



# Compliance Updates

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

## Health Insurance Portability & Accountability Act (HIPAA) UPDATE

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). In addition to creating consumer protection for health care benefits, which is the portability part of HIPAA, the law was meant to do the following:

- Standardize financial and administrative health transactions for the public and private sectors;
- Increase speed and efficiency;
- Cut the costs of delivering health care services; and
- Set minimum standards of protection for the storage, use, and transfer of protected health information (PHI).

The terms *security and privacy* are often used interchangeably; however, both terms are distinctly different. *Privacy* refers to sensitive, proprietary, and /or confidential information and limits the circumstances and individuals allowed to access, use, and disclose the information. *Security* refers to the mechanisms and safeguards used to protect private information.

The security final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality of electronic protected health information (ePHI).

Morehouse School of Medicine has implemented an on-line HIPAA Compliance training program. It is an interactive computer training program which incorporates text, audio, and video in engaging, realistic scenarios. The course will tailor itself to your job-specific needs. It contains up to four modules, including topics on:

- HIPAA Awareness
- Privacy (confidentiality)
- Security (Administrative safeguards, Technical safeguards, Physical safeguards)
- Electronic Transactions

HIPAA is a Federal mandate and training of all MSM /MMA employees is **required annually**. The program will take between one and two hours to complete in one session or in multiple sessions. The Office of Compliance will have the ability to track who has signed on to the program and the modules each person has completed. You may access the HIPAA on-line training via the MSM compliance website – [www.msm.edu/compliance/default.htm](http://www.msm.edu/compliance/default.htm) click **HIPAA training / HCCS**. Use your 5-digit payroll / HR number as your password. All MSM employees are in the system. If you have any problems while viewing the program, you can call DITS or the Compliance Office. REMEMBER, to access the modules you must disable your Pop Up Blocker for the site.

### ***New on the Horizon!***

### **R \* E \* S \* P \* E \* C \* T - Find out what it means to me**

Remburse Every Service, Procedure, and Enforce Collections Timely!

The Office of Compliance is developing a training course for staff and providers. The purpose of this curriculum is to provide departments with coding and billing principles affecting the revenue process. Doctors should be PAID according to services rendered, in a timely fashion. This necessitates appropriate front end “scrubbing” prior to data entry. Once claims are compensated; tracking must occur to ensure proper reimbursement. Coding and Reimbursement has become a skilled profession for our health care providers that require the knowledge of many different skill sets. If you intend on keeping your pulse on the heart-beat of the reimbursement game, you better know the rules! We hope that every department is represented well in this course!

## National Provider Identifier

HIPAA requires establishing and assigning a standard identifier that physicians and other health care providers, health plans, and employers will use for every electronic health care transaction. Its purpose is to uniquely identify a health care provider in standard transactions, such as claims. EVERY health care provider is required to obtain an NPI. The NPI will eventually replace all other identifiers, enrollment numbers in various healthcare plans like Blues, Cigna, etc. and the Medicare or UPIN numbers. MMA must be compliant by May 23, 2007. **Did you know that the credentialing department has obtained 99% of our providers' NPI numbers?** Great job Louise and Tamika!

## Individuals Exposed

A woman reports she secretly removed pages from her medical record showing she was at risk of Huntington's disease, a fetal genetic disorder. Fearing the consequences of the disclosure of the information, she said she removed information from her file to protect the ability of her children to obtain health insurance. (R. Klizman, The quest for privacy can make us thieves, *New York Times*, May 9, 2006)

Seventeen hospital workers (including doctors, supervisors, and lab technicians) tried to access the record of former President Bill Clinton as he was undergoing heart surgery at New York's Columbia Presbyterian Hospital. ("Hack Attack, How Safe is your Computer," *Physician's Practice*, June, 2005)

## Unauthorized Access

The names, birth dates, Social Security numbers and medical information for 60,000 students, faculty and staff at Ohio University were stolen in the third electronic security breach in three weeks. The university learned on May 4, that an unauthorized person gained access into a computer server that supports the Hudson Health Center. (J. Gonzales, Third computer breach at Ohio University; Records involve 60,000 who used health center, *Plain Dealer* (Cleveland), May 12, 2006.

## Poor Security

The Georgia Division of Public Health has shut down a clinic in Carrollton which provided care to about 75 people living with HIV due to "client confidentiality required for the privacy of clinical services was not being observed," according to a statement by health officials. The storage of PHI did not meet standards. (Z. Hudson, Carrollton HIV clinic shut down, *Southern Voice*, April 21, 2006.

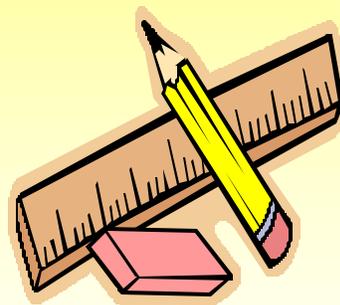
## Medical Necessity vs. Volume of Documentation

- You must have enough documentation to support the level of service you've billed.
- The volume of documentation does not determine the level of service to bill.

**Medical necessity of a service is the overarching criterion** for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management 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.

- Select the level of E/M services based on the following:

The key components must meet or exceed the stated requirements to qualify for a particular level of E/M service. Key components – Hx, Exam, MDM.



Remember the Golden Rules of Coding:  
If it isn't documented,  
**IT DIDN'T HAPPEN!**

## Office of Inspector General (OIG) 2006 Workplan

Annually the Office of Inspector General (OIG) releases a report that list areas of risks and issues affecting Federal Health Care Programs. Compliance programs are advised to target their Compliance plans and audits on these issues. Listed below are just a few of OIG's indicators that pertain to Part B physician billing.

**Modifier -25** – inappropriate usage, high use by individual providers or groups

**Initial Preventive Physical Exam (IPPE)** – OIG will evaluate the impact of IPPE on Medicare payments and physician practices. In addition to screening, EKG, the IPPE must include Wt, BP, a review of medical and social history, assessment of the potential for depression and evaluation of the functioning ability.

**Duplicate Part B payments** - made with the same carrier and among multiple carriers

**Excluded providers** – relating to inappropriate claim submissions

**Provider Education and Training** – Medicare's carriers' efforts to educate and train providers to improve billing practices and to reduce payment error and Medicare program losses.

**Health Care Fraud** – business arrangements and coding

**Provider Self-Disclosure** – encourage healthcare providers to promptly self-disclose improper conduct that threatens Federal Health Care programs

**Resolution of False Claims Act (FCA) and negotiation of Corporate Integrity Agreements (CIA)**

## OIG Hammers CONSULTS

In a March 29, 2006 report, OIG noted that the biggest mistakes dealing with consults were with high level consults and follow-up consults. "Physicians billed approximately 2 million services at the highest level of consultation codes, but coded just **5 percent of these correctly.**" Follow-up consults were billed incorrectly **94% of the time.** \$1.1 billion was the cost of these errors to Medicare. In response, **CMS deleted follow-up consult codes**. Remember in order to bill the highest level of consultation, a *comprehensive history*, a *comprehensive exam* and MDM of *moderate to high complexity* are required. Providers must bill a subsequent visit for inpatient follow up visits or as an established patient for ambulatory patients. To bill for a CONSULT – remember the three R's.



- **Request** must be documented
- **Render** a medically necessary service
- Provide a written **Report** of your opinion back to the requesting physician.

## Modifiers—Those Pesky Little 2 Digit Numbers

Modifiers are used in CPT coding to indicate that a service or procedure has been altered by some specific circumstances, but has not changed in its definition or code. They are used to communicate an increase or decrease in the level of services, to indicate bilateral or multiple procedures, or provide other information valuable in determining payment for a service.

Modifier 25 is one of the most challenging and controversial to assign, and its use is closely monitored by the OIG. This is used to show that a patient received a medical visit (E/M code) and procedure on the same date of service. It provides information that the medical visit was not related to the procedure. For example, modifier -25 is used when a patient presents for an office visit and the physician decides to perform a procedure at the time of the visit, based on his/her findings during that office visit.

### General Guidelines

- Appended only to E/M codes, not to procedure codes
- Documentation guidelines for the appropriate E/M level must be met.
- Different diagnoses are not required for the E/M service and the procedure. The diagnosis chiefly responsible for each should be assigned. This may be the same diagnosis code or different diagnosis codes.
- Routine use of modifier -25 should be avoided.

Medicare typically requires modifier -25 to be used when a documented, significant, separately identifiable E/M services is provided on the same day as a minor surgical procedure (all procedures assigned 0-10 day global surgical period).

## Scenario

An established patient presents to the physician for evaluation of actinic keratoses of the face, neck, and arms. The patient has not seen the physician for more than a year. An interval history, examination medical decision making consistent with a level 3 office visit (99213) are documented. Upon examination, a mildly irritated skin tag on the back of the neck is identified and removed. The procedure is documented in a separate clinical note.

**Code the scenario.**

**Suggestion for using modifier - 25.**

- Have a separate procedure note, even if the procedure is a “minor” one. It helps to paint the picture that the procedure was truly separate when the decision to perform the procedure/service was made that day.

### Answer to Scenario

99213 – 25  
11200 removal of skin tags



### 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**



## Compliance Updates

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