Compliance Compass

Volume 7, Issue 4 | Your Guide to Compliance Issues | September-2005

Cigna Targets Level 5 Visits

At CMS's instruction, Cigna Medicare is systematically beginning to audit providers who have high rates of level 5 visit for established patients. Cigna Medicare recently completed a targeted review of level 5 established patient office visits. Cigna utilized data analysis to identify providers with an exceptionally high utilization of CPT Code 99215.
When billing a level 5 established patient visit, two of the three key components must be included in the documentation supporting the service. (i.e. a comprehensive history, comprehensive exam and high complexity medical decision-making)

Following is a summary of errors identified by Cigna during the probe:

- Records did not support a **medically necessary** comprehensive history. They found that considerable history beyond that medically necessary for a particular problem is being counted by physicians in scoring the level of service. CMS has indicated that this is an abusive practice. Because of this, the official position of the compliance office is that the degree of recorded history should be appropriate to the clinical condition, and where it appears to be excessive, will not be counted towards the level of service. This is particularly a problem on return visits. In our observation the violation of this generally occurs when electronic copy forward or cut and paste techniques are used from prior visits rather than recording an interval history which is focused on the specific problem.

- Records did not support comprehensive exams. Many of the exams were appropriately only problem focused and did not meet the level of exam required for CPT Code 99215.

- Records did not support medical decision-making of high complexity as required by CPT Code 99215.

- Some services were billed based on the volume of documentation rather than the level of service warranted based on the patient's condition.
The following information is quoted directly from the July 2005 Medicare Newsletter Article.

"Word processing software, electronic medical records, and formatted/templated note systems facilitate the "carry over" and repetitive "fill in" of stored information. Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of E/M service."

"Cigna noted that in many records reviewed the notes carried over

identical information from date to date. This causes the appearance of records being cloned as opposed to actual data being collected due to medical necessity at the time of the visit. Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. <u>Cloning also occurs when medical documentation is exactly the same or similar from patient to patient.</u>"

New Vs. Established Patient Rules: Physician Changes Practice Location

Question: Would it be appropriate to bill a patient as "new" <u>if a physician changes practices and sees a patient that he/she had previously seen within the past three years while working for another medical group?</u>

Answer: According to AMA, the determining factor in assigning an evaluation and management code for New vs. Established patient is whether the patient received professional services from the physician within the past three years, regardless of the place of service. Thus, if the patient has received professional services from the same physician within the past three years, the patient is considered an established patient, even though the physician has changed medical groups. So, for example, if a Cardiologist joins the VMG from a practice in Chattanooga, TN and one of that providers patients is seen by that Cardiologist at TVC, the visit would be billed as an established patient visit.

Frequently Asked Questions

In the July 2005 issue of the Cigna Medicare Bulletin, there was an article on Medical Review Frequently Asked Questions. Some of the questions addressed are very similar to the questions the compliance office staff often receive when educating providers. The following is representative of some of the questions asked and Cigna Medicare's responses.

Q: **What is acceptable for correcting medical records/documentation and what is the time period allowed?**

A: Medicare expects the documentation 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. 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.

Q**: Can a radiologist order additional tests if medically necessary as long as they document the medical necessity and write an order?**

A: It is Cigna Medicare's interpretation that an order for additional tests can be given only by the treating physician. NOTE: A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician. A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while a patient is still at the facility for the screening exam.

Q: **How do you bill for two hospital visits that occur on the same day?**

A: Medicare Part B pays a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all service provided on that date. The physician should select a code that reflects all services provided during the date of the service. Physicians in the same group practice who are in the same specialty must bill and be paid as they were a single physician. If more than one evaluation and management service is provided on the same day to the same patient by the more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service that is representative of the combined visits and submit the appropriate code for that level. Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group. Both visits would have to be medically necessary and each doctor would need to be managing different aspects of the patient's care.

ABN Needed For Smoking Cessation Services

If you are billing the new smoking cessation codes to Medicare patients (G0375 and G0376), you are required to issue an Advanced Beneficiary Notice or ABN. The patient must be advised of the potential financial liability for this service including the frequency and qualifying conditions of coverage. Coverage includes 2 attempts each year and each attempt may include a maximum of 4 intermediate sessions or intensive session. If you would like additional information about this benefit or

the ABN requirements contact the compliance office at 343-7266.

Inservice For Web Based Data Collection Services

In the spring of 2002, the Compliance Office formalized an agreement with an Atlanta, Georgia based company known as MC Strategies for web-based training. What began as a way to educate VUMC faculty and staff on compliance-focused topics has blossomed into an extremely wide array of training topics that covers anything from policy review on dress code to data collection for satisfaction with work environment.

The first broad based implementation of the training system (known in the VUMC as webinservice) began in the fall of 2002 with the release of the Standards of Conduct and the HIPAA training sessions. Both of these lessons were based on in-house content. With the success of these two training sessions came an epiphany; we realized that we could implement more than just compliance related training sessions. We could, in fact, use in-house experts to develop any number of topics and then use webinservice as the vehicle for administering the content. Over the past 3 years, some 220 of these in-house training sessions have been built and delivered to faculty and staff at Vanderbilt University.

The most recent trend in webinservice initiatives at VUMC has been to use the platform as a vehicle for delivering web-based data collection systems. These commonly come in the form of a survey. There are currently several surveys that are being piloted or have been rolled out that utilize a database for collecting users' responses. These databases are housed locally and are really independent, free-standing data collection tools. This differs from the conventional Lesson and Test pairing in that there is no educational content (lesson) or test. The learner is assigned a survey which when completed, satisfies the assigned task. They could be administered without using webinservice; however, webinservice has proved to be a clever way to assign training and monitor response rates. Administrators can see in real-time the response rate percentages and determine when a large enough sample has been collected so that data analysis can be initiated. Integrating data collection tools into a training system whose strong suit combines timely delivery of content and a well recognized delivery route opens a plethora of opportunities. This strategy could be utilized for storing data for things as varied as satisfaction surveys to credentialing information.

If you are interested in developing a data collection strategy like what has been described above, please contact Mark at the Compliance Office.

For questions or additional information regarding the above, contact the Compliance Office at 615-343-7766.