Teaching Physician Compliance ALERT

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Government Corner

Quality of care a factor in hospital reimbursement

Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on admission (POA) of patients effective for discharges on or after October 1, 2007. Present on admission is defined as present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

The Centers for Medicare & Medicaid Services (CMS) have selected eight high cost or high volume (or both) diagnosis codes that:

- Represent conditions (including certain hospital acquired infections) that could reasonably have been prevented through the application of evidence-based guidelines; and
- When present on a claim along with other (secondary) diagnoses, have a DRG assignment with a higher payment weight.

According to the final Inpatient Prospective Payment System (IPPS) rule, the eight diagnoses are:

- catheter-associated urinary tract infections
- pressure ulcers
- vascular-associated UTIs
- three kinds of serious preventable events (object left in during surgery, air embolis, blood incompatibility)
- falls
- mediastinitis (a preventable surgical site infection that follows heart surgery)

Then, for acute care inpatient PPS discharges on or after October 1, 2008, while the presence of these diagnosis codes on claims could allow the assignment of a higher paying DRG, when they are present at the time of discharge, but not at the time of admission, the DRG that must be assigned to the claim will be the one that does not result in the higher payment.

The Focus is on Quality of Care

Ensuring the quality of care provided by health care organizations has never been more critical. Both consumers and payers are demanding more accountability in this area and health care quality is emerging as an enforcement priority for health care regulators.

The Office of the Inspector General (OIG) in concert with the American Health Lawyers Association has developed a publication to address senior leadership's responsibility towards quality of care issues within their institution. The publication is titled

"Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors."

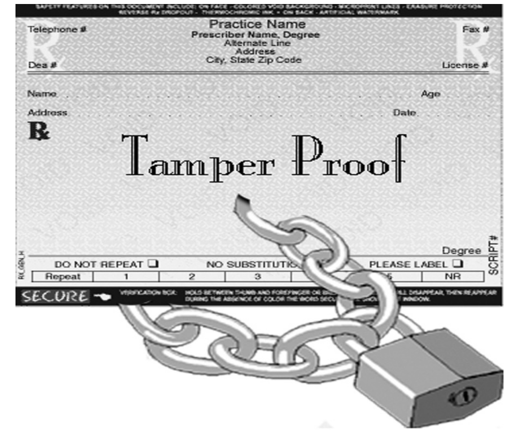
To view that publication, go to: http://www.oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf

Your participation is requested.

William D. Rogers, M.D., FACEP, Medical Officer in the Office of the Administrator Director at CMS, has written an article that invites all physicians to participate in the Practicing Physicians Advisory Council (PPAC), the CMS' Open Door Forum (ODF), and the Physicians Regulatory Issues Team (PRIT) to help reduce Medicare's administrative burden. To read the article, go to this link:

http://www.medicarepatientmanagement.com/issues/02-04/mpmJA07-BurdenRogers-0626.pdf

Tamper proof prescription pads



As of October 1, 2007 practitioners are required to use tamper-proof prescription pads for Medicaid patients for prescriptions in order for the prescription drugs to receive Medicaid reimbursement. The rule applies to all written prescriptions – even those for over-the-counter drugs – issued to Medicaid patients. There are exemptions for Medicaid managed care patients and emergency prescriptions – though you'd be expected to provide a compliant written prescription in an emergency situation within 72 hours.

CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each State will define which features it will require to meet those characteristics in order to be considered tamper-resistant. The baseline characteristics must: (1) prevent unauthorized copying of a completed or blank prescription form; (2) prevent the erasure or modification of information written on the prescription by the prescriber; or (3) prevent the use of counterfeit prescription forms. By October 1, 2007, States must require at least one of these baseline requirements. By October 1, 2008, States must require all three characteristics on prescription pads in order to be considered tamper-resistant.

Legislation has been introduced in the House and Senate to delay implementation of the required tamper-proof prescription pads for Medicaid patients, but action has not yet been taken on these bills.

NOTE: President George W. Bush has delayed the implementation date for all Medicaid prescriptions to be written on tamper-resistant paper until April 1, 2008.

IN THE NEWS

Haddam physician arrested

A Haddam physician who practiced at the Pain & Headache Treatment Center in Meriden was arrested and charged with multiple counts of illegally prescribing narcotics and other drugs. Karen Warner, M.D., faces 10 counts of illegal prescription or sale of narcotics, 10 counts of illegal prescription or sale of controlled substances and one count of failure to keep controlled substance records. Some of Dr Warner's patients sold the drugs she had prescribed. Other patients received prescriptions for drugs for which they had previously received drug rehabilitation. One patient went into respiratory failure after taking oxycontin, roxicodone, Klonopin and Kadian while wearing a Duragesic patch all in one day. The Medicaid Fraud Control Unit is prosecuting the case.

Westport chiropractor sentenced

A 52-year-old Westport resident with a chiropractic office in Norwalk was sentenced Thursday to eight months in prison and must also pay more than $1.1 million in restitution for health care fraud. Richard Fogel was sentenced by U.S. District Judge Janet Bond Arterton in New Haven to eight months of imprisonment. The prison term will be followed by three years of supervised release, the first three months of which Fogel must serve in home confinement with electronic monitoring. In addition, Fogel must perform 200 hours of community service. Fogel, who owned and operated the East Avenue Chiropractic Center in Norwalk, admitted he created false medical records for patients who were involved in personal injury claims, settlements and lawsuits.

Have a medical billing concern? Here's what to do.

As part of the Yale Medical Group's (YMG) commitment to medical billing compliance, a confidential hotline was implemented in October of 1998. The hotline is a simple way for employees to anonymously report concerns that may involve potential violations of medical billing regulations. All employees, both faculty and staff, may use the hotline. This includes all employees in the Clinical Departments, Patient Financial Services, including offsite practice locations.

The hotline is available to employees for those situations that are related to compliance with medical billing regulations. The hotline is an avenue of reporting available to all employees in the event that:

- The employee does not feel comfortable bringing their concerns to their supervisor, or
- employee has brought their concerns to his or her supervisor and the employee was not satisfied with the action or possibly lack of action taken.

The YMG has a policy of non-retaliation for those employees who in good faith report possible compliance issues. For detailed information about the hotline, please refer to the January 2000 Alert newsletter which can be found on the Compliance website at http://yalemedicalgroup.org/yfp/ymg/comply/alert/June2000.html

The Hotline Number is 1-800-351-2831

What's new in your department?

Is your department moving to a new documentation system or an electronic medical record? If so, the Compliance Department should be reviewing your new system or process to make sure that it would meet current audit criteria. The Compliance Department recommends that you:

- notify the Compliance Department before the implementation of any new system or process for documentation
- make sure your new system or process provides a clear audit trail of who entered what data
- ensure adequate security is in place including id and password protection, and
- educate users of the system that ids may not be shared.

With electronic systems and/or templates, it is best to avoid the use of "cloned" medical record documentation. "Cloning" is the use of the same, pre-entered documentation for the same patient or for other patients. One Medicare carrier has published a bulletin stating it will not pay for cloned documentation because they view it as misrepresentation of the medical necessity requirement. On audit, Medicare will generally ignore information that has been carried over from a previous note and only give credit for the new information in the medical record unless it was medically necessary for the physician to re-review the past or social history. Please contact Judy Harris, Director Medical Billing Compliance, at 785-3868 or judy.harris@yale.edu for more information or questions.

2008 CPT changes

Brace yourself for the 2008 CPT code changes! According to our sources, there will be 242 new procedure codes, 51 deleted, and 298 revised codes for a total of 591 changes. The 2008 CPT books will become available to the departments in November and December. Since the codes will be effective 1/1/2008, dedicated staff time should be allocated so that our encounter forms and other billing tools can be updated.

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