Teaching Physician
Compliance
ALERT
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Lighten the Load

In response to President Obama's January 18th executive order aimed at reducing federal regulatory burdens, the American Medical Association (AMA) surveyed individual physicians and asked their member organizations to identify the most burdensome regulations they have to deal with along with any suggestions on how regulations could be improved. The following unfunded mandates may be of interest to physicians in our practice:

Translators: Since 2000, physicians have been required to provide translators for Medicare and Medicaid patients with hearing impairments or limited English proficiency. The cost for translator services frequently exceeds the physician's payment for the visit. However, translator services are not reimbursed under the Medicare or Medicaid program. The AMA recommended that CMS allow interpreters to bill Federal programs for translator services.

Drug Plan Authorizations:
Formulary changes and time-consuming pre-authorization requirements can delay care to patients and create additional burdens to physicians. Some suggestions for improvement include: requiring plans to pay physicians for prior authorizations that exceed a specified number or that are not resolved within a set period of time; prohibiting repeated prior authorizations for ongoing use of a drug by patients with chronic disease; prohibiting prior authorizations for certain standard or inexpensive drugs; and enforcing the requirement that plans use a standard form.

Consultations:
Medicare's decision to eliminate the consultation codes has forced physicians to bill for these services with lower-valued visit codes and has created confusion and administrative complications when physicians bill Medicare secondary payers or private payers for consultations. The AMA recommended that CMS reinstate the consultation codes.

Inconsistent Audit Policies:
Currently physicians are subject to claim reviews by at least six different Medicare contractors. The AMA urged CMS to eliminate redundant and/or inconsistent audits and to compensate physicians for the administrative burden of office staff in responding to medical record requests.

Education and Outreach:
Keeping up with the large amount of Medicare rules and never ending new and changing policies can prove to overwhelm even the most diligent physician. It was suggested that CMS create more specialty-tailored list serves, be more selective about what it sends out on the list serves; prohibit contractors from limiting the number of items that can be discussed in a single phone call; strive for prompter replies to email and phone queries; and provide more specific examples of proper documentation.

For a complete copy of the AMA response please see http://www.ama-assn.org/resources/doc/washington/regulatory-burden-reduction-letter-13april2011.pdf

A Reminder for Global Billing

In order to code and bill as a global service, the following criteria must be met:

- The physician or practice (such as YMG) must own or lease the equipment
- The physician must personally perform the technical component, or the practice must pay the techncian to do the technical service
- The physician or practice must own or rent the space where the service is performed

If all three of these criteria are not met, the services cannot be billed as global.

Correct Coding Of Place of Service

Recently, the Centers for Medicare and Medicaid Services (CMS) published a reminder to physicians of the importance of correctly coding the place of service to avoid potential overpayments. An audit by the Office of the Inspector General (OIG) found that some physicians used non-facility place-of-service codes on their claims for services that were actually performed in hospital outpatient departments or ASCs. For example, in our practice where services are provided in YNHH space that the University does not lease, the place of service to bill is 'outpatient hospital'. To bill as 'office' space would create an overpayment.

E&M Note Bloat

In a recent article published by the Connecticut Medicare contractor, National Government Services (NGS), it was stated that they will continue to review documentation for evidence that the medical necessity of the service is supported, and the correct level of E&M code is billed.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted. The volume of documentation is not the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

While reviewing documentation for E&M services, NGS has found that though both the history and examination components were documented at the comprehensive level, the medical decision making was low.

In other words, it may not be medically necessary to always perform a complete history and examination on an established patient who may be presenting with a minor problem.

The Compliance Department has noted that the volume of documentation in an electronic medical record environment has greatly increased. This is sometimes referred to as "note bloat". It is important to remember that only the documentation that is relevant to the current condition of the patient will be considered on audit when determining the E&M level.

Welcome new Compliance Auditor Kathryn M. Engle

Please welcome Kathryn Engle, RN, MS to the Compliance Office as our newest senior compliance auditor. Since January of 2002 Kathy has worked as a clinical research nurse for the department of Internal Medicine, section of Pulmonary & Critical Care. Kathy's focus will be on clinical research auditing. She can be reached at 737-3340 or kathryn.engle@yale.edu .

Signature Requirements

Medicare has issued the following policy in regards to medical record documentation: the author of each entry in the medical record must be identified and must authenticate their entry. Authentication may include handwritten signatures or computer generated signatures. If a computer-generated signature is used, each provider must have been assigned a unique code so that only the provider can use the signature. In addition, a teaching physician cannot edit and/or sign a resident note and bill based on that note alone. The resident must sign their own note and the attending must add their own personal note that supports that they saw and evaluated the patient and demonstrates their contribution to the plan.

In the News

Modifier 25 issue costs Connecticut MD $380,000

William Garrity, a doctor of osteopathic medicine with a practice located in Suffield, CT, is alleged by federal prosecutors to have improperly billed Medicare for E&M services that were not medically necessary or were not provided. In addition to billing Medicare for osteopathic manipulative treatment (OMT), Dr. Garrity also billed an E&M service on the same day by appending modifier 25 to the code. Medicare does not normally allow additional payments for E&M services done by a provider on the same day as a procedure. However, if a provider performs an E&M service on the same day as a procedure that is "significant, separately identifiable and above and beyond the usual pre-procedure and post-procedure care associated with the procedure," then the modifier 25 may be attached to allow payment for the E&M service. In Dr. Garrity's case, there was no documentation to support the E&M service. ***Source: BNA Health Care Fraud Report 04/06/2011***

Masonicare to pay $447,776 for facility violation

Masonicare Health Center has agreed to pay the government $447,776 on charges that the facility violated the False Claims Act. The facility improperly billed Medicare and Medicaid for injections of leuprolide acetate, or lupron. The billing code for the female-related dosage has a higher reimbursement rate than the code for male-related doses. The government states that Masonicare regularly billed for the female-related code for male patients who were being treated for prostate cancer, so it received a substantially higher reimbursement rate. Even though this was an unintentional coding error and Masonicare has since taken corrective action, this problem was identified in 2009 and the company never disclosed its error to the government or made any attempt to pay the money back. ***Source: Record-Journal April 27, 2011***

Phony Doc Foiled Again

A Connecticut man will serve prison time for a second conviction of posing as a physician. In 2004 Barry Lichtenthal of Putnam, CT was sentenced to five years in prison followed by five years probation for posing as a doctor and for performing sexual experiments on young women. This was done at his ex-wife's psychiatric practice in Bridgeport while she was out on maternity leave. In January of this year, Mr. Lichtenthal claimed to be a retired doctor when disputing his wife's OB-GYN bill. This violation of his probation landed him back in jail for thirty days. ***Source: The Connecticut Post***

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