Did you know that the first week of May is designated as Corporate Compliance & Ethics Week?

To commemorate Corporate Compliance & Ethics Week, the USF Health Professional Integrity Office is launching this PIO Connections on Billing Integrity, Privacy and other professional integrity topics. To kick this off, look at what is new in the world of Billing Integrity and Privacy:

**BILLING INTEGRITY:**

Increased auditing of claims by outside agencies!

One aspect of Healthcare Reform is an expansion in funding of audits to recoup erroneous payments. We should expect to see increased auditing by all of these:

- Medicare Carrier, Florida - First Coast Service Options, Inc. (FCSO)
- Medicare Audit Contractors (MACs)
- Medicare Comprehensive Error Rate Testing (CERT) Contractors
- Medicare Recovery Audit Contractors (RACs)
- Medicare Program Safeguard Contractors (PSCs)
- Medicare Zone Program Integrity Contractors (ZPICs)
- Medicaid Integrity Contractors (MICs)
- Managed Care independent audit contractors

This highlights the importance of medical record notes that support medical necessity of the services billed; adequate Teaching Physician notes, and accurate coding!

Audits to Increasingly Focus on Medical Necessity!

- Documenting extensive Hx & ROS does not always support high level E&M service
- Medical necessity of the service billed is considered as primary driver of E&M code

What’s in a Name? For Medicare, it can be the difference between payment and denial:

- The author of each medical record entry must be signed and dated
DOUBLE CHECK - Always Verify Your Patient’s Identity Before You Release a Document.

Protecting Patient Information:
• Builds Trust in our Patient Relationships
• Demonstrates our Commitment to Patient Confidentiality
• Builds our Culture of Respect for Privacy

One of the most common breaches of a patient’s privacy is giving the wrong prescription, order or medical record to the patient. Before you give, mail or fax documents containing patient information (e.g., prescription, order, medical record copies or any other documents)
• Verify the patient identity on the document before you release it.
• Check every page before you hand it to the patient. Many mistakes happen when grabbing a stack of papers from a common printer or sending several faxes or letters at the end of a busy day in clinic.
• Check the name and address before sealing the envelope for mailing.
• Verify the fax number before sending the fax and attach a USFPG fax cover sheet.

Following is a case report from the Office of Civil Rights (“OCR”) showing how HIPAA was enforced against a provider who misdirected a fax:

A doctor’s office disclosed a patient’s HIV status when the office mistakenly faxed medical records to the patient’s place of employment instead of to the patient’s new health care provider. The employee responsible for the disclosure received a written disciplinary warning, and both the employee and the physician apologized to the patient. To resolve this matter, OCR also required the practice to revise the office's fax cover page to underscore a confidential communication for the intended recipient. The office informed all its employees of the incident and counseled staff on proper faxing procedures.

The USF Health Standards on faxing PHI documents:

OUTGOING FAXES -- The authorized USFPG approved cover sheet is to accompany every outgoing fax transmission containing patient health information. The authorized fax will include the following information:
1. Address, phone and fax number and the name of the individual sending the fax.
2. Receiving facility’s name, address, phone number, facsimile number, and authorized receiver’s name.
3. Number of copies (pages) sent (including cover sheet).
4. Confidentiality statement included on fax cover sheet.
5. Upon receipt of the fax confirmation sheet, the confirmation sheet should be filed in the patient’s medical record serving as documentation PHI has been released. Documentation that a receipt confirmation occurred should also be written on the fax confirmation sheet.
From the Desk of Patricia Bickel  continued

- Signatures are required on all orders
- Medicare can disregard unsigned orders and entries with illegible signatures

PRIVACY:

The HIPAA HITECH Act increases our responsibilities!
- USF Health must notify affected individuals of a breach of the privacy of their Protected Health Information (PHI)
- If a breach affects >500 individuals, there are additional notification requirements
- HIPAA enforcement includes increased audits and penalties applicable to the organization and, potentially, to the individual who breaches privacy
- Of special concern is computer password security and security of portable devices containing PHI.

These changes emphasize the need for the privacy and security of all patient information in all formats. If you use any portable device for storing or transmitting patient information, be certain the data is password protected/encrypted.

If you have questions about Billing Integrity or Privacy, visit the PIO website [www.health.usf.edu/pio](http://www.health.usf.edu/pio) or call the PIO Helpline at 813-974-2222. Call to arrange for a training session for your group!

If you have questions about Security of patient information, contact the USF Health Information Services Helpdesk at 813-974-6288.

I hope you find this new PIO Connections helpful and welcome your input and feedback.

Regards,

Patricia J. Bickel, CPA, MBA, CPC
Compliance and Privacy Officer
Director, Professional Integrity Program
USF Health
BILLING INTEGRITY

Supervised Services – Residents & Fellows

Timely and accurate completion of Teaching Physician notes is of utmost importance to our Practice. These medical record notes are needed to support billing of services provided by Residents and Fellows under Faculty supervision.

The financial consequences for absent or incomplete Teaching Physician notes can be significant:
- Reversal of billing and refund of payments for samples of such identified internally.
- Repayments to Medicare/Medicaid based on results of statistically valid samples extrapolated over 4-7 years.

Other consequences for faculty physicians with absent or incomplete Teaching Physician notes can include reduction in billed RVUs for reversed billing; reductions in ASF to cover costs of repeated billing integrity reviews; and/or reversal of billing and disciplinary action for not meeting the College of Medicine standards.

In order to support billing, Teaching Physician notes must be added to ALL medical record notes made by Residents and Fellows:
- **ALL sites** – USF Health clinics, ASC, Endoscopy/Diagnostic Centers; Affiliated Hospitals inpatient, outpatient clinics, ER, observation; other Affiliated sites
- **ALL documentation methods** – Allscripts, handwritten notes, dictated notes

Navigating the Hurdles:

- Because the rules vary depending upon the type of service (E/M, procedure, diagnostic), detailed guidance is available on the PIO website: go to [http://health.usf.edu/pio](http://health.usf.edu/pio) - click on “Billing Standards and Processes with Forms” (this is an intranet site requiring your hscnet login); then, under “Services Involving,” select “Residents / Fellows and Students”. See also the “Frequently Asked Questions - TP Rules”. These documents are also located on pages 7-11.
- For assistance with completing TP notes in **ALLSCRIPTS**, refer to the “Job Aid” section on pages 5 and 6 of this publication, ask one of the Allscripts HEROES in clinic or contact the Allscripts Support Team at (813) 201-8218.
- For assistance with the **TGH** electronic TP attestations available as part of the electronic signature, stop by the TGH HIM Department.

For additional assistance, contact the PIO Helpline at (813) 974-2222.
NOTE: Teaching Physician (TP) attestations should be added ONLY BY THE ATTENDING FACULTY PHYSICIAN. Residents SHOULD NOT ADD them to any notes.

Teaching Physician documentation is necessary to support billing. Timely and accurate Teaching Physician notes must be added to all medical record notes made by Residents, Fellows, and Medical Students; see separate guidance for Medical Students notes.

When an E&M service and a separate procedure, i.e., a diagnostic service, are performed on the same visit and separately documented, be sure to select an appropriate TP attestation for each service.

**ATTESTATIONS – V10 Structured Note**

Accessible within these Note sections:
- Assessment, or
- Assessment/Plan, or
- Dictation Note, or
- Attestation

1. Open the Note.
2. Select the Note section(see above) and click Text.

**Figure 1:** A Structured Note.

3. Select the appropriate Attestation in the Free Text — Web Page Dialog box, See figure 2 below.

**Figure 2:** The Free Text Dialog screen.

4. Free text any additional information.
5. Click OK.
The Attestation Statement will appear in the Note.
6. Save the Note.
7. Final Sign your note when it is complete.

**ATTESTATIONS – V10 Unstructured Note**

1. Open the Note.
2. Click Text. See figure 3 below.

**Figure 3:** An Unstructured Note.

3. Select the appropriate Attestation in the Free Text — Web Page Dialog box, See figure 4 below.

**Figure 4:** The Free Text Dialog screen.

4. Free text any additional information.
5. Click OK.
The Attestation Statement will appear in the Note.
6. Save the Note.
7. Final Sign your note when it is complete.

USF Health IS | 813.974.6288:
NOTE: Teaching Physician (TP) attestations should be added ONLY BY THE ATTENDING FACULTY PHYSICIAN. Residents SHOULD NOT ADD them to any notes.
Teaching Physician documentation is necessary to support billing. Timely and accurate Teaching Physician notes must be added to all medical record notes made by Residents, Fellows, and Medical Students; see separate guidance for Medical Students notes.

When an E&M service and a separate procedure, i.e., a diagnostic service, are performed on the same visit and separately documented, be sure to select an appropriate TP attestation for each service.

**ATTESTATIONS – V11 Note**

Accessible within these Note sections:
- Assessment, or
- Assessment/Plan, or
- Dictation Note, or
- Attestation

1. Select the Note section (see above).
   The Attestation Note Form will display.

![Attestation Note Form](image)

**Figure 1:** The V11 Note Authoring window.

2. Select the appropriate Attestation by clicking the radial button.
3. Click Save & Close.
4. Final Sign your note when it is complete.

USF Health IS | 813.974.6288
### Service

<table>
<thead>
<tr>
<th>Required TP Supervision</th>
<th>Required TP Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E&amp;M w/ RESIDENTS/FELLOWS</strong></td>
<td>All payers—TP must be present during key/critical portions &amp; participate in management of patient.</td>
</tr>
</tbody>
</table>

**Medicare**—TP must be present during key/critical portions & participate in management of patient.

**Non-Medicare**—TP see & evaluate & participate in management of patient.

**All payers**—TP note in 1st person must indicate s/he:
- Saw & evaluated the patient
- Participated in the management
- Agreed with/edited Resident/Fellow note
TP note must be signed & dated.

Example: “I saw and evaluated the patient. Discussed with Dr. Resident/Fellow and agree with his findings and plan as written above. Sign/date”

### TIME BASED CODES

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>TIME BASED CODES</strong></td>
<td>All payers—TP must be present for entire period of time for which claim is made.</td>
</tr>
</tbody>
</table>

### MAJOR SURGERY w/RESIDENT/FELLOW INVOLOVEMENT

(Generally services where critical portions may be identified).

**Medicare**—At a minimum, the TP must be present during key/critical portions & immediately available to furnish services throughout entire procedure.

**Non-Medicare**—TP must be present during key/critical portions & be on premises during entire procedure.

**Medicare**—(TP present for entire procedure) Either the TP or Resident/Fellow may document procedure and state TP presence during entire procedure. The TP must sign & date note.

**Medicare**—(TP present key/critical portions only) TP or Resident/Fellow may document procedure: TP must personally document presence for key/critical portions; TP must sign & date note.

**Non-Medicare**—(TP present for entire procedure OR key/critical portions only) TP or Resident/Fellow may document procedure and state TP presence during entire or key/critical portions of service. TP must sign & date.

*Please call the Professional Integrity Office Helpline at (813) 974-2222 with questions regarding Overlapping Surgeries.*

Continued on page 8

Call the USF Health Professional Integrity Office Helpline at (813) 974-2222 with any questions regarding the Teaching Physician rules.
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</tr>
</thead>
<tbody>
<tr>
<td><strong>MINOR PROCEDURES w/ RESIDENT/FELLOW involvement</strong> (when critical portions cannot be identified, the procedure takes only a few minutes and involves little or no decision making once the need for the operation is determined).</td>
<td><strong>Medicare</strong> – The TP must be present for the entire procedure.  <strong>Non-Medicare</strong> – The TP must be on the premises during the entire procedure, see and evaluate the patient at the time of service, and participate in the management of the patient.</td>
<td><strong>Medicare</strong> – The TP or Resident/Fellow may document the procedure and the TP presence during the entire procedure. The TP must sign and date the note.  <strong>Non-Medicare</strong> – (If TP present for entire minor procedure) The Resident/Fellow may document the procedure and TP presence. TP must sign and date note.  <strong>Non-Medicare</strong> – (If TP is not present for entire minor procedure) The Resident/Fellow may document the minor procedure. The TP note in 1st person must indicate s/he:  - Saw &amp; evaluated the patient at the time of service  - Participated in the management  - Agreed with/edited Resident/Fellow note.</td>
</tr>
<tr>
<td><strong>ENDOSCOPY</strong> (procedure conducted via natural orifice)</td>
<td><strong>Medicare</strong> – (Residents/Fellows/Medical Students) The TP must be present during the entire viewing (from insertion through removal of endoscope)  <strong>Non-Medicare</strong> (Residents/Fellows) – The TP must be present during all key/critical portions of the procedure &amp; be on the premises during the entire procedure.  <strong>Non-Medicare</strong> (Students) – The TP must be present during the key/critical portions and on the premises during the entire procedure. The TP or advanced Resident/Fellow must be present in the OR/Treatment room during the entire procedure.</td>
<td><strong>Medicare</strong> – The TP or Resident/Fellow may document both the procedure and the TP presence during the entire procedure. The TP must sign and date the note. Medicare does not allow for use of Medical Student documentation for billing purposes.  <strong>Non-Medicare</strong> – The TP, Resident/Fellow, or Medical Student may document both the procedure and the TP presence either during the entire procedure OR during the critical portions. The TP must sign &amp; date the note.  <em>When a Medical Student is involved, a statement of TP or advanced Resident/Fellow presence during the entire procedure must be included in the note.</em></td>
</tr>
<tr>
<td><strong>HIGH RISK PROCEDURES</strong> (EP Studies, Cardiac Catheterizations, Stress Tests, TEEs, interventional radiology)</td>
<td><strong>All payers</strong> – The Teaching Physician must be present in the treatment room during the entire procedure.</td>
<td><strong>All payers</strong> – Either the TP or Resident/Fellow may document procedure and state TP presence during entire procedure. The TP must sign &amp; date. For example, the Fellow dictation can include “Dr. (TP) was present during the entire procedure”. Or, the TP may add a personal signed &amp; dated statement indicating s/he was present for the entire procedure.</td>
</tr>
<tr>
<td><strong>INTERPRETATIONS</strong> of EKGs, Echos, TEEs, Stress Tests, X-rays, nerve conduction studies, sonograms)</td>
<td><strong>All payers</strong> – The Teaching Physician must review the image and review Resident/Fellow’s interpretation.</td>
<td><strong>All payers</strong> – When the Resident/Fellow prepares and signs the interpretation, the TP must add a personal entry that indicates s/he has reviewed the image and agrees with or has edited the Resident/Fellow’s findings. Sample TP verbiage for report: “I reviewed the image on (date) and agree with/edited the Fellow’s interpretation as above. Sign &amp; date”</td>
</tr>
</tbody>
</table>
General:

1. Can a stamp or pre-printed verbiage on progress notes be used to assist in meeting the TP documentation requirements?
   No; to meet the TP medical record documentation criteria, the TP must personally make an entry that meets the requirements for the service provided.

2. Can “text inserts” be utilized in Allscripts and other electronic records to assist in meeting the TP documentation requirements?
   Yes, if the TP has to manually select the insert or verbally instruct insertion of such. The regulatory focus is on the TP making a personal entry. Documentation templates, including text inserts, should be submitted to the Professional Integrity Office for obtaining Billing Integrity & Privacy Committee (BIPC) approval of such.

3. Do the TP Rules apply to Fellows or just Residents?
   The TP Rules apply to both Residents and Fellows, regardless of post-graduate year.

4. The USFPG Patient Encounter Forms I sign include a statement about my performing or supervising the service and a checkbox for me to indicate Resident involvement. Doesn’t signing this statement suffice as the Teaching Physician documentation?
   No; the statements on the Encounter Forms are considered Billing Authorization Statements, and are not a part of the medical record. Signing these statements documents the billing provider’s authorization to bill the service in their name and confirms they have completed the supporting medical record documentation. To meet the TP medical record documentation criteria, the TP must personally make an entry in the medical record that meets the requirements for the service provided.

Surgical Procedures:

5. Can a PA serve as the “covering physician” in an overlapping surgery scenario?
   No. The Teaching Physician (TP) rules require another Attending Physician to serve as the “covering physician”. Therefore, a senior Resident or Fellow would also be excluded from serving as a “covering physician”.

6. If the Attending Physician dictates the operative note him/herself, does he/she still have to include an attestation in first person that he/she was present for the entire procedure?
   When a Resident/Fellow participated in the procedure, the Attending must include an Attestation, regardless of whether or not the procedure is overlapping.
   **Example of a TP note meeting the requirements:**
   “I was present for the entire procedure. Sign/ date”

7. If the Attending Physician does the case independently, without a Resident/Fellow, does he/she have to include an attestation in first person that he/she was present for the entire procedure?
   No. The attestation requirement is ONLY when Residents/Fellows are involved. If a Resident/Fellow is not involved, the TP Policy is not applicable.
8. If the Teaching Physician personally documents his presence during a procedure and signs/dates this note, will this meet the College of Medicine as well as Medicare’s documentation requirements for TP documentation of supervision of surgical services?

Yes, this is the surest way for the TP to meet the documentation requirements for surgical services.

**Examples of a TP note meeting the requirements:**

“I was present for the entire procedure. Sign/date”

“I was present for the key/critical portions of the procedure and remained immediately available for the duration of the procedure. Sign/date.”

**Surgical Procedure on Same Day as an E/M Service:**

9. If a patient requires both an E/M service and a procedure on the same day, and a Resident documents both services in one note (handwritten, dictated or electronic), what documentation is needed from the Teaching Physician to support billing for both services?

The Teaching Physician must meet the TP requirements for both the E/M service as well as for the surgical procedure. This can be done via two separate entries, or a combined entry.

**Example of a TP note meeting the requirements:**

“I saw and evaluated the patient, participated in the management and agree with the Resident’s findings and plan, above. Additionally, I was present during the entire biopsy. Sign/date”

**E/M Services:**

10. If an E/M visit is conducted at the same time as a diagnostic test (i.e. EKG), which TP rule should the Attending follow?

In the case of an E/M and a diagnostic procedure/test involving a Resident/Fellow, the Attending Physician must meet the TP requirements for both E/M services as well as the Diagnostic procedure/test. This can be done via two separate entries, or a combined entry.

**Example of a TP note meeting the requirements:**

“I saw and evaluated the patient, participated in the management and agree with above Resident note. Additionally, I reviewed the EKG tracing and agree with the Resident’s documented interpretation. Sign/date”

11. Does “See and evaluate” mean the TP has to perform a physical exam of the patient?

It depends on the insurance payer:

- For Medicare, the TP must be present during or repeat the key/critical portions.
- For all others, the TP must personally evaluate (see) the patient and participate in the management/care plan. Although “evaluate” might seem to imply “examine”, if the examination is NOT key to the service, evaluation may be limited to visual/cognitive observations.

12. If the Attending writes “Pt seen/agree with Housestaff. Follow-up ABGs and CBC”, does this meet the TP documentation requirements?

No, because the note is not in first person tense and does not appropriately link to the Resident/Fellow note. In other words, it is not clear from this note that the Attending personally saw/evaluated the patient, and it is not clear which Resident/Fellow note was reviewed.

**Example of a TP note meeting the requirements:**

“I saw and evaluated the patient, participated in the management and agree with above Resident note. Sign/date”

Continued on page 11
13. Does the Attending have to be present to bill a hospital discharge service, or can he/she just sign the note?

As with all E&M services, the Attending must see and evaluate the patient, participate in the management, and document such in order to bill for the service. It is advisable to make the TP note in the Progress Notes at the time of service and to reference the discharge summary for details. Signing the discharge summary later dictated by a Resident, which may be required by the hospital, does not suffice as the TP note for billing.

Of note, Discharge services are reported with one of two time-based codes, either \( \leq 30 \) minutes (99238) or \( >30 \) minutes (99239). Therefore, when billing for 99239, in addition to a TP attestation, the TP must specifically document the total time s/he spent in providing the discharge service. The Resident's time does not support billing.

**Progress Note Example of discharge service 99239 TP note meeting the requirements:**

"I saw/evaluated the patient and discussed the discharge plan with the patient and Resident, spending a total of (40) minutes. See the Discharge Summary for details. Sign/date."
Integrity

Doing what is right even when it is difficult.