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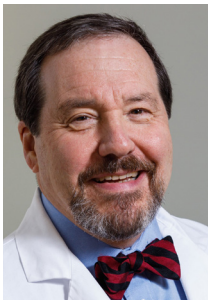
ALERT

Yale Medicine's Compliance newsletter for teaching physicians

A Message from Joshua A. Copel, MD



Dear Colleagues,

Based on recent audits, the Yale Medicine (YM) Compliance Department is finding more instances of faculty copying and pasting someone else's note and using it as their own. Notes of residents, fellows, advanced practice providers, attendings and others should not be copied and shared. In fact, YM Practice Standards prohibit this practice. Sometimes it's important to use part of another practitioner's note, in which case there should be proper attribution to the original author (for example, "As noted earlier today by Dr. Resident, . . . "). This must include reference to the date, time, and author of the original entry. Billing providers may use the copy functionality in the medical record for their own prior notes if the documentation is accurate and clearly reflective of the services provided on a given date, and medical necessity is supported. In other words, if you saw and examined the patient on consecutive days and the exam is unchanged, you could copy and paste it forward from your own note.

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AMA Gets on Bandwagon with CMS for E&M 2021 Changes

At its February CPT Editorial Panel Meeting, the AMA took action to mirror many of the changes that CMS is proposing for the 2021 revised evaluation and management (E&M) documentation and billing guidelines. AMA's

acceptance of the direction that CMS is going is a big win for providers since commercial carriers are required to follow current coding conventions set by the AMA.

The AMA is in agreement with CMS that the level of E&M should be selected based on medical decision making (MDM) or the time spent performing the service. Any documentation of the history and/or examination components will not contribute to the level of E&M that can be billed. The AMA is also planning a major overhaul of the MDM documentation guidelines to emphasize complexity of the conditions being addressed in place of the number of diagnoses reported.

The AMA will revise the E&M guidelines into three sections:

- guidelines common to all E&M services
- guidelines specific to office and other outpatient visits, and
- guidelines specific to E&M services in the facility setting, including observation, hospital inpatient, consultations, emergency department, nursing facility, domiciliary, rest home, or custodial care in the home setting.

Other changes planned by the AMA include:

- deleting Level 1 new patient office visit code 99201
- changing the definition of the time element associated with codes 99202-99215 from typical face-to-face time to total time spent on the day of the encounter, and
- changing the amount of time associated with each code.

It remains to be seen whether CMS is in agreement with the changes planned by the AMA with regard to MDM and the new time requirements. It is important to remember that these changes don't go into effect until 2021, but it is reassuring that documentation relief is on the way.

Date of Service Clarified by CMS

Radiology Services

Typically, radiology services have two separate components: a professional component and a technical component. The technical component is billed on the date the patient had the test performed. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation are completed or can submit the date of service as the date when the technical component was performed. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would be the date the patient received the service, and the date of service for the professional component would be the date the review and interpretation are completed.

Surgical and Anatomical Pathology

Surgical and anatomical pathology services may have two components: a professional and a technical component. The technical component is billed on the date the specimen was collected. This would be the surgery date. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation are completed or can submit the date of service as the date when the technical component was performed. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would be the date the patient received the service, and the date of service for the professional component would be the date the review and interpretation are completed.

When the collection spans two calendar dates, use the date the specimen collection ended.

Care Plan Oversight (CPO)

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency or Medicare-approved hospice. Clinicians must provide physician supervision of a patient involving 30 or more minutes of the physician's time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim can be the last date of the month or the date in which at least 30 minutes of time is completed.

Home Health Certification and Recertification

The date of service for the certification is the date the physician/non-physician practitioner (NPP) completes and signs the plan of care. The date of the recertification is the date the physician/NPP completes the review.

Physician End-Stage Renal Disease (ESRD) Services

A physician may provide monthly or daily oversight of a patient on dialysis with ESRD. The date of service for a patient beginning dialysis is the date of their first dialysis through the last date of the calendar month. For continuing patients, the date of service is the first through the last date of the calendar month. For transient patients or less than a full month of service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient dies during the calendar month. When submitting a date of service span for the monthly capitation procedure codes, the day/units should be coded as "1."

Transitional Care Management (TCM)

TCM services are 30-day services provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit.

Clinical Laboratory Services

Generally, the date of service for clinical laboratory services is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended.

Home Prothrombin Time (PT/INR) Monitoring

There are several procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. This service is payable only once every four weeks. The date of service is the date of the fourth test interpretation.

Cardiovascular Monitoring Services

There are many different procedure codes that represent cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, while others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.

Psychiatric Testing and Evaluations

In some cases, for various reasons, psychiatric evaluations (90791/90792) and/or psychological and neuropsychological tests (96101/96146) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded.

Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric testing when provided over multiple days based on the patient being able to provide information is billed based on the time involved as described by CPT and the last date of the test.

Services Which Transpire Over to Another Calendar Date

This category could include multiple types of services. The service would be started on one day and concluded the following day. The service cannot be submitted to Medicare until completed. Unless otherwise noted, the billing entity can use either the date the service began or the following day when the service concluded.

In the News

Urology Group to Pay $1.85 Million for Incorrect Use of Modifier 25

Skyline Urology will pay the United States $1,850,000 to resolve claims under the False Claims Act alleging that Skyline submitted false claims to Medicare by billing for evaluation and management (E&M) services that were not eligible for reimbursement.

According to the settlement agreement, the United States contends that from January 1, 2013, through December 31, 2016, Skyline improperly used Modifier 25 to falsely claim that E&M services were unrelated to other procedures performed on the same day on the same patient, and thus, eligible for separate reimbursement. In fact, the E&M services were performed as part of, and in connection with, other procedures performed on the same day on a single patient, and Skyline received more reimbursement than it was entitled to under Medicare. The amount payable by insurers for a procedure includes the cost of evaluating a patient for the procedure; therefore, under most circumstances, health care providers are not permitted to bill for E&M services on the same day a related procedure is performed. An exception applies, however, if the E&M service is distinctly separate from other services provided, or if the E&M service is above and beyond the care usually associated with the procedure itself. Under these circumstances, a provider may bill for both the E&M service and the procedure, and does this by submitting the bill with Modifier 25, which permits both claims to be paid. Utilizing the code incorrectly results in overbilling.

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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