2017 1st Quarter
Volume 11, Issue 1

Compliance Quarterly

From the Compliance Office...

Newsletter Format

As you can see, we have given our compliance newsletter a makeover! Along with a new look, we have given it a new name. The newsletter will continue to provide you with important information, developing news, updates and training information. It will always include a section at the end with our contact information and our Hotline information, allowing us to keep the lines of communication open by giving you a quick reference for contacting us with any questions or concerns. The final page will still be the short quarterly quiz that should be completed online for .25 compliance training credit toward the required 2 hours biannually.

Compliance Training Update

Sexual Harassment Training

Some of you have recently inquired whether or not Sexual Harassment Training is something the Compliance Office could provide. We are looking into this and will keep you updated.

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 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, 11:30-12:30pm
Dates: March 14 & 18; April 11 & 25; May 9 & 23

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 me as noted to the right.***

Location & Time: 77 Goodell St., Room 208, 11:30-12:30
Upcoming Sessions: March 21; April 18; May 16

Inside this issue

Training Questions:

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

1995 or 1997 Documentation Guidelines?

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

CMS has published two separate Documentation Guidelines for Evaluation and Management (E&M) Services: one in 1995, the other in 1997. For any patient encounter, either may be used but not a combination of the two. An understanding of these two guidelines allows a physician to make an informed choice between them, selecting the one most suitable to his clinical practices and preferences.

The only significant difference between 1995 and 1997 is their requirements for physical examination. Both versions identify 12 organ systems (OS) and 7 body areas (BA) that may be used for documentation of a physical examination. E&M recognizes 4 levels of physical examination as defined by the guidelines: comprehensive, detailed, expanded problem focused (EPF) and problem focused.

The Coding Corner

At one time CMS stated that they were going to merge the two sets of guidelines and release the "2000 Documentation Guidelines". This did not occur, nor is there any expectation that new guidelines will be released. With changes in reimbursement for health care to more of a pay for performance model these rules will eventually have less applicability. During this transition period we feel it is prudent to allow UBMD providers to use either the 1995 or 1997 guidelines.

The 1997 guidelines have specific "bullet" requirements that must be documented, while the 1995 guidelines do not require specific content for the areas examined, leaving this to the provider's discretion. Because the 1995 guidelines do not specify documentation expected for areas/systems examined, they may be subject to audit challenges. To minimize subjectivity, we are following *Marshfield* guidelines *(see the table below)* recommended by NGS, our MAC (Medicare Administrative Contractor).

The type of physical exam performed is one of the 3 key components defining the E&M level of service that can be billed and therefore a controlling factor in reimbursement for services rendered. Some E/M services require that all 3 key components be met while others require that only 2 of the key components be met. If you are billing a service that requires all 3 and the physical exam is not documented as required by the guidelines (either 1995 or 1997), the level of service intended cannot be billed and will be have to be downgraded to the level for the type of exam supported by the documentation.

For example, if a high-level admission history and physical (99223) was intended with a comprehensive history and high-complexity decision making but examination of only 7 organ systems is documented, code 99221 (lowest E&M level) must be billed.

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The greatest opportunity for improving E&M code assignment is the documentation of the comprehensive physical exam required for the initial patient encounter (admission H&P, new patient office visit or consultation) by both high and moderate E&M levels of service. If a comprehensive exam is not documented, a lower level E&M code must be assigned. Documentation of subsequent visits is not nearly so challenging, since only 2 of the 3 key components is required.

In conclusion, physical examination requirements for both the 1995 and 1997 guidelines are comparable, other than the comprehensive examination. The 1995 guidelines are more lenient and may be easier to challenge while 1997 guidelines are a bit stricter which could minimize audit challenge. Adhering to the *Marshfield* guidelines for 1995 exam seems like a viable option for UBMD providers. However, the choice of 1995 or 1997 is still yours to make.

Remember:

"If it isn't documented, it didn't happen!"

UBMD 1995 Physical Exam	
Body Areas 1) Head, including the face 2) Neck 3) Chest, including breasts and axillae 4) Abdomen 5) Genitalia, groin, buttocks 6) Back, including spine 7) Each extremity	**Organ Systems** 1) Constitutional 2) Eyes 3) Ears, nose, mouth and throat 4) Cardiovascular 5) Respiratory 6) Gastrointestinal 7) Genitourinary 8) Musculoskeletal 9) Skin 10) Neurologic 11) Psychiatric 12) Hematologic/lymphatic/immunologic
Problem Focused—a limited examination of the affected body area or organ system **(1 system/area)**	
Expanded Problem Focused—a limited examination of the affected body area or organ system and other symptomatic or related organ systems **(2-5 systems/areas)**	
Detailed—an extended examination of the affected body area(s) and other symptomatic or related organ system(s) **(6-7 systems/areas)**	
Comprehensive—a general multi-system examination with comprehensive examination of affected organ system and examination other related systems **(at least 8 organ systems)**	

Prohibition Against Use of UB Outlook Calendar to Store PHI

By: Lawrence C. DiGiulio, Chief Compliance Officer

PHI may not be entered into University Outlook Calendars because the University at Buffalo is not currently permitted to act as a Business Associate to any Covered Entity (except the Dental School) including our practice plans. CIT is the University Department that provides Outlook to all University, UBF and RF employees. CIT servers host practice plans Outlook accounts (any Outlook account using the Buffalo.edu domain). All information stored in Outlook is kept on these University Servers, not servers owned or controlled by the practice plans.

This means that the Outlook Calendar and Outlook Email servers cannot contain Protected Health Information without violating HIPAA. In past articles and reminders I have repeatedly said that emails (unless protected by encryption services such as Zix) cannot contain PHI.

For the same reasons, PHI must not be placed on the University Outlook Calendar. Using UB Outlook to store PHI is a HIPAA violation that carries with it penalties that can equal $50,000 per disclosure for intentional acts.

Examples of improper use of University Outlook are: listing patient schedules including patient names; listing operating schedules using PHI identifiers; and, granting access to your Calendar to individuals who are not practice plan employees.

"Using UB Outlook to store PHI is a HIPAA violation that carries penalties…"

As an alternative to placing PHI on University Outlook Calendars, please use calendars embedded in your practice plan's EHR or inside our hospital partners' Outlook servers (for instance, use the Kaleida Outlook Calendar) or simply use the University Outlook Calendar to block time without using any PHI identifiers. Examples of blocking time without violating HIPAA regulations is to generally block office time or procedures without using names or other PHI identifiers; list surgery types without attaching names to the surgery; and, list the location of your office or surgery time without other PHI identifiers.

While this may cause some limited inefficiencies, compliance is important and may be tested. This year, one of our practice plan will be forced to report a HIPAA breach on the University Outlook Calendar to its affected patients and to the Secretary of the Department of Health and Human Services. If there is an investigation of the University Outlook Calendar servers that is initiated because of this report, your practice plan may be investigated also.

Currently, University CIT is exploring the possibility of making its servers HIPAA complaint and signing Business Associate Agreements with our practice plans. If the University decides to do so, it will have to prepare and implement a HIPAA compliance plan including policies and procedures. To investigate the feasibility of this course of action, the University has engaged a consultant to conduct a gap analysis of its IT operations to determine the steps it would need to complete to become HIPAA compliant. That analysis will be conducted in the next several months. We cannot wait for the University and must immediately ensure we do not have any PHI on our University Outlook Calendars.

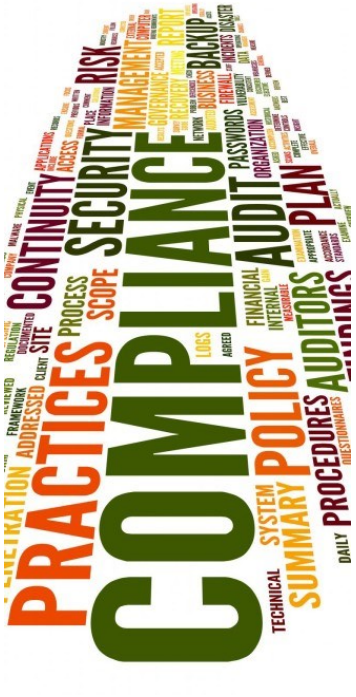
As always, if you know of any compliance issues, have any compliance related questions, or suspect any fraud or abuse, please call our anonymous compliance hotline at (716) 888-4752, call us directly or email us. We have a strict non-retaliation policy that will be adhered to in all instances to protect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

General Compliance: 2017 OIG WORK PLAN

By: Sue Marasi, CHC, CPCA, Compliance Administrator

The OIG is responsible for protecting the integrity of HHS programs and operations and the well being of beneficiaries. 78% of their funding is directed to oversight of the Medicare and Medicaid programs, with a focus on:

- Detecting, deterring and preventing fraud, waste and abuse;
- Ensuring quality and safety of medical services;
- identifying opportunities to improve program economy, efficiency and effectiveness;
- Holding accountable those who do not meet program requirements or violate Federal health care laws.



The Work Plan that the OIG releases annually outlines and identifies both new and ongoing investigative, enforcement and compliance activities that it will undertake during the fiscal year, and beyond, to achieve all of the above.

According to the 2017 Work Plan, which was released at the end of last year, the OIG will continue to carefully examine many compliance risk areas that have been the focus of previous years' work plans, including but no limited to:

- Billing for medically unnecessary services;
- Outpatient outlier payments for short-stay claims;
- Reconciliation of outlier payments;
- Hospitals' use of outpatient and inpatient stays under the "Two-Midnight Rule";
- Selected inpatient and outpatient billing requirements;
- Duplicate Graduate Medical Education payments;
- Indirect Medical Education payments.

Additionally, they will continue to investigate criminal activity, including kickbacks, fraudulent billing, money laundering, drug diversion and organized crime such as medical identity theft. In order to accomplish their efforts efficiently and completely, the OIG works with other agencies such as federal, state and local law enforcement, the FBI, and Medicaid Fraud Control Units.

Some new highlights in this year's plan may affect some, if not all, of you. The OIG will be on the lookout for Medicare payments for service dates after individuals' dates of death. Prior OIG reviews have identified such payments. Focus will also be put on Transitional Care Management (TCM). Medicare rules require that other covered services, including those related to chronic care management, end-stage renal disease, and prolonged services without direct patient contact cannot be billed during the same period as TCM. Hyperbaric Oxygen Therapy Services will be monitored. The OIG will be looking for treatments of non-covered services, insufficient documentation to support need for services, and cases where more treatments provided than were medically necessary. Also, a review/comparison of provider-based and free-standing clinics' Medicare payments for physician office visits to determine the difference in payments for similar procedures.

The Work Plan is nothing to roll your eyes at or ignore. In Fiscal Year 2016 the OIG reported expected recoveries of more than $5.66 billion; exclusions of 3,635 individuals and entities from participation in Federal health care programs; 844 criminal actions; and 708 civil actions.

Although this summary touches on some of the highlights of the 2017 Work Plan, there is plenty of more information contained in the Plan. Therefore, it would be in everyone's best interest to take the time to review the entire Work Plan here.

"If you think Compliance is expensive—try Non-Compliance."

~ Paul McNulty, Former US Deputy Attorney General

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Use the following link for the complete survey: http://www.corporatecompliance.org/Resources/View/tabid/531/ArticleId/5765/Data-Breach-Incidents-Causes-and-Response.aspx

Human Error the Main Cause of Data Breach?

Minneapolis, Minn.---December 14, 2016---Data breaches resulting from hackers often leads the news headlines, however, a survey of compliance professionals conducted in November 2016 by the Society of Corporate Compliance and Ethics (SCCE) and the Health Care Compliance Association (HCCA) found **human error to be the main cause of data breaches.** While 17% of respondents reported a hacktivist or hacker was responsible for a breach, lost device (20%) and lost paper files (45%) were far more likely to cause a breach.

"What's likely to be surprising to most is the importance of human factors in preventing data breaches. While the threat of hackers is real, organizations can't afford to neglect training their people on the risks and setting up the proper controls to prevent these often expensive and damaging incidents from occurring," said SCCE and HCCA CEO Roy Snell.

The survey, "Data Breach Incidents, Causes, and Response", first conducted in 2012, was conducted again in November to learn what changes occurred in the past four years and found relatively little has changed when it comes to both managing the issue and the number of incidents.

According to the survey, 38% of respondents reported that their organization had not suffered a data breach in the last year (up from 32% in 2012). But the survey report noted, "company size played a large role. While 51% of organizations with 1,000 employees or less reported a breach, 81% of organizations with 100,000 or more employees had been breached."

The survey also found employees other than IT were the "#1 source of reporting an incident." The survey results found that audits discovered 5%, IT reported 10%, and employees other than IT reported 46%. [1]

[1] Health Care Compliance Association

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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:

2017 First Quarter Quiz

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1. Which statement is/are true about 1995 and 1997 documentation guidelines is:

   A. Both versions identify 12 organ systems.
   B. Both versions identify 7 body areas.
   C. Both A and B are true.
   D. None of the above are true.

2. Because the 1995 guidelines do not specify documentation expected for areas/systems examined, they may be subject to audit challenges.

   A. True
   B. False

3. An example of improper use of University Outlook is:

   A. Listing patient schedules including patient names.
   B. Listing operating schedules using PHI identifiers.
   C. Granting access to your calendar to individuals who are not practice plan employees.
   D. All of the above.

4. Which of the following is/are example(s) of blocking time without violating HIPAA?

   A. 1:00 Smith gall bladder surgery at Gates.
   B. 1:00 Knee replacement surgery at Millard Gates.
   C. 1:00 Consult with John Doe regarding treatment options
   D. All of the above.

5. Which of the following is/are true of the OIG or OIG Work Plan?

   A. 78% of the OIG's funding is directed to oversight of the Medicare and Medicaid programs.
   B. Billing for medically unnecessary services is one focus of the OIG Work Plan.
   C. The OIG investigates criminal activity including kickbacks, fraudulent billing, money laundering, drug diversion and medical identity theft.
   D. All of the above are true.