Teaching Physician
Compliance
ALERT
September 2015 Issue 102

Fall is bringing many changes to our practice. By the time you get this, we will be using ICD.10 codes instead of ICD.9, joining the rest of the medical world. Everyone hates codes, whether the old system or the new, but with computerized billing, it's the only way to get information to payors in a standardized fashion.

The most important part of using ICD.10 from the compliance standpoint is to make sure your documentation for the patient encounter matches the code you used. If the code requires laterality of a lesion, or size of a wound, make sure that's in your note. That sounds like good medical care as well.

The staff of the Medical Billing Compliance Office is ready to help with any questions you may have. I'm hoping the built-in calculators in Epic will make this easier for all of us.

Joshua A. Copel, MD
Associate Chief Medical Officer
Yale Medical Group

Providing services for your mother? Don't bill Medicare

If you are a physician treating a relative's lingering cold—or any other ailment—you might not be able to bill for it. Medicare does not pay for services that are provided by an immediate relative of the patient or another member of the patient's household.

This exclusion applies to items and services rendered by a physician who is related to the patient, even if an unrelated individual, partnership or professional corporation submits the bill or claim. However, if one partner provides a service for a relative of another partner in the same practice, the first partner may legally bill and receive Medicare payment.

Who is an immediate relative, according to Medicare?

- Husband and/or wife
- Natural or adoptive parent, child and sibling
- Stepparent, stepchild, stepbrother and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild
- Members of the patient's household

A member of a household means anyone who shares a common abode as a part of single family unit, including individuals related by blood, marriage or adoption, as well as domestic employees and others who live together as part of a single family unit. Roomers and boarders are not included.

The following patients are not immediate relatives and can be billed to Medicare: the husband or wife of any siblings the physician's spouse has (some people assume these are bona fide in-laws, but they're not), and the stepparents of the physician's spouse. It's important to remember that direct step- and in-law relationships—relatives that cannot be billed—continue to exist even after divorce or death of one of the parties.

Coding: Don't confuse 'new patient' and 'consultation'

Sometimes the right billing code is crystal clear, other times it can be confusing. Some questions can be cleared up by remembering:

New patients are those who have NOT received professional services from a YMG physician or another physician within the same specialty in the same YMG group within the past three years. A new patient may schedule a visit directly with the practice or be referred by a community practitioner for a transfer of care.

Insurance companies review a provider's specialty designation to make the determination if a visit should be considered a new patient visit. For example, there is one specialty designation for ophthalmology. If a patient new to our practice saw two ophthalmologists, one specializing in retina and one specializing in glaucoma, the insurance company would pay the first ophthalmologist as a new patient visit but the second ophthalmologist must bill as an established patient visit.

On the other hand, if a patient is initially seen by Yale Pulmonology and the pulmonologist recommends a Yale rheumatologist to treat the patient's osteoarthritis, both practitioners could bill a new patient visit since each provider has their own unique specialty designation.

Established patients have visited the practice sometime in the past three years, and received professional services from any physician in the same group and same specialty. They may be patients following up on a previous office visit; patients following up in the office with a

specialist they've seen there before; or patients visiting the office to see the peer of a provider in same specialty and subspecialty as a physician who provided care for them in the hospital.

Consultation is a "type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate sources," according the CPT (Current Procedural Terminology) book. A consultant's documentation must include the three 3 R's:

1. Requesting attending's name
2. Recommendations and/or opinions from the consultant
3. Report—evidence that a written one was submitted to the requesting physician

Anyone who still has questions about proper coding may call Medical Billing Compliance at **203-785-3868**.

Why you need to know about Medicare's exclusion rules

Providers should know that their participation in Medicare can be jeopardized if they utilize staff who are excluded or "debarred," or if their practice or facility is suspected of inappropriate billing.

Recent amendments to Medicare exclusion rules, authorized under the Affordable Care Act, continue to expand the circumstances under which a provider can be kicked out of the program. For example, a provider can be suspended while "suspected" fraud is investigated, which could take months or years. Unsuspecting providers can be cut out of Medicare simply upon notice. Other reasons for exclusion include failing to pay back a federal school loan, loss of medical license due to a drug or alcohol conviction, or incurring a federal health care fraud conviction.

YMG cannot employ excluded individuals, because it receives federal funding through the Medicare program, among other sources. As a result, the practice uses a protocol to identify

faculty, employees or contractors who are debarred or excluded. Compliance routinely checks excluded provider lists to ensure the practice is following the exclusion rules.

Spotlight: Patricia Waleski is an auditing veteran

Auditor Pat Waleski has been contributing to the growth of Medical Billing Compliance for almost 17 years. She joined YMG after spending the first 15 years of her career working for a Medicare Part B contractor in Meriden. Each of YMG's 10 compliance auditors work with particular departments and sections, and Pat provides support for genetics, obstetrics and gynecology, rheumatology and the Yale School of Nursing.

What has changed over the years in compliance?

The biggest change has been the expansion of our practice and the significant increase in the number of faculty members. For example,

I work with ob-gyn, and Yale has acquired many new ob-gyn groups in the last few years. Epic was also a major change. There is still a learning curve with Epic, but it's made things more efficient, so the days of auditors struggling to read a doctor's handwriting are long gone. However the EMR has made it more time consuming given all the audit trails to review records.

What has stayed the same?

The continuing need to educate the providers on documentation, coding and billing policies. That is even more intense than it used to be. There is a much closer eye on everything.

From your compliance perspective, what is the most important thing physicians and staff need to know?

The services Medical Billing Compliance provides reflects YMG's desire to document and bill correctly for clinical care services. We want to positively contribute to the bottom line by making sure we are paid appropriately for the services our faculty provide. Compliance auditors shouldn't be looked at with fear and dread, but rather as a resource to assist and train faculty about billing and coding policies.

What do you like best about your job?

After 16 years it is still challenging and exciting. I like the fact that I can work together with the different departments to resolve issues that come up.

What do you find the most challenging?

Time management. There is a fast pace here and an urgency to resolve certain issues quickly.

What are your hobbies?

Gardening, cooking and kayaking.

In the News

Wrong code led to significant overcharges in Medicare

The Office of the Inspector General review revealed that the Hospital of Central Connecticut did not comply with Medicare requirements for billing for kwashiorkor on any of the 30 of the claims that they reviewed. Kwashiorkor is a rare form of malnutrition generally seen in children in poor countries during famines.

The Hospital of Central Connecticut used kwashiorkor diagnosis code 260 when it should have used codes for other forms of malnutrition or no malnutrition code at all. For 27 of the 30 inpatient claims, the errors resulted in Medicare overpayments of $114,000. Hospital officials attributed the errors to a lack of clarity in the diagnosis coding guidelines.

Read more at http://oig.hhs.gov/oas/reports/region3/31500003.asp

Connecticut dentist charged with larceny, fraud

The owner of Plantsville Family Dental is facing larceny and fraud charges after allegedly performing unnecessary procedures and improperly billing Medicaid, and making false claims of more than $7,000. Thomas DeRienzo, DMD, the owner of the practice, was charged with first-degree larceny by defrauding a public community, second-degree vendor fraud and insurance fraud.

Authorities said DeRienzo submitted numerous claims to Medicaid for payment between 2010 and 2014. A subsequent investigation determined 282 claimed procedures were either never performed or were assigned incorrect billing codes to increase payment. Another 67 claimed procedures were not documented in medical records. An additional 193 claimed procedures were deemed medically unnecessary.

Read more at http://www.myrecordjournal.com/southington/southingtonnews/7634398-129/details-released-for-southington-dentist-charged-with-fraud.html

Ridgefield doctor will pay to settle billing allegations

Edward Berman, MD, a Ridgefield physician, entered into a civil settlement with the government in which he will pay $218,633 to resolve allegations that he violated the False Claims Act. The allegations against him involve fraudulent billing to Medicare for subsequent skilled nursing facility services that were not performed in accordance with Medicare requirements. Berman allegedly "upcoded" certain services, using a higher-paying billing

code when services with lower-paying billing codes were actually provided.

To resolve his liability under the False Claims Act, Berman will pay $218,633, in order to reimburse the Medicare programs for overcharges from Jan. 1, 2008, through March 4, 2014.

Read more at http://www.justice.gov/usao-ct/pr/ridgefield-doctor-pays-218633-settle-allegations-under-false-claims-act

Derby APRN pleads guilty to taking $83,000 in kickbacks

Heather Alfonso, waived her right to indictment and pleaded guilty recently to receiving kickbacks in relation to a federal health care program while working as an APRN at Comprehensive Pain & Headache Treatment Centers in Derby, according to an article by C-HIT, a web-based news information service that covers health care issues.

Alfonso was employed as an advanced practice registered nurse at the clinic and prescribed various controlled substances.

An investigation revealed that Alfonso was a heavy prescriber of Subsys, a drug used to treat cancer pain. Medicare and most private insurers will not pay for Subsys unless the patient has an active cancer diagnosis and an explanation that the drug is needed to manage the patient's cancer pain. A review of Medicare Part D prescription drug events for prescribers of the drug showed that Alfonso was responsible for more than $1 million in claims and was the highest prescriber of the drug in Connecticut.

The investigation further revealed that Insys Therapeutics, the drug's manufacturer, paid Alfonso to be a speaker at more than 70 dinner programs at a rate of roughly $1,000 per event. In many instances, Alfonso and a drug company salesperson were the only people in attendance. On other occasions, the programs were attended by colleagues and friends of Alfonso who did not have licenses to prescribe controlled substances. At most of these dinner programs, Alfonso did not give any presentation about the drug at all.

Alfonso received $83,000 from the drug manufacturer from January 2013 through March 2015. In pleading guilty, she admitted that the money she was paid influenced her decisions to prescribe the drug. She faces a charge that carries a maximum term of imprisonment of five years and a fine of up to $250,000. Sentencing was scheduled for September.

Read more at http://c-hit.org/tag/heather-alfonso/

Teaching Physician
Compliance ALERT

Compliance Programs—Preventive Medicine for Healthcare Providers

Chief Medical Officer: Ronald Vender, MD
Compliance Medical Director Joshua Copel, MD
Director of Medical Billing Compliance: Judy L. Guay
judy.guay@yale.edu | (203) 785-3868

P.O. Box 9805 • New Haven, CT 06536
1-877-360-YALE (9253) hotline
http://comply.yale.edu/index.aspx

If you have concerns about medical billing compliance that you are unable to report to your supervisor or to the Compliance Officer, please call the hotline number above.

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