Teaching Physician
Compliance
ALERT
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Consultation audit alert!

Medicare is auditing claims for level 5 consultations to see if the documentation supports the level billed and to see if the service is truly a consultation. Since January of this year, our practice has received close to 500 requests for documentation. As a result of these reviews, the Compliance Department would like to offer the following reminders.

1. According to the Center for Medicare and Medicaid Services (CMS), a consult is a request from one practitioner to another for the consulting practitioner's advice and opinion. Consultation services cannot be performed as a split/shared evaluation and management service. This means that a non-physician practitioner (NPP) such as an APRN and a physician cannot each perform certain aspects of the consult service and bill the combined documentation as a consultation.

2. A level 5 consultation requires a comprehensive history, exam and medical decision making of high complexity.

3. Before billing for a service, there should be appropriate documentation in the patient's medical chart to support the services billed.

4. Medical record documentation must be signed in a timely manner by the individual performing and documenting the services.

If you have any questions regarding consultation billing or would like a session on how outside auditors determine if you've billed the correct level, please contact Judy Harris at 785-3868.

RAC attack modified

Recovery Audit Contractors (RACs) located in four areas around the country will review Medicare claims on a post-payment basis and be paid a contingency fee based on the errors they find. In response to health care provider concerns, the Centers for Medicare & Medicaid Services (CMS) has made several changes to the RAC program to minimize the burden on health care providers and ensure accuracy.

When the program goes into effect this year nationwide, providers can expect some key improvements. CMS has limited the RAC "look-back

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Shared/Split visit Clarification

Since August of 2008, National Government Services (NGS) has been our Medicare Administrative Contractor. According to NGS, for physicians to bill split/shared visits both the physician and the Non Physician Practitioner (NPP) must each participate in a face-to-face evaluation and management of the patient and the medical record must document a substantive contribution of each.

".....seen and examined" is also insufficient for physician documentation of a teaching visit under the teaching physician documentation rules.

If the physician writes "seen and examined" without providing any information about the extent or results of the examination then it would not be possible to determine that physician's participation and the service should be billed under the NPPs billing number.

NGS has also stated that "seen and examined" is also insufficient for physician documentation of a teaching visit under the teaching physician documentation rules.

Operative reports

The following Q&A is based on JCAHO requirements in regards to documentation of operative reports.

Q: In what timeframe must an operative report be dictated and placed in the medical record?

A: The operative report must be written or dictated immediately after an operative or other high risk procedure. An organization's policy, based on state law, would define the timeframe for dictation and placement in the medical record. The most important issue is that there needs to be enough information in the record immediately after surgery in order to manage the patient throughout the postoperative period. This information could be entered as the operative report or as a hand-written operative progress note.

If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then an operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This operative progress note should contain at minimum comparable operative report information.

These elements include:

- the name of the primary surgeon and assistants,
- procedures performed and a description of each procedure,
- findings,
- estimated blood loss,
- specimens removed, and
- a post operative diagnosis

Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver. In addition, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.

Medical record documentation is required before billing for services. The guidelines above will help us meet billing requirements as well.

Outpatient Psychiatric services

Psychiatric services provided in an outpatient hospital or clinic setting have specific documentation requirements. At a minimum, the documentation should include:

1. the specific services rendered
2. the date and actual time the services were rendered
3. who rendered the services
4. the setting in which the services were rendered
5. the amount of time it took to deliver the services
6. the relationship of the services to the treatment regimen described in the plan of care, and
7. updates describing the patient's progress.

As noted above, the time the service was rendered and the duration of the services needs to be recorded regardless of whether you are billing a time based code or not.

Source: 4221 Outpatient Psychiatric Services D. Documentation

In the News

Therapy scheme aborted

Sanjay Patel and his wife, Leena Patel were arrested in Connecticut for allegedly filing false Medicare claims. The couple, held at Hartford County Jail in Connecticut, faces 13 criminal counts, including grand theft, identity theft, health benefits fraud, receiving stolen property, and money laundering. The allegations include stealing the identities of people on Medicare and submitting claims for procedures that were never performed. The Patels, along with an accomplice, are accused of paying unsuspecting seniors at retirement homes $100 to obtain their insurance information and sign their names on blank medical forms. They then matched the seniors' signatures and Medicare insurance numbers with provider ID numbers from licensed physicians to submit fake claims.

None of the claimed procedures were performed, and the physicians listed on the claims had no idea their names were being used to perpetrate the scheme. When some senior citizens began to receive explanation of benefits from Medicare indicating they had been treated at Balboa Therapy Center, they contacted the authorities.

The Patels owned Balboa Therapy Center in San Diego which was used as a front for the scheme but the couple was found in Connecticut trying to flee the country to India. If convicted, the couple faces a prison term of more than 12 years.

Second Connecticut facility hires excluded individual

In the December 2008 Alert, we reported that Walnut Hill Nursing Home agreed to pay $222,000 to settle allegations that it illegally submitted claims to federal health care plans for services performed by a nurse whom the federal government excluded from Medicare. A second Connecticut facility, Silver Hill Hospital in New Canaan, CT has also been fined for the same issue.

In 2004, Silver Hill hired a full-time registered nurse whose license to practice in Connecticut had recently been reinstated. However, the nurse had neglected to be reinstated to the Medicare and Medicaid programs, and Silver Hill allegedly failed to check the OIG's exclusion database, where she was still listed as an excluded provider. After employing the RN for four years, Silver Hill learned that she was excluded. Silver Hill agreed to settle False Claims Act allegations and to pay $60,338.49 and entered into a Corporate Compliance Agreement.

As a precaution against a similar fate, the Compliance Department of the Yale Medical Group conducts monthly screening of faculty and staff to ensure that we don't employ any excluded individuals.

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period" to three years, with a maximum look-back date of Oct. 7, 2007 in response to concerns raised about indefinite retrospective review of past claims. Second, to reduce the paperwork burden, RACs will accept imaged medical records from providers on CDs or DVDs. Third, CMS is limiting the number of medical record requests that RACs can make. For inpatient hospital claims, the limit will be 10 percent of average monthly Medicare claims per 45 days, up to a maximum of 200. Limits for physician claims will vary by the size of the practice, with larger groups exceeding 16 individuals having to submit a maximum 50 medical records per 45 days.

The RAC is required to employ a physician medical director and certified coders to help ensure accuracy. To maximize transparency of RAC procedures, new issues targeted by audits will be posted to the RAC's Website. Patterns of vulnerabilities will also be posted on the CMS Website.

Information on the RAC program is available on the Web at ***http://www.cms.hhs.gov/RAC/01_Overview.asp#TopOfPage.***

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