Teaching Physician Compliance

ALERT

Published by the Yale Medical Group

May 2012 Issue 83

EMR issues for Connecticut MDs

The Yale Medical Group (YMG) recently learned that providers in Connecticut are experiencing a variety of compliance issues as a result of electronic medical record (EMR) implementations. In one instance, an insurer audited a health-care provider after they noticed an increase in the provider's utilization of the higher level of evaluation and management (E&M) codes. The provider billed level 4 and 5 E&M codes for established patient visits with a diagnosis of otitis media. It turns out that the provider's EMR checkboxes were generic and the provider checked off multiple checkboxes to complete the record. The checkboxes were used by the EMR to calculate the E&M level. Since many of the checkboxes indicated services that would not be medically necessary for the diagnosis of otitis media, incorrect information was used to calculate the level of E&M. The insurers calculated an extrapolated overpayment which the provider had to refund.

Moving from a paper-based system to an EMR should not result in changes to a physician's utilization, assuming the provider was billing correctly to begin with. Insurers are on the alert for changes in utilization, as the above example demonstrates. It is not recommended that physicians rely on an EMR's automatic E&M calculator. Most E&M calculators cannot assess the level of medical decision-making. In addition, many calculators use the 1997 E&M rules, which are more difficult to comply with for most specialties than the 1995 rules.

Insurers are also noting the same wording in the medical records for 15 to 20 patients by the same provider. Having the same wording from patient to patient sends up a red flag to payers and auditors. Of note, the Recovery Audit Contractors (RACs) are said to be using software that detects cloned notes.

There have been some cases of patient complaints to the Attorney General's Office. The complaints alleged that the services documented in the physician's note were not provided and/or the items the note documented as discussed were not actually discussed between the physician and patient. This can be called a "clicking/talking disconnect," where the physician is clicking templated information in the EMR; however, the template may contain more history, exam or discussion elements than were provided.

A recent email from our Medicare contractor stated:

"Select the code for the service based on the content of the service. The documentation should support the level of service reported. One thing Medicare reviewers are seeing with electronic medical records is "cloned" charting, where documentation is worded almost exactly the same as in previous entries. It would be highly unlikely that every patient had the same problem, symptoms, and treatment, or that the information would be the same for each patient seen by the provider. We would expect to see specific, individual information for each unique patient."

Whatever format you use to document the exam, whether it is electronic records, a check list, narrative notes, or some other format, we would expect to see your documentation reflect the work that was actually done. You should caution your providers to use templates with care, and edit them judiciously from visit to visit to accurately demonstrate the work actually done for the patient and to support medical necessity for the service billed."

Implementation of EMRs had led to problems with diagnosis coding. In some cases, not all diagnoses are going out on the claims – for example, comorbidities that help justify the level and frequency of visits.

Keep in mind that EMRs date and time-stamp notes, which provide an audit trail. It is therefore important to be particularly accurate when billing for time when more than half of the visit was spent in counseling or coordination of care.

While the EMR offers many time-saving features for physicians, the information entered needs to be accurate and complete. A free-form area for physicians to write a concise note with the visit's key points may be the best bet in saving time for those that need to use the EMR when taking care of patients.

Medicaid Integrity Contractor update

The Medicaid Integrity Contractors (MIC) are part of the Medicaid Integrity Program, which was created by the Deficit Reduction Act of 2005 to fight Medicaid fraud. The OIG oversees the activities of the MIC and in a recent report stated that 81 percent of audits performed by MICs in the first half of 2010 failed to identify any overpayments. The report also found that as of June 2011:

- 42% of the audits had been completed with out finding any overpayments.
- 39% were ongoing but with no likelihood of finding overpayments.
- 7% were ongoing with a potential for finding an overpayment.
- 11% percent had identified $6.9 million in overpayments, however $6.2 million of that amount resulted from seven completed collaborative audits involving Audit MICs, Review MICs, States, and CMS.

Collaborative audits appear to have improved data analysis and the selection of audit targets and the efficiency of the audit process, leading to better results. The OIG recommended that CMS: (1) increase the use of collaborative audits and (2) improve audit target selection in states that choose not to be involved in collaborative audits. CMS concurred with the audit findings.

Medicare may increase pre-payment reviews by 50 percent

On December 8, 2011, the Center for Medicare and Medicaid (CMS) posted a notice in the Federal Register seeking to increase the amount of prepayment requests Medicare contractors could conduct. A prepayment request is a demand by a Medicare contractor to the provider of medical services for the medical record documentation which supports the services that are billed. Medicare reviews the documentation before making a payment determination. The notice, submitted with emergency clearance status, gave the public seven days to respond!

Both the American Medical Association (AMA) and the Medical Group Management Association (MGMA) submitted letters in opposition of the notice to CMS. The AMA and MGMA estimate

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the expense for copying and submitting requested medical records will cost providers about 90 million dollars annually. The cost to the government to request and review the records is estimated to be around 67 million.

It is likely that the emergency notice was the result of a release from the CMS Office of Public Affairs in November 2011 that announced plans by President Obama to reduce improper Medicare payments in 2012. The 2012 plan allows Recovery Audit Contractors (RACs) to conduct prepayment reviews. The RACs were hired by CMS to assist in cutting improper Medicare payments, and their prepayment reviews would be in addition to those requested by other Medicare contractors.

The AMA and MGMA, among others, have prompted CMS to delay the new prepayment reviews until at least June.

In the News

Cheshire MD has license revoked

Dr. Jyoji Bristol's medical license was revoked in March for allegedly overmedicating drug-addicted patients and crossing sexual boundaries. The 25-page Memorandum of Decision included allegations of consensual sex with a drug-addicted patient and continuing to prescribe oxytocin after each of three occasions when the patient got out of a rehabilitation and detox program. Three other female patients alleged inappropriate sexual conduct, which resulted in a $3,000 fine.

A 1998 graduate of Spartan Health Sciences University in St. Lucia, Bristol obtained his license to practice in Connecticut in 2008 and had it suspended in 2009. The Oregon Medical Board fined Bristol $10,000 and denied him a medical license in 2010 because he failed to disclose a criminal arrest and other disciplinary action taken against him as a U.S. Air Force doctor in 2006. Bristol had been charged with domestic battery by civil authorities and was convicted in military court of assault, disobeying a lawful order and being absent without leave, resulting in his dismissal from the Air Force

Bristol filed an appeal on May 1 to have his Connecticut license reinstated. Source: Record-Journal, Meriden, CT 3/21/12; Physician/Physician Assistant Disciplinary Actions, Connecticut Department of Public Health

PA prescription problems

The state Medical Examining Board issued a reprimand to Donald Kagan of Cheshire, a physician assistant, in connection with allegations that he authorized prescriptions for oxycodone for his father in 2011 without maintaining appropriate records. The Board also alleged that Kagan authorized prescriptions for a patient who was a personal friend, without requiring an office visit. Both the friend and his father suffered from back pain, Kagan said. The Department of Consumer Protection entered into an agreement with Kagan that prohibits him from dispensing, administering or prescribing controlled substances to himself, family or friends, according to documents filed with the medical board. Source: CT Health I-Team

CT radiologist gets reprimand

In April, the state Medical Examining Board reprimanded the license of a New Milford radiologist and one-year probation for patient-care lapses. The action was taken against Dr. Michael Waldman after an incident in which he punctured a patient's spleen during a procedure and failed to properly care for and monitor the patient afterward. The patient was sent home without adequate discharge instructions and died three days later. Dr. Waldman admitted the lapses and has since resigned his position at New Milford Hospital, which is now affiliated with Danbury Hospital under the umbrella of the Western Connecticut Health Network. Source: CT Health I-Team

New Compliance Auditor

Please welcome Mabel Goessinger, RN, who joins the Compliance Department as the newest Compliance Auditor. For the past eleven years, Mabel has worked in various roles at an Ophthalmology practice in Trumbull, CT. Mabel's focus will be auditing the departments of Lab. Medicine, Pathology, Ophthalmology, Therapeutic Radiology, and Psychiatry. She can be reached at (203) 737-5536 or via email at mabel.goessinger@yale.edu.

Place of service new effective date

The "place of service" billing clarification published in the March issue of the Alert has a new effective and implementation date of October 2012. The initial instruction from the Center for Medicare and Medicaid (CMS) had an effective date of April 1, 2012.

United Health Care Code of Conduct

United Health Care (UHC) has asked the Yale Medical Group (YMG) to make available to its faculty and staff their Code of Conduct policy. The policy, which incorporates the UHC Conflict of Interest policy, can be found at:

http://www.unitedhealthgroup.com/about/UNH-Code-of-Conduct.pdf

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