Teaching Physician
Compliance
ALERT
January 2017 Issue 105

A Message from Joshua A. Copel, MD

The time between Thanksgiving and the new year always seems too short and rushed for everything that we try to cram into those five weeks or so. For the Medical Billing Compliance Office, that includes ensuring that all of our faculty have completed their annual billing compliance training. This year we had over 98 percent completion, leaving about 45 faculty and advanced practice providers (APPs) who still did not complete their required training by year's end. We've got lots of ways for you to complete training, including in-person classes with the popular game show formats that Yale Medical Billing Compliance has pioneered, on-line programs, and the "E&M University" program from David Jensen, YNHH Hospitalist. Annual training is required at many institutions, and while it doesn't make the complex CMS rules on Evaluation & Management coding any more rational, it can help improve your billing and ensure you are paid for the level of service you are providing.

So, thanks to all who completed the training on time. If you have suggestions for how we can improve the education, please let us know. (But unfortunately we are stuck with ICD.10, the CPT system, E&M codes, and Epic, so let's not go there.)

Joshua A. Copel, MD
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Alert for physicians working with advanced practice providers (APPs)

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 the above required documentation is missing, the service must be billed under the APP's billing number. The bulletin provides no acceptable examples of this requirement, however, 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."

Other documentation requirements stated in the bulletin and already required under CMS guidelines are:

- Detailed documentation by the physician for the part(s) of the service that he or she personally provided; generic attestations are not acceptable. Medicare requires substantive documentation supporting the physician's face-to-face services to the patient in order to allow physician billing
- The aspects of the plan of care, response to care and changes/revisions to the plan of care that are different from that documented by the APP, or if the documentation provided by the APP is accurate, complete and sufficient, the physician must attest agreement with this portion of the APP's note; and
- Signature of both the APP and practitioner providing the services

Always remember that "Teaching Physician" rules never apply to APP visits. The documentation required for MD billing of shared visits is more stringent and **new patient "office" visits cannot be billed using shared visit guidelines**. New patient visits in all other settings are allowable, including provider-based settings. In some cases, you may wish to let the APP submit the bill and accept the slightly lower reimbursement if the patient encounter time and documentation requirements outweigh the benefits of your billing the visit.

Billing for smoking cessation counseling

Recent audits have found that providers billing for smoking cessation counseling are not documenting the time spent counseling in the medical record. The smoking cessation codes are time-based codes as described below.

CPT 99406 - Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes

CPT 99407 - Smoking and tobacco use cessation counseling visit; intensive, greater than ten minutes

These codes are used to report services provided face-to-face by a physician or advanced practice provider when providing smoking cessation counseling. They are distinct from evaluation and management (E&M) services that may be reported separately with modifier 25 when performed.

Your documentation must include your actual time spent with the patient and summarize the topics covered in the counseling session. The smoking cessation summary should be specific to discussions with the patient on tobacco prevention or quitting to meet Medicare's criteria for the service.

Medicare provides coverage of smoking and tobacco-use cessation counseling services for outpatient and hospitalized beneficiaries who use tobacco regardless of whether they exhibit signs or symptoms of tobacco-related disease, and are competent and alert at the time of counseling.

As far as frequency, two individual tobacco cessation counseling attempts per year are allowed. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to eight sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than three minutes up to ten minutes) or intensive (more than ten minutes) tobacco cessation counseling sessions for each attempt. The Medicare co-payment and deductible are waived for tobacco cessation counseling.

Spotlight: Kathleen Bartolotta, Compliance Auditor

How long have you been with compliance?

I officially joined the Compliance Department on June 1, 2014. My Yale University employment began in 2003 in the Department of Diagnostic Radiology. In 2011, I transitioned to a position in the Yale Medical Group (now Yale Medicine) working in Clinical Research Billing Compliance. Throughout my Yale employment I grew in my understanding of the importance of the Medical Billing Compliance program. I was the recipient of the 2006 Compliance Award.

What has changed over the years in compliance?

What has changed is the increased scrutiny on the medical practice whether clinical or research, from all payers, whether private or federal, especially since the EMRimplementation. The pre- and post-payment reviews by payers has increased.

What has stayed the same?

What has stayed the same are the constant changes to the rules and regulations by payers (private and federal) and the AMA guidelines (CPT and ICD) and the need for the Medical Billing Compliance training and education program.

What do you like best about your job?

It has been the people that has made my job enjoyable and rewarding. I have and continue to have the pleasure to work with very talented, knowledgeable and helpful faculty and staff within Yale Medicine and its partner, Yale New Haven Health.

What do you find the most challenging about your job?

What is most challenging is the task of keeping up to date on the ever changing rules and regulations, and interpreting and communicating the changes to all appropriate parties in a timely manner that is delivered to a varied audience in a way that can be understood for their roles in our practice.

What are your hobbies?

I am an avid walker with a preference for walking on the beach. I collect sea glass and use the sea glass for art creations.

What contributions are you able to make to the practice in a position like this?

My contributions to the practice and to my position are my accountability, and to do the best job I can every day, in a timely and professional manner.

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

I believe the most important thing for the physicians and staff to know is that Compliance is their advocate. Compliance did not make the rules, regulations or guidelines, however we are here to help navigate the complexities of Medical Billing Compliance.

In The News

Two behavioral health care fraud cases

Family First Community Support Services, LLC

Patricia Lafayette and Maurice Sharpe, mother and son and co-owners of Family First Community Support Services, LLC (FFCSS), a social services agency located in Torrington, Conn., admitted defrauding Medicaid of over $1.6 million. FFCSS submitted claims to Medicaid using the billing number for Anne Charlotte Silver, a licensed clinical social worker who owned and operated Silver Counseling Services, LLC, in Canton and Bantam. Claims for psychotherapy services were submitted to Medicaid that falsely represented that Silver had personally provided the services. Hundreds of claims were also submitted to Medicaid for psychotherapy services purportedly provided to Sharpe's family members, including his children and nieces and nephews, when no such services were ever provided. Under the scheme, Silver allegedly kept 25 percent of the proceeds. The charge of health care fraud carries a maximum term of imprisonment of 10 years. A sentencing date has not been scheduled.

Danbury physician pays $36,000 to settle False Claims Act allegations

Anton Fry, MD, and CPC Associates, Inc., have entered into a civil settlement agreement with the federal government in which they will pay $36,704 to resolve allegations that they violated the False Claims Act. The government alleged that Dr. Fry and CPC Associates submitted improper claims to Medicare for psychiatric services that were provided over the phone to certain Medicare beneficiaries, instead of by meeting with the beneficiaries in the office and treating them in person. This case was prompted by two whistleblowers, a former patient of Dr. Fry, and Medical Bill Consultants, LLC, a billing company.

UConn wound closure settlement

UConn Health will pay $184,984 to resolve allegations that it overbilled the Medicare Program by submitting claims using codes for higher paying wound closure procedures, rather than using codes for the lower paying wound closure procedures that were actually performed. By coding the wound closure procedures improperly, UConn Health received payments from Medicare that it was not entitled to receive.

Pediatric dentist pays $1.3 million to settle False Claims Act allegations

Jesus Villegas, DDS, and his two pediatric dental clinics located in Milford and West Haven, Conn., have entered into a civil settlement agreement with the federal and state governments in which they will pay $1,367,466 to resolve allegations that they violated the federal and state False Claims Acts and entered into a three-year billing Integrity Agreement with the U.S. Department of Health and Human Services.

The allegations focused on the taking of pediatric dental X-rays at Fairfield Pediatric Dentistry, LLC in Milford and Haven Pediatric Dentistry in West Haven. Under Connecticut law, a dental assistant may take dental X-rays if the dental assistant can demonstrate successful completion of the dental radiography portion of an examination prescribed by the Dental Assisting National Board ("DANB"). In the Villegas case, the government alleged that the majority of X-rays taken at Dr. Villegas' dental clinics were taken by dental assistants who were not DANB certified.

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Compliance Programs—Preventive Medicine for Healthcare Providers

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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.

Published by
Yale Medicine