Teaching Physician Compliance

ALERT

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Boost your practice income!

Physician Quality Reporting Measures

The Center for Medicare and Medicaid Services (CMS) is developing and implementing pay for performance to encourage quality improvement and avoid unnecessary costs in the care of Medicare patients. YMG is in the process of developing a framework for departments to implement this where applicable. The Physician Quality Reporting Initiative (PQRI) is effective as of July 1, 2007. CMS hopes this financial incentive will encourage physicians and non-physician practitioners to participate in a voluntary quality reporting program. Healthcare providers who elect to participate may earn a bonus payment of 1.5% of their charges during the reporting period, subject to a cap. A healthcare provider's cap is calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80% threshold), (2) a constant of 300%, and (3) the national average per measure payment amount.

The final 2007 PQRI Quality Measures list is available at www.cms.hhs.gov/PQRI, as a download from the Measures /Codes webpage. All specialties are eligible to participate as the quality measures cover a broad spectrum of patient care.

PQRI uses numerators, CPT Level II codes, new CMS "G" codes, and sometimes modifiers to designate the quality measure being reported. The measures are reported using the standard HCFA-1500 claim form which is used today to bill charges to Medicare. The quality measures are entered on the claim form with 'zero' as the charge. The shaded box below contains an example of a quality measure for LDL levels.

NUMERATOR:

Patients with most recent LDL-C < 100 mg/dL

Numerator Coding:

Most Recent LDL-C Performed

CPT II 3048F: Most recent LDL-C < 100 mg/dL

OR

CPT II 3049F: Most recent LDL-C 100-129 mg/dL

OR

CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL

OR

LDL-C Level not Performed for Medical Reasons

Append a modifier (1P) to CPT Category II code 3048F or 3049F or 3050F to report documented circumstances why testing was not conducted.

• 1P: Documentation of medical reason(s) for not performing LDL-C level during the performance period (12 months)

OR

LDL-C Level not Performed, Reason Not Specified

Append a reporting modifier (8P) to CPT Category II code 3048F to report circumstances when the reason why the testing was not done cannot be specified.

• 8P: LDL-C was not performed during the performance period (12 months), reason not otherwise specified

"CMS recommends that physicians report on every quality measure"

CMS recommends that physicians and non-physician practitioners report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80% satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

The bonus payment will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS National Claims History (NCH) file by February 29, 2008, and (3) paid under the Medicare Physician Fee Schedule. Participating healthcare providers should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary co-payment or notice to the beneficiary regarding the bonus. The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. For further information visit the PQRI website or contact Cynthia Dwyer in the Patient Financial Services Department at 737-2360 or email cynthia.dwyer@yale.edu.

HIGH ALERT!

This will likely change your inpatient documentation practices

Are you in the habit of timing all your medical record documentation entries for inpatient services? If not, now's the time to start. Effective January 1, 2007, all inpatient medical record documentation, including progress notes, history and physicals (H&P), procedure reports, and verbal orders must be legible, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating a service provided. Verbal orders should also be timed and authenticated within 48 hours of being issued.

These changes were published in the Federal Register, 42 CFR, Section 482 on November 26, 2006 and are just one of the changes CMS made to the Conditions of Participation (COP) for hospitals to receive federal healthcare reimbursement. Other areas revised in the COP include mandating the completion of the H&P no more than 30 days before or 24 hours after admission, and securing medications. For more information, please contact Judy Harris at 785-3868 or judy.harris@yale.edu.

IN THE NEWS

The Scooter Store hits a bump in the road.

The Scooter Store will pay the U.S. government $4 million and give up "many millions more" in pending claims for Medicare reimbursements under a settlement agreement between the company and the Department of Justice (DOJ). The agreement settles allegations that the company violated the civil False Claims Act by allegedly engaging in an advertising campaign to entice Medicare patients to obtain power scooters but instead sold them more expensive power wheelchairs. The firm received $5,000 to $7,000 in reimbursement for each power wheelchair it sold, more than twice the amount for a scooter, which costs approximately $1,500 to $2,000.

In addition to the cash payment, the company will give up the right to reimbursement for most of its pending Medicare claims, totaling more than $43 million. CEO Doug Harrison, will personally pay $500,000 as part of the settlement. Mr Harrison is also prohibited from collecting dividends for his shares in the company over the next year in exchange for a release of his personal liability. Source: Department of Justice

Senior Medicare Patrol alive and kicking

The Office of Evaluations and Inspections announced the accomplishments of the Senior Medicare Patrol in a report issued in May of 2007. The Senior Medicare Patrol Projects receive grants from the Administration on Aging to recruit retired professionals to serve as educators and resources in assisting Medicare patients to detect and report fraud, waste, and abuse in the Medicare program. In 2006, a total of 65 projects educated 411,458 Medicare patients in 210,780 group training sessions and one-on-one sessions.

The Patrol received 11,830 complaints, of which 4,123 were referred to Medicare contractors for follow-up. A total of 2,501 complaints resulted in $110,592 recouped to the Medicare program. The projects also reported $589,288 in savings to Medicare patients. In many of these cases, Medicare patients were charged inaccurate co-payments, deductibles, or premiums for prescription drugs covered under the Medicare Part D benefit.

Congratulations on Excellent Medicaid Audit Results to...

...the departments of Neurosurgery, Ophthalmology, Genetics, Orthopedics, Dermatology, Adult Emergency Medicine, and Therapeutic Radiology. These departments currently bill the Medicaid program under our Multi-Specialty number. Obtaining the medical record documentation in response to the Medicaid audit can be challenging since the records are housed in various locations. Since 1994, the Medicaid audit results have included instances of 'no documentation' for a clinical service which was billed and part of the audit universe. For the first time since 1994, there wasn't a single finding of 'no documentation' by the Medicaid auditors for our Multi-Specialty audit. This is a significant achievement since overpayments identified by Medicaid are extrapolated across the universe of dollars paid during the audit period. Congratulations to all!

Medicare names the top ten claims processing errors

Medicare has published the top ten claims billing errors made by health care providers. The errors are as follows;

1) Listing the wrong Medicare name or number
2) Reporting an incomplete Medicare patient address
3) Omitting the UPIN or NPI of the referring physician
4) Using an incorrect place of service for an Evaluation and Management (E&M) code
5) Listing the provider billing number in the wrong field when billing for more than one physician in the same group
6) Reporting invalid diagnosis codes
7) Reporting invalid or deleted CPT Procedure codes
8) Omitting Medicare secondary payer information
9) Submitting duplicate claims
10) Submitting bundled services separately.

These errors will keep your claims from getting paid by Medicare. Therefore obtain the correct demographics and keep your encounter forms up to date in order to be successfully reimbursed by all payers.

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Compliance Programs—Preventative Medicine for Healthcare Providers

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