



Compliance Wise



The Brody School of Medicine Office of Compliance Newsletter

UPCOMING COMPLIANCE EVENTS

- May 9: Chat with the Director of Compliance Online from 12:00 – 1:00 p.m.
- May 10: CAM Meeting—Presentation on Fair Market Value Determinations
- May 17: Clinical Trial Coordinators Lunch and Learn from 12:00–1:00 p.m. in the Life Science Building, Room 202.

You Have Signed Your Centricity Note, But Is Your Documentation Complete?

Please make sure that your documentation is complete before signing your note in Centricity. While signing your note before completing your documentation may keep your name from appearing on the documentation deficiency list, such actions could lead to

potential allegations of fraud and false claims. Signing a note in Centricity before documentation is completed is contrary to ECU policy, and federal and state law and regulations, and you may be subject to disciplinary action per ECU policy if you are en-

gaging in this practice. If you are behind in your documentation, please work with your Department Chair to formulate a plan to complete your documents.

Billing For Critical Care Services: It's Not Just Location

So your patient is receiving care in an intensive care unit or the emergency department - however that alone does not necessarily mean that the services you provide qualify as "critical care services" for billing purposes. There are a number of requirements that must be followed to bill services as critical care. While the nuances of these rules can get somewhat complex, knowing these requirements will allow your department to bill appropriately for critical care services and receive the more favorable reimbursement rates typically associated with critical care.

The American Medical Association in Current Procedural Terminology (CPT) 2007 defines

critical care service (99291 and 99292) as service related to an injury or illness that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care services involve decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: Central nervous system failure, circulatory failure, and shock, renal, hepatic, metabolic, and/or respiratory failure.

The Center for Medicare and Medicaid Services ("CMS") has

also stated that to qualify as critical care, there must be (i) direct personal management by the attending physician; (ii) life and organ supporting interventions that require frequent personal assessment and intervention by the attending physician; and (iii) the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

Unfortunately, Medicare auditors in the past have occasionally denied claims in which the provider used the word "stable" to describe various

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Billing For Critical Care Services: It's Not Just Location (continued)

aspects of the patient's condition. To the extent a revision in wording accurately describes the patient's condition, it may be more beneficial to replace the word "stable," with other language. For example, instead of "hemodynamically stable," one could document "hemodynamically acceptable."

Providers must spend at least 30 minutes (continuous or interrupted) performing critical care services in order to use CPT Code 99291. Only one physician is permitted to bill for the first hour of critical care services. For example, if a patient requiring critical care services is seen in the emergency department by both an emergency medicine attending physician and a hospitalist physician, only one of those two providers can bill for the first hour of critical care services.

A provider must devote his or her full attention to the patient during the critical care service time. The time that can be reported as critical care is the actual time spent engaged in work directly related to the patient's care, and can include time spent at the patient's bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results

or studies, or documenting the critical care services in the medical record may be counted towards critical care time. Also, if the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment may be reported as critical care, provided that the conversation bears directly on the medical decision making.

CMS notes that neither patient care time provided by a resident in the absence of the teaching physician nor time spent teaching can contribute to critical care time. The Society of Critical Care Medicine has stated, based on its communications with CMS, that the teaching physician's note may tie-in to the resident's note related to various findings (e.g., physician exam, evaluation, etc.); however, the attending physician's note should specify that the patient was critically ill, why the patient was critically ill, the time spent providing critical care, and the teaching physician's treatment and management of care.

Critical care services have been targeted in the past by the government given the increased reimbursement associated with critical care. In fact, the single largest settlement entered into between a physician group and the Department of Justice recently occurred and was related to critical care billing. In September, 2006, Pediatrix Medical Group, Inc. (Pediatrix) agreed to pay the government \$25,078,918 to settle claims under the False Claims Act. The government alleged that Pediatrix improperly billed Medicaid, TRICARE, and the Federal Employees Health Benefits Program for neonatal intensive care when the infants were not critically ill. Pediatrix also entered into a 5-year Corporate Integrity Agreement with the Office of Inspector General ("OIG") which required, in part, written standards and policies, comprehensive employee training programs, review of all claims submitted to federal health care programs, and submission of various reports to the OIG.

If you have any questions related to billing for critical care services, please do not hesitate to contact your departmental billing manager or the Office of Compliance at 744-5200.

OIG Update

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported a record \$789.4 million in audit receivables, and \$1.6 billion in investigative receivables for fiscal year 2006. OIG also reported the exclusion of 3,425 individuals and organizations for fraud or abuse of federal health care programs; 472 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 272 civil actions, which included False Claims Act, civil Monetary

Penalty settlements, and administrative

recoveries related to provider self-disclosure matters.

Recent OIG settlements include:

- Lincare Holdings, Inc. (Lincare) agreed to pay \$10 million to resolve allegations that Lincare had paid illegal kickbacks and violated the Physician Self-Referral Law (the "Stark" Law). OIG alleged that from January 1993 through December 2000, Lincare engage in a nationwide scheme to pay physicians kickbacks to refer their patients to Lincare.



- AdvancePCS, a pharmacy benefits manager, agreed to pay the OIG \$137.5 million and enter into a 5-year corporate integrity agreement to resolve its liability for allegedly soliciting and receiving kickbacks from pharmaceutical manufacturers and paying kickbacks to potential customers to induce them to contract with the company.
- East Tennessee Heart Consultants agreed to pay \$2.9 million to settle

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Research Compliance Corner

The Office of Human Research Protections (OHRP) has issued new guidance over the past few months related to several areas. First, OHRP issued "Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or other Adverse Events" (dated January 15, 2007). This guidance addresses issues such as what OHRP considers to be "unanticipated problems" and "adverse events." It also explains how to determine which adverse events are considered "unanticipated problems." The guidance document contains a helpful flow chart and provides other useful information related to the reviewing and reporting of unanticipated problems and adverse events. The guidance can be located on the OHRP web site at <http://www.hhs.gov/ohrp/policy/AdvEvtntGuid.htm>

OHRP also issued new guidance documents related to continuing review at <http://www.hhs.gov/ohrp/humansubjects/>

[guidance/contrev0107.htm](http://www.hhs.gov/ohrp/guidance/contrev0107.htm), written IRB procedures at: <http://www.hhs.gov/ohrp/humansubjects/guidance/irbgd107.htm>, and new FAQs on prisoner research at <http://www.hhs.gov/ohrp/faq.html>.

The National Institutes of Health (NIH) recently released its findings resulting from its program of Targeted Site Reviews on Financial Conflict of Interest. The Targeted Site Review Program is an NIH initiative that focuses on compliance with the financial conflict of interest regulations (42 CFR Part 50, Subpart F) in connection with NIH grants. The NIH found no instances of intentional noncompliance during its reviews, and also found that many of the institutions had diligently implemented the financial conflict of interest requirements.



However, the NIH noted that common compliance issues involved incorrectly defining the term "investigator" (i.e., some institutions defined "investigator" too narrowly and inconsistent with regulation). Other issues involved the failure to report identified financial conflicts of interest prior to expenditure of funds, inconsistent reporting processes, and failure to monitor subrecipients. The NIH also made a number of implementation suggestions including the development of clear financial conflict of interest policies and procedures that would include definition of terms, enforcement actions for noncompliance, compliance activities, and oversight of subrecipients. You can find more information at <http://grants.nih.gov/grants/policy/coi/>.

CIGNA Medicare Publishes Documentation Pointers in March 2007 Bulletin

Periodically, CIGNA Medicare, the Part B contractor for North Carolina, will publish guidance and expectations related to medical record documentation. Generally, these types of articles are based on review activity that has occurred in the preceding months by CIGNA Medicare in which problems or concerns may have been identified. The following information was published in the March 2007 Medicare Bulletin but it should be noted that this article is a reprint from 2001. Also please note that this CMS guidance does not attempt to address any legal or risk management issues that may be associated with the topics discussed below.

Documentation Pointers Including Correcting Errors and/or Making Late Entries to the Medical Record

- Medicare expects the documen-

tation to be generated during the time of service or shortly thereafter.

- Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note stands alone, i.e., the performed services must be documented at the outset.
- Delayed written explanations will be

considered for purposes of clarification only. They cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

- All entries must be legible to another reader to a degree that a meaningful review can be conducted.
- All notes should be dated, preferably timed, and signed by the author.
- In the office setting, initials are acceptable as long as they clearly identify the author.
- If the signature is not legible and does not identify the author, a printed version should be also recorded.

Billing E/M Services Based on Counseling and/or Coordination of Care Time

Documentation of a patient history, examination and medical decision making are not the only way that an Evaluation and Management (E/M) service can be billed. Time may be the determining factor when selecting a level of service if counseling and/or coordination of care was provided. In order to code and bill based on counseling and/or coordination of care, the time spent in this activity must account for more than 50% of the total time of the patient encounter. Providers are required to document the total time of the visit and the amount of time spent counseling, either as a percentage or by recording the time counseled/ coordinating care.

Example:

Total face to face visit time 40 minutes. Total counseling time: 25 minutes

OR

Face to face time of 40 minutes of which more than 50% was spent counseling the patient.

Office and other outpatient setting:

Counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time spent with the practitioner that is eligible to bill services. Counseling by other staff, such as nurses, is not considered to be part of the face-to-face practitioner/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. As an example: A 72 year old established patient is being counseled for treatment options regarding a diagnosis of

cancer. The physician spent 30 minutes of the total 45 minutes (face to face encounter with the physician). The physician's nurse also provides dietary counseling following the physician's service. This additional 15 minutes of counseling by the nurse, cannot be included in the counseling time provided for the service that day. The code selected for the service is 99215.

Inpatient setting: Counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

Suggestions for information to include when documenting counseling:

- Diagnostic results, impression and recommended procedures
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment and/or follow-up
- Importance of compliance with chosen treatment options
- Risk factor reduction
- Patient and family education

Suggestions for information to include when documenting coordination of care:

- Arrangement of ongoing care for

the patient with other facilities

- Instructions to primary care givers
- Communication of treatment changes (by specialists) to a patient's primary care physician.



Time spent counseling or coordinating care must account for more than 50% of the total time of the patient encounter.



Counseling by other staff is not considered to be part of the face-to-face practitioner/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service.

WE'RE ON THE WEB!
[HTTP://WWW.ECU.EDU/BSOMCOMPLIANCE/](http://www.ecu.edu/bsomcompliance/)

The Brody School of Medicine

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The Brody School of Medicine is committed to maintaining the highest standards of ethics, honesty, and integrity as it furthers its mission of patient care, education, and research. The Office of Compliance was established to support and enhance this mission by ensuring that the Brody School of Medicine conducts its operations in an ethical and law-abiding manner. The Office of Compliance is committed to building and maintaining a culture of compliance that encourages employees, students, faculty, and agents to conduct all the Brody School of Medicine operations with honesty and integrity.

We encourage all faculty, staff, and agents of the Brody School of Medicine to contact the Office of Compliance at any time with questions or concerns, and to use the Compliance website frequently as a resource for compliance activities at the Brody School of Medicine.

If it concerns you, it concerns us!

Compliance Hotline: 1-866-515-4587

OIG Update (continued)

claims that they kept overpayments from patients, federal health care programs and insurance companies since 1995.

- SCCI Houston, a former acute-care hospital based in Dallas, agreed to pay \$7.5 million to resolve allegations of submitting false claims to Medicare and for violating the Stark Law.
- Raritan Bay Medical Center agreed to pay \$7.5 million to settle claims that they took advantage of Medicare's supplemental reimbursement program by purposefully inflating charges.
- Danbury Hospital agreed to pay \$2,355,846 to settle allegations that it

violated the False Claims Act by improperly billing codes that resulted in higher reimbursement to the hospital.

- Hillsboro Area Hospital in Illinois agreed to pay \$300,000 and enter into a 3-year CIA to settle allegations that they submitted claims to Medicare which were not supported by the patient medical records and which resulted in higher reimbursements.



Special Notices

- Code of Conduct Attestation Statements are due to the Office of Compliance no later than May 11, 2007.
- Annual Faculty Conflict of Interest reports are due to the Office of Compliance no later than May 11, 2007.
- Annual HIPAA Privacy Training via Blackboard should be completed by all ECU Brody School of Medicine faculty and staff working in the ECU Healthcare Component no later than April 30, 2007.