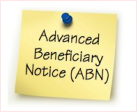
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Compliance Newsletter

March 2017



Advanced Beneficiary Notice (ABN)

An ABN is issued to notify a patient that a service usually covered by Medicare may not be covered at this time for a specific reason. The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. The beneficiary must receive written notice when it is required or the beneficiary may not be held financially liable when Medicare denies payment, and TTUHSC would be financially liable.

You must issue the ABN when Medicare is expected to deny payment for the item or service because it's deemed to not be medically reasonable and/or necessary. Services must meet specific medical necessity requirements contained in the statute and regulations, as defined by National Coverage Determinations (NDCs) and Local Coverage Determinations (LCDs) if any exist for the service.

An ABN must be issued when you expect Medicare to deny payment for an item or service because:

- It is not considered reasonable and necessary under Medicare Program standards;
- The care is considered custodial;
- Outpatient therapy services are in excess of therapy cap amount and do not qualify for a therapy cap exception;
- A beneficiary is not terminally ill (for hospice providers only); or
- A beneficiary is not homebound or there is no need for intermittent skilled nursing care (for home health services only).

The most common reasons Medicare denies services ordinarily covered include:

- Service is deemed experimental, investigational, or considered "research only" in this case.
- Service is not indicated for the diagnosis and/or treatment in this case.
- Service is not considered safe and effective in this case.

Notification: Updated Ambulatory Clinic Policies

During CY 2016, a total of 79 Ambulatory Clinic Policies and Procedures have been reviewed and updated. Please click here to access all Ambulatory Policies and Procedures.

Also the Office of Institutional Compliance updated more than 30 HIPAA and Billing Compliance policies and procedures.

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The Annual Well Woman Exam & Medicare

A well woman examination is an exam offered to women to review elements of their reproductive health. It is recommended once a year for most women. The exam includes a breast examination, a pelvic examination and a pap smear but may also include other procedures. Medicare reimburses for these screening examinations every two years in most cases. **They are reimbursable every year if the patient meets Medicare's criteria for high risk (ICD10 Z91.89).** The following are the only criteria that are accepted by Medicare to indicate a high risk patient:

- If a woman is of childbearing age AND Cervical or vaginal cancer is present (or was present) OR Abnormalities were found within last 3 years OR Is considered high risk (as described below) for developing cervical or vaginal cancer.
- If a woman is not of childbearing age AND she has at least one of the following High risk factors for cervical and vaginal cancer: onset of sexual activity under 16 years of age; five or more sexual partners in a lifetime; history of sexually transmitted diseases (including human papilloma virus and/or HIV infection); fewer than 3 negative Pap smears within the previous 7 years; DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy.

Collection of Screening Pap Smear Specimen: Use HCPCS code Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). Both the deductible and co-pay/coinsurance are waived for the laboratory's interpretation of the test.

Screening Pelvic Exam: Use HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). A screening pelvic examination should include documentation of at least seven of the following eleven elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses
3. External genitalia (for example, general appearance, hair distribution, or lesions)
4. Urethral meatus (for example, size, location, lesions, or prolapse)
5. Urethra (for example, masses, tenderness, or scarring)
6. Bladder (for example, fullness, masses, or tenderness)
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
8. Cervix (for example, general appearance, lesions or discharge)
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity) and/or
11. Anus and perineum

HCPCS code G0101 includes only the above examination elements. It does not include the many other services normally included in a Comprehensive Preventive Visit that will be billed with the appropriate E/M code and a reduced services modifier (52).

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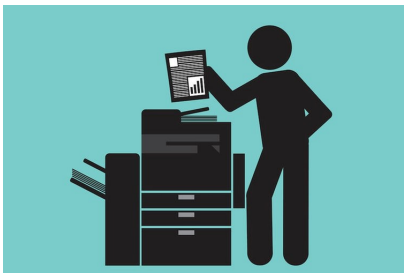
HHS: Guard Patient Information in Copiers

Digital copiers used by a covered entity to make copies of patient health information may be a source of privacy violations. The U.S. Department of Health and Human Services (HHS) warns that while digital copiers may be fast, efficient, and relatively inexpensive, they can pose a potential risk to the privacy of patient health information.

Digital copiers can utilize hard drives that retain the images of the documents fed into the device, even after the copying process is completed. According to the Managing Director in General Services, about ten percent of the copiers leased from third party vendors at the TTUHSC Lubbock campus contain a hard drive where patient PHI can be stored. When a copier is replaced, General Services removes each hard drive from the existing copier and it is taken to IT and bulleted punched to completely destroy the disk. The remaining copiers (90%) do not contain a hard drive. General Services sends white pages through these machines to store only blank pages in the memory.



Personal printers and copiers can contain small memory that can store PHI. These printers are often the small desk top printers or scanners. Usually, these types of devices may only store the last page of a print job. Prior to departments sending these devices to surplus, it is recommended department personnel make a copy of a blank sheet of paper. This will insure the last copy made will be blank and not possibly contain patient or institution confidential information.

2017 Conflict of Interest and Commitment Training & Disclosure

It's time to complete the 2017 Conflict of Interest and Commitment (COIC) Training & Disclosure module! You have until **May 1, 2017** to meet this annual requirement. The following are some key points to keep in mind:

- TTUHSC's assets should not be used for anything other than authorized activities.
- All employees shall disclose and discuss with their supervisor any external activities that could create a conflict of commitment, or the appearance of a conflict of commitment, to ensure proper management of any potential conflict.
- Your external activities must not detract from your primary TTUHSC responsibilities and must not require such extensive absence so as to cause you to neglect your institutional obligations.
- You may not review, approve, or administratively control contracts or business relationships when the contract or business relationship is between TTUHSC and a business entity which you have significant financial interest with.
- **Conflicts of interest are not necessarily bad!** It's how they are handled that can lead to untoward, inappropriate, or bad outcomes.

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Reminders:

2016 CMS Open Payments Data Review Period is Coming!

Drug, device, biological, and medical supply manufacturers are required to report payments or transfers of value they make to physicians or teaching hospitals, and the Centers for Medicare & Medicaid Services (CMS) collects this data annually, and makes it publicly available and searchable online at www.cms.gov/openpayments

What do you need to know?

- CMS publishes this data twice annually: Initial Publication (June 30 of each year) and Refresh Publication (early part of the calendar year after submission)
- Physicians have 45 days starting **April** to review and dispute
- You can still review and dispute at any time after June 30, but the data will be published on the CMS website
- You'll still be affected even if you don't treat Medicare or Medicaid patients

What do you need to do?

- Please make sure to register and review the data reported about you and ensure that the information is accurate.
- If you find errors in records submitted by a reporting entity, you can initiate a dispute on those records.

Physicians:

*You will be able to review and dispute the 2016 data reported about you in **April 2017.** The CMS Open Payments dataset for CY 2016 will be published on **June 30, 2017.***

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Office *of* Institutional Compliance

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

Click here to view past issues of the Compliance Newsletter.

Department Update

Teri Murphy, Sylvia Riojas and Tonny Smith from Office of Institutional Compliance have earned a new credential:

CEMA (Certified E&M Auditor)

Congratulations to all of them!