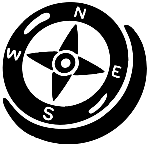

Compliance Compass

Vanderbilt University Medical Center Office of Compliance and Corporate Integrity

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Coming Soon: Medicaid Audits

Changes to the Deficit Reduction Act (DRA) that became effective on January 1, 2007 take the relationship between the Centers for Medicare and Medicaid Services (CMS) and the States to a new level. These changes will impact compliance activities at Vanderbilt in several different ways. Congress is providing CMS with resources to significantly increase audits and monitoring of Medicaid services. The additional funding will be used to establish the Medicaid Integrity Program also known as MIP. The Medicaid Integrity Program will identify providers seeking inappropriate payments from the Medicaid Program, work with the States to enhance their program integrity activities, suspend payments and make referrals for suspected fraud to the OIG. States will be paid a percentage of the money recovered as an incentive. The new funding allocations include $87 million for 2007, and increases to $99 million in 2008, $136 million in 2009 and $160 million in 2010. Newly formed Medicaid Integrity Contractors will conduct audits and identify overpayments on behalf of MIP. The audits are expected to focus on high expenditures for medical and other services that do not require prior authorization, and on providers billing more high level E/M services. Thus, we can expect to see an increase in audits of Medicaid services similar to what we now see for Medicare services. The compliance office will monitor these audits.

Another component of the DRA amendments include new requirements by health care providers to provided mandatory education of staff and Faculty about the False Claims Act (FCA). Any entity that receives annual Medicaid payments of at least 5 million dollars must establish written policies for employees that provide detailed information about the state and federal laws related to the False Claims Act, including whistleblower protection and the role of these laws in preventing and detecting fraud and abuse in federal health care programs. Vanderbilt has a new policy HR#040 False Claims Act and Whistleblower Protection Policy . The policy can be referenced on the HR web site at the following link: http://hr.vanderbilt.edu/policies/hr-040.pdf. The policy defines both the Federal and State of Tennessee False Claims Acts. There is guidance and examples of potential violations of the False Claims Act. Instructions for reporting suspected violations and information related to whistleblower protection are also outlined in the policy. We want concerned faculty/staff to call us!

Vanderbilt's Compliance Office manages a 24 hour report line (343-0135) that Faculty and Staff are encouraged to use for reporting any compliance related questions or concerns. All calls are investigated and the information related to the calls as well as the investigative results are logged into a centralized data base. Because of the nature of some of the calls, investigations are sometimes handled by other departments such as Human Resources and the HIPAA Privacy Office. Regardless of who is assigned, the Compliance Office is apprised of the resolution of all investigations. All calls are kept confidential, and all callers are protected from retaliation.

Thinking on Paper: Guidelines for Documenting Medical Decision Making

Medical decision making (MDM) is arguably the most important of the three key factors which go into selecting an evaluation and management (E&M) service level. Though only the physician can determine the level of medical decision making, when subjected to audit, somebody other than the physician has to be able to determine whether the level of decision making is supported by the documentation. There is a point system used by auditors (both internal and external to Vanderbilt), to determine the complexity of the visit. Following is an overview of the components of documentation note that determine medical decision making.

I. Presenting Problems
Number of diagnosis/management options is charted on a scale of one to four. Each stable established problem to the clinician is worth one point. Each established problem that is worsening is worth two. Points are given for each established problem, so it is important to identify in your note each problem that affects your decision process, regardless of whether treatment is provided for each problem during the visit. New problems to the provider with no further lab or diagnostic radiology are worth three points. New problems to the provider requiring further work up are worth four points.

II. Complexity of Data
The amount and complexity of data review is figured on a scale of one to four. Each category of diagnostic testing (labs, radiology, medicine) ordered and/or reviewed is also worth one point. Deciding to obtain records from another provider is worth one point. Personally visualizing a diagnostic image or review and summarization of old records and/or obtaining history from someone other than patient is worth two points.

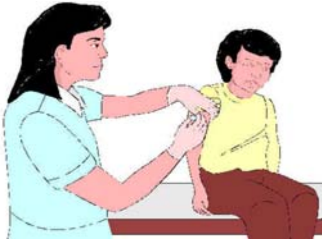
III. Level of Risk
There are four levels that determine the patient risk level:
Minimal -1 minor problem may require, splints, UA, chest X-rays, Ultrasounds).
Low -2 or more self-limited problems or one stable chronic illness that may requires OTC drugs, minor surgery.
Moderate-1 or more chronic illnesses with exacerbation or side effect of treatment involving either prescription drug management, diagnostic endoscopies, deep needle biopsies, elective major surgery with no identified risk factors.
High -1 or more chronic illnesses with severe progression or side effect of treatment, illness posing threat to life or bodily function, abrupt change in neurological status; drug therapy requiring intense monitoring for toxicity.

The table below depicts the requirements for meeting each level. To arrive at a final score, **choose the highest two** categories of points from Presenting Problems, Data and Level of Risk.

Type of Decision Making:	StrForward	Low	Moderate	High
I. Presenting Problems =	0 or 1	2	3	4 (+)
II. Amount of Data =	0 or 1	2	3	4 (+)

III. Overall risk =	Minimal	Low	Moderate	High

Billing for Influenza Vaccinations



The flu is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to death. The best way to prevent the flu is by getting a flu **vaccination** each year.

People at high risk for complications from the flu, include but are not limited to:

- People 50 years of age and older,
- People of any age with certain chronic medical conditions, and
- People who live in nursing homes and other long term care facilities.

Reporting Flu Vaccinations given to Medicare Patients

Report both the vaccine product and the procedure associated with administering the vaccine.

Vaccination Product: report one CPT code from the range 90655 – 90660
Administration of Vaccine: report HCPCS code G0008, *administration of influenza virus vaccine,* in addition to the product CPT code (90655-90660).

Billing for Critical Care Services

The AMA definition of critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury 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 provided to a patient over 24 months of age for the first 30 – 74 minutes is reported by using CPT code 99291. Each additional 30 minutes of critical care report the add on code 99292. The documentation must include the total time spent by the attending (not time spent by the resident, nurse, etc), what the provider did, and must clearly indicate that the patient is critically ill. Total time spent with the patient does not have to be continuous.

When multiple physicians from different specialties/divisions provide critical care (99291 and 99292) during the same clock hour, only one physician may bill the critical care. The other physicians would bill a consultation or subsequent day visit when documentation requirements are met.

If multiple physicians within the same division/specialty provide critical care during different clock hours on the same day, the time must be combined. CPT code 99291 (critical care for the first 30 – 74 minutes) may be billed only once per specialty on any given day.

Can I Use the NPP as a Scribe?

For some time there has been controversy surrounding the opening question. The dilemma is not "can I use the NPP/PA as a scribe?" but rather "should I use the NPP/PA as a scribe?"

A November 2006 article published by Non-Physician Practitioner News makes valuable and reasonable points. Employing a credentialed billing Nurse Practitioner or Physician Assistant as a human Dictaphone (aka scribe) is unproductive and wasteful. A scribe is defined as someone who writes down (or types) exact dictation. It cannot include any observations by the scribe or any independent thought. Thus, a NP/PA cannot do any more than a recorder or typist function while being a scribe. No H&P, DX, or Plan

done using their credentials as a NP/PA medical provider may be employed in a scribed note.

The article states, it is important for physician's to ask themselves "what responsibilities am I willing to share with an NP/PA?" Will they be generating revenue that will compensate for their salary? If I am looking for a scribe would it be in the best interest of the practice to employ a credentialed billing NP/PA for such a position or is there an alternative professional for such a position?

When using anyone as a scribe it is important to follow the guidelines as set for by CMS (Center for Medicare/Medicaid Services). The guidelines state the individual writing the note should note "written by xxxx, acting as scribe for Dr. yyyy." The scribe is functioning as a expensive, "living recorder," recording in real time the exact words of the physician as they are dictated to the scribe. Medicare pays for medically necessary and reasonable services and expects the person receiving payment to be the one delivering the services. For additional information about the requirements related to the use of a scribe contact the compliance office at 343-7266.

Medicare AAA Screening Benefit

The Center for Medicare and Medicaid Services (CMS) added a new screening benefit effective January 1, 2007. A One-time Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) is a covered service when provided in conjunction with the Initial Preventive Physical Examination aka Welcome to Medicare Physical Exam.

This is a **one-time** benefit. For medical necessity and reimbursement, the patient must meet the following criteria:

- A referral for the screening ultrasound **must** be initiated as a part of the IPPE. *This is crucial. If the patient does not qualify for the IPPE, they do not qualify for this benefit.*
- The beneficiary must not have been previously furnished an ultrasound screening for AAA under the Medicare program.
- The patient must be included in at least one of the following risk categories:
    - Has a family history of an AAA
    - Is a man age 65 to 75 years who has smoked at least 100 cigarettes in his lifetime. *No coverage is provided to female patients who **only** have a history of smoking at this time.*

The service should be reported using new HCPCS code G0389 (ultrasound, B-scan and/or real time with image documentation; for AAA screening) and reimbursement is comparable to CPT 76775 (ultrasound, retroperitoneal (e.g., renal aorta modes), B-scan and/or real time with image documentation; limited). The service is covered under the OPPS, and modifiers for the technical (TC) and professional (26) components of the ultrasound apply.

VMG Change in Consultation Request Requirements

The VMG has announced a change in policy related to documentation of consultation requests. Written request for consultation are required for all Federal payers. Written or verbal requests are accepted for non Federal payers if described in opening lines of the consultant's notes. Please refer any questions regarding this change in policy to Racy Peters at 343-3917.