TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Compliance Newsletter

July 2017

HIPAA Minimum Necessary Standard

The minimum necessary standard is a key protection of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The basic idea behind the minimum necessary standard is that covered entities (CE) must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information (PHI) needed to accomplish the intended purpose of the use, disclosure, or request. If the PHI is not necessary for a specific purpose or to carry out a specific function, the information should not be used within the entity, disclosed to third parties outside of the entity, or sought from another entity.

Exceptions to the minimum necessary standard are:

1. When a CE discloses PHI to a health care provider for treatment purposes.
2. When a health care provider requests treatment information regarding the provider's patient from another CE.
3. When disclosing PHI to the patient.
4. When providing the patient with copies of records the patient is allowed access to by law.
5. When providing the patient with an accounting of disclosures under HIPAA.
6. When the patient authorizes the disclosure pursuant to a written authorization.
7. When disclosing PHI to the Secretary of the Department of Health and Human Services, or his or her designee, for HIPAA compliance and enforcement activities.
8. When using or disclosing PHI that is required by law, including the mandated reporting of child, elder, and dependent adult abuse.
9. When using or disclosing PHI required for compliance with HIPAA's Administrative Simplification Rules.

Members of the TTUHSC workforce are reminded to always be mindful of protecting patient confidentiality when working on and off campus. Keep in mind that when you are representing TTUHSC, sharing medical information about a patient with someone, other than the exceptions to the minimum necessary standards, is an inappropriate disclosure of PHI, even if your intentions are to help the patient.

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Consultation or Transfer of Care, What are the Differences?

What is Consultation?

According to 2017 Current Procedural Terminology (CPT), a Consultation is a type of E&M service provided by a physician at the request of another physician or other appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

When billing for Consultations, keep in mind that:

- Consultations can be requested by a physician or other appropriate source (non-physician practitioner).
- The written or verbal request for consult must be documented in the patient's medical record by either the consulting or requesting physician or appropriate source.
- The consultant's opinion and any services that were ordered or performed must be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

- Exception would be a group practice. When a provider from a group practice requests a consult from another provider in the same group practice, documentation in the medical record will be sufficient. Both providers have access to the patient's medical record a separate written report is not required.
- A consultation initiated by a patient and/or family member is not reported using the consultation codes but may be reported using office visit (99201-99215), home visit (99341-99350), or domiciliary/rest home care (99324-99337) codes as appropriate.

What is Transfer of Care?

Transfer of Care is the process whereby a provider who is providing management for some or all of a patient's problems relinquishes this responsibility to another provider who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The provider transferring care is then no longer providing care for these problems though he or she may continue providing care for other condition(s) when appropriate.

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before the initial evaluation, but are appropriate to report if the decision to accept care cannot be made until after the initial consultation evaluation, regardless of site of service.

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Add More patients to Hepatitis B Screening Ranks

Use a new code G0499 (Hepatitis B screening in non-pregnant, high risk individual) for hepatitis B screening when you perform the service on newly eligible patients. Previously, a covered hepatitis B screening applied only to pregnant women, but now you can run the screening on any adolescent or adult who meets the high-risk criteria that CMS outlined in Change Request 9859 released April 28. That criteria, which mirrors changes to the hepatitis B national coverage determination (NCD), becomes effective immediately, and G0499 is considered an active code retroactive to Sept. 28, 2016. That means you can move ahead under the expanded high-risk eligibility criteria and submit G0499 claims.

Defining High-Risk Patients: People born in countries and regions with a high prevalence of hepatitis B virus (HBV), HIV-positive persons, men who have sex with men, injection drug users; and those who have contact with HBV carriers are all considered high risk.

CMS will cover the hepatitis B screening once per year as long as two conditions are met:

- High-risk factor remains, according to a provider's assessment
- Persons have not received the hepatitis B vaccination

The change also broadens the scope of pregnancy-related testing. CMS will continue to cover a screening test for high-risk pregnant women during the first prenatal visit and again during delivery, a screening during the first prenatal visit would be appropriate for each pregnancy, regardless of past history of vaccination or prior negative test results.

CMS is essentially giving providers an important new tool to improve their patients' health, particularly for pregnant women and some high-risk individuals, such as injection drug users, who are not aware that they are at risk or have not been vaccinated. Patients may not know how to ask for screening, it is up to the provider to emphasize the importance of the test. Providers can take advantage of yearly check-ups, such as the annual wellness visit (AWV), to monitor patients' risk status and perform the screening if necessary.

How to Report the Screening Hepatitis B Test?

- You can stick to four current CPT codes 86704, 86706, 87340 and 87341 for all pregnancy-related HBV screening tests, including the non-high-risk women who now meet eligibility criteria.
- New code G0499 will apply only to the high-risk, non-pregnant patients who are now covered under the preventative service. Avoid G0499 for pregnant patients.
- Medicare will only pay for HBV screening tests when ordered only by primary care practitioner under one of the following specialties- general practice, family practice, internal medicine, ob/gyn, pediatrics, geriatrics, certified nurse midwife, nurse practitioner, certified clinical nurse specialist, physician assistant.

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Texas Tech University Health Sciences Center

Free CME Training:

HIPAA Right of Access

Would you like to learn more about patients' right of access under HIPAA, and also earn free CME/CE credits? The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has launched a new video training module for health care providers on patients' right of access under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

The video module provides an review of: 1. The components of the HIPAA right of access, including an individual's ability to direct a copy of their health information to a third party, including a researcher; 2. How the HIPAA right of access enables individuals to be more involved in their own care; 3. How health care providers can integrate aspects of the HIPAA access right into medical practice.

The module is available via Medscape at: http://www.medscape.org/viewarticle/876110 The program requires user account registration at www.medscape.org but is free of charge. Upon completion of this activity, participants will receive free Continuing Medical Education (CME) credit for physicians and Continuing Education (CE) credit for health care professionals.

More training materials can be found here for HIPAA:

https://www.hhs.gov/hipaa/for-professionals/training/index.html

Government Enforcement Update

More than 412 Individuals were Charged with $1.3 billion in False Billings

Largest Health Care Fraud Enforcement Action in Department of Justice History

On July 13, 2017, the Department of Health and Human Services (HHS) and Department of Justice (DOJ) announced that 412 defendants across 41 federal districts (including 115 doctors, nurses and other licensed medical professionals) were charged for their participation in health care fraud schemes that accounted for about $1.3 billion in false billings as part of the National Health Care Fraud Takedown. The charges targeted schemes that billed Medicaid, Medicare and TRICARE for prescriptions of medically unnecessary drugs or medications and services that were never distributed or provided to beneficiaries. Read more at:

https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible

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Questions or suggestions? Email shen.wang@ttuhsc.edu

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Department Update

Corlis Norman, Billing Compliance Analyst, has retired on July 27, 2017.