SAINT LOUIS UNIVERSITY

Compliance News

Saint Louis University Compliance Department Newsletter

Summer 2008

Toll Free Help Line (877) 525-KNOW

Saint Louis University Compliance Department

NEW COMPLIANCE BULLETINS/FAQ

Question: Has Saint Louis University adopted an "anti-fraud/abuse" policy?

Answer: The Saint Louis University Policy for the Prevention of Healthcare Fraud, Waste and Abuse was effective January 1, 2007 and may be accessed through the SLU Compliance website www.slu.edu/services/compliance.

New Medicare Carrier

Effective June 1, 2008, **Wisconsin Physician Services** (WPS) Insurance Corporation will be the new Medicare Part A and Part B Administrative Contractor (MAC) for Iowa, Kansas, Missouri and Nebraska. Their website is www.wpsmedicare.com

HIPAA General Education

3 pm Thursday, July 31
Caroline Building, Room 108

RESOURCES

- Compliance Department 977-5545
- Compliance HELPLINE (877) 525-KNOW
- SLU Compliance website www.slu.edu/services/compliance
- SLU HIPAA website www.slu.edu/hipaa/
- Center for Medicare & Medicaid Services http://cms.hhs.gov/
- Missouri Medicare Carrier www.wpsmedicare.com

Any comments or questions regarding the Compliance Newsletter should be directed to the Saint Louis University Compliance Department at monahanl@slu.edu.

CMS CHANGES TO THE "INCIDENT TO" POLICY RESCINDED

On May 2, 2008 the Centers for Medicare & Medicaid Services (CMS) issued lengthy revisions to the incident to policy in response to numerous questions and requests for clarifications. Incident to services are typically provided in a physician's outpatient office setting for established patients and represent a service that is integral to, although an incidental part of, that service.

Incident to services may be furnished by an individual who qualifies as an employee of the physician practice when the services are provided in the office under the direct personal supervision (present in the office suite) of the physician or qualified provider such as a nurse practitioner (NP) or physician assistant (PA).

The revisions address specifics related to drugs and biologicals that are not usually self-administered, services and supplies, professional services including services provided by NPs/PAs/CNSs and auxiliary personnel, authorization for services and supplies, supervision requirements and documentation guidelines.

One interesting revision/clarification addresses initial services. The policy states that a physician or advanced level provider (NPP) shall perform an initial assessment or service to which the subsequent service is integral, but incidental. Therefore, each incident to service must be preceded by a MD/NPP service related to the same problem. Additionally, when an established patient presents with a new problem, the physician/NPP must *first* see the patient and provide a service *before* subsequent service may be considered incident to.

The revisions were initially effective June 2, 2008. However due to immediate feedback from the American Medical Association (AMA), the American Association of Medical Colleges (AAMC) and the Management Group Medical Association (MGMA) the transmittal was rescinded for more discussion. A new transmittal will be released at a future date. The original CMS document, Transmittal 87, may be reviewed at: www.cms.gov/transmittals/downloads/R87BP.pdf

HEALTH CARE FRAUD AND ABUSE HEADLINES

- The University of Medicine and Dentistry of New Jersey agreed to pay the federal government $1.4 million to resolve allegations that the medical schools falsely represented that services billed to Medicare were personally provided by teaching faculty, when there was insufficient documentation that those physicians were "personally and identifiably involved" in the care. A federal monitor has been overseeing the school finances since December 2005.

- An ophthalmologist in Washington, D.C. was sentenced to 18 months in prison and an additional 6 months of home detention for committing health care fraud and filing a false federal income tax return. In pleading guilty the physician admitted he billed Medicare, several Federal Employee Health Benefit Plan third party insurers and other private insurers for diagnostic and surgical procedures that he either did not provide or were not medically necessary. In total, $1,011,467 will be provided in restitution.

- The U.S. Court of Appeals for the Eight Circuit in St. Louis reversed the judgment of a federal district court, saying a jury's guilty verdict in a health care fraud case should stand. The clinic office manager had been previously convicted of one count of conspiracy and 81 count of health care fraud in August 2006. The individual had originally been hired by his brother, a physician, to submit the clinic's claims for reimbursement to federal health care programs and private insurers. The feds alleged that the clinic billed for services that either were not performed or were not medically necessary. The U.S. Court of Appeals agreed the government provided evidence through witness testimony to support the original verdict.

- A Belleville, IL psychiatrist pleaded guilty in U.S.District Court in East St. Louis to two counts of health care fraud. On 76 days from 2001 to 2004, the psychiatrist billed Medicare and Medicaid more than 24 hours per day for patients' individual therapy. He acknowledged billing for 45-50 minute sessions when no patient was present and billing for group therapy when he exceeded the recommended 12 patients per session. The indictment cites over 1200 claims to Medicare and Medicaid for services provided when he was actually out of the country.

SURGICAL MODIFIERS
UNIQUE CIRCUMSTANCES

Health care providers in surgical settings frequently have questions regarding billing for procedures which may require more than one surgeon or in which assistants at surgery are used. Correct usage of modifiers in these instances presents particular challenges. Understanding the role the surgeon plays during the procedure is critical.

The table below has been prepared to demonstrate the different situations where the individual modifiers may be applied. As a side note, when physician assistants (PA's) and nurse practitioners (NP's) are employed by the practice and their services are used as an assistant in surgery the modifier (AS) is used.

MEDICARE SURGICAL MODIFIERS

Assistants @ Surgery

Modifier 80

Surgical assistant services

The qualified individual serves as an additional pair of hands for the operating surgeon but does not carry primary responsibility for, or perform, distinct parts of the procedure.

CMS identifies in the physician fee schedule which procedures they may reimburse for assistant @ surgery. Payment is set at the lower of the actual charge or 16% of the fee schedule amount for the global surgical service.

CMS does not pay in teaching hospitals where there are resident training programs related to the surgical specialty.

Modifier 81

Minimum surgical assistant services

CMS rarely recognizes for payment.

Modifier 82

Assistant @ surgery when qualified resident surgeon not available

In emergency or life threatening situations where multiple traumatic injuries require immediate treatment, another surgeon may serve in the assistant surgeon role.

Must be medically necessary and documented.

CMS may pay, but will require certification as follows:

"I understand that #1842(b)(7)(D) of the Social Security Act generally prohibits Medicare Part B reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the service. I further understand that these services are subject to post payment review by the Medicare carrier."

Co-Surgery

Modifier 62

In co-surgery, two primary surgeons, in different specialties, share responsibility for a surgical procedure. Each surgeon performs distinct parts of the surgery during some part of the procedure. Each is responsible for dictating the op report for their portion of the surgery and for the post-op care.

Must be medically necessary and documented.

CMS pays co-surgeons half of 125% of the global fee.

Example: In a procedure where a pacemaker is inserted, a surgeon creates the pacemaker pocket and a cardiologist may position the electrodes.

Team Surgery

Modifier 66

More than 2 surgeons involved in highly complex procedures requiring specially trained personnel and complex equipment.

Must be medically necessary and documented.

Payment is determined by CMS Carrier medical consultants.

Example: A multi-trauma patient may require a number of specialists at the same time to provide orthopaedic, neurological, or general surgical procedures.

TEST YOUR COMPLIANCE/CODING KNOWLEDGE

1. Counseling /Coordination of Care and Critical Care billing have this type of documentation requirement.
2. In the Medicare billing world a fellow is considered to be a resident. (T/F)
3. Medical Necessity documentation is the first requirement for justifying billing medical services. (T/F)
4. In order to bill medically necessary Critical Care codes what documentation is required?
5. What are the key elements of an Evaluation and Management Service?
6. Documentation of two of the three key elements is satisfactory for billing a consult service. (T/F)
7. Anesthesiologists are allowed to medically direct more than 1 case at a time when billing for their services. (T/F)
8. When a separately identifiable service is provided in conjunction with an Evaluation and Management Service, the modifier 25 should be applied to the E & M code billed. (T/F)

1. Amount of time providing services 2. True 3. True 4. Time of service, Type of services provided, Status/condition of the patient. 5. History, Exam, Medical Decision-Making 6. False 7. True 8. True