Teaching Physician Compliance ALERT
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A physician examines her patient during a hospital visit. Under Medicare's consultation policy, a physician may not bill for a consultation if a physician assistant or nurse practitioner performed any portion of the care.

Standing behind team-based care

AAMC protests regulations by CMS prohibiting shared or split consultations, urges a change in the rules.

The Association of American Medical Colleges (AAMC) sent a letter on behalf of 50 medical societies to the Center for Medicare and Medicaid Services (CMS) requesting changes to the CMS consultation policy, which does not allow the service to be conducted as a shared/split visit between a physician and a non-physician practitioner (APRN or PA).

The AAMC letter stated:

This policy presents a number of challenges to physicians as it does not reflect current medical practice. Today, as with the delivery of many medical services, a team-based approach is often employed in conducting a consultation. This approach provides a higher quality of care for the patient, allows the physician to see additional patients by having the non-physician practitioner (NPP) take on a portion of the patient's care, and fosters a collaborative approach to the practice of medicine."

Current practice

"That CMS' approach is inconsistent with the way medicine is practiced today is well illustrated in a hospital cancer ward. In such environments, an oncologist and a Certified Registered Nurse Practitioner (CRNP) who are devoted to cancer care are often employed by the same oncology medical group practice. While the physician performs the majority of the work, the CRNP may obtain a patient's complete history; perform certain aspects of the medical exam, and order diagnostic tests and medications. Under Medicare's consultation policy, a physician is precluded from billing for a consultation if an NPP performed any portion of the care. Such an approach is unfair, and discourages collaborative, team-based treatment."

The AAMC also stated the CMS policy was in conflict with the American Medical Association's (AMA) Current Procedural Terminology (CPT) definition of a consultation.

Bottom line

The bottom line is that the AAMC requested that CMS recognize consultations as E/M services under Medicare Transmittal #788, and add language that specifically permits the practice of shared/split billing for consultations.

Take care with record-keeping when billing for actual time spent

Many of our faculty bill the evaluation and management (E&M) services according to time since over 50% of the visit was spent counseling or coordinating care of the patient.

For example, a return patient office visit, level 4 (99214) is typically 25 minutes. This is an easy area to target for audits if the patients seen and time spent during the day turn out to be 13 or 14 hours when added up. That isn't to say it's not possible, but it does send up a red flag for audit.

If you bill according to time, you must record the total time spent with the patient and a statement that over 50% was spent on counseling or coordination of care. The issues that were discussed or types of care coordinated should also be documented in the patient's medical record. It is not sufficient to document this information on the encounter form. Before using time as a determinant, you should be aware of the following:

1) In the office and other outpatient settings, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to face time refers to the time with the billing physician or billing Non-Physician Practitioner (NPP) (APRN or PA) only. Counseling by other staff is not considered to be part of the face to face physician or NPP/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends on the physician service provided. *Reference: Med-Manual, 15501. Evaluation and Management Service Codes - General (Codes) 99201-99499.*

2) "Keep in mind that Medicare does not cover family education. Discussions with family members when patients are not present will not, in most cases, be covered by other payors. The patient must be present when family members want an update from the physician in order to be considered as a time factor and reimbursable by insurance carriers." *Reference: April 2000 Bulletin of the American College of Surgeons.*

Examples of templates to use for time-based E&M services can be found at http://yalemedicalgroup.org/comply/alert/Timetemp.html.

IN THE NEWS

Record year for fraud and false claims

The United States government recovered over $3.1 billion in fraud settlements and judgments in 2006, the most ever for a single fiscal year, including about $2.2 billion for health care fraud, the Department of Justice announced on November 21, 2006. Compared to fiscal year 2005, health care-related recoveries were up about a billion dollars and non-health care recoveries were up about a half-billion dollars. The previous record year was 2003, when the government recovered $2.2 billion from fraud. About half of the 2006 total came from two settlements, the $920 million settlement with Tenet Healthcare Corporation, America's second largest hospital chain, and a $565 million recovery from the Boeing Company, the second largest defense contractor.

The Tenet settlement resolved claims of:

- Receiving excessive "outlier" payments from Medicare.
- Paying kickbacks to physicians to get Medicare patients referred to its facilities.
- Engaging in improper coding of certain procedures in order to receive higher reimbursement.

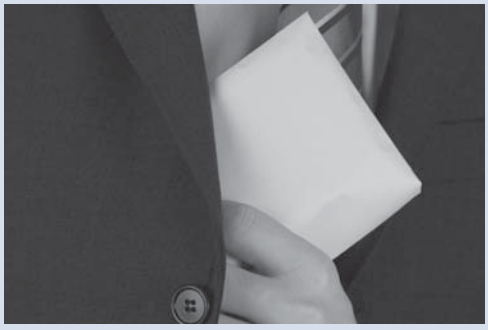
One-point-three-million dollars were recovered as a result of whistle-blower cases. Under the equitam (whistle-blower) provisions of the Federal False Claims Act, whistle-blowers can receive 15-25% of the governments' recovery from a case they initiated. Whistleblowers received a total of $190 million in 2006.

Physician accused of illegal patient referral scheme

A world-renowned physician at the University of Medicine and Dentistry of New Jersey (UMDNJ) has been accused of an illegal referral scheme under investigation by the U.S. Attorney's Office.

The university said it placed Jerrold Ellner, the chair of medicine at UMDNJ's Newark campus, and Ronald Pittore, the second-in-command of its legal management department, on administrative leave while the school continues reviewing the referral program. Both individuals were identified as key figures in UMDNJ's plan to hire at least 18 local cardiologists as part-time clinical assistant professors. The cardiologists, who did no work for the department or the school, were expected to do little more than refer patients to University Hospital, in an effort to save the hospital's struggling cardiac surgery program.

The Sunday Star-Ledger reported that the doctors were paid as much as $150,000 a year for no work with the understanding that they would refer their patients to the surgery program.



A federal monitor alleged that UMDNJ's payments to referring cardiologists were essentially kickbacks.

How many diagnosis codes can I bill?

As early as July 1, 2007, Medicare will allow eight diagnosis codes on Medicare claims. It is important that billing staff and providers are made aware of this change. The primary diagnosis code is usually the reason the patient is presenting for the visit. For example, if a cancer patient comes in because they are experiencing extreme nausea, the nausea would be the primary diagnosis and cancer would be the secondary diagnosis. Expanding the number of diagnosis codes available on the CMS-1500 form was mandated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

Training alert

All billing physicians and non-physician practitioners must complete their one-hour of medical billing compliance training by December 31, 2006 or their billing numbers may be suspended. To check your training status, visit http://www.yale.edu/training/.

The training requirement may be met by attending a compliance session on December 19 at 5:00 pm in Fitkin Amphitheater or by taking the online training at http://yalemedicalgroup.org/comply/index.htm and clicking on Med Billing Quiz.

Over 3,000 excluded by OIG

In FY 2006, OIG reported the exclusions of 3,425 individuals and organizations for fraud or abuse of Federal healthcare programs and/or their beneficiaries; 472 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 272 civil actions.

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Compliance Programs—Preventative Medicine for Healthcare Providers

P.O. Box 9805
New Haven, CT 06536
1 (800) 351-2831 hotline
www.yalemedicalgroup.org/comply

Director: David J. Leffell, MD
Director of Compliance: Judy L. Harris
judy.harris@yale.edu | (203) 785-3868

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