Teaching Physician Compliance

ALERT

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2008 Teaching Physician test results

One of the options offered to faculty to meet their medical billing compliance training requirement is the online tutorial and quiz. Based on the 2008 training results, the following three questions were most frequently answered incorrectly. The question and corresponding correct answer are provided below. For additional information or questions about these Q&As, please contact Judy Harris at 785-3868 or judy.harris@yale.edu.

1. For all initial hospital care, emergency department visits, new patient visits and inpatient or outpatient consultations all three key components must be performed and documented by the teaching physician.

Answer: False. For purposes of payment, these E&M services billed by teaching physicians require that they personally document at least the following;

That they performed the service or were physically present during the key or critical portions of the service when performed by the resident

The participation of the teaching physician in the management of the patient; and

All three key components (history, exam and medical decision making) must be documented and can be achieved by combining the attending and resident note.

2. This same patient with hypertension is followed by the internist to adjust new medications while in the hospital. These visits would be reported as:

Answer: Subsequent visits - managing a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

3. Without the teaching physicians presence the resident performs and documents a history, examination and medical decision making for a new patient. Following the resident the teaching physician sees the patient and documents:

"I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note". This is acceptable documentation by the teaching physician.

Answer: True. CMS teaching physician guidelines revisions state that the teaching physician must document at least that they performed the service or were 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.

Following are examples of minimally acceptable documentation:

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

For follow-up visits: "See resident's note for details. I saw and evaluated the patient and agree with the resident's findings and plans as written.

Consultation reminder

Effective for dates of service January 1, 2006, a written request and reason for a consultation needs to be included in the requesting physician's plan of care in the patient's medical record documentation. The consulting physician's medical record documentation must include who requested the consultation and the reason for the consultation.

A consultation request may be verbal however the verbal interaction identifying the request and reason for a consult needs to be documented by the requesting physician and also by the consultant physician in the patient's medical record. These rules apply to office, inpatient and outpatient consultations.

Consultation service can not 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. 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.

In an office or outpatient setting, another consultation may be requested of the same consultant physician if the consultant has not been providing ongoing management of the patient for this con-

continued on page 2

Surety bonds help in fight against home health fraud

The Centers for Medicare & Medicaid Services (CMS) will now require durable medical equipment (DME) suppliers to post a surety bond of $50,000. This requirement was due in part to the large number of improper and potentially fraudulent payments to medical equipment suppliers for furnishing medical equipment and devices to people with Medicare. Existing suppliers must comply with this requirement by Oct. 2, 2009 while newly enrolling suppliers must meet this requirement by May 4, 2009.

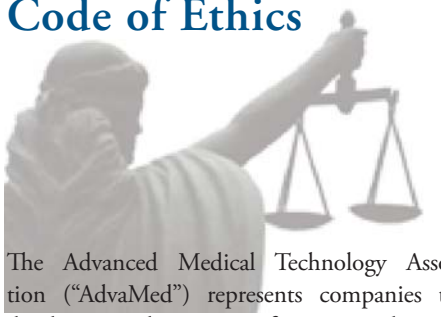
The 2007 Medicare error rate report found approximately $1 billion in improper payments for medical equipment and supplies. CMS has revoked the billing privileges of more than 1,100 medical equipment suppliers in south Florida and southern California and is suspending payments to home health agencies in the Miami-Dade, Fla. area.

In addition to suspending payment, CMS is:

- Implementing extensive pre- and post-payment review of claims submitted by ordering/referring physicians;
- Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;
- Verifying the relationship between physicians who order a large number of home health services and the beneficiaries for whom they ordered those services; and
- Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the services for which Medicare is being billed.

These precautions and the surety bonds are designed to limit the Medicare program risk from fraudulent equipment suppliers and help to ensure that only those suppliers who remain in the program furnish items to Medicare beneficiaries that are considered reasonable and necessary from legitimate DME suppliers.

AdvaMed updates Code of Ethics



The Advanced Medical Technology Association ("AdvaMed") represents companies that develop, produce, manufacture, and market medical products, technologies and therapies.

AdvaMed recognizes that companies can serve the interests of patients through beneficial collaborations with health care professionals and has a Code of Ethics that governs these interactions. AdvaMed recently updated its Code of Ethics and Frequently Asked Questions which will become effective July 1, 2009.

The new code which replaces the 2005 code adds new provisions addressing practices such as royalty arrangements and establishes a new certification mechanism to foster compliance with the Code.

Although the code is similar to the PhRMA Code, the AdvaMed Code provides additional compliance guidance on certain types of interactions with healthcare professionals that are more relevant to, or prevalent in, the device industry, such as reimbursement support and providing free products for evaluation or demonstration purposes.

AdvaMed is strongly encouraging all companies to adopt the code and to submit to AdvaMed an annual certification that the Company has adopted the Code and has implemented an effective compliance program. AdvaMed's decision to update the Code is timely given the current environment of government investigations and Congressional inquiries in the conflict of interest area.

Consulation Reminder continued

dition after his/her initial consultation. A transfer of care occurs when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patients' complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

A consultation service may be based on time when counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient. The total time for the visit must be recorded in the medical record and a statement that over 50% of the visit was spent on counseling or coordination of care.

Payment can be made for a consultation if a physician or qualified NPP in a group practice requests a consultation from another physician or qualified NPP in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting physician or NPP.

The confirmatory consultation codes (99271 – 99275) and follow-up consult codes (99261-99263) were deleted in 2006.

Bill requires companies to report payments to doctors

Senators Herb Kohl (D-Wisconsin) and Chuck Grassley (R-Iowa) introduced bill (s. 301) on January 22, 2009 that would require drug and device companies to report financial payments and gifts they make to doctors that total more than $100 annually. The purpose of the bill is to improve transparency in how federal programs like Medicare and Medicaid pay for drugs and devices. In line with the bill, the AdvaMed gift policy in their updated Code of Ethics advocates that only educational items valued at less than $100 can be provided.

The legislation would require that the self-reported data be posted online and available to the public, and would impose fines of as much as a $1 million for companies that failed to comply with the reporting mandate.

The 2009 bill is similar to legislation the senators introduced in 2007 but which was never taken up by the full Senate. The physician payments bill is available at

http://aging.senate.gov/letters/ppsabill2009.pdf

In the News

Temple Health Services pays $284,398

Temple Health Services, LLC (THS) located at 230 George Street, New Haven, Connecticut, has entered into a civil settlement agreement with the Government in which it will pay $284,398 to resolve allegations that it violated the False Claims Act. The allegations against Temple involved charges billed to Medicare for physical therapy services and physician's services that were not medically necessary, or were not provided as billed. Cardiologists would refer Medicare patients with certain cardiac conditions to THS for cardiac rehabilitation. However, almost every time a Medicare patient went to the clinic for the cardiac rehabilitation services, THS would also bill Medicare for physical therapy services and a physician's office visit, in addition to the cardiac rehabilitation services. The settlement resolves claims submitted between January 1, 2005 and December 31, 2007. *Source: United States Attorney's Office*

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