TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Compliance Newsletter

December 2016

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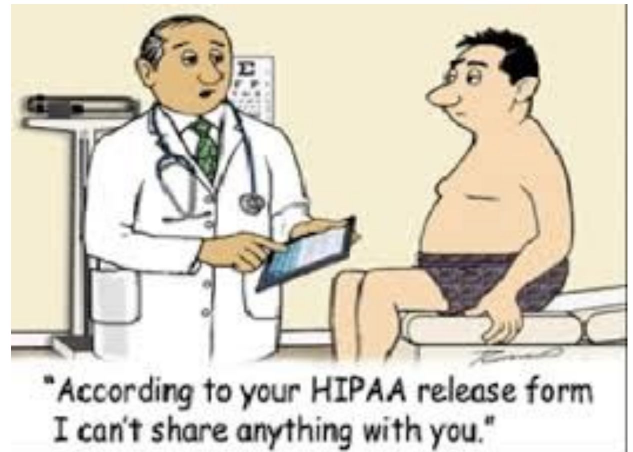
HIPAA Uses & Disclosures of Protected Health Information

Per guidance derived by the Office of Civil Rights, the HIPAA Privacy Rule establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information (PHI), with certain limits and protections, for treatment, payment, and health care operations activities (TPO). A CE is permitted to use or disclose PHI as follows:

- To the individual
- A covered entity (CE) may, without the individual's authorization, use or disclose PHI for its own treatment, payment and health care operations activities.
- A covered entity may disclose PHI to another CE or a health care provider (including providers not covered by the Privacy Rule) for the payment activities of the entity that receives the information.
- A CE may disclose PHI to another CE for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information, and the PHI pertains to the relationship; and the disclosure is for a quality-related health care operations activity or for the purpose of health care fraud and abuse detection or compliance.
- A covered entity that participates in an organized health care arrangement (OHCA) may disclose protected health information about an individual to another covered entity that participates in the OHCA for any joint health care operations of the OHCA.



Members of the TTUHSC workforce are reminded to always be mindful of protecting patient confidentiality when working on and off campus. Always keep in mind that when you are representing TTUHSC, sharing information about a patient with someone, other than for the treatment, payment, and operations is an inappropriate disclosure of PHI, even it is disclosed as a good gesture to help the patient.

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E/M Services Furnished in Certain Primary Care Centers

Teaching Physicians may submit claims to Medicare for services furnished by GME Residents program granted as a **Primary Care Exception** for reasonable and necessary low-to mid-level E/M services.

⇒ **When scheduling for Primary Care Clinics, what type services should be scheduled?**

Answer: Routine, problem focused visits. Remember Primary Care Exception (PCE) only applies to low-mid level E/M services (99201-99203 and 99211-99213), Medicare Initial Preventive Physical Exam (IPPE) (G0402), Annual Wellness Visit (AWV) (G0438 & G0439) and now the THSteps Well-Child Visits for Texas Medicaid Well Child visits (99381-99385 and 99391-99395).

Please refer to BC Policy 4.2 Teaching Physician Requirements for E/M Services Provided under Medicare's PCE Rule and CMS Transmittal 1780, Section 15016, Supervising Physician in a Teaching Setting

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care and be immediately available. Teaching physicians may include one resident with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the resident with less than 6 months training in the program. That is, the primary care exception does not apply in the case of the resident with less than 6 months in a GME approved residency program. Teaching physicians submitting claims under this exception 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 that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies);
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients.

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Coding Guidelines for Cerumen Removal

In 2016 AMA implemented a new CPT code 69209, described as removal of impacted cerumen using irrigation/lavage, unilateral. The procedure may be performed by a physician or any qualified healthcare provider, including clinical staff. There were no changes made to CPT code 69210, for removal of impacted cerumen using instrumentation, other than to clarify 69209 cannot be reported with 69210 when performed on the same ear. For cerumen removal that is not impacted, report an E/M service as appropriate.

If removal of impacted cerumen using irrigation or lavage and instrumentation were performed on the same ear on the same date of service, you would only report 69210. The CPT guidelines for these codes indicate they may be billed as bilateral when the procedure was performed on both ears. Use modifier LT for the left ear, modifier RT for the right ear, and modifier 50 for bilateral payment.

Medicare does not recognize 69210 as eligible for bilateral payment under its bilateral modifier rules. As a result, it's appropriate to bill Medicare for one unit of 69210 regardless of whether the lavage is performed on one or both ears.

Medicare does recognize bilateral modifiers for 69209, when both ears are cleaned modifier 50 would be used for 150% of the payment.

The CCI policy confirms "Removal of cerumen by an audiologist prior to audiologic function testing is not separately reportable". If the audiologist refers the patient to another provider for removal on the same date of service as the audiologic function testing, the provider who performs the procedure would report G0268.

Federal Update:

Dramatic Increase in False Claims Act Penalties

The False Claims Act is a federal law that prohibits anyone from submitting false or fraudulent claims to the federal government for payment. The False Claims Act also sets provisions that provide financial incentives for individuals, known as "whistleblowers," to allege fraud on behalf of the federal government and receive a percentage of the monetary recovery.

On June 30, 2016, in connection with the November 2015 enactment of the Federal Civil Penalties Inflation Adjustment Act Improvements Act (28 U.S.C. § 2461), the Department of Justice (DOJ) issued an Interim Final Rule that almost doubled the False Claims Act Penalties. The minimum per-claim penalty under Section 3729(a) (1) of the FCA increased from **$5,500 to $10,781** and the maximum per-claim penalty increased from **$11,000 to $21,563**.

The Interim Rule went into effect on August 1, 2016, and it applies to civil penalties assessed after August 1, 2016, whose violations occurred after November 2, 2015.

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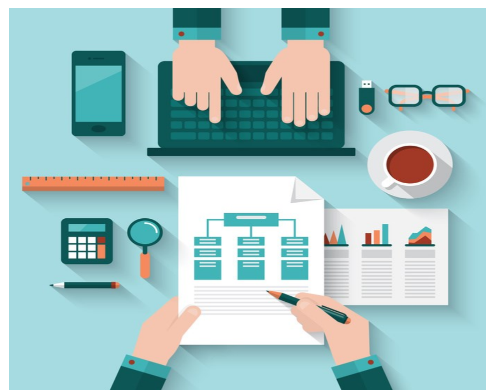
Useful Tool:

Faculty Practice Solutions Center (FPSC)



The Vizient-AAMC Faculty Practice Solutions Center (FPSC) is an online tool to analyze data unique to academic clinical, operational and financial performance. The FPSC database contains data from more than 90 academic medical centers across the country. FPSC provides data to inform and improve areas such as physician productivity, **coding and compliance**, charge capture, and collections, denials and contract rates management. The following is a summary of the available FPSC reports:

Clinical Activity Reports	Revenue Cycle Reports	Revenue Cycle Exception Reports
• New Patient Visit Analysis • Clinical Fingerprint • Productivity Summary • EM Analysis • Procedure Summary • Payer Mix • Charge Lag	• Collections Analysis • Denial Rates Analysis • Denial Reasons Analysis • Rates Analysis Summary • Contract Portfolio	• Aged A/R: Open Invoices>12 months • Denials Action Report • Rates Analysis Under Charge • Rates Analysis Under/Over Payment

All FPSC reports may be pulled by physician level, as well as by specialty level. TTUHSC transfers its data monthly to FPSC. When you run a report, you may set the desired time period, e.g., monthly, quarterly or yearly.

The Office of Institutional Compliance has the ability to run compliance related reports such as E&M coding distribution analysis. If you need assistance with any FPSC compliance reports, please do not hesitate to contact Shen Wang by email at shen.wang@ttuhsc.edu

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Questions or suggestions? Email shen.wang@ttuhsc.edu
Click here to view past issues of the Compliance Newsletter.

Department Update

Lubbock:

Shen Wang, Unit Manager in the Office of Institutional Compliance, has obtained a new certification: CHC (Certified in Healthcare Compliance). Congratulations to Shen!