2023 - 1st Quarter

Compliance Quarterly

From the Compliance Office...

Provider Chart Audits

UBMD has an audit program in place to monitor compliance with applicable laws and UBMD policies. Our focus is to assess the accuracy of documentation of UBMD providers, to ensure proper coding and billing based on the documentation, and to determine and correct any problem areas that may exist.

Please be reminded that each practice plan is responsible for having periodic audits done annually, on a minimum of 10 records per provider, by either an internal auditor, or an external auditor obtained by the practice. **The auditor must not be the same person who codes the medical records.** More detailed audit information can be found on our website at: https://www.ubmd.com/about-ubmd/Compliance/Auditing-monitoring/provider-audits.html

All completed audit reports are to be forwarded to the Compliance Office to my attention (smmarasi@buffalo.edu). If you have not yet sent us your 2022 audit reports, please do so.

Compliance Hotline Flier

We have updated our compliance hotline flier. Please print copies of the flier and put in all practice plan back-office areas where it will be visible to all practice plan staff.

Compliance Training Updates

New Provider E/M & Documentation Training

Required for all newly hired providers. It also serves as a good refresher for not-so-new providers. This training is now available online by visiting the Education & Training page on the UBMD Compliance website.
(https://ubmd.com/about-ubmd/Compliance/Education-training.html).

2023 Fraud, Waste & Abuse Training

2023 Mandatory Annual Fraud, Waste and Abuse (FWA) training will once again be done in lieu of the 2nd quarter newsletter & quiz. This allows more time for everyone to complete the mandatory FWA training before the end of the year as required. FWA training is a federal requirement for ALL practice administration, providers & staff. An email with further instruction will be sent during the 2nd quarter.

Active Shooter Training

Last year, University Police provided an Active Shooter Training presentation at the Conventus Building, which was recorded so that others could view this important training. All employees, including providers and staff, are **strongly encouraged** to view the video to help ensure your safety, and the safety of those around you. The video helps prepare you both mentally and physically for an active shooter situation, and advises what you should and should not do before and after law enforcement arrives on the scene.

Click on the following link, and click on the Active Shooter Training tab to view the video.
https://www.ubmd.com/about-ubmd/Compliance/Education-training.html

Inside this issue

HELP WANTED!!

We want you to be involved! If you have a question or topic you would like to see covered, general or specific practice-focused, in a future edition of the *Compliance Quarterly,* please contact Sue Marasi at: smmarasi@buffalo.edu

HIPAA: Information Blocking - Cures Act

Lawrence C. DiGiulio, Chief Compliance Officer

The Information Blocking Rules found in the 21st Century Cures Act require that patients have access to their medical records including their notes and lab results. This article was put together by the Allscripts team, Megan Veirs and the Compliance Office. Please let us know if you have any questions.

Changes Coming to Notes, Labs and Reports

The 21st Century Cures Act, more widely known simply as the Cures Act, has many important components to it affecting health care delivery. One of the provisions from the Cures Act was to increase patient access to their health information and remove obstacles patients encounter when trying to access their own electronic health information.

To that end, more information will now automatically be available in the patient portal, such as provider notes from all encounters, lab results and radiology and pathology reports.

New information has been posted to your portal account. Please note, lab results and reports are automatically sent to your patient portal at the same time they have been sent to your provider. Therefore, your provider may not have reviewed the results yet. Any results should be discussed with your healthcare provider to obtain the best clarity on how they pertain to your health and treatment. If you have any questions or concerns on any documents in your portal, please call your provider's office or message your healthcare team through the portal.

These changes will begin Monday, April 17.

Notes & Confidential Notes:

Notes will automatically be released to the patient portal. However, there are certain circumstances where that may not be appropriate. This can be because:

- There is concern of patient harm or 3rd-party harm
- Patient requests it for any reason
- Privacy exception

Confidential Note:

In these cases, the provider may create a new **Confidential Note Type** [will link to document]. In the note selector, there will now be a "Confidential Note – Does not release to FMH" option. *This allows the note to remain visible in Allscripts but will not be added to the patient's portal account.* Additionally, once this note is selected, another drop down will appear with an option to elaborate on why this information is to remain confidential.

What constitutes concern of patient or 3rd-party harm?

Any situation that the patient or provider believes there is reasonable concern that information shared in the portal may cause the patient or another person harm. Examples may include but are not limited to information related to domestic abuse or child abuse reported in a note, especially if someone other than the patient may have access to the patient's portal whether through proxy access or the person voluntarily or involuntarily shared their portal login credentials.

Lab Results:

Currently, lab results are released to the portal upon verification. As of April 17, lab results will be released to the patient portal immediately upon receipt whether verified by a provider or not, regardless of where the labs were ordered from (in house or an outside source).

Radiology & Pathology Reports:

Both radiology and pathology reports, regardless of why they were ordered, will go to the patient portal after a 72-hour delay. This delay is by calendar day, not business day. If you believe you need to speak to the patient before they can review the results on their own, please contact them within this 72-hour window.

What doesn't go to the portal?

At this time, and in accordance with the Cures Act, the following are not sent to the portal:

- Confidential notes
- Protected psychotherapy notes
- Coding summaries
- Scanned records from outside facilities

However, patients can request any document related to their care at any time. If a patient requests any portion or all of their record electronically, and they do not have a patient portal, the practice must provide that information within 15 calendar days of the request.

General Compliance: NYS Pay Transparency Law & Amendment

Sue Marasi, CHC, CPCA, Compliance Administrator

While this may not seem like a typical compliance topic, compliance and human resources often do overlap in various ways. Since many practices are currently conducting contract negotiations or looking to hire personnel, we decided it was important to bring the topic to your attention.

In December 2022, Governor Hochul signed a legislative bill into law which is commonly referred to as the New York State Pay Transparency Law. This law will require covered employers in New York State to comply with obligations related to pay transparency in job advertisements. On March 3, 2023, the governor also signed into law a bill amending the original law. The Law, along with the Amendments, will go into effect September 17, 2023.

Who does the law affect?

Any employer, which includes agents and recruiters, in New York State with four or more employees is subject to the NYS Pay Transparency Law.

What does the law require?

The New York State Pay Transparency Law requires employers to include the minimum and maximum annual salary or hourly range when advertising for a job, promotion or transfer opportunity in the State of New York. For commission-based positions, the posting must state that compensation is based on commission.

In addition, employers must disclose the job description for the position, if one exists.

The law applies to both internal and external job postings.

What changed with the Amendment?

The Amendment clarifies a question regarding remote work positions. The law now states that if a job is to be performed at least partially within the state of New York, or if a job is outside of New York State but reports to a supervisor, office, or other work site in New York State, the employer is subject to the law.

The Amendment also removed a requirement that the employer maintain records of the history of compensation ranges for each job. Although no longer required by this law, it remains best practice to maintain such records to protect your business.

What are the penalties for non-compliance?

If a person believes they were wronged in accordance to this law, they may file a complaint with the NYS Department of Labor. If a business is found to be in violation of the NYS Pay Transparency Law will be subject to civil fines as follows:

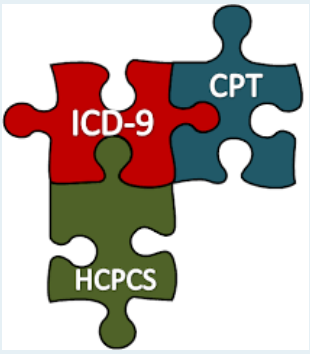
- First violation: $1,000
- Second violation: $2,000
- Third violation & beyond: $3,000

There is an anti-retaliation provision in the law as well, prohibiting employers from retaliating in any way against an applicant or employee for exercising their rights under this law. This includes, but is not limited to, refusing to interview, hire, promote or employ the person.

As always, if you have any questions regarding this, or any other issue, do not hesitate to contact the Compliance Office.

"It takes less time to do things right, than to explain why you did it wrong."

~ Henry Wadsworth Longfellow



The Coding Corner

Top Reasons for Claim Denials & How to Avoid Them - Part 1 of 2

Sue Marasi, CHC, CPCA, Compliance Administrator

It's likely everyone has had claims denied by a payer. One at a time, a denied claim may not seem like a big deal but, the fact is, claims denials can be very costly to a practice. According to a recent article in BC Advantage Magazine, denial rates are on the rise, and the average cost to either rework a single denied claim or appeal the denial is $35 per claim for a practice, and $117 for hospitals. That can add up to a lot of lost revenue, and increased operational costs, over time.

The first step to reducing denials is identifying the reason for them. The following summarizes some of the top reasons for claim denials.

1. ***Billing & Coding Errors***
   - **Using improper or outdated CPT or ICD-10 codes**
   - **Missing Information**
     This can include a Social Security Number, plan code, modifier, or any field left blank on a claim form.
   - **Services Reported Separately/Bundled Services**
     In some cases, a service shouldn't be separately reported because the work was already captured as part of another service being billed. An E/M service performed on the same day as a procedure, but billed separately from the procedure, would likely be denied unless an appropriate modifier had been added to the E/M service to indicate it was significant enough to warrant separate payments.
   - **Improper Modifier Use**
     Modifiers 25 and 59 are the most commonly misused modifiers.
   - **Data Discrepancies/Inconsistent Data**
     Examples include a diagnosis specific to female conditions used on a male patient, a procedure code for a newborn billed for an adult patient, or a flu vaccine billed with a diagnosis describing pneumonia vaccine.
2. ***Duplicate Claim or Service***
   Claims resubmitted for a single encounter on the same date, by the same provider, for the same beneficiary, for the same service.
3. ***Service Already Adjudicated***
   This error occurs when benefits for a certain service are included in the payment or allowance for another service that has already been settled.
4. ***Insurance Issues***
   - **No Pre-authorization**
     A varying range of sometimes confusing requirements and contractual obligations from the payer organizations is often a root cause.
   - **Incorrect Insurance ID Number**
     Old insurance cards and ID numbers submitted on an original claim might not be recognized by an insurance company or payer. It is the provider's responsibility to verify a patient's current information upon each visit.
   - **Lack of Eligibility/Services Not Covered by Payer/Lack of Medical Necessity**
     Issues with pre-authorization, coding errors, insufficient documentation and inability to prove medical necessity can cause a claim denial. Also changes to a patient's benefit plan can alter the level of coverage. Oftentimes, patients don't realize such changes have occurred. Many plans also require the provider be in network, so an out of network provider will cause a denial.
5. ***Insufficient Documentation***
   Physician codes and notes that don't satisfy CMS requirements will result in a claim denial more readily than ever before.

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6. ***Limit for Filing Expired/Claims Not Filed on Time***
   Failing to submit a claim within the required period, including the time it takes correct a coding error or to rework rejections, can often result in your practice having to write off the charges.

7. ***Documentation Errors at Intake***
   - **Simple errors, such as the following, can cause a claim to be denied:**
     - ⇒ Misspelled name
     - ⇒ Miswriting a street address
     - ⇒ Transposing numbers in a date or insurance ID number
     - ⇒ Missing social security number
     - ⇒ Wrong plan code
     - ⇒ Forgetting to complete other patient demographics

Correct coding is a responsibility shared by providers, coders, billers and other staff members. As such, it is important for all involved to examine the reasons for claims denials in your practice, and to work together to take steps to keep denials at a minimum. Now that we have identified some of the top reasons for denials, in our next *Compliance Quarterly,* we will explore ways to reduce and avoid them.

Welcome Spring....finally!!

UBMD Compliance Office Website: https://ubmd.com/about-ubmd/Compliance.html

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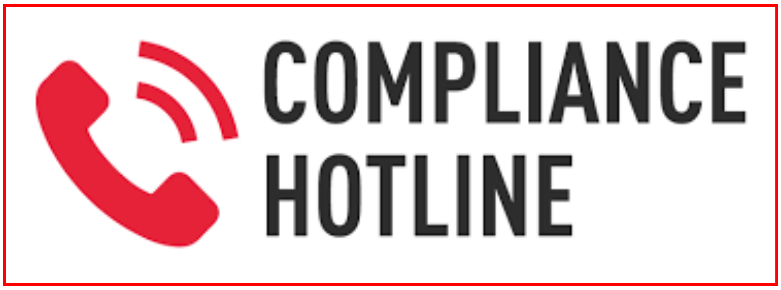

UBMD COMPLIANCE HOTLINE: 716.888.4752

CONFIDENTIAL!

Report known or suspected fraud/abuse, HIPAA concerns, or other potential problems.

Ask questions or request guidance | Provide relevant information

Remain anonymous if you wish | Non-retaliation policy will be adhered to

CLICK HERE FOR PRINTABLE FLIER: Hotline Flier

(This is a voice mail box monitored during working hours. If there is an immediate threat to person or property, do not leave message; contact direct supervisor immediately!)

Compliance Quarterly Quiz

To submit your quiz answers, please click link below:

2023 First Quarter Quiz

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1. At this time, in accordance with the Cures Act, which of the following is not sent to the portal?

   A. Confidential notes and protected psychotherapy notes
   B. Coding summaries
   C. Scanned records from outside facilities
   D. All of the above are not sent to the portal

2. Under the Cures Act more information will automatically be available in the patient portal, including provider notes from all encounters, lab results, and radiology and pathology reports.

   A. True
   B. False

3. If a business (employer) is found to be in violation of the NYS Pay Transparency Law it will be subject to civil fines up to $3,000.

   A. True
   B. False

4. Some of the top reasons for claims denials include which of the following?

   A. Billing and coding errors.
   B. Documentation errors by providers or intake personnel.
   C. Insurance issues.
   D. All of the above

5. Correct coding is the exclusive responsibility of the coder.

   A. True
   B. False