Compliance Alliance

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Notes from the Compliance Office…

By: Sue Marasi, CHC, CPCA, Compliance Administrator

ICD-10 Grace Period Ending as of October 1st

The one-year grace period that CMS established for the new ICD-10 diagnostic codes ended as of October 1st. This means that CMS will no longer accept unspecified ICD-10 codes on Medicare fee-for-service claims when a specific code is warranted by the medical record. This is further explained below in the *Coding Corner* article.

Medicare providers who incorrectly submit unspecified ICD-10 codes after October 1st will be putting their practices at risk for increased post-payment audits, quality reporting issues, and close scrutiny of their clinical documentation.

2016 Corporate Compliance & Ethics Week: November 6-12

Corporate Compliance & Ethics Week is celebrated each year to recognize and promote the importance of a cooperative and effective Compliance Program. During Compliance Week, the UBMD Compliance Office will once again highlight important, current compliance issues through email transmissions, via the newsletter distribution list. We ask that the emails be distributed to all physicians and staff of all practices, and strongly encourage everyone to take a few minutes to read them.

Fraud, Waste & Abuse Training

As in the past, the next edition (4th Quarter) of the *Compliance Alliance* newsletter will serve as your annual mandatory Fraud, Waste & Abuse training. By reading the 4th Quarter newsletter and successfully completing the brief quiz at the end, you will fulfill your Fraud, Waste & Abuse training requirement for 2016. All providers and practice employees are required to complete annual Fraud, Waste & Abuse training.

HIPAA Issues with Cell Phones

By: Lawrence C. DiGiulio, Chief Compliance Officer

There is a trend for using cell phones in more and more aspects of patient care. The Office of Civil Rights is catching up to this trend and starting to discipline health care providers for improper use or safeguarding of Electronic Protected Health Information (ePHI) on cell phones.

A recent OCR enforcement action was initiated against a not-for-profit healthcare organization after an employee lost a cell phone containing 412 nursing home residents' ePHI. The phone was not encrypted and was not protected with a passcode. There was no indication that the ePHI was used outside of the not-for-profit. The not-for-profit timely reported the lost phone to the federal government as HIPAA requires.

OCR initiated its investigation within two months of receiving notice of the breach and found that the not-for-profit had failed to conduct a security risk assessment as is required by HIPAA and as a result did not have proper security policies and procedures in place. (Our own annual security risk assessment process started earlier this month and will conclude by the end of the year.) The investigation concluded in June 2016 and resulted in a fine of $650,000 and the imposition of a Corrective Action Plan (CAP) with onerous reporting requirements over and above HIPAA requirements. The CAP also required the not-for-profit to develop and implement fifteen new policies after

conducting the HIPAA required security risk assessment. If this fact pattern occurred in NY, the not-for-profit would have also been under a requirement to report the loss to three different state agencies because the PHI included social security numbers.

There are several lessons that can be learned from this investigation. The first is to understand the magnitude or the harsh discipline that the federal government issues for HIPAA violations. The monetary penalty was only part of the cost of fighting the penalty and investigation. Attorney fees, expert witness fees and wasted employee time means the cost is much greater than the $650,000. Onerous CAP requirements will cost further resources for years in the future. In this case, simply locking the iPhone with a password and engaging its encryption would have mitigated its loss. If the phone was encrypted its loss would not violate HIPAA and would not require the report to OCR that triggered the investigation.

"It is easy to dodge our responsibilities, but we cannot dodge the consequences of dodging our responsibilities."

~ Josiah Charles Stamp

There are other issues raised by this recent OCR investigation. While smart phones and the plethora of medical related applications now available are helpful to providers, there are HIPAA directives that must by followed. The first is cell phones cannot be used to transmit PHI without that transmission being encrypted. To assist in this requirement, Kaleida has purchased the Cortext product to encrypt text messages that contain PHI. Please contact Kaleida directly to learn how to use this functionality that it provides to healthcare professionals practicing in its facilities.

There is a similar requirement for emailing PHI. Emails containing PHI must also be encrypted. Some practice plans have purchased licenses from Zix mail. This is the email encryption system used by Kaleida, Independent Health and other covered entities across the country. ECMC has purchased another, but equally compliant, email encryption solution. Without using an email encryption product, UBMD employees cannot email PHI.

There is one exception to the texting and emailing encryption rule. When a patient initiates an unencrypted electronic communication, we, as Covered Entities, can respond in the same unencrypted method. We cannot then initiate new conversations using that method. In this way, HIPAA has allowed Covered Entities to provide quick communications with the patients HIPAA is designed to protect.

As always, if you know of any compliance issues, have any compliance related questions, or suspect any fraud or abuse, please call our anonymous compliance hotline at (716) 888-4752, call us directly or email us. We have a strict non-retaliation policy that will be adhered to in all instances to protect any person who reports compliance issues to the compliance department or their supervisor.

Coding Corner: ICD-10-CM Diagnosis Codes Gain Momentum in Value-Based Care Models

By: Beverly Welshans, CHC, CPMC, CPC, CPCI, COC, CCSP, UBMD Director of Audit & Education

Value based care models and the quality payment programs implemented by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will begin in 2017 and affect 2019 reimbursements. The quality of data in physicians' claims will need to accurately reflect both the patient's encounter and diagnoses on the date of service.

Every year there are new ICD-10 codes released for implementation on October 1st. This year, ICD-10 presents increased challenges with the release of these new codes coinciding with the end of the CMS 1-year grace period for ICD-10 codes. Reporting standards are stricter, now limiting the acceptance of unspecified codes. The grace period allowed a diagnosis code within the same "family" to be submitted on a claim in which only a related code was represented in the medical documentation. CMS contractors were not allowed to deny payment during a retroactive review for claims fitting this category through September 30, 2016. Now that this time frame has passed, providers are expected to adhere to ICD coding guidelines and levels of specificity. Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category (family) of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail. A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

This year, the new ICD-10-CM diagnosis code set has; 1943 new codes, 422 revised codes, and 305 deleted codes. The new codes allow even greater specificity to be reported in the patient's medical record provided there is sufficient documentation placing an additional documentation burden on provider. As we transition from the current CPT driven fee-for-service environment to more quality based payment programs, the diagnoses documented in the record and listed on a claim form will have a significant impact on reimbursement.

Many of the changes in the ICD-10 code set for 2017 have been made to facilitate this transition. There is a large increase in diabetes codes with ophthalmic complications. These codes now indicate laterality and new concepts to include staging of retinopathy and more detailed coding for retinal detachments. Obstetrics and gynecology codes have also increased to include laterality for many ovarian disorders and additional pregnancy and delivery complication codes. Orthopedics has numerus new injury codes that include fractures of the femur and skull base. Other conditions include cervical disc diseases and temporomandibular joint disorders.

Quality payment programs use patient outcomes as one of their assessment measures. The transition from ICD-9 to ICD-10 saw new codes for concepts not previously captured making it easier to evaluate outcomes such as patient noncompliance. Code selection allows for specific issues of noncompliance; such as failure to adhere to renal dialysis schedule or dietary regime, under-dosing of medication or refusal to have a colonoscopy to list few. The changes for 2017 ICD-10 Codes continue to facilitate outcomes based data collection. Codes identifying complications of procedures have increased. Hemorrhages, hematomas, and seromas following a procedure can now be identified with greater accuracy, and mechanical complications identified in greater detail.

All of these changes make clear, concise documentation imperative. Accurately coding to the highest level of specificity can only be accomplished with thorough medical record documentation. Every encounter should accurately reflect the care rendered to the patient and the rationale for it.

That is not to say that a nonspecific code or a symptom can never be used as the diagnosis for a service rendered. Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. It would be inappropriate to select a specific code that is not supported by the medical record documentation. However, a greater level of specificity can be achieved with minor documentation improvements such as laterality. Certainly, documentation of right, left or bilateral should be within the level of certainty for an encounter.

ICD-10 coding specificity and coming changes in reimbursement admittedly place an increased burden on the provider. Our office is available to help you with any coding questions or concerns you may have. I will conduct training programs throughout 2017, and will send encounter specific guidance for concerns identified on audit.

There are many coding resources available; http://www.icd10data.com is one that you may find useful. It is very easy to search for codes and should assist providers who are unsure as to whether an additional 4th, 5th, 6th or 7th character is needed.

Have a question or topic regarding compliance or coding that you would like to see covered in *Compliance Alliance*?

We are always looking for suggestions!

Please send them to Sue Marasi in the Compliance Office.
(You may remain anonymous if you wish.)

Common Documentation Errors

By: Kaitlyn Marasi, Legal/Compliance Intern

"On the second day the knee was better and on the third day it disappeared."

"Skin: Somewhat pale but present."

"Patient treated with O2 inhalation via Foley bag catheter attached to urobag."

Taken on their own, the above actual documentation errors are humorous and seemingly innocuous. However, in reality, these errors are nothing to laugh at. Lack of or incorrect details can lead to a lower reimbursement than would be received had documentation been complete. Even more serious, typos, such as "hyper" instead of "hypo", mean others who read the chart have incorrect information which can negatively affect patient care and, in turn, patient health.

The following are common areas in which documentation errors are made, and should always be taken carefully into account each time you're documenting a patient visit:

1. PATH – Physicians at Teaching Hospitals
   - For a non-resident physician at a teaching hospital documentation is as usual.
   - A resident physician must have a teaching physician present during the critical or key portions of the service, and this must be in the documentation, in order for services performed at teaching hospitals to be billed properly.
   - Failure to do so may result in paying settlements to Medicare.
   - Failure to use a PATH attestation in a Kaleida facility or clinic leads to monetary penalties against your UBMD practice plan.
2. Time based services
   - The codes for medical services that are predominantly (more than 50%) counseling or coordination of care, and properly documented in the medical record, are based on time – that is, the proper code is determined in part by how much time it is documented a provider spent face to face with a patient.
   - This can result in a change in the code used for billing services, and therefore a change in how much can be charged in the bill.
3. Copy & Paste Errors
   - With EMRs, it can seem easier to copy and paste notes that would be similar from one chart to another.
   - Copy and paste can result in numerous errors.
     - ✓ A typo in one note leads to a typo in all following notes.
     - ✓ Inaccurate information is accidentally placed in a patient's chart (in one case cited by HHS, a patient went from having a family history of breast cancer to having breast cancer herself).
     - ✓ Information is not sufficiently updated which leads to inadequate patient care.
4. Untimely Signing
   - Failure to electronically sign an EMR results in an inability to bill for the services provided.
   - The longer period of time a chart spends incomplete or unsigned, the more time it takes to bill for services.
5. Incomplete Information
   - The more detailed documentation is, the more likely the payment received is proper for the service provided.
   - Failure to fully list History of Present Illness, Review of Symptoms, and Assessment and Plan can result in not fully billing for service provided.

Taking an extra few minutes to make sure your documentation is accurate and complete can make a big difference in reimbursement amounts, payment rejections and, most important, patient well-being.

Updating Business Associate Agreements

By: Sue Marasi, CHC, CPCA, Compliance Administrator

In the 2nd Quarter *Compliance Alliance*, one article defined who your business associates are, and explained the importance of Business Associate Agreements ("BAAs"). Equally important is the assurance that all of your BAAs have been reviewed and updated to be in compliance with the HIPAA Omnibus Final Rule.

The HHS Omnibus Final Rule implements a number of provisions of the HITECH Act to strengthen HIPAA privacy and security protections. Under the Final Rule, covered entities and business associates were allowed to operate under existing BAAs for up to one year beyond the September 23, 2013 compliance date.

All BAAs, including those written before the September 23, 2013 compliance date, must include the following:

- Account of permissible or required uses and disclosures of PHI.
- Specification that the PHI may not be used or disclosed by the business associate for purposes not specified in the agreement.
- Requirement that appropriate safeguards preventing unauthorized use or access to PHI be implemented.
- Requirements and timelines for the business associate to report to you any unauthorized use of, disclosure of or unsecured PHI, or any security breaches.
- Requirements for the business associate to assist and comply with any of your obligations to individual requests for copies of PHI.
- Requirement that the business associate make its internal practices, books and records that relate to use and disclosure of PHI available to the HHS.
- Contract termination requirements regarding the disposition and destruction of PHI that was received from you, or created or received on your behalf.
- Stipulations that the business associate obtain BAAs from any subcontractors who may access your PHI. These BAAs must include all the same requirements as your agreement.
- Authorization to terminate the BAA if there is a breach of the agreement.

If these requirements are not included, the BAAs are not valid, and open you up to liability should a breach occur, or fines if you are audited and it is discovered that you don't have BAAs, or they are expired, or are so outdated that they don't adequately address the contractor's use of your PHI.

In one case, the Department of Health and Human Services Office for Civil Rights (OCR) received notification on November 5, 2012 of the loss of unencrypted backup tapes, containing ultrasound studies of approximately 14,000 individuals, including patient names, birth data, date of exam, physician names, and some Social Security Numbers. It was found that the BAA between the covered entity and the business associate was effective March 15, 2005. Since it was not updated until August 28, 2015 as a result of the OCR's investigation, it did not contain the required revisions of the Omnibus Final Rule. That resulted in a settlement including a monetary payment of $400,000 and a comprehensive corrective action plan.

You cannot continue to share PHI without a valid and active BAA in place. It is, therefore, in your best interest to take the time to review your BAAs to make sure they are all valid and in compliance with the Omnibus Final Rule if you have not already done so.

UBMD ANONYMOUS COMPLIANCE HOTLINE

888-4752

Training Update – What's Available?

By: Beverly Welshans, CHC, CPMC, CPC, CPCI, COC, CCSP, UBMD Director of Audit & Education

New Provider E/M and Documentation Training

This is a one session training class. All are welcome to attend any of the sessions. It's also a good refresher for the not-so-new providers! ***Please contact me if you would like to attend a session so that I can be sure to have enough materials for all attendees.***

Location & Time: 77 Goodell St., Room 208, 12:00-1:00pm

Remaining 2016 dates:
November 8th, November 22nd
December 6th

Lunch-n-Learn

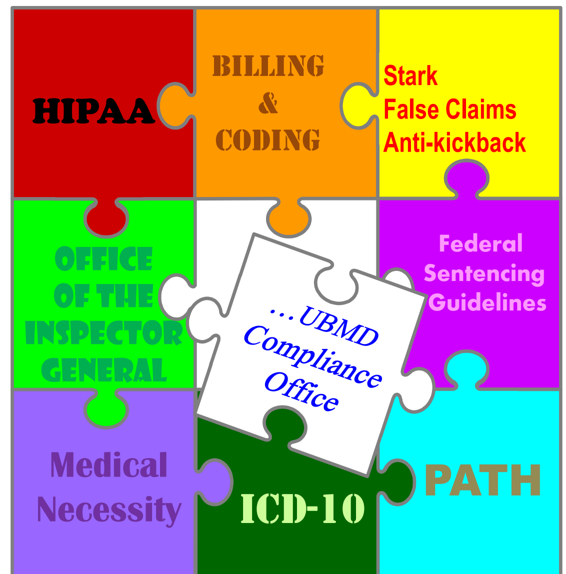
Sessions are usually held once a month. Feel free to bring your lunch, and join us as we cover a variety of important topics related to coding and compliance! AAPC & AHIMA CEUs are often available for the sessions. All are welcome to attend. ***If you would like to be added to the session notification list, please contact me.***

Location & Time: 77 Goodell St., Room 208, 12:30-1:30pm

Next Session: November 11th
Topic: MACRA: A Review of the Critical Information You Need for January 2017

If you have questions on any the above, please contact me by telephone (888-4702) or e-mail: welshans@buffalo.edu

LET'S WORK TOGETHER TO SOLVE THE COMPLIANCE PUZZLE



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Third Quarter 2016 Quiz

**** To submit your quiz answers, please go to**
https://smbsweb.med.buffalo.edu/ubmd/training.aspx
and select Training Module "2016 –3rd Quarter Newsletter"

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1. Which of the following is true?
   a. Cell phones cannot be used to transmit PHI without that transmission being encrypted.
   b. Emails containing PHI must be encrypted.
   c. As an exception, when a patient initiates an unencrypted electronic communication, we, as Covered Entities, can respond in the same unencrypted method, but cannot initiated new conversations using that method.
   d. All of the above are true.
2. As we transition from the current CPT driven fee-for-service environment to more quality based payment programs, the diagnoses documented in the record and listed on a claim form will have a significant impact on reimbursement.
   a. True
   b. False
3. Which of the following statements regarding ICD-10 codes is not true?
   a. Diagnosis codes are to be used and reported at their highest number of characters available.
   b. Quality payment programs use patient outcomes as one of their assessment measures.
   c. Sign/symptom and "unspecified" codes have acceptable, even necessary, uses.
   d. A Nonspecific code or a symptom can never be used as the diagnosis for a service rendered.
4. Time-based services, PATH, copy & paste, Incomplete information and untimely signing are all common areas of documentation errors, and should always be carefully taken into account when documenting patient visits.
   a. True
   b. False
5. A Business Associate Agreement written before September 23, 2013 is automatically compliant with the HHS Omnibus Final Rule.
   a. True
   b. False

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PLEASE <u>DO NOT</u> EMAIL OR FAX YOUR ANSWERS

Answers <u>must be submitted online</u> at:

https://smbsweb.med.buffalo.edu/ubmd/training.aspx

Be sure to click on your <u>correct practice plan</u> to ensure proper credit!