



Compliance- Matters!

A Quarterly Newsletter from the Morehouse School of Medicine Office of Compliance and Internal Audit
July 2009

UMDNJ to pay \$2 million in Medicaid settlement

The University of Medicine and Dentistry of New Jersey has agreed to pay the federal government \$2 million to resolve allegations it defrauded Medicaid. The U.S. Justice Department announced the settlement June 9, 2009. "Today's settlement demonstrates that the Department of Justice will not tolerate fraud on our Medicaid programs, which were created to serve our nation's low-income families, children and seniors," remarks Tony West, the assistant attorney general for the Justice Department's Civil Division. UMDNJ was accused of submitting claims to Medicaid from 1993 to 2004 for outpatient physician services that were also being billed by doctors in the hospital's outpatient centers.



The case against UMDNJ and the University Hospital originated in a whistleblower suit filed by Steven Simring, MD. The double-billing scheme was brought to the hospital's attention, but the management looked the other way, and continued to double-bill for the three years following the warning. Evidence shows that there were many discussions about the double-billing in which doctors expressed concern.

According to Marcella Auerbach, managing partner at Nolan & Auerbach, the hospital could have avoided the lengthy and costly litigation and saved millions, if it had acted differently. "Rather than play by the rules and fess up, many facilities try to sweep problems under the rug and pretend they never happened." Auerbach says many times employees will raise compliance concerns only to be handed a pink slip for their trouble, which raises another legal problem. This settlement reflects the urgency to take seriously compliance concerns presented, and when appropriate address, to eliminate lengthy, expensive, public whistleblower cases. Simring will collect \$801,000 for his efforts.

Reference: Compliance Monitor, June 17, 2009. "Double-billing settlement highlights whistleblower concerns"

Teaching Physicians and Resident Supervision



The Balanced Budget Act stipulates the Medicare funding for GME approved residency programs. Medicare and Medicaid will reimburse faculty for resident teaching and resident supervision. The key is the understanding of physician supervision. This article excludes Primary Care Exception and addresses hospital inpatient services. In order for attending physicians to bill for services provided by residents, the teaching physician, also known as the Supervising Physician, must be physically present. Physician supervision is defined as the physical presence during the key or critical portions of the service when performed by the resident; and the participation of the teaching physician in the management of the patient. When such criteria are met, the Supervising Physician can LINK his or her documentation to the resident's note and bill.

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service from 20 – 30 minutes may be paid only if the teaching physician is physically present for 20 – 30 minutes. Examples of codes falling into this category include:

- Hospital discharge day management (CPT codes 99238 – 99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor;
- Critical care services (CPT codes 99291-99292).

Reference: Medicare Claims Processing Manual; Chapter 12, 100 – 100.1.4

1-888-756-1364

“DO THE RIGHT THING”

“Quality means doing it right,

When no one is looking.”

Henry Ford

“Alone we can do so little;

Together we can do so much.”

Helen Keller

In this issue:

UMDNJ and \$2M Settlement

Physician Supervision

CMS Policy Changes

Six Steps to HIPAA

Preventive Medicine –
Squeaky Clean documentation



Lori Collins, JD

Chief Compliance & Internal
Audit Officer

Office: (404) 756.8919
lcollins@msm.edu

Sarita Cathcart, NP-C, CHC

Clinical Compliance and
Chief Privacy Officer

Office: (404) 756.1353
scathcart@msm.edu

Karen Carswell, CPC, CPAR

Education Manager

Office: (404) 756.1467
kcarswell@msm.edu

Andreas Kaempf

Chief Security Officer

Office: (404) 752.1833
akaempf@msm.edu

No more CONSULTS? CMS Policy Changes

The proposed 2010 Medicare Physician Fee Schedule Rule released by CMS July 1, 2009 included a proposal to discontinue reimbursement for the E/M consultation codes (CPT 99241 – 99255). These codes have long been a bane for both coders and insurers due to confusing and sometimes conflicting rules governing their appropriate usage. After years of clarification and code description changes, it seems that Medicare has had enough and decided to do away with the use of these codes altogether. Since consultation codes are reimbursed at significantly higher rates than regular office visit codes, CMS has proposed to increase rates for the remaining covered E/M codes to not penalize doctors while maintaining budget neutrality in their payments. If this proposal is implemented in the November final rule, it will become imperative that all physicians review their charges for E/M services (for Medicare, Medicaid and commercial carriers) to ensure they are not undercharging Medicare and Medicaid for these visits and are in coding compliance if commercial insurers continue to pay for the consultation codes.

CMS is also proposing to increase the payment rates for the Initial Preventive Physical Exam (IPPE), also called “Welcome to Medicare” visit to be more in line with payment rates for higher complexity services. The period for the IPPE benefit was extended last year to within one year of the beneficiary’s enrollment in Part B.

Reference: www.federalregister.gov/inspection.aspx#special



Squeaky Clean Claims for Preventive Services

Preventive medicine services describe comprehensive evaluation and management (E/M) services provided to patients with no current symptoms or diagnosed illness. Preventive codes are used to report annual well examinations and must include the following:

- Counseling/anticipatory guidance/risk factor reduction interventions
- Age and gender appropriate comprehensive history
- Age and gender appropriate comprehensive physical examination including in most cases but not limited to:
 - Prostate or GYN exam
 - Breast exam
 - Collection of Pap smear or PSA
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory/diagnostic procedures and immunizations
- Discussions about issues related to the patient’s age or lifestyle

Preventive medicine codes 99381-99387 and 99371-99397 differ from problem oriented E/M services in several ways. Preventive codes do not require a chief complaint, history of present illness, or medical decision making (MDM); cannot be reported using time; and may be performed in any setting. Compliance recommends that providers use templates to ensure comprehensive documentation of Preventive Medicine Services. It is difficult to support billing for an E/M *and* complete physical exam with a single documentation note.

Six Steps to Comply with HIPAA

Despite the fact that HIPAA laws are constantly changing with the Health Information for Economic and Clinical Health Act, we must keep in mind, HIPAA is about authorization, improving quality, safety, efficiency, access, and coordination of care without obstructing patient flow and physician process.

- Don’t muddy up the water – Keep it simple
- Check policies and procedures
- Make patients comfortable
- Compliance awareness
- Focused HIPAA training
- Make learning entertaining, applicable – demonstrate liabilities!

