates that CMS is taking electronic medical record systems and functionality into consideration when drafting policies.

In order to bill for services furnished in teaching settings, the services must be:

- Personally furnished by a physician who is not a resident;

or

- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service.

For purposes of payment, Evaluation and Management (E/M) services billed by teaching physicians require that they personally document at least the following:

- That the teaching phyisican was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

Examples of Acceptable Teaching Physician Documentation

"I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

"I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

"See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

"I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Examples of Unacceptable Teaching Physician Documentation

"Agree with above.", followed by legible countersignature or identity;

"Rounded, Reviewed, Agree.", followed by legible countersignature or identity;

"Discussed with resident. Agree.", followed by legible countersignature or identity;

"Seen and agree.", followed by legible countersignature or identity;

"Patient seen and evaluated.", followed by legible countersignature or identity; and a legible countersignature or identity alone.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

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The "unacceptable" documentation examples do not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

All documentation systems should be able to provide an audit trail of who provided each component of the medical record documentation, the discipline of who provided the documentation and the date the documentation was created or revised.

Teaching Surgeon Documentation

CMS has indicated that all operative reports document that the attending surgeon was present for all key/critical portions of the procedure. A note dictated by the attending surgeon does not adequately support that the attending was present for the entire procedure or the key/critical portions. The following statement should be included in your OR reports as appropriate: "I was present for the key/critical portions of the procedure."

Increased Audits of Modifier 59

The Correct Coding Initiative (CCI) was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment for Medicare Part B claims. The CCI edits ensure that the most comprehensive groups of codes are billed rather than the component parts. CCI also checks for mutually exclusive code pairs; those services that are not expected to be billed for the same patient on the same day.

Modifier 59 can be used to bypass the CCI edits in claims processing system. Modifier 59 indicates that a provider performed a distinct procedure or service for a patient on the same day as another procedure or service. The modifier is used to seek payment for both services or procedures. Many private insurers use the CCI edits as well.

Recently, the OIG released a report that found that that forty percent of code pairs billed with modifier 59 in FY 2003 did not meet program requirements, resulting in $59 million in improper payments. The two main categories of errors were:

(1) the services were not distinct from each other or
(2) the services were not documented.

Given the results of this report, there will likely be increased scrutiny of the claims we submit to Medicare with modifier 59. Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a patient on the same day as another procedure or service. It may represent a:

- Different session,
- Different procedure or surgery,
- Different anatomical site or organ system,
- Separate incision or excision,
- Separate lesion, or
- Separate injury (or area of injury in extensive injuries).

The medical record should demonstrate that the service was distinct from other services performed that day. Any questions regarding modifier 59 can be directed to the Reimbursement Department (737-2130) or the Compliance Department (785-3868)

Update To 2006 Deleted Codes

The article in the October Alert Will You Be Ready for E&M Changes in 2006? stated:
The Evaluation and Management (E&M) codes for confirmatory consults and inpatient follow up consultations are slated to be deleted in the 2006 CPT. The confirmatory consult codes (99271 – 99275) are utilized when a patient seeks a second opinion. There is no physician request for a consult involved. Chances are the new or established patient office visit codes will be used in place of the confirmatory consult codes in 2006.

It has been confirmed by CMS that the new or established patient office visit codes are to be used in place of the confirmatory consult codes when the requirements for a consultation are not met. Consultation requirements include:

- your advice and opinion has been requested from another healthcare provider (not a patient initiated request)
- documenting the reason for the consultation
- completing a report back to the referring provider

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