



Compliance - Matters!

A newsletter from the Office of Compliance at Morehouse School of Medicine
June 2006

Evaluation and Management Services Furnished in Primary Care Exception Clinics

Teaching Physicians providing E/M services with a GME program granted a primary care exception may bill Medicare or Medicaid for lower and midlevel E/M services provided by residents. For E/M codes listed below, the teaching physician may submit claims for services furnished by residents where the **teaching physician did not see the patient**:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213
G0344	Welcome to Medicare Initial Exam

If a service other than those listed above needs to be furnished, the general teaching physician policy applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception. The MSM Compliance Office and the department should have documents on file validating center attestations.

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least six months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.86(i).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity within the suite as to constitute immediate availability. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident
- Have the primary medical responsibility for patients cared for by the residents
- Ensure the care provided was reasonable and necessary
- Review the care provided by the resident during or immediately after each visit. This includes a complete review of the history, physical exam, MDM and any tests, labs ordered or reviewed.
- Document the extent of his own participation in the review and direction of the services furnished to each patient.

Patient under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. Resident programs most likely to qualify for the primary care exception include: Family Medicine, General internal medicine, Geriatric medicine, Pediatrics, and Obstetrics/Gynecology.

Remember PCE applies only to low level E/M visits which means

- NO procedures
- NO consults
- NO high level visits for Medicaid or Medicare patients.

Modifier –**GE indicates PCE**.
When TP see patients in collaboration with residents, use **Modifier GC**.

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HIPAA Compliance Q+A

True or False. The HIPAA Privacy Rule never requires a covered entity to disclose protected health information.

False. One primary purpose of the HIPAA Privacy Rule is to limit the circumstances in which an individual's protected health information may be used or disclosed. A covered entity must disclose protected health information in two situations: (1) to a subject individual or his or her personal representative, if he or she specifically requests access to or he or she specifically requests an accounting of disclosures of his or her protected health information; and (2) to HHS, when HHS is undertaking a compliance investigation, review or enforcement action.

Patients do Have Rights!

MSM /MMA recognize that patient rights are a critical aspect of maintaining quality care and service. We are committed to allowing patients to exercise their rights under 45 Code of Federal Regulations (CFR) §165.524, and other applicable federal and state laws and regulations. These rights are in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that ensures patients' rights to access review and obtain a copy of protected health information.

Patients' Rights

- Right to Inspect
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper Copy of the **Notice of Privacy Practices**

More details are available for each of the listed rights within the MMA NOPP www.msm.edu (Homepage / Information and Resources link).

MSM HIPAA on-line Training Update

As of **June 1, 2006**, 176 MSM employees have completed the HIPAA on-line training course. Not every employee completed the same modules due to selection of the curriculum track most appropriate for their job function. This summary provides aggregate Quiz scores by curriculum tracks.

HIPAA awareness	82%
Privacy Rule Introduction	81.9%
Protected Health Information	81.7%
Patient Rights	68.3%
Business Associates	88.9%
Electronic PHI/Security Introduction	81.3%
Administrative Safeguards	86.5%
Physical Safeguards	89.7%
Technical Safeguards	81.3%
Electronic Transactions Introduction	65.3%
On-line Implementation evaluation	90%

One must be particularly concerned with the areas of Patient Rights and Electronic transactions. Participants scoring < 75% on any of the modules will be notified along with your supervisors for remedial compliance education.

Compliance Education for MSM

HIPAA On-Line Training
www.msm.edu / Homepage / click More MSM Events

Compliance Essentials Course

- June 15 – July 27, 2006
- Thursdays ONLY / 12:30 – 2:00 p.m.

Call the Compliance Office for topics.

Medical Necessity

The OIG recognizes that physicians must be able to order any tests, including screening tests that they believe are appropriate for the treatment of their patients. However, physicians must be made aware that Medicare will only pay for tests that meet the definition of “medical necessity” and that Medicare may deny payment for a test or procedure that the physician believes is appropriate i.e. screening test, but which does not meet the Medicare definition of medical necessity.

Providers/office personnel must look to both national coverage policies, such as NCDs, and local coverage policies, such as LMRPs, to determine what Medicare considers to be reasonable and necessary. The OIG takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties. Medicare carriers advise that a waiver of liability must be signed by the patient BEFORE a non-covered service is rendered and must be procedure code and diagnosis code specific stating the possible reasons the service may be denied by Medicare.

SO, the question is **WHEN** is **BEFORE**? The personnel at the front desk have no idea what services the patient may need on a given date. If the ABN is signed at check out it's too late because the possible non-covered service has already been provided. That leaves the signing happening somewhere in-between. Such as “before I do this procedure or test, Medicare (will or may not) pay for this because...” That doesn't mean before the patient sees the physician. A good choice would be to get waivers signed as soon as the doctor orders the procedure in question. That way, the health care provider can explain to the patient the need for the test or procedure if there's any question. Remember that the goal is to give patients information / education to make an informed choice about their health care and to accept the consequences of that choice, i.e. payment for the service. Having an ABN on file allows the physician to bill the patient for non-covered services which must otherwise be “written off” as a loss – A Freebie! The **GA modifier** indicates that the provider has appropriately obtained a signed ABN form from the Medicare beneficiary. Other modifiers pertaining to ABNs are GZ and GY. For more information, refer to the following CMS website: www.cms.hhs.gov/medlearn/modchtgy.pdf and www.cms.hhs.gov/medlearn/modchtgz.pdf.

Billers and Doctor Indicted!

On December 23, 2005, *Associated Press* reported that “a doctor who operated an Orange County medical clinic and his business associate have been convicted of federal fraud charges for billing more than \$7.6 million worth of respiratory treatments that were unnecessarily performed on the mentally ill or not done at all, officials said Friday.

“Dr. Aziz F. Awad, 43, who operated Active Care Medical Group in Anaheim, and his biller, Herman Thomas, 47, of Bellflower, were convicted Thursday afternoon by a jury in Santa Ana of 24 counts of health care fraud and four counts of money laundering, the U.S. attorney's office said in a statement.”

Physicians Regulatory Issues Team

Physicians have a special role in our health care system, as they not only care for the health of individual patients, but also help to shape the broad health care delivery system.

The Physicians Regulatory Issues Team (PRIT) is a group of CMS subject matter experts who work to reduce the regulatory burden on physicians who participate with the Medicare Program. The PRIT was established under HCFA administrator Nancy Ann Deparle. In 2003 CMS (formerly HCFA) administrator Thomas Scully appointed Dr. William Rogers, FACEP, who was working at CMS on EMTALA regulations, to Director of PRIT.

Over 80 examples exist of how the PRIT has been effective in helping physicians; all of which can be found on the PRIT website (www.cms.hhs.gov/prit). One such example is helping to modernize CMS' perspective on the common use in electronic health records, of “macros”. PRIT helped gather the proper CMS policy experts to discuss the use of macros and helped craft language that permits the appropriate use of macros in an electronic health record. The PRIT has also been working on the implementation of the Prescription Drug Benefit and has been advocating for physicians during policy decisions. A good example of this involves the prescribing of drugs which are sometimes covered by Part B and sometimes by Part D.

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The plans are required by law to verify that a drug is being used for a Part D diagnosis before they can pay for it. The plans were requiring physicians to submit prior authorization requests before the prescriptions could be filled even for drugs as cheap as prednisone (because it is sometimes a Part B drug). The PRIT suggested a more efficient approach would be to let the physician write a Part D diagnosis (essentially any diagnosis other than prevention of organ rejection and treatment of cancer) and the words "Part D" on the prescription. This policy has been adopted by all the plans and has reduced dramatically the work required to prescribe these B/D drugs. Dr. Rogers and the PRIT work toward the common goal of simplifying the lives of physicians by eliminating unnecessary regulations. Specialty medical societies, state medical societies, and individual physicians who have a suggestion, a complaint, or need assistance navigating Medicare's numerous regulations are invited to contact the PRIT at PRIT@cms.hhs.gov. (Article submitted by Dr. Rogers, Director of PRIT).



Rules of Thumb for 99214

Think 99214 in any of the following situations:

- If the patient has a new complaint with a potential for significant morbidity if untreated or misdiagnosed,
- If the patient has three or more old problems,
- If the patient has a new problem that requires a prescription,
- If the patient has three stable problems that require medication refills or one stable problem and one inadequately controlled problem that requires medication refills or adjustments.

Confidential Disclosure Line

Report suspected non-compliance in the workplace.

- **It's your responsibility to maintain a culture of "do the right thing."**

1-888-756-1364



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Office of Compliance**

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