Teaching Physician
Compliance
ALERT
April 2017 Issue 106

A Message from Joshua A. Copel, MD

A reminder that Medicaid issued a *Provider Bulletin* in October 2016 mandating specific physician documentation requirements when physicians bill for a shared visit under their number when working in collaboration with an APP. One of the requirements is a significant change that will likely impact your current documentation practices.

The *Bulletin* states that the documentation by the physician must clearly indicate the reason why the work of the physician was required during the visit in addition to that of the APP.

If this documentation is missing, the service must be billed under the APP's billing number. The bulletin provides no acceptable examples of this requirement, but we believe the wording of the memo supports that it would be sufficient to have a statement by the physician such as "I was asked to see the patient by APRN Jones due to the patient's complex medication regime and the need for adjusting several medications due to an increase in abnormal blood pressure readings." We have contacted officials at Medicaid and are awaiting confirmation that this documentation is acceptable.

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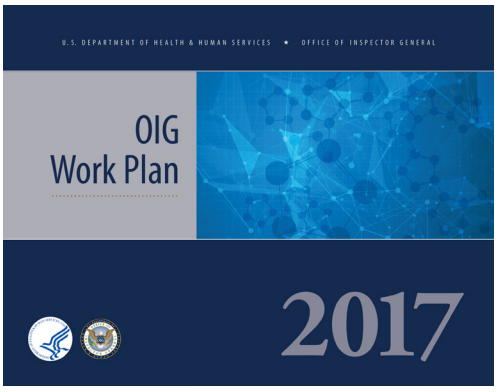
OIG 2017 Work Plan



The 2017 Office of Inspector General (OIG) Work Plan has been released by the U.S. Department of Health and Human Services (HHS). Items of interest to physicians include:

Chronic Care Management (CCM) – The OIG will determine if payments for CCM, a new benefit as of 1/1/15, were in accordance with Medicare requirements.

Transitional Care Management (TCM) – The OIG will determine if payments for TCM were in accordance with Medicare requirements and not billed during the same period as CCM services.

Open Payments Program – The OIG will determine the extent to which data in the open payments system is missing or inaccurate, the extent to which CMS oversees manufacturers' and group purchasing organizations' compliance with data reporting requirements and whether the required data for physicians and teaching hospital payments are valid.

Anesthesia Services – Non-Covered & Personally Performed – The OIG will review anesthesia claims to determine whether the beneficiary has a related Medicare service and whether claims where the anesthesiologist billed for personally performed services met the Medicare requirements.

Home Visits – Medicare paid $718 million for physician home visits between January 2013 and December 2015. The OIG will review home visit claims to determine if they met medical necessity requirements.

Prolonged Services – Prolonged services are for additional care provided to a beneficiary after an evaluation and management (E&M) service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion E&M service. The necessity of prolonged services is considered to be rare and unusual.

Drug Waste of Single-Use Vial Drugs – Modifier JW is used to bill for discarded drugs. The OIG will review claims for modifier JW and determine the amount of waste for the 20 single-use vial drugs with the highest paid-for waste and provide specific examples of where a different size vial could significantly reduce waste.

Sleep Disorder Clinics – The OIG has identified high utilization of polysomnography; sleep staging with four or more additional parameters of sleep (95810) and polysomnography with initiation of continuous positive airway therapy or bi-level ventilation (95811), especially as it relates to retesting. The OIG will review claims for 95810 and 95811 to look for medical necessity.

Payment for Immunosuppressive Drugs Modifier KX – Modifier KX signifies that the provider retains documentation in the medical record of the beneficiary's transplant date and that such transplant date preceded the date of service for the immunosuppressive drug. The OIG will review claims with modifier KW to insure appropriate documentation is in the medical record.

Incarcerated Beneficiaries – Medicare does not pay for services rendered to incarcerated beneficiaries. The OIG will review Medicare payments and recoup Medicare payments for items and services furnished to incarcerated Medicare beneficiaries.

See the complete 2017 OIG Work Plan.

Moderate Sedation Separately Billable

Effective Jan. 1, 2017, reimbursement for moderate (conscious) sedation (MS) is no longer bundled in with procedures and may be reported separately. There are six new MS codes to report as shown below.

Age of patient	MS provided by same physician as performing the procedure	Physician performing MS only
Total intra-service time for patient under 5 years old	99151 (initial 15 minutes), 99153 (each additional 15 minutes)	99155 (initial 15 minutes); 99157 (each additional 15 minutes)
Total intra-service time for patient 5 years or older	99152 (initial 15 minutes); 99153 (each additional 15 minutes)	99156 (initial 15 minutes), 99157 (each additional 15 minutes)

Some important coding tips to remember:

- If the time of MS is **less than 10 minutes**, MS may not be reported.
- For **facility settings** (including inpatient and provider-based), you may report +99157 (each additional 15 minutes) when you are performing MS only.

• For **office settings**, you may report the additional time code +99153 (each additional 15 minutes) when you are performing both the procedure and MS.

The MS codes are time-based codes and require documentation of the time spent during the intra-service work (commonly referred to as "skin-to-skin" time) in order to bill. Pre-service and post-service work time cannot be included. Intra-service work:

• Begins with the administration of the sedating agent(s);

• Ends when the procedure is completed, the patient is stable for recovery status, and the physician providing the sedation ends personal continuous face-to-face time with the patient;

• Includes ordering and/or administering the initial and subsequent doses of sedating agents;

• Requires continuous face-to-face attendance of the physician;

• Requires monitoring patient response to the sedating agents, including:

- o Periodic assessment of the patient;
- o Further administration of agent(s) as needed to maintain sedation; and
- o Monitoring of oxygen saturation, heart rate, and blood pressure.

If you are providing and billing MS with a resident/fellow, your teaching physician (TP) documentation must support the following:

• your *presence during all critical or key portions* of the MS service; and

• your *immediate availability* to provide MS services during the entire procedure.

Example: I was present and immediately available for key and critical components of the 35- minute moderate sedation service.

For documentation questions, please contact Terry Turcio, compliance manager, at Theresa.Turcio@yale.edu. Questions regarding reimbursement should be directed to the Revenue Integrity Analytics (RIA) Department.

STUDENTS

Services rendered by students are not considered billable services. "Students" include but are not limited to medical students, advanced practice practitioner students, and audiology students.

Any participation or contribution of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or in the physical presence of a resident in a service that meets the requirements for teaching physician billing. This does not include review of systems (ROS) and/or past family/social history, which is not separately billable but taken as part of an E&M service.

Students may document services in the medical record. However, the documentation of an E&M service by a student that may be referred to by the teaching physician is limited to documentation related to the ROS and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision-making in their personal note.

If the medical student documents E&M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision-making activities of the service.

In the News

CT Home Health Agency Pays $5.24 Million

Family Care Visiting Nurse and Home Care Agency, LLC (Family Care VNA) entered into a civil settlement with the federal and state governments in which it will pay approximately $5.24 million to resolve allegations that it violated the federal and state False Claims Acts. Family Care VNA, owned by David A. Krett and Rita C. Krett, RN, BSN., provides home health services in Fairfield, New Haven, Hartford and Middlesex Counties.

The allegations against Family Care VNA involve fraudulent billing to Medicaid for home health 60-day assessments, which must be performed by a registered nurse and allegedly were not, but were billed to Medicaid with the knowledge and at the direction of its owners. Additionally, it is alleged that Family Care VNA, with the knowledge of its owners, submitted claims to Medicaid for patients who were or may have been dually eligible for Medicare and Medicaid, without first following required procedures for submitting claims to Medicare.

To settle allegations under the federal and state False Claims Acts, Family Care VNA, David Krett and Rita Krett have paid $5,253,908, which covers the time period from Jan. 1, 2009, through April 30, 2016, and they entered into a Corporate Integrity Agreement with the Office of Inspector General.

Source: Department of Justice U.S. Attorney's Office District of Connecticut

Two Connecticut State Medical Examining Board Cases

The state Medical Examining Board recently disciplined a Fairfield pulmonologist for improperly prescribing opioids and a former UConn Health doctor who had stolen medication from the health center for his private practice.

Dr. Igal Staw, who works at Respiratory Associates in Fairfield, was reprimanded, fined $7,500 and has been permanently restricted from prescribing opioids, under a consent order to which he agreed. He also must hire a supervisor to monitor his drug prescriptions and will be placed on two years of probation if his state registration to prescribe controlled substances is ever reinstated, the order said.

In 2012 and 2013, Staw prescribed opioids to eight patients with chronic pain, including some who may have been abusing the medicine, the order said. He also failed to document the reasons for the prescriptions or justify in the patients' medical charts why he was increasing the doses.

In the UConn Health case, the board fined Dr. Micha Abeles of West Hartford $5,000 for stealing Depo-Medrol, an anti-inflammatory drug, and Humira, which is used to treat arthritis, from the hospital's stock for use in his private practice in Meriden.

The thefts occurred in 2015 and 2016. Abeles retired in 2016 from his post as associate director of the UConn Multipurpose Arthritis Center. Abeles had been arrested in June 2016 and charged with one count of second-degree larceny in connection with the thefts, the Hartford Courant reported. In September, Abeles, then 71, was granted a special form of probation for one year, the Courant reported. Abeles had been at UConn for 40 years and replaced the medication he had taken before the arrest, the Courant said. A condition of his probation was that he pay UConn $20,000.

Source: Connecticut Health I-Team

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Compliance ALERT
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Published by
Yale Medicine