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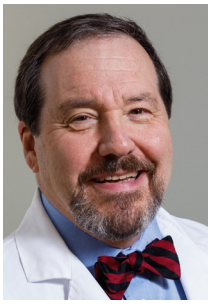
ALERT

Yale Medicine's Compliance newsletter for teaching physicians

A Message from Joshua A. Copel, MD



Dear Colleagues,

As you know, teaching physician rules require that the teaching physician personally document that he/she performed the service or was physically present during the key or critical portions of the service performed **by the resident**, and the teaching physician has to participate in the management of the patient in order for the services to be billable.

With regards to medical students, in order to bill for the services, any participation of a **medical student** must be in the presence of the teaching physician in order to qualify as a billable service. Just having the resident with the student, while the student performs an exam, does not allow billing from the resulting documentation, because the rule requires the teaching physician to have performed the exam or been present during the key/critical portions of an exam by a resident. The "benefit" of the new guidance is that the teaching physician can verify student documentation in the record. The teaching physician does not necessarily have to rewrite everything — he/she can acknowledge its accuracy in the record. The teaching physician still, however, must personally perform or re-perform the exam and decision-making activities of the service being billed when services are performed by a student.

Joshua A. Copel, MD
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Shared Visit Video

The YM Compliance Department in collaboration with YM Learning and Development and Central Coding, has created an instructional video for documentation and billing of shared visits. Shared visits are those performed collaboratively between a physician and an advanced practice provider. The video may be viewed on the Compliance website at https://medicine.yale.edu/ymadmin/medicalbilling/education/

Changes to the Medicare Physician Fee Schedule for 2019

This article contains some of the highlights from the final Medicare Physician Fee Schedule effective for billing in 2019.

Evaluation and Management Services (E/M)

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- CMS is clarifying that for E/M office/outpatient visits, for new and established patients, practitioners need not re-enter information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Beginning in CY 2021, CMS is proposing to further reduce the burden associated with E/M documentation requirements by revising the payment structure and simplifying the coding requirements. Until that time, practitioners must continue to use either the 1995 or 1997 E/M guidelines.

Based on legal advice, YM will not be implementing the revision to who can document the teaching physician presence during E/M services at this time.

Communication Technology Services

CMS is providing coverage for two newly defined physicians' services furnished using communication technology:

- Brief communication technology-based service, e.g. virtual check-in (G2012)
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)
- For both of the new codes, the following rules apply. The services:
- Can only be performed for billing purposes by a practitioner who can report E/M services;
- Pertain to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;

- Result in five to ten minutes of medical discussion;
- Require advance consent from the patient obtained verbally or electronically and must be documented in the medical record.
- For G2010, the interpretation and follow-up with the patient needs to occur within 24 business hours. If the review of the video/image results in a follow up E/M visit, G2010 cannot be billed.

Interprofessional Consultations

CMS is covering two sets of CPT codes for interprofessional consultations as described below.

Interprofessional internet consultation CPT codes 99451, 99452

99451 (Interprofessional telephone/ Internet/electronic health record assessment and management service provided by a consultative physician including a **written report** to the patient's treating/requesting physician or other qualified health care professional, five or more minutes of medical consultative time).

99452 (Interprofessional telephone/ Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, thirty minutes)

Interprofessional telephone/Internet assessment and management service CPT 99446, 99447, 99448, and 99449

CMS will allow payment in 2019 for interprofessional telephone/Internet assessment and management service provided by a consultative physician including a **verbal and written** report to the patient's treating/requesting physician or other qualified health care professional. Each of these CPT codes has specific time requirements for the minutes of medical consultative discussion and review. Please note that these CPT codes require a verbal and written response.

Telehealth

CMS is finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. CMS is finalizing the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments. CMS is also finalizing policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

As of July 2019, CMS will remove the geographic constraint for telehealth and add "home" for telehealth services for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.

In the News

Settlement for Incorrect Billing of New Patients

St. Agnes Healthcare in Maryland will pay the United States $122,928 to resolve claims under the False Claims Act alleging that St. Agnes submitted false claims to Medicare by billing for new patient evaluation and management (E/M) services when established patient E/M visits should have been billed. Medicare permits a higher rate of reimbursement for E&M services provided to new patients as opposed to E&M services provided to established patients.

In June 2011, St. Agnes acquired a medical practice consisting of 12 cardiologists who were formerly members of MidAtlantic Cardiovascular Associates. The 12 cardiologists became employees of St. Agnes and continued to provide services to their patients through Maryland Cardiovascular Specialists, a specialty practice affiliated with St. Agnes. Since these were established patients of these practitioners, the established patient office visits should have been billed.

The civil settlement resolves a lawsuit filed under the whistleblower provision of the False Claims Act by Jonathan Safren, a former cardiologist employed by St. Agnes. Dr. Safren will receive $20,000.

Stamford Hospital Fined $55,000

Stamford Hospital has been fined $55,000 by the state for allowing a phlebotomist to draw blood at a Southington facility before obtaining a certificate of approval to operate.

A state Department of Public Health (DPH) inspection at Feel Well Health Center in Southington found that a phlebotomist who had contracted with Boston Heart Diagnostics in Massachusetts was conducting venipuncture before Stamford Hospital obtained the necessary written certificate to operate the blood collection facility, according to a consent order signed Sept. 7 by the hospital and DPH.

The order said the Stamford Hospital blood collection facility violated state law because it failed to: have or display a state blood collection facility certificate with a gold seal of approval, have or display emergency procedures for a distressed patient, and have a supervisor visit the facility on at least a monthly basis. The hospital also failed to maintain the blood collection area, as inspectors found rips in chair arms and noticed that centrifuges that should have been calibrated annually hadn't been calibrated since January 2016.

In September, DPH received and accepted a "comprehensive plan of correction" from the hospital, which includes a plan for training all laboratory staff.

In addition to the fine and other monitoring requirements by DPH, the hospital agreed to appoint a phlebotomy supervisor who has at least an associate's degree in biological, physical, or chemical science and a certificate as either a phlebotomist or medical laboratory scientist, technician or technologist.

Source: CTwatchdog.com

ALERT
Teaching Physician Compliance

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.

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