Teaching Physician
Compliance
ALERT

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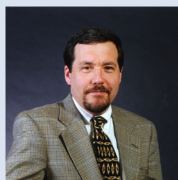

A Message from Joshua A. Copel, MD

This issue of Alert contains some practical information on common issues. One of the things we see most often around Yale Medical Group is uncertainty about using advanced practice practitioners (APPs). Be sure you know who your practice pays for, since we must cover some of the salary for these practitioners in order to bill for their work, and that is provided for in a master lease agreement with Yale-New Haven Hospital (YNHH). Always remember that APPs are not residents or fellows, so we cannot attest to their notes under teaching physician rules. It may seem silly, and it is, since they are highly competent professionals who do top-notch work, but those are the rules CMS instructs us to use.

Joshua A. Copel, MD
Associate Chief Medical Officer
Medical Director Billing Compliance
Yale Medical Group

Surgical assistant billing: be sure to submit properly

Are you using an APRN or PA as an assistant at surgery? The Centers for Medicare & Medicaid Services expects that residents at academic medical centers will fill the assistant-at-surgery role as part of their training program. If there isn't a qualified resident available to assist, the center may bill for the services of another physician, APRN or PA acting as an assistant.

It's important to know that only certain CPT codes allow for assistant-at-surgery billing, and the assistant must be credentialed with the payer. Modifier GE must be submitted with the claim to attest that there was no qualified resident available to act as an assistant. The operative report should also indicate that there was no qualified resident available.

Diagnostic testing orders face increase in reviews

Current audits by external entities such as Medicare and Medicaid have shown an increased focus on reviews of orders for diagnostic testing. The Centers for Medicare and Medicaid Services define an order as "communication from the treating physician/practitioner requesting that a diagnostic test be performed for beneficiary." The Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by the treating provider for the patient—the provider who will use the test results in that patient's care.

An order may include any of the following:

- A written communication signed by the treating physician/practitioner (hand-delivered, mailed or faxed to the testing facility)
- A telephone call
- An email from the treating physician/practitioner or his/her office to the testing facility
- Medicare allows the treating physician to issue an oral or verbal order for a diagnostic study; however, if a physician or practitioner communicates an order via telephone, both the treating physician and the testing site must document the phone call in their respective copies of the patient's medical record.

Although this is not an inclusive list, common diagnostic tests that require orders include EKGs, device interrogations, pulmonary function tests and all radiology exams.

Preparing medical record documentation ahead of time

The Compliance Department has received several inquiries from faculty and staff about prepopulating medical records. In July 2014, the Compliance Office and its medical director, Joshua Copel, MD, sent an email to faculty stating that "prepopulating notes is a practice that should be discouraged and should be used only in unusual circumstances."

Some of the recent inquiries have focused on preparing operative or progress notes ahead of time and revising them after the service has occurred. While this may seem like an efficiency provided by the electronic medical record (EMR), this practice is still highly discouraged.

Some of the pitfalls include retaining information in the note that is not relevant, or that is incorrect or not updated. This is true especially in regards to the physical exam, which may be identical from one visit to the next. In addition, the information pertaining to history copied and pasted from the previous note often leads to "note bloat."

In September 2012, the federal Department of Justice, and Department of Health and Human Services issued a letter addressing fraud and abuse concerns over certain EMR documentation practices. The letter stated "[a] patient's care information must be verified individually to ensure accuracy; it cannot be cut and pasted from a different record of the patient, which risks medical errors as well as overpayments."

In December 2013, the HHS Office of Inspector General produced a report titled, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology."

This report covered the risks and benefits of the copy-and-paste feature in EMR technology.

Our Medicare contractor in Connecticut, National Government Services, has published an article that states: "Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. … cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made."

In summary, we continue to recommend judicious use of "copy and paste" as it may present a concern for patient safety and is viewed with suspicion by payers. Please address any questions to Judy Harris, director of compliance at 203-785-3868 or judy.harris@yale.edu.

Spotlight: Lucy Wozdusiewicz stresses keeping up with change

Lucy Wozdusiewicz (commonly shortened to as 'Woz') joined the Compliance Office in October 2011 as a senior compliance auditor. Her areas of training and audit responsibility include the Yale Cancer Center, as well as internal medicine (sections including aids, infectious diseases and pulmonary). In a recent interview, Lucy provided the following insights into her role in the Compliance Office.

What has changed since you joined compliance?
Since I joined compliance in 2011 our department has grown by 25 percent, and we moved to a larger office, providing us with much needed space. In addition, we have transitioned to Epic and ICD-10. A lot has changed in just four years.

From your compliance perspective, what is the most important thing physicians and staff need to know?
It's important for physicians and staff to stay current with the ever changing federal and state guidelines that govern medical billing compliance.

What do you like best about your job?
I work with a wonderful group of auditors who exemplify teamwork and excellence. Our director and manager possess a wealth of knowledge and provide a continuous learning environment.

What do you find the most challenging?
Managing several high priority projects at once.

What are your hobbies?
My hobbies include card making and scrapbooking. I enjoy party planning and entertaining for friends and family. I make invitations and party favors. I also spend a great deal of time volunteering for my children's school community.

In the News

OIG concludes Danbury overstated wage data

The Office of Inspector General (OIG) recently issued a report concluding Danbury Hospital did not always comply with Medicare requirements for reporting wage data in its FY 2010 Medicare cost report. Specifically, the hospital reported overstated wage data totaling $4.9 million and 10,000 hours, which affected the numerator and denominator of its wage rate calculation.

Because of the errors, the OIG estimated that in FY 2014, Medicare overpaid Danbury Hospital approximately $249,000 and overpaid five other hospitals in the same core-based statistical area a total of approximately $741,000. The full report can be found at Danbury Hospital Reported Overstated Wage Data Resulting in Medicare Overpayments (A-01-14-00506) http://go.usa.gov/cpj8R.

J&L Medical pays $600,000 to resolve false claims allegations

J&L Medical Services, a durable medical equipment company in Middlebury, Connecticut, has agreed to pay $600,000 to resolve allegations that it violated the federal and state False Claims Acts by regularly utilizing the services of unlicensed technicians to provide respiratory therapy services to Medicare and Medicaid beneficiaries.

J&L provides Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) devices and accessories to Medicare and Medicaid beneficiaries diagnosed with obstructive sleep apnea.

The allegations against J&L cover a period from January 1, 2008 through May 15, 2013, and include the use of unlicensed technicians to set up CPAP and BiPAP machines, fit the patients with masks used with those machines, and educate the patients about the use of the machines.

A former J&L employee, John Hart, filed a whistleblower suit against the company, prompting the investigation. The whistleblower provisions of both the federal and state False Claims Acts provide that the whistleblower is entitled to receive a percentage of the proceeds of any judgment or settlement recovered by the government. As a result of his participation, Hart will receive $102,000. J&L was also required to implement a compliance program.

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Compliance Programs—Preventive Medicine for Healthcare Providers

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If you have concerns about medical billing compliance that you are unable to report to your supervisor or to the Compliance Officer, please call the hotline number above.

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