Teaching Physician Compliance

ALERT

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DID YOU KNOW YOU WERE SUPPOSED TO. . .

This article is meant to highlight certain obligations of the clinical departments by the Yale Medical Group (YMG) Compliance Program. The following excerpt comes from section g in *"IV. Departmental, Physician and Related Responsibilities 1. Departmental Obligations."*

Each clinical department is expected to:

g. Timely perform related administrative tasks, including: (i) initiating corrective action on overpayments identified by the department or the Compliance Department including timely notification to PFS and department verification of corrective action; (ii) sending copies of all correspondence with insurance carriers regarding billing or compliance to the Director of Compliance, who monitors all such correspondence; (iii) submitting all draft departmental training materials regarding billing and documentation to the Director of Compliance for review and approval in advance of use;

(i) When the Compliance Department identifies an overpayment and asks the clinical department to submit a charge correction to Patient Financial Services (PFS), this task needs to be carried out promptly. This is especially true in light of the new Patient Protection and Affordable Care Act (PPACA) which mandates that identified overpayments need to be refunded within 60 days or the False Claims Act may be invoked. The reason for the charge correction should be identified on the Patient Financial Services Charge Correction Form as #12 Compliance Audit. PFS also has guidelines to promptly refund overpayments.

(ii) The Compliance Department should be notified immediately of any compliance audit-related correspondence received from federal or private insurers. Such correspondence may include the following terms: Special Investigation Unit (SIU), Progressive Corrective Action (PCA), Medical Review, Provider Audit, CERT, Program Integrity, and Medicaid Fraud Control Unit. Billing clarifications or instructions received from insurance carriers by PFS or the clinical departments should also be forwarded to the Compliance Department.

(iii) We encourage clinical departments to discuss and hold medical billing compliance training sessions with faculty. Credit may be given to faculty to meet the annual medical billing compliance training requirement if the content qualifies. Before the training session, all training materials should be sent to the Compliance Department for review.

The YMG Compliance Program and manual is online at: http://comply.yale.edu/medicalbilling/index.aspx

HEALTHCARE PRACTITIONERS NOW REQUIRED TO ENROLL IN MEDICAID

Effective January 1, 2012, the Department of Social Services is requiring most performing providers employed by or contracted with hospitals or clinics to enroll in the Medicaid program. This impacts the following practitioners:

- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Midwife (CNM)
- Chiropractor
- Dentist, with the exception of hygienists
- Licensed Alcohol and Drug Counselors (LADC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Physician
- Physician Assistant (PA)
- Podiatrist
- Psychologist

This requirement is intended to support the enrollment of ordering and referring providers mandated by the Health Care Reform legislation, Medicaid restructuring, and the Medicaid Electronic Health Record (EHR) Incentive Payment program. All applicable YMG provider types (APRN, CNM/LNM, LADC, LCSW, LPC, MD/DO, PA, DPM, PhD/PsyD) are currently enrolled in Medicaid, but if you have questions please contact Joni Jones, Manager of YMG Credentialing at 737-1835.

PLACE OF SERVICE CLARIFICATION

The Center for Medicare and Medicaid Services (CMS) has issued MM7631 which provides instructions for place of service (POS) coding. Of note was the following example involving a service with a professional and technical component:

If a patient has an MRI in a hospital outpatient department (POS 22), the technical component (TC) is billed with POS 22. If the professional component (interpretation) is done in a physician office setting (POS 11), the PC should be billed with POS 22 to match the TC billing.

MM7631 can be found at: http://www.cms.gov/MLNMattersArticles/Downloads/MM7631.pdf

UNLISTED CPT CODES

The American Medical Association (AMA) owns copyright on the Current Procedural Terminology (CPT) that is used by all health care professionals to bill for their clinical care services. The AMA recognizes that there may be services that health care professionals provide that are not found in the CPT code set. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. There are many unlisted codes in the CPT book. Some examples of unlisted codes include:

99499	unlisted evaluation and management service
19499	unlisted procedure breast
29999	unlisted procedure arthroscopy
32999	unlisted procedure lungs and pleura

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49659	unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
59899	unlisted procedure, maternity care and delivery
64999	unlisted procedure, nervous system
86849	unlisted immunology procedure
89398	unlisted reproductive medicine laboratory procedure

Unlisted CPT codes are often used to represent new and emerging technologies for which U.S. Food and Drug Administration (FDA) approval has not yet been granted. Unlisted codes provide the means of reporting and tracking services and procedures until a more specific code is established.

Because unlisted and unspecified procedure codes are not specific, health care providers must submit supporting documentation so that billing can determine coverage and payment. Pertinent information should include:

- A clear description of the procedure or service; its nature, and extent, and why it was needed
- Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening.
- Any extenuating circumstances which may have complicated the service or procedure.
- Time, effort, and equipment necessary to provide the service.
- The number of times the service was provided.

When submitting supporting documentation, it is helpful to underline the portion of the report that identifies the test or procedure associated with the unlisted procedure code. Before selecting an unlisted CPT code, please remember to check the Category III codes in the CPT book. Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes allow data collection for these services/procedures. Use of unlisted codes do not offer the opportunity for the collection of specific data. An example of a Category III code in CPT 2012 is:

0095T Removal of total disc arthroplasty, anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure.

The use of Category III codes allow physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services and procedures for clinical efficacy, utilization and outcomes. The bottom line is that it is inappropriate to select a CPT code for billing that is "closest to" describing the service provided. The CPT description must be an exact match for the services provided. If there is no exact match, an unlisted CPT code must be used.

IN THE NEWS

Norwich Oncology practice pays $316,513

Eastern Connecticut Hematology and Oncology, P.C. (ECHO), with offices located at 330 Washington Street in Norwich, has entered into a civil settlement with the government in which it will pay $316,513 to resolve allegations that the practice violated the False Claims Act. The allegations against ECHO involved fraudulent billing to Medicare, Medicaid, and Tricare for services provided by medical assistants. In Connecticut, medical assistants are unlicensed. State of Connecticut rulings and guidance indicate that medication administration is a licensed activity that should not be delegated to unlicensed personnel, unless a specific statutory exemption exists. ECHO would regularly have unlicensed medical assistants administer injections of medications, including Epogen, Neupogen, Neulasta, and Aranesp and insurers were then billed for the administration of the injections. Because medical assistants are not authorized to administer medication in Connecticut, the government health care programs would not have paid the claims.

This matter was investigated by the Office of Inspector General for the Department of Health and Human Services; the Federal Bureau of Investigation; the Defense Criminal Investigative Service; the United States Food and Drug Administration, Office of Criminal Investigations; the United States Railroad Retirement Board, Office of Inspector General; and the Medicaid Fraud Control Unit, Office of the Chief State's Attorney.

New Milford Hospital Pays $472,000

The $472,000 settlement by New Milford Hospital is the latest in a round of investigations in the state for Lupron billing. Federal prosecutors alleged that the hospital regularly billed the higher-paying female related Lupron billing code, thereby receiving substantially higher reimbursement, for its male patients who were treated for prostate cancer. New Milford Hospital is the third Connecticut hospital in 2011 to settle allegations involving improper billing to Medicare for Lupron injections. Masonicare Health Center in Wallingford and St. Francis Hospital in Hartford settled similar allegations.

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Compliance Programs—Preventative Medicine for Healthcare Providers

P.O. Box 9805

New Haven, CT 06536

1 (877) 360-YALE hotline

http://comply.yale.edu/medicalbilling

Chief Medical Officer: Ronald Vender, MD

Compliance Medical Director Joshua Copel, MD

Director of Medical Billing Compliance: Judy L. Harris

judy.harris@yale.edu | (203) 785-3868