2023 - 3rd & 4th Quarter

Compliance Quarterly

From the Compliance Office...

Welcome!

Although she joined us back in June, at this time we would like to formally welcome and introduce our new Director of Audit & Education, Sandy Setlock! Sandy comes to us with 20 years of experience in healthcare administration. She is certified as a Professional Coder, Risk Adjustment Coder, Evaluation Management Auditor and HIPAA Compliance Officer, and her areas of expertise include Medical Documentation & Regulatory Compliance Audits, CPT & ICD-10 codes, Provider & Staff Education, Risk Adjustment Coding, Revenue Cycle Management, and HIPAA Privacy & Security. Sandy is already proving to be an excellent addition to our UBMD Compliance Office with her wealth of knowledge, positive attitude and strong desire to contribute to UBMD's continued growth and success.

Happy Holidays!

We in the Compliance Office hope you and your families had a holiday season filled with joy, celebration and warmth, and wish you all a new year of health and happiness.

Compliance Training Updates

2023 Mandatory Fraud, Waste & Abuse Training - NEW 3rd Party Payer Requirement!

On October 18th, one of our practices received a notification from Independent Health stating that they require each of their participating provider groups or practices to complete Fraud, Waste & Abuse Training **and submit an electronic attestation to confirm completion of this training by each of their staff members**. They further specify that staff members of practices required to complete this training includes physicians, mid-levels, ancillary providers, registered nurses, licensed practical nurses, administrative and office staff, technicians, coders and others. FWA training is also a federal requirement for ALL practice administration, providers & staff. ***If you have not yet completed the training, please do so at this time.*** The training program and quiz can be found on our UBMD Compliance website under the Education & Training tab (https://www.ubmd.com/about-ubmd/Compliance/Education-training.html). You must successfully complete the quiz online to receive credit for training.

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).

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! Help us help you...if you have a question or topic you would like to see covered (general, specific or practice-focused) in a future edition of the *Compliance Quarterly,* please contact Sue Marasi at:
smmarasi@buffalo.edu

HIPAA: Information Blocking - Cures Act - Final Rule

Sue Marasi, CHC, CPCA, Compliance Administrator

As you may recall, in the 1st Quarter edition of *Compliance Quarterly* this year we discussed the Cures Act Information Blocking Rule which went into effect on April 17, 2023. The Rule requires that patients have access to their medical records, including their notes and lab results, and detailed the increased patient access.

On June 27, 2023, the HHS-OIG issued its Final Rule implementing the penalties for information blocking. The Final Rule does not impose any new information blocking requirements, but sets forth the enforcement and penalties for information blocking violations.

On September 1, 2023 the enforcement of the Information Blocking Rule, using the Civil Monetary Penalty, went into effect. The OIG and the Office of the National Coordinator for Health Information Technology (ONC) are now enforcing statutory penalties in response to violations of Information Blocking Rules. Violators will be subject to fines of up to $1 million per violation.

The OIG's focus will continue to be on allegations of information blocking where there is a heightened risk to patients, providers and healthcare programs. Penalty amounts will be determined after considering the nature and extent of the information blocking, and the resulting harm such as:

- Actual or potential harm to patients;
- The number of patients affected;
- The impact on a provider's ability to care for patients;
- The number of providers affected;
- Length of time the information blocking continued;
- Potential financial loss to Federal healthcare programs or other government or private entities;
- Whether they knew, or should have known, that the practice was likely to interfere with, prevent or discourage the access to PHI.

If the OIG receives a complaint of information blocking, it will assess the complaint using the above priorities. If OIG opens an information blocking case based on that assessment:

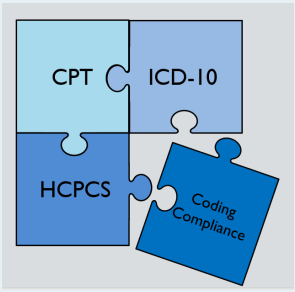
- OIG will investigate the complaint by gathering facts, conducting interviews, document requests, etc.
- OIG may consult with ONC to assess facts and information blocking regulations.
- Case will be closed if OIG concludes information blocking was not committed.
- OIG will provide the entity with an opportunity to discuss OIG's investigation.
- If OIG concludes the entity committed information blocking, a demand letter is sent to the entity.
- The entity will have the opportunity to appeal OIG's imposition of the penalty.

Enforcement does not include a look-back period, meaning OIG will not impose a penalty on information blocking actions that occurred before September 1, 2023.

HIPAA: Artificial Intelligence (AI) & Zoom Meetings

We were recently advised that the University is getting ready to turn on "AI Companion" in Zoom. This allows an AI to listen to the meeting and provide a written meeting transcript or summary of the meeting.

Because this data goes to Zoom for processing, and no Business Associate Agreement (BAA) is in place, it is very important to know and understand that UBMD practice plans ***cannot*** use this feature when any HIPAA regulated data or PHI will be discussed during the meeting.



The Coding Corner

Allscripts Alert!!

Effective 01/16/2024 in Allscripts there will be new direction on how to enter time based coding! Details included in Article.

Article also includes time based coding information for non-Allscripts users.

Coding & Documenting Based on Time

Sandy Setlock, CPC, CRC, CEMA, CHCO, Director of Audit & Education

We have an opportunity to improve the initial education that was offered regarding Time based coding. **Effective 01/16/2024** in Allscripts there will be new direction on how to enter this important information for leveling your patient encounter.

In the 2021 guidelines for Time there was no qualification of the "time statement" issued; however, as charts and medical documentation have had time to now be reviewed, we have an opportunity to move forward with best practices.

In doing this, be sure to include the qualification statements that are needed and not just the minimal. They must be defendable and meet medical appropriateness and necessity. Although there is no printed documentation requirement, there is a hard rule that every note must have medical appropriateness and be backed by medical necessity. Does your note justify the level of code you have chosen based on time if it was pulled by payer audit?

Some key points to ask yourself when you are inserting the time statement:

- Does your documentation pass the medically appropriate and necessary coding based on TIME Rules?
- Are you using the same statement for every patient without it being unique to the patient encounter?
- Does the time statement accurately reflect the work you did with the patient?
- Do you have a "carve out statement?" A carve out is a service or procedure that may be billable separately, as long as you have supporting and documenting the medical necessity to stand alone.

When Time is used for reporting E/M service codes, the time defined in the service descriptors is used to select the appropriate service level. It must be distinct and noted in the patient's chart.

Once you have the total time spent on the encounter date, it should be documented in the medical record and used as the basis for code selection **IF** you are utilizing TIME as the basis for your coding.

As a physician or other qualified health care professional, time includes the following activities, when performed on the same day as the service is provided:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health records
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Do not count time spent on the following:

- performance of other services that are reported separately
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

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This is an excerpt from the Medicare Guidelines Regarding Time:

> *"As of January 1, 2023, for most E/M visits, families and practitioners will select visit level based on the* ***level of medical decision-making (MDM) or the amount of time spent by the physician or non-physician practitioner.***
>
> *For some types of visits (such as emergency department visits and critical care), in accordance with their CPT codes, practitioners do not have this choice and will use only MDM or only time to bill.*
>
> *The CPT E/M Guidelines for MDM apply. For all E/M visits, history and physical exam must be performed in accordance with code descriptors, but history and exam no longer impact visit level selection. When practitioner time is used to select visit level, the full time must be completed; the general CPT rule regarding the midpoint for certain timed services does not apply.*
>
> *The medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of an E/M visit code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted.* ***The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."***

Appropriate Time Statements:

Documentation is important if you are going to base your coding on time. Rather than just writing "Total time spent was XX minutes" or "Total time coordinating patient care was XX minutes" it's helpful to explain what was included in the time, especially now that patients have access to your notes.
They may not understand that the time you've listed includes more than just the face-to-face portion of the visit.

Here's an example of a well-explained note:

> ***"Total time spent caring for the patient today was XX minutes. This includes time spent before the visit reviewing the chart, time spent during the visit, and time spent after the visit on documentation. I spent discussing the plan of care with patient ……. etc."***
>
> ***Time excludes a simple lesion repair of 5 minutes documented separately.***

Closing tip: Carve Outs

A little extra explanation in your time statement will also be helpful in case of an audit. This will assure medical necessity and shore up any doubt of compliance concerns regarding dependability. Upon review, we look at the chart note from several different approaches. When we do "carve out statements," they can stand n their own and answer the "Why and What" you did for 45 minutes.

For example, if you did a procedure during a visit and billed for it separately, you might want to add, "*Time excludes procedure time*" to ensure there's no confusion about that.

Resources:
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
https://namas.co/qualification-statements-for-time-based-em-services/

The following page is an educational illustration for Time Attestation in Allscripts.

Time Attestation in **Allscripts**: Time Statement Education

OCTOBER 2023

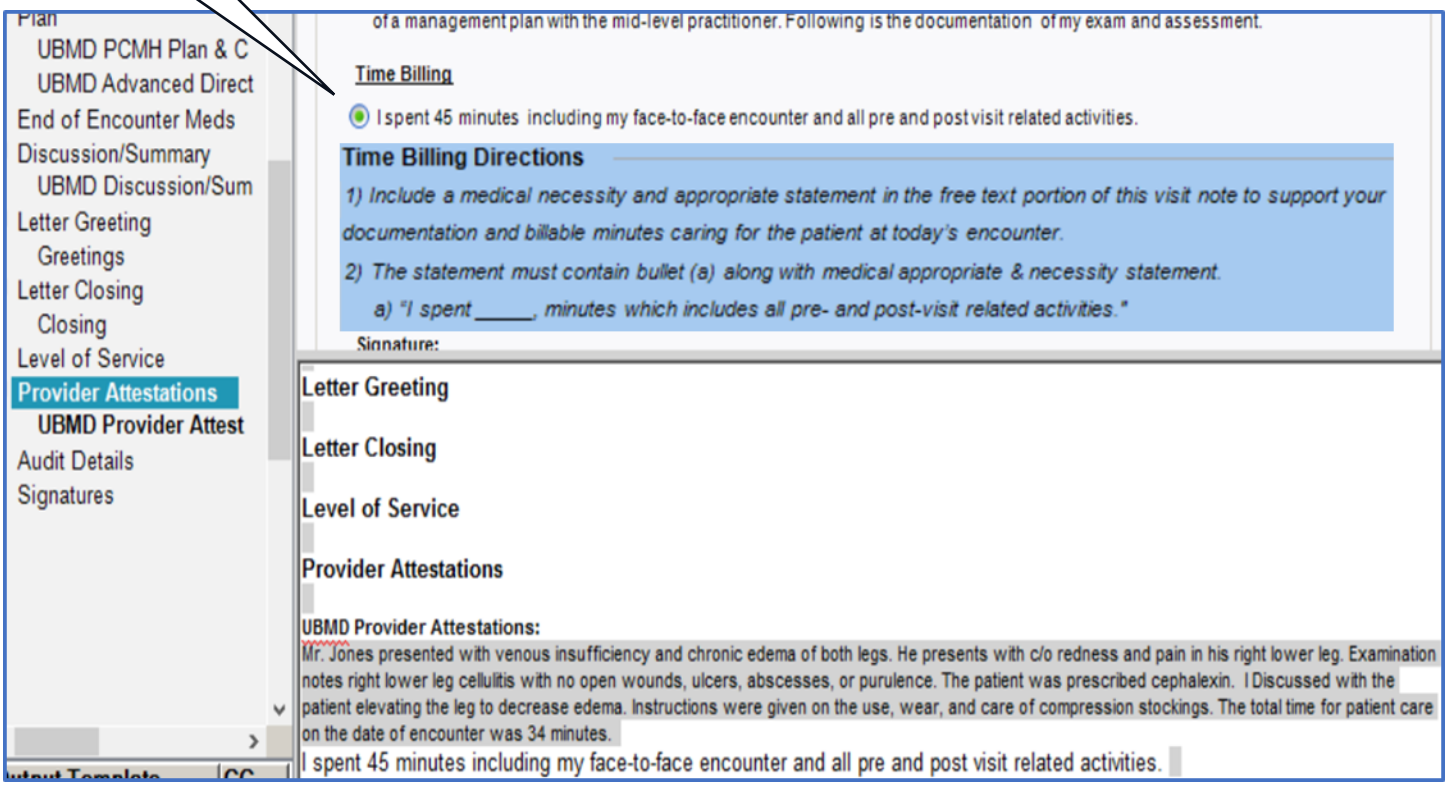
Rationale for Time Validation Statement: This training will provide further information regarding the requirements to use "time" for billing a patient encounter.

Steps to Enter Time Attestation: Mandatory Field

1. In the Provider Attestation section of your note, click the radio button for Time Billing. Make sure you fill in and account for how much time you spent managing the patient pre, intra, and post-service. This renders text into the note accumulator to which you should add more detail using the free text options.
2. Review the directions noted for the Time Attestation for a Medical Appropriate and Necessary Statement.
3. You will enter your medically appropriate statement and validate your encounter in the free text area of the note accumulator. This text statement describes your patient's encounter and qualifies the time needed to represent the code selected for billing and should precede the time spent statement (see example below).
4. If you perform a separate billable service, you must "carve out" that time from the total time of the encounter.
5. Remember: The validation statement is to be unique to each patient.

Click radio button for Time Billing statement to render

Screenshot From Allscripts EHR



HIPAA Alert: Disclosing PHI on Patients' Social Media Reviews

Sue Marasi, CHC, CPCA, Compliance Administrator
Megan Veirs, Director of Marketing & Communication

In June, the Health & Human Services Office for Civil Rights (HHS OCR) announced a $30,000 settlement with a New Jersey health care provider, resolving a complaint which alleged that the provider disclosed PHI of a patient, without permission, when the provider's entity posted a response to the patient's negative online review. That response included information regarding diagnosis and treatment of the patient's mental health condition. The provider will also be required to follow a corrective action plan that will be monitored for two years by the OCR.

The OCR Director stated that they continue to receive complaints regarding patients' PHI being disclosed on social media and the internet by health care providers in response to negative reviews. It is important for all UBMD providers and staff to understand that patients are protected from this type of activity by the HIPAA Privacy Rule. In addition to a violation of law, such activity is also a violation of patient trust.

If you come across a negative review you would like to address, keep in mind that no PHI can be included. It is recommended that any conversation or discussion about a review be moved off-line. The following are general responses that maintain PHI, but also help direct the conversation.

- We would like to hear more about your experience. Please call _____ and ask for the office manager.
- Thank you for alerting us to this experience. The clinic manager will be reaching out to you directly to rectify this matter.
- Thank you for providing this feedback. One of our team members will be reaching out directly to discuss this further.
- If you would like to share more about your experience, please call _____ and ask for the office manager so that we may be able to address your concerns.
- If you would like to speak further about this, please call _____ and ask for the office manager.

By using the ones asking the reviewer to call, this also takes the burden off the practice. If the person wants to reach out to further discuss, you've provided an avenue for them to do so, but you're not responsible for chasing them down. However, in situations where it may be deemed more critical, its advised to reach out directly and use those specific responses above.

It's good practice to respond to all negative reviews. Even if the issue presented cannot truly be addressed or rectified, responding will also show others who may read the review that you care about your patients' experiences and aren't ignoring complaints.

For the responses themselves, it's best to use titles rather than team member or physician names, such as in the above examples with "clinic manager" or "team member." Even if the person leaving the review mentions someone from the practice by name, do not use it in the response. This helps reduce risk of any liability in your response.

If you have a good review, comment on those, too! Someone went out of their way to leave a rating or share their experience, so it's good to engage with that. Beware – just because it's positive, doesn't mean you don't have to worry about PHI. Keep things general just as you would responding to a negative review.

- Thanks so much for sharing your experience with us!
- Thanks for sharing your story.
- Thanks for sharing! We're so happy to hear about your experience.

If you have any questions or concerns about how to respond to a review (negative or positive), please reach out to Megan Veirs at modonnel@buffalo.edu.

"It takes twenty years to build a reputation and five minutes to ruin it. If you think about that, you'll do things differently."

~ Warren Buffett

Coding Alert!! Split Shared Visit Inpatient Update

Sandy Setlock, CPC, CRC, CEMA, CHCO, Director of Audit & Education

As of January 1st, 2024, the Split Shared Visit guidelines will be updated to be in line with Medicare and the Coding (CPT) guidelines . This Coding Alert provides the following information to you.

1. What is a Split Shared Visit?
2. Who bills for a visit?
3. Identify what is "Substantive Portion."
4. Sample documentation attestation.

1. **What is a Split Shared Visit**:

Split/shared visits only apply to **facility visits** and not outpatient encounters. Split Shared is a collaborative visit between an APP and MD provider during an inpatient visit.

2. **Who bills for a Split Shared Visit:**

- **A split shared visit should be billed under the NPI of the provider who did the substantive portion of the work. That could be either the Physician or the APP**
- **Our Local Medicare jurisdiction: NGS Guidelines billing split shared.**

"In order to bill the service as the "substantive" provider, the physician's documentation would need to describe the physician's work as exceeding the NPP's work in completing the service. In either reviewing the NPP's history and/or exam findings and in formulating a medical decision, the physician's performance and documentation would need to exceed the NPP's efforts and documentation of the split/shared service."

3. **What does "Substantive Portion" to be documented in the patient chart mean?**

The definition of "substantive portion" of a split (or shared) visit means more than half of the total time spent by the physician or non-physician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making. **In other words, Medicare will allow time or medical decision making to serve as the substantive portion of a split or shared visit.**

- The medical record must identify the physician or APP who performed the visit.
- The individual who performed the substantive portion of the visit will bill the visit.
- Both the APP and Physician must sign and Date the medical record
- **IF** the physician does not see the patient until the next day, the APP will receive the billing.
- **Distinct Time**: When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

4. Sample Documentation Attestation:

Sample Physician Attestation Statements (will vary based on above selections). Choose Only **ONE** - either **MDM or TIME**

YOUR FIRST CHOICE: By Medical Decision Making (MDM)

- I saw and evaluated the patient with___ (*insert APP name*) __. I provided the substantive portion of the care for this patient. I personally performed the medical decision making for this encounter. I have reviewed and verified this documentation and it accurately reflects our care of plan.
  - ◊ **Ensure documentation reflects pertinent information regarding the problems addressed, data reviewed, assessment and treatment plan.**
- **Documentation should note** If the APP performed the substantive portion the MD will append the following attestation: **"I participated in the care of the patient and verified the documentation."**

YOUR SECOND CHOICE: By Time

- If selecting your code **level by TIME**, the quantification of time must be >50% either by physician or APP. The attestation must state that you spent >50% of your time evaluating the patient. Your time must be documented and detailed on how it was accrued.

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Sample Attestation Time:

- "I spent greater than 50% involved in the care of the (***insert patient name)***. A substantial portion of this visit was performed monitoring, evaluating, addressing, and treating the patient. I formulated the treatment plan and goals addressing the following conditions for the patient….
- **Documentation should note the** If the APP performed the substantive portion the MD will append the following attestation: **"I engaged in the care of the patient and verified the documentation."**

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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 Third/Fourth Quarter Quiz

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1. The Cures Act Information Blocking Rule, requires that patients have access to their medical records, including their notes and lab results.

   A. True
   B. False

2. Violators of the Cures Act Information Blocking Rules will be subject to the following penalty:

   A. Up to $1 million fine total for all violations.
   B. $1 million fine and possible imprisonment.
   C. Up to $1 million fine per violation.
   D. There is no penalty.

3. Practice plans cannot use the AI Companion feature during Zoom meetings when any HIPAA regulated data or PHI will be discussed during the meeting.

   A. True
   B. False

4. Which of the following is true regarding time-based coding and documentation?

   A. Every note must have medical appropriateness and be backed by medical necessity.
   B. Time includes documenting clinical information in the electronic or other health records when performed on the same day the service is provided.
   C. Documentation is important if you are going to base your coding on time; it is helpful to explain what was included in the time.
   D. All of the above are true.

5. In time-based coding you may include travel time in time spent.

   A. True
   B. False

6. If you come across a negative or positive review online that you would like to address, no PHI can be included in your response.

   A. True
   B. False

7. Which of the following is incorrect in responding to a negative and positive reviews online?

   A. It is best to use titles rather than team member or physician names, even if the person leaving the review mentions someone from the practice by name. This helps reduce risk of any liability in your response.
   B. It is recommended that any conversation or discussion about a review be moved off-line.
   C. You should never respond to negative reviews.
   D. PHI being disclosed on social media and the internet by health care providers in response to negative reviews is not only a violation of law, but a violation of patient trust as well.

8. Split Shared is a collaborative visit between an APP and MD provider during an inpatient visit, and should be billed under the NPI of the provider who did the substantive portion of the work. That could be either the Physician or the APP.

   A. True
   B. False