2019 1st & 2nd Quarter
Volume 13, Issue 1 & 2

Compliance Quarterly

From the Compliance Office...

Combined 1st & 2nd Quarter Newsletter

Due to an unavoidable delay in distributing the 1st quarter newsletter, we are combining the 1st and 2nd quarter newsletters for 2019. You will see that the quiz consists of 10 questions so that you can still receive .25 hour credit for each quarter (for a total of .50 hour credit) toward the 2 hours of compliance training required biennially by the UBMD Compliance Plan. Thank you for your understanding.

Newsletter Topics

In the *Compliance Quarterly,* we focus on currently relevant Compliance & HIPAA topics, regulatory updates, and helpful tips. If anyone has a topic you would like to see covered, general or practice-focused, in a future edition of *Compliance Quarterly,* please contact Sue Marasi (smmarasi@buffalo.edu).

Compliance Training Update

New Provider E/M & 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 Bev if you would like to attend a session so that she can be sure to have enough materials for all attendees.***

Location & Time: 77 Goodell St., Room 310F
2019 Dates:

9/10 11:30am	11/12 11:30am
10/7 9:00am	12/2 9:00am
10/15 11:30am	12/10 11:30am
11/4 9:00am	

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 contact list, please contact Bev as noted to the right.

Location & Time: 77 Goodell St., Room 205, 12:00-1:00PM
2019 Dates: 9/17, 10/22, 11/19, 12/17

Inside this issue

Training Questions

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

Requests for Medical Records

By: Lawrence C. DiGiulio, Chief Compliance Officer

We are often asked for medical records. This article addresses a few of the more frequent questions practices plans have when responding to medical records requests.

What is an Access Request?

There are two main types of requests for medical records: (1) for information to be provided to the individual, and (2) for information to be sent to a designated personal representative. Third-party requests are those where a third party, such as an attorney, obtains permission from the patient (via a HIPAA authorization) and then makes a request for the patient's medical records. The guidance below applies ONLY to an individual's request, not a request by an attorney for a party who is not the patient.

What fees does HIPAA allow?

HIPAA regulations state that covered entities are permitted to charge a "reasonable, cost-based fee" in fulfilling access requests. Under 45 CFR § 164.524(c)(4), a covered entity may only charge for:

1. **Labor for copying** (whether in paper or electronic form);
2. **Supplies** for creating the paper copy (or electronic media if the individual requests that the electronic copy be on portable media);
3. **Postage** (when the individual has requested that the information be mailed); and
4. **Preparing an explanation or summary** of the protected health information, if agreed to by the individual.

" OCR will take action against covered entities that it finds do not meet the cost restrictions set forth by the HIPPA rules..."

In recent years, the Office of Civil Rights (OCR) has published additional guidance on what constitutes a reasonable, cost-based fee. One key item from this guidance is that costs related to "labor for copying" include only the time spent actually photocopying or scanning paper records and/or transferring electronic records to portable media, email or app. In other words, copying does **not** include the time it takes for the staff member to review the request for access or to search for or retrieve the information (and therefore the covered entity cannot charge for such time/costs). Further, OCR has stated that a covered entity cannot charge an individual a fee when it fulfills the access request using the view, download, and transmit functions of the covered entity's Certified Electronic Health Records Technology (CEHRT), as there are no permissible costs associated with this process.

OCR has also taken a strong position on the use of so-called "per-page fees" declaring that, although potentially acceptable where the records are maintained only in paper form, using per page fees as the basis of covered entity's costs is not permitted when the records are maintained electronically. OCR provided some background to its position by stating per-page fees have "resulted in fees being charged . . . that do not appropriately reflect the permitted labor costs associated with generating copies from information maintained in electronic form. Therefore, **OCR does not consider per page fees for copies of PHI maintained electronically to be reasonable**. . ." OCR considers amounts under $10 to be reasonable, especially if it is possible to respond to the request with electronic as opposed to paper records.

What fees are permitted under New York's Public Health Law?

State laws regarding access to medical records are typically subject to (or preempted by) HIPAA. Accordingly, New York's laws and regulations allowing for health care providers to impose fees on access requests are only permitted to the extent that they do not contradict HIPAA.

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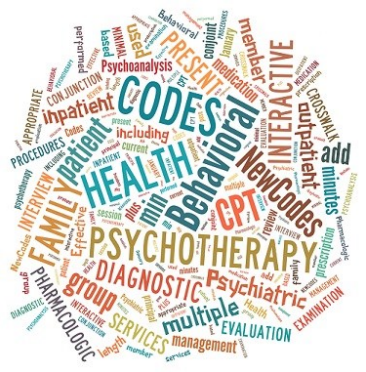
New York's Public Health Law allows for a health care provider to "impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider" and that "the reasonable charge for paper copies shall not exceed seventy-five cents per page." Although the language of the statute does not contradict the HIPAA rules, some health care providers have interpreted this language in a way the leads to a violation of both the state law and the HIPAA rules. Specifically, providers mistakenly believe that the Public Health Law enables them to charge 75 cents per page regardless of how the information is maintained and regardless of how the information is provided. This is not the case; costs must be reasonable as defined under both state and federal laws.

Conclusion

Please know that OCR will take action against covered entities that it finds do not meet the cost restrictions set forth by the HIPAA rules, and that other federal and state agencies may impose similar requirements.



Please feel free to contact me with any questions:
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Billing for Services Provided by an NPP

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

The Coding Corner

A Physician's Assistant (PA) or Nurse Practitioner (NP), or, together,j Non-Physician Practitioner (NPP), can be a valuable addition to your staff. It is important to understand the correct way to bill for the services they provide. There are three basic ways their services can be billed:

1. ***Direct Billing:*** Billed under the NPP's own numbers for any service within their scope of practice. A supervising physician has to provide General Supervision (being available by telephone is sufficient). Their services are reimbursed at 85% of physician fee schedule.

2. ***Incident-to:*** Billed under the NPP's supervising physician's numbers. The supervising physician must be in the office and the services cannot be provided for new patients or new problems for existing patients, (straight Medicare is the only payer that follows these rules) reimbursed at 100% of the physician fee schedule.

2. ***Split/shared visit:*** The patient is seen by the NPP and the supervising physician. Each documents their portion of the service and signs the note. The services are then billable under the supervising physician's numbers reimbursed at 100% of the physician fee schedule. This is what some of the local insurers consider their "Incident-to" policy.

You can also find more information in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.1.bAdobe Portable Document Format, and 100-02, Chapter 15, Section 60Adobe Portable Document Format

Important Reminder: NPP's can act as a scribe; however, when they are assuming the role of a scribe, they **cannot** perform any clinical activities. They are simply a human tape recorder for the physician's observations and recommendations.

General Compliance: 2019 OIG Work Plan Activities

By: Sue Marasi, CHC, CPCA, Compliance Administrator

As everyone should know by now, the OIG no longer publishes an Annual Work Plan and instead regularly updates its Work Plan website with new points of emphasis that focuses on many areas that the OIG plans on addressing both in the near future in its efforts to protect the integrity of federal healthcare programs and to combat fraud, waste and abuse. The Work Plan is more of a "living document," which is now updated monthly.

For 2019, the OIG has identified several specific concerns for regarding billing and documentation requirements that they will be reviewing and assessing. Below are a few areas that may relate to UBMD practices.

1. **Critical care billing**
   Because reimbursement for critical care physician services is time-based, physicians must make sure their records and documentation support the codes they are billing, as well as the time spent by the physician evaluating the patient, and providing and managing the patient's care.

2. **Outpatient cardiac and pulmonary rehab**
   Physicians who regularly order and perform cardiac care and pulmonary rehab services must make sure their records reflect medical necessity and satisfy all necessary documentation requirements.

3. **Off-the-shelf orthotics**
   According to CMS, charges for lumbar-sacral orthoses and knee orthoses (represented by CPT codes L0648, L0650 and L1833) have grown significantly since 2014, and have resulted in improper payment rates as high as 79%. Lack of documentation of medical necessity in medical records of patients is a top concern. OIG will be reviewing whether devices were supplied in the absence of and encounter with a referring physician within 12 months prior to their orthotic claims. Physicians who order or supply orthotic devices must be sure records reflect medical necessity and satisfy related documentation and billing requirements.

4. **Post-operative services**
   The accuracy of post-operative services included in global surgery payments will be reviewed by the OIG and verified for accuracy. Physicians who submit such claims should review their claims to ensure that their records meet billing requirements.

Also in 2019, opioid-related issues - prescribing, monitoring, and treatment programs - are a big concern for the OIG. Physicians who prescribe opioids need to make sure their prescribing practices are complying with all state and federal rules, and that their records support that compliance.

We can't repeat it enough, and OIG actions supports it: **Complete and accurate documentation is crucial**! Hand-in-hand with documentation accuracy, is **medical necessity**. OIG continuously stresses that only medically necessary items and services are provided to patients, and that all determinations of medical necessity are strongly documented in the patient record.

Physician practices can be proactive by routinely monitoring the OIG Work Plan website to determine if any new items might pertain to them and their practice plan.

https://oig.hhs.gov/reports-and-publications/workplan/index.asp

"Right is right, even if everyone is against it; and wrong is wrong, even if everyone is for it."

~ William Penn

Voicemail Retention

A Message from UB IT Leadership

The IT department has enabled the new voicemail retention policy this summer. At this time a global policy was enacted that will delete any voicemail that is older than 1 year. The plan is that after 180 days a message will be moved from the "new messages" folder to the "saved messages" folder, after another 180 days the message will be moved to the "deleted messages" folder, and 7 days later the message will be permanently deleted. As an FYI, listening to a message is not sufficient to reset the clock for that particular message. i.e. If a user listens to a message a day after they receive it and does nothing with it, it will stay in the "new messages" folder for another 179 days and progress through the timers as listed above. If the same user pressed the save option for that message, it would then be moved to the "saved messages" folder and the second 180 day window will begin counting down at that point, when that counter reaches 0 it would then be moved to the "deleted messages" folder and permanently deleted 7 days later.

OIG Summary of 2018 Fiscal Year Health Care Enforcement Actions

- Over $2.3 billion in fraud judgments, settlements & other administrative actions implemented;
- Department of Justice (DOJ) opened 1,139 new criminal health care fraud cases;
- Criminal fraud charges filed in 572 cases involving 872 defendants;
- 497 defendants convicted of health care fraud-related crimes;
- DOJ opened 918 new civil health care fraud cases;
- FBI cases resulted in over 812 operation disruptions of criminal fraud organizations;
- OIG cases resulted in 679 criminal and 795 civil actions; and
- 1,267 OIG exclusions from criminal convictions, 201 exclusions for patient abuse/neglect, and 996 exclusions that included licensure revocations.

The numbers above are real, and they illustrate why continuous compliance training and, more specifically, Fraud, Waste & Abuse training are so important for ALL health care workers.

Stay tuned...your annual Mandatory Fraud, Waste & Abuse training is coming in the next edition of *Compliance Quarterly.*

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Report suspect fraud/abuse, potential problems,

or HIPAA concerns.

Ask questions or request guidance | Provide relevant information.

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

(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:

2019 First & Second Quarter Quiz

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1. HIPAA allows a covered entity to charge for what costs in fulfilling records requests?

   A. Labor for copying
   B. Supplies
   C. Postage
   D. All of the above

2. OCR does not consider per page fees for copies of PHI maintained electronically to be reasonable.

   A. True
   B. False

3. OCR will take action against covered entities that it finds do not meet the cost restrictions set forth by the HIPAA rules, and other federal and state agencies may impose similar requirements.

   A. True
   B. False

4. The correct way to bill for the services provided by an NPP is:

   A. Direct Billing
   B. Incident-to
   C. Split/shared visit
   D. All of the above

5. For Direct Billing, the supervising physician must be in the exam room.

   A. True
   B. False

QUIZ CONTINUED ON NEXT PAGE

Compliance Quarterly Quiz

Continued

6. Which of the following is incorrect regarding NPPs?

   A. In Direct Billing, an NPP's services are reimbursed at 85% of physician fee schedule.
   B. In a split/shared visit, the patient is seen by both the NPP and the supervising physician.
   C. An NPP acting as a scribe may also perform clinical activities.
   D. Incident-to visits are billed under the NPP's supervising physician's numbers.

7. In critical care billing, it is not necessary to document the time spent by the physician evaluating the patient.

   A. True
   B. False

8. OIG continuously stresses that only medically necessary items and services are provided to patients, and are strongly documented in the patient record.

   A. True
   B. False

9. Which of the following statements is true?

   A. In Fiscal Year 2018, over $2.3 billion in fraud judgments, settlements & other administrative actions were implemented by the OIG.
   B. In Fiscal Year 2018, the DOJ opened 1,139 new criminal and 918 new civil health care fraud cases.
   C. Both A and B are true.
   D. None of the Above

10. When calling the UBMD Compliance Hotline, which of the following is true?

    A. You can report suspected fraud/abuse, potential problems, HIPAA concerns, or request guidance.
    B. You may remain anonymous if you wish.
    C. The UBMD non-retaliation policy will be adhered to.
    D. All of the above.