UNIVERSITY OF XXX MEDICAL CENTER COMPLIANCE ACADEMY

CHAIR AND SENIOR ADMINISTRATOR COMPLIANCE DISCUSSION

JANUARY 31, 2018

COMPLIANCE CHALLENGES IN TEAM BASED DOCUMENTATION: REGULATORY, BILLING AND THE FALSE CLAIMS ACT

ROBERT G. TRUSIAK, ESQ.

RETIRED ASSISTANT UNITED STATES ATTORNEY

NORTHERN DISTRICT OF OHIO, WESTERN DISTRICT OF NEW YORK

FORMER CHIEF COMPLIANCE OFFICER, SENIOR ASSOCIATE GENERAL COUNSEL, PRIVACY OFFICER, KALEIDA HEALTH

ADJUNCT PROFESSOR, UNIVERSITY OF BUFFALO

"HEALTH CARE FRAUD AND ABUSE"

Robert@trusiaklaw.com

www,trusiaklaw.com

716-352-0196

COMPLIANCE

WHO YOU GONNA CALL?

275-1912

WHO IS RESPONSIBLE FOR COMPLIANCE?

BUT FIRST, INSPIRATIONS AND ASPIRATIONS

- *SINSKY PRESENTATION*
  - PRACTICING AT THE TOP OF YOUR LICENSE THROUGH TEAM BASED DOCUMENTATION
  - DOCUMENTING RATHER THAN DELIVERING CARE; “I USED TO BE A DOCTOR, NOW I AM A TYPIST.”
  - OUR RHETORIC IS FOR TEAM-BASED CARE, BUT OUR TOOLS AND REGULATIONS ARE OFTEN BARRIERS TO THAT TEAM BASED CARE
  - COMPLIANCE CREEP DUE TO OVERIMPLEMENTATION OF FEDERAL AND STATE LAWS AT THE HEALTH SYSTEM LEVEL


COMPLY WITH ME, COMPLY, LET'S COMPLY AWAY


TEAM BASED CARE DOCUMENTATION:

INCIDENT TO, SHARED VISIT, BILLING AND THE FALSE CLAIMS ACT

DISCUSSION POINTS

1. **PROVIDE AN INTERACTIVE, HIGH LEVEL PRIMER ON BASIC TEAM BASED CARE BILLING RULES**
2. **DISCUSS THE COMPLIANCE INTERSECTION OF THE MISAPPLICATION OF THE RULES TO THE FALSE CLAIMS ACT**
3. **OFFER A VIGNETTE TO EXEMPLIFY THE EVOLUTION OF RISK**

MD/NPP BASED CARE :

A well-established patient, Mrs. Brown, calls the health system clinic in the morning for an urgent “fit in” appointment. The clinic is staffed by 3 MDs and 4 Advanced Practitioners. Well-known to all of the providers, the patient has been steadily followed for diabetes and hypertension. Today she has called to be evaluated for new onset high grade fever, lassitude, and generalized joint pain. She’s also mentioned to the receptionist that her antihypertensive medication may not be working as well as she hoped since her last visit five (5) months ago.

WHAT ARE MY 3 E&M BILLING OPTIONS?

- **Medicare “Incident to”**
- **NPP Direct**
- **Shared/Split**

- **Medicare “Incident-to”**
  - **Pays at 100% of Physician Fee Schedule *but***
  - **Medicare only**
  - **Multiple pre-requisites and office limitation make this a limited option**

- **NPP Direct**
  - **Simplest way to bill *but***
  - **Pays at 85% of Physician Fee Schedule**

- **Shared/Split**
  - **Pays at 100 % of Physician Fee Schedule *but***
  - **Participation and documentation required**

DOES PLACE OF SERVICE MATTER?

- Medicare “Incident-to”
  - Private office only
- NPP Direct
  - Applicable in private office, hospital outpatient, and inpatient
  - Medicaid does not allow NPP professional billing in the hospital outpatient or inpatient settings
- Shared/Split
  - Applicable in private office, hospital outpatient, and inpatient
  - Medicare does not allow in private office setting

WHAT ARE THE BILLING, DOCUMENTATION AND COMPLIANCE IMPLICATIONS OF:

- **Example A**: The NPP sees the patient totally on their own.
  - NPP direct visit is reimbursed at 85%
  - NPP documents the encounter which supports the billable level of service
  - MD is not required to document or co-sign the note

- **Example B**: The NP/PA as well as one of the clinic MDs see the patient.
  - Shared/split visit is reimbursed at 100%
  - NPP and MD must both perform a substantive face-to-face service
  - Combined documentation must support the billable level of service
  - MD must document and sign his/her personal participation in the encounter
    - Include 2 of 3 (History, Physical Exam, Medical Decision Making)

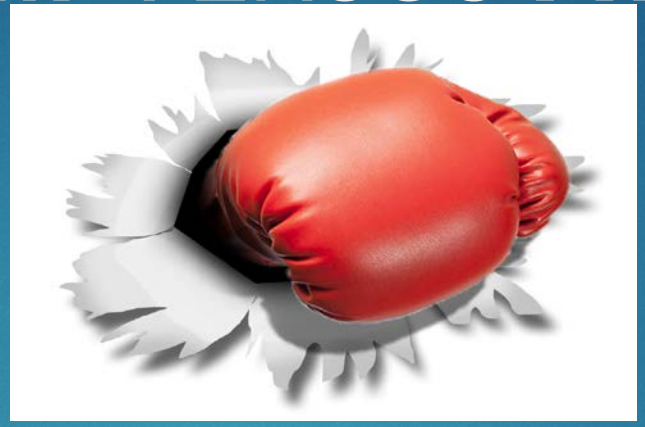
- **Compliance Implications**

HOW ARE MINOR PROCEDURES BILLED WHEN:

- **Example A**: The NPP performs a procedure independently
  - MD supervision of NPP performed procedures does not allow for additional reimbursement
  - Shared/split billing **does not** apply to procedures
  - Procedure must be direct billed by the NPP at 85%

- **Example B**: The NPP assists the MD with a procedure
  - MD must personally perform and document the procedure
  - Service may be billed by the MD at 100%

ADDENDUM VERSUS **ATTESTATION**



- An **attestation** is used when following Teaching Physician guidelines
  - Teaching Physician guidelines **do not** apply to NPPs
  - An attestation should never be applied to an NP note

- An **addendum** is commonly used by MD in shared/split scenarios
  - Addendum is applied to the NPP note
  - Used to document the MD's personal involvement in the encounter
  - Must be unique to the encounter, not a pre-populated template

FALSE CLAIMS ACT ISSUES IN TEAM BASED DOCUMENTATION VIGNETTE

- A health system senior coder attends a coding conference. The coder thinks the coding presentation included instruction that provided the opportunity to bill all NP and PA work through the physician's NPI at 100% of the fee schedule for physician work.
- The physician's bonus increased due to the increased work attributed to the physician. All is good.
- This practice continues for a few years.

FALSE CLAIMS ACT ISSUES IN TEAM BASED DOCUMENTATION VIGNETTE (Cont'd)

- The clinic coder takes maternity leave. The replacement coder immediately discovers the billing concerns and performs an audit.
- The physician requests a meeting with the Director of Coding and Audit prior to any changes in billing practice. There are several e mail exchanges. Health system counsel is copied on the e mails. There is an initial meeting after 60 days from the audit. The MD's attorney, a corporate lawyer, insists the billing practice is fine given Medicare's continued payments.
- **Discussion**: How risk really evolves, the error of most whistleblower and FCA discussions, privilege, 60 day, continued payments.

FALSE CLAIMS ACT ISSUES IN TEAM BASED DOCUMENTATION VIGNETTE (Cont'd)

- The physician is concerned with the reduction in pay due to the billing change. The physician is a medical oncologist who generates significant 340B revenue for the health system. The physician's attorney writes an e mail to a senior hospital official threatening to leave absent a medical directorship to make up the deficit in compensation.
- The compliance officer insists the health system must repay Medicare for the physician bonus payments based on the incorrect billing at 100% of the fee schedule rather than 85%. A senior hospital official decides to fix it going forward and forget about the historical overpayment because the conduct was unintentional. The compliance officer finalizes the audit, requests repayment and is discharged the next week.
- The compliance officer files a whistleblower complaint against the health system and the senior hospital official.
- **Discussion**: retrospective application despite benign error, Yates memo, individual liability, retaliation **and the frog in the pot.**

The Yates Memorandum

On September 9, 2015, Deputy U.S. Attorney General Sally Quillian Yates issued a memorandum to all DOJ attorneys entitled “Individual Accountability for Corporate Wrongdoing” (the “Yates Memo”).

Addresses “how the Department approaches corporate investigations, and identified areas in which it can amend its policies and practices in order to most effectively pursue the individuals responsible for corporate wrongs.”

The Yates Memorandum – Key Provisions

Corporations must provide all relevant facts about individuals involved;
Both criminal and civil corporate investigations should focus on individuals from inception;

Absent extraordinary circumstances, no corporate resolution will provide protection from criminal or civil liability for individuals;

Corporate cases should not be resolved without a clear plan to resolve related individual cases; and

Civil attorneys should consistently focus on individuals as well as the company.

Calif. Health System Settles False Claims Allegations Over Incident-To Billing for PTs

Scripps Health in San Diego agreed to pay $1.5 million to resolve false claims allegations that it ran afoul of incident-to billing rules,
The Department of Justice (DOJ) alleged that Scripps Health billed Medicare for physical therapy incident to a physician's services when the physician wasn't there to supervise. Because the physical therapists weren't enrolled in Medicare and TRICARE and didn't have billing privileges, Scripps Health couldn't bill directly for their services as a fallback, according to DOJ, which announced the settlement Jan. 19. DOJ alleged Scripps "falsely identified a certain physician as the provider for outpatient physical therapy services" performed at its Rancho Bernardo Clinic from Jan. 1, 2010, to Dec. 31, 2015, when they were actually performed by "non-authorized" providers, the settlement states. Scripps Health, however, says that it didn't benefit financially from the "technical billing issues," according to a statement.

Calif. Health System Settles False Claims Allegations Over Incident-To Billing for PTs

"As a matter of policy, Scripps required only that physicians be available by telephone, and not on-site, as the Medicare Coverage Manual required," the complaint alleged.

The whistleblower found out about the incident-to problem through "an email chain," the complaint alleged.

Report on Medicare Compliance, 1/29/18, V. 27, No. 4.

CONCLUSION

- QUESTIONS?

- TAKEAWAYS
  - The most important compliance personnel of any health system include its clinicians.
  - The 60 day repayment obligation requires deliberative and prompt action devoid of any appearance of retaliation.
  - Privilege and the ability to insulate e mails from disclosure require a specific request for legal advice rather than merely copying health system counsel on an e mail.
  - The status quo is not a legal defense to a billing problem nor is the claim that Medicare always paid it.
  - The potential for individual liability is real.

Robert G. Trusiak, Esq.
Robert@trusiaklaw.com
www.trusiaklaw.com
716-352-0196

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Billing Options When Working With Non-Physician Practitioners (NPP)
Evaluation and Management Services

1. **MD personally documents the service and bills under MD's name/number**

Pros:

- Service documented by MD specialist
- Would not disrupt the current patient flow (NPP evaluates patient, presents to MD, then MD personally evaluates patient)
- Service reimbursed at 100% of MD fee schedule

Cons:

- Additional documentation required by MD (MD may reference NPP documentation or a questionnaire for the review of systems and past, family and social history). MD would then have to personally perform and document the history of present illness, physical exam and medical decision making.

2. **Direct bill the service under NPP's name and number**

Pros:

- NPP can document entire service
- NPP utilizes billing number. Lack of use can result in external review of billing practices
- Would not disrupt the current patient flow (NPP evaluates patient, presents to MD, then MD personally evaluates patient)
- MD specialist may co-sign the note to reflect his/her review of the encounter (A co-signature does not allow the service to be billed under the MD's name/number)

Cons:

- NPP salary must be funded by private practice for the time NPP is billing
- NPPs are generally reimbursed at 85% of MD fee schedule

3. **Combine NPP and MD documentation and share/split bill under MD's name/number**

Pros:

- Service reimbursed at 100% of MD fee schedule
- Level of service is based on combined documentation of MD and NPP

Cons:

- MD must document his/her personal participation in the encounter. This is generally accomplished as an addendum to the NPP note. A simple attestation is not sufficient.
- MD documentation should include at least two of three categories (history, physical exam, medical decision making).
- Combined MD/NPP documentation must support the billable level of service
- NPP salary must be funded by private practice for the time NPP is billing
- MD and NPP must me part of the same group practice
- **In the Private Office setting (Place of Service 11)**
  - **Does not apply to Medicare New Patient Visits (99201-99205)**
  - **Medicare Established Patient Visits (99211-99215):** Medicare "Incident-to" requirements must first be met. These requirements include: MD has previously seen the patient and established a plan of care; NPP is following the MD's original plan of care (no new problems).
- *** **Procedures can never be share/split billed**

MD FAQ: E&M Billing Options When Working With NPPs

1. For E&M billing purposes, is there a difference between a NP and PA?
   - No. An NP and PA billing independently are reimbursed at 85% of MD fee schedule
   - Medicare "Incident-to" guidelines apply to both NPs and PAs
   - Shared/Split guidelines apply to MDs working with either a NP or PA

2. Can I use my NPP the same way as my resident?
   - No. Teaching physician guidelines apply to residents/fellows only
   - Never apply a teaching physician attestation to an NPP note

3. Can I bill the service "Incident–to" at 100% of MD fee schedule?
   - Because **Medicare** "Incident-to" guidelines for E&M services is so restrictive, the likely answer for most specialists is "no"
   - Medicare "Incident-to" requirements include:
     - **Medicare only**. Does not apply to any other insurer
     - MD has previously seen patient and established a plan of care
     - No new problems
     - Established patient codes only (99211-99215)
     - Private office only. Not applicable in hospital outpatient or inpatient setting
     - MD must be in the office suite at the time of visit

4. Can I apply shared/split billing rules to bill the E&M encounter at 100% of MD fee schedule?
    - If both the MD and NPP have a face-to-face encounter with the patient, in most instances the answer is "yes"
    - Medicare does allow shared/split billing in the hospital outpatient and inpatient settings. However, **Medicare does not allow it in the private office setting**.

5. How do we document a shared/split billed E&M encounter?
    - The combined NPP and MD documentation must support the billable level of service
    - MD must personally document his/her participation in the encounter. This is generally accomplished as an addendum to the NPP note
    - MD's documentation should describe his/her participation in at least 2 of 3 E&M categories (history, physical exam, medical decision making)

6. I had a face-to-face encounter with the patient, co-signed the note, but did not document my personal participation. How should this be billed?
    - Bill under the NPP at 85% of MD fee schedule

7. I am a hospital practice employed MD. Can I utilize a hospital-employed NPP for shared/split billing purposes?
    - No. The MD and NPP must be part of the same billing group
    - The NPP salary must be funded by the faculty practice for the time involved in the URMFG billing

8. Can I share/split bill procedures?
    - No. Shared/split billing guidelines do not apply to procedures
    - Procedures must be billed by the provider who performed the service