Compliance Alliance

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Notes from the Compliance Office…

By: Sue Marasi, CHC, CPCA, Compliance Administrator

OIG Semi-Annual Report

As most of you know, the Office of the Inspector General (OIG) has an annual work plan that it follows in an effort to detect questionable, undocumented, medically unnecessary or incorrectly coded services, identify and investigate patterns of fraud, and to deter misconduct. In May, the OIG released its Semi-Annual Report for the first half of FY2016 (October 1, 2015 – March 31, 2016).

In summary, the report states that during this time there were **expected recoveries of over $2.77 billion**; **428 criminal actions** against individuals or entities that in engaged in crimes against HHS programs; **383 civil actions** including false claims, unjust-enrichment lawsuits filed, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosures; and **1,662 exclusions** of individuals and entities from participation in Federal health care programs.

This is why an effective compliance program is so important. Don't become a number. Let's *work together* to ensure UBMD's compliance program is effective.

The Importance of Business Associate Agreements

By: Lawrence C. DiGiulio, Chief Compliance Officer

Since 2004 when HIPAA became effective for small groups, the need for business associate agreements has been stressed by lawyers, commenters and most importantly, the government. More recently, HIPAA enforcement has increased to the point that the Office for Civil Rights (OCR), the agency tasked with enforcing HIPAA in the Department of Health and Human Services, is conducting HIPAA audits. OCR audits are conducted based on reported breaches, complaints received and desk and field audits picked at random.

One of the issues that is examined during a HIPAA audit is covered entity use of business associate agreements. A *covered entity* includes all providers who bill electronically (all of our practice plans), employer health plans and health insurance companies. A *business associate agreement* is the document that must be fully executed before any patient Protected Health Information (PHI) is transmitted by a covered entity to a business associate. A *business associate* is a person who:

> (i) On behalf of such covered entity … other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information …, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities …, billing, benefit management, practice management, and repricing; or
>
> (ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation …, management, administrative, accreditation, or financial services to or for such covered entity, … where the provision of the service involves the disclosure of protected health information from such covered entity or

arrangement, or from another business associate of such covered entity or arrangement, to the person.

In other words, a business associate is any billing company, lawyer, accountant, data analyst, consultant, collection agency, cleaning company or other entity to whom we transmit PHI or who has access to our PHI. We must have business associate agreements with all of our business associates.

In a recent case, OCR fined a North Carolina Orthopaedic practice $750,000 because the Orthopaedic practice handed over x-ray films to a company to digitize and harvest the silver from the old films. The handover was accomplished before the parties entered into a business associate agreement. In addition to the fine, the Orthopaedic group is required to revise its policies and procedures including the establishment of a process for assessing whether entities are business associates, designate a responsible individual to ensure business associate agreements are in place prior to disclosing PHI and limiting disclosures to business associates to the minimum necessary.

OCR obviously had a strong case against the Orthopaedic group because the issue was settled in an agreed Resolution Agreement and Corrective Action Plan, not a federal court case.

When providing PHI to a business associate through the required business associate agreement, we must only provide the minimum necessary PHI for the intended purpose. The HIPAA Privacy Rule requires a covered entity to make reasonable efforts to limit use, disclosure of, and requests for protected health information to the minimum necessary to accomplish the intended purpose. An example of minimum necessary is when we send a patient to collections. In that example, we do not send the collection agency the entire medical record. We only send that portion of the record necessary to collect the outstanding balance. We do not send notes, test results, diagnosis, etc. We do send name, address, billing history and amounts owed.

"Relativity applies to physics, not ethics."
~ Albert Einstein

Great care must be taken to follow required processes to protect our patients' PHI. Government is ready to penalize us like the Orthopaedic group in North Carolina if we don't take the necessary precautions.

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 to the compliance department or their supervisor.

Coding Corner: Split/Shared E/M Services

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

When an evaluation and management encounter is provided as a service shared between a physician and a credentialed non-physician provider (NP, PA, CNS, CNM) it may qualify as a split/shared service billable under the physician's UPIN/PIN for 100% of the physician fee schedule.

The requirement for billing these services varies for Medicare and non-Medicare patients based on payer rules. Independent Health and Health Now (the Blues) allow applicable encounters to be billed under the physician UPIN/PIN provided there is documentation from each of the providers supporting their appropriate level of involvement in the care of the patient. The physician's documentation must be more than a simple attestation, a co-signature or a statement from the NPP noting that the patient was also seen by Dr. X.

The following from Independent Health Policy No. M040301528 clarifies their rules:

> **Purpose:** To clarify reimbursement related to out-patient office visits where care is jointly rendered by a physician and mid-level practitioner **credentialed** with Independent Health. (Credentialed mid-level practitioners include physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CMWs).

Policy: Independent Health reimburses the appropriate Evaluation and Management code (E&M) at the prevailing physician fee schedule under the physician identification number when the following criteria are met:

1. The physician participated in key components of the visit, including, at minimum, the member's physical examination and the development of the management plan.
2. The combined entries of the physician and the mid-level practitioner constitute the documentation for the services and together support the Medical Necessity of the service.
3. Physician documents that he/she personally saw the patient, and was present and conducted key portions of the service. The mid-level practitioner's note that the physician was present and participated is not sufficient documentation to establish either the Medical Necessity of the service or the presence and participation of the physician. In addition, the following notations are examples of *insufficient documentation* by the doctor:
   - *"Agree with above."*
   - *"Discussed with practitioner. Agreed."*
   - *"Seen and agree."*
   - *"Patient seen and evaluated."*
   - *Physician's countersignature only.*

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.)

Medicare, on the other hand, is a completely different story. While CMS does allow for split/shared services with the same documentation requirements; they also add the provision that all "*incident-to*" requirements must also be met. This limits these services to established patients following an established treatment plan with no new problems.

The following from CMS Transmittal 178 clearly defines Medicare's rules:

Office/Clinic Setting
In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting
When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

CMS EXAMPLES OF SHARED VISITS

1. *If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.*
2. *In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.*

Please keep in mind that the following services may not be billed as split/shared services regardless of the payer:

1. Critical Care services;

2. Procedures; and
3. E/M services performed in the skilled nursing facility (SNF)/nursing facility (NF).

NOTE: Although Allscripts has an attestation in it for services provided as a split shared visit, this alone is not sufficient documentation to support billing the service. There must be additional documentation from the physician.

HIPAA Privacy: To Waive or Not To Waive

By: Sue Marasi, CHC, CPCA, Compliance Administrator

Following the June tragedy at the Pulse nightclub in Orlando, some confusion arose regarding when HIPAA waivers are required and/or granted. The Orlando mayor had stated to reporters that, at the request of the hospital CEO, he had asked the White House to waive HIPAA regulations, thus allowing the hospital to give information to the victims' family members quicker. It was also reported that the waiver was granted. The fact is, one was not granted because it was not required.

While the HIPAA regulations generally require that patient information be kept confidential and released only if a patient, or his or her family member or loved one, authorizes the release, there are exceptions. §42 CFR 164.510(b)(3) of HIPAA states:

> "If … the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is … needed for notification purposes."

In other words, HIPAA allows providers the flexibility and discretion to disclose certain limited health information when it is appropriate and determined to be in the best interest of the patient; for example, to help identify incapacitated patients, or to locate patients spouses, family members and close personal friends, including long-term unmarried partners and same-sex partners, to share information about their condition. However, due to the heavy fines and criminal penalties that can result from a HIPAA violation, providers tend to err on the side of caution.

Actual broad-scale HIPAA waivers, such as the one rumored in Orlando, are rare. But waivers can be issued when there is a public health emergency declared by the White House. The last one was issued in 2005 after Hurricane Katrina to assist in disaster relief efforts. Such waivers are in effect for up to 72 hours.

HIPPA can also be suspended or waived under the following circumstances:

- In the context of public health disclosures;
- In the case of a health care oversight, such as an audit;
- For health care research; and
- For law enforcement purposes.

Training Update – What's Available?

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

<u>New Provider E/M and Documentation Training</u>

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

2016 dates:
August 23rd
September 6th, September 20th
October 18th

November 8th, November 22nd
December 6th

Lunch-n-Learn
Sessions are usually held once a month. 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 as noted below.***

Location & Time: 77 Goodell St., Room 208

Next Session: September 13th, 12:30pm
Topic: AAPC Webinar – *ICD-10 Changes for 2017*

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

Bowling for a Good Cause

On May 20th the UBA/UBMD Legal & Compliance Office once again participated in the 17th annual Lawyers for Learning Bowling Tournament.

LFL is a non-profit corporation through which members of the Erie County legal community - judges, lawyers, paralegals and other staff - volunteer throughout the school year as tutors and mentors to students in grades 1-8 at Public School 18 in Buffalo.

The bowling tournament draws nearly 400 participants from the legal community every year.

Brian White was UBA/UBMD's star kegler, bowling an impressive 230 in his 2nd game!

(L to R): Sue Marasi, Compliance Administrator; Brian White, Counsel; Larry DiGiulio, Chief Compliance Officer; Bev Welshans, Director of Audit & Education; Jess Wachowicz, former Internal Medicine Auditor

UBMD ANONYMOUS COMPLIANCE HOTLINE

888-4752

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Second Quarter 2016 Quiz

**** To submit your quiz answers, please go to**
https://smbsweb.med.buffalo.edu/ubmd/training.aspx
and select Training Module "2016 – 1st Quarter Newsletter"

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1. In reference to Business Associate Agreements, a business associate is:
   a. Any entity to whom we transmit PHI
   b. Any entity who has access to our PHI
   c. Neither a nor b
   d. Both a and b
2. When providing PHI to a business associate through the required business associate agreement, we must only provide the minimum necessary PHI for the intended purpose.
   a. True
   b. False
3. Which of the following cannot be billed as split/shared services regardless of the payer?
   a. Critical Care Services
   b. Procedures
   c. E/M Services performed in the skilled nursing facility/nursing facility.
   d. All of the above
4. Which of the following statements is true regarding an attestation in Allscripts for services provided as a split/shared visit?
   a. No such attestation exists.
   b. The attestation is sufficient documentation to support billing the service.
   c. Additional documentation from the physician is necessary.
   d. None of the about are true.
5. HIPAA never allows for provider flexibility and discretion to disclose limited health information.
   a. True
   b. False

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PLEASE DO NOT EMAIL OR FAX YOUR ANSWERS

Answers must be submitted online at:

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

Be sure to click on your correct practice plan to ensure proper credit!