



SAINT LOUIS
UNIVERSITY

Compliance News

Compliance Department Newsletter
Summer 2006



"Medicare just rejected three more claims."

Cartoon by Dave Harbaugh

COMPLIANCE FAQ

Question: What does Medicare require of the teaching physician when billing for endoscopic services?

Answer: In order to bill for endoscopic services, the teaching physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device. Medical record documentation should demonstrate the presence of the teaching physician throughout the entire procedure. (MCM #15106)

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 Services www.momedicare.com

Hot Topic: Modifiers -25 and -59

The Department of Health and Human Services Office of the Inspector General released two reports in November of 2005 outlining their findings regarding the use of modifier-25 (*significant, separate identifiable E/M service, above and beyond another service, same physician, same day*) and modifier-59 (*distinct procedural service*). A significant error rate was associated with both modifiers which resulted in formal OIG recommendations to Centers of Medicare and Medicaid Services (CMS) and local carriers.

The AMA CPT 2006 Current Procedural Terminology Manual defines Modifier-25 as: **Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service:** "The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed." The additional E/M service is defined and substantiated by physician medical record documentation.

The DHHS/OIG modifier-25 report was based on 450 randomly selected billed claims for the year 2002. The OIG found thirty-five percent of claims using modifier -25 in the selection did not meet program requirements, resulting in \$538 million in improper payments. The Medicare payments for these claims were made inappropriately because the claims failed to meet basic Medicare documentation requirements, or the E/M services were not significant, separately identifiable, and above and beyond the usual pre- and postoperative care. The OIG recommended CMS work with carriers to reduce the number of claims with modifier -25 that do not meet the requirements by focused reviews and provider education.

The CPT-2006 Manual also states, "different diagnoses are not required for reporting of the E/M services on the same date." *Example:* A patient visits the orthopaedic physician with complaints of knee pain and swelling. After evaluation, it is determined appropriate management of the problem includes draining the knee of fluid at the time of the visit. Because the decision to perform the procedure was made at the time of the evaluation, the procedure and the E/M visit with the modifier -25 may be billed. Adequate documentation must be present to support both codes.

The AMA CPT 2006 Manual defines Modifier-59 as a **distinct procedural service**. "Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. Only use modifier-59 when there is no more descriptive modifier.

The modifier-59 OIG report was the result of review of 350 randomly selected Medicare billed claims which bypassed CCI edits for the year 2003. The OIG found forty percent of code pairs billed with modifier-59 did not meet program requirements because the services were not distinct from each other or were not documented. The OIG concluded that these errors resulted in \$59 million in improper payments. In addition, eleven percent of code pairs were erroneously paid when the modifier was billed with the primary code instead of the secondary code. This billing error represented \$27 million in Medicare payments. The OIG recommended that CMS encourage carriers to conduct pre- and postpayment reviews and ensure the carriers' claims processing systems only pay claims with modifier -59 when the modifier is billed with the correct code.

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

In order to determine whether services are “normally reported together” CMS developed the Correct Coding Initiative (CCI). These edits may be found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

Additional information can be obtained on the local carrier website which displays flow sheets outlining the process for modifier usage (including modifiers 25 and 59). The Missouri website may be accessed through the following URL:

<http://momedicare.com/provider/dataanaly/modflow/default.htm>

Recent Fraud Alerts

-SERONA LABORATORIES, INC plead guilty and was sentenced in federal court December 15, 2005 on criminal charges in connection with several illegal schemes to promote, market and sell its drug Serostim, used to treat AIDS patients. The company was charged with conspiring with a medical device manufacturer in use of a non-federally approved device to calculate body cell mass and diagnose AIDS wasting. In addition, SERONA employees induced doctors to prescribe Serostim and to get Medicaid agencies and other payers to reimburse for the drug. As a result of the sentencing, the company will pay a \$137 million criminal fine as part of \$704 million global settlement, be excluded from all federal health care programs for five years and enter into a corporate integrity agreement. Five past employees of SERONA, as “whistleblowers,” will share in approximately 17% of the civil recovery, or approximately \$52 million.

-TENET HEALTHCARE CORP. agreed to pay \$900 million to the federal government to settle allegations involving Tenet’s billings to Medicare and other federal health care programs. In the agreement, Tenet admitted no wrongdoing but will pay \$725 million over four years and waive its right to pursue \$175 million in Medicare payments for past services. The deal concludes a four-year investigation by the U.S. Justice Department.

Since 1986, the False Claims Act has returned over \$16 billion to the U.S. Government, getting back \$15 for every \$1 invested in health care investigations and prosecutions. Currently state governments have joined the effort with 16 states passing False Claims laws.

Recap: Compliance Year in Review

The June Billing and Compliance Meeting provided an opportunity for Compliance Education Specialist Sally Frese, to offer a synopsis of the year’s Compliance events, along with some “friendly year-end reminders”.

- For billing documentation purposes, medical students can only provide documentation of *ROS* (Review of Systems), and *PFSH* (Past, Family and Social History). Residents and teaching physicians must document the *HPI* (history of present illness), *Exam* and *Medical Decision-Making*.
- Mid-level provider services may be billed either “incident to” or under their own provider number.
- Confirmatory consult and follow-up consult CPT codes have been deleted. When billing consults, be sure documentation of the request, recommendation and response to referral source has occurred. A *transfer of care* occurs when the physician whose opinion or advice was sought takes over care of the patient for the current condition. In these situations, use appropriate *new* or *established patient* visit CPT codes.
- Procedures require documentation of teaching physician presence throughout the entire procedure or for “critical or key portions”. Overlapping procedures must not have overlapping critical or key portions and the TP must identify a designated teaching surgeon immediately available as the backup surgeon for the first case.
- *Medical Necessity* is defined as care or services deemed necessary and reasonable for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Documenting medical necessity must be done before diagnostic services can be performed. Reason(s) for the exam, specific to the individual patient must be documented. An appropriate diagnosis code (ICD-9) must be provided or linked to the diagnostic service. “Standing orders” and “rule out” diagnoses or syndromes are not acceptable.
- If you have HIPAA questions regarding release of medical record information, authorization forms, policies and procedure please contact our medical record experts or Chief Privacy Officer Ron Rawson.
- The federal government has begun to offer monetary rewards to individual state governments that establish

Medicaid fraud and abuse initiatives. As a result, scrutiny of provider services and claims for Medicaid beneficiaries are expected to increase. If contacted by a representative from Medicaid or CMS requesting information, contact the SLU Compliance Department at 977-5545.

Happy New (Academic) Compliance New Year!

Welcome to all new faculty, residents and staff, and to all “old” practice members. Best wishes as we begin the academic and fiscal New Year! We are pleased to share the following important information about compliance education:

1. New Faculty/Clinician General Compliance Session – **required** for all providers that bill for services - physicians, nurse practitioners, physician assistants, etc. Sessions are generally provided on an individual or small group basis and should be scheduled by calling 977-5545 or emailing Sally Frese at fresesm@SLU.EDU
2. Health Insurance Portability and Accountability Act (HIPAA) General Education session – **required** for all faculty, staff, students that work with/are exposed to protected health information.
HIPAA session schedule:
 - September 19 – 9:00 a.m. LRC Room 113
 - October 17 – 3:00 p.m. LRC Room 110
 - November 14 – 3:00 p.m. LRC Room 112
3. Resident/Fellow Sessions – Recently we have had the privilege of participating in Grand Rounds presentations for the Departments of Orthopaedic Surgery, Psychiatry and Ophthalmology. Topics included documentation and coding, general compliance issues, medical necessity, consultations, specialty specific topics, and HIPAA updates. We welcome the opportunity to participate in education and interaction with the faculty and housestaff. To arrange a session contact Sally Frese at fresesm@SLU.EDU
4. Clinical Department Billing and Coding staff and Financial Services staff education sessions are held on a bi-monthly basis. The next meeting will feature Kate Becker, SLU Office of the General Counsel - “Legal Issues and Update” on Tuesday, October 10th from 10:00 -11:00 a.m. in the LRC Auditorium C.