TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Compliance Newsletter

March 2018

Texas Tech University Health Sciences Center

Don't Forget Medical Record Integrity

Electronic Health Records (EHRs) were designed to save your time, money and to make documentation easier. In an era where demands for the provider's time continue to go up, it is hard to walk away from the time-saving advantages that EHR systems can potentially provide. However, carrying forward information without careful review can cause contradictions, and can lead to serious consequences for both patient care and reimbursement.

First, there are many instances when the documentation for a single patient looks the same from encounter to encounter – across multiple encounters – because of the way in which the provider brings forward documentation and/or copy & pasting.

Second, the provider is choosing to consistently review the exact same systems in the same way for the review of systems and examination across multiple encounters, regardless of the patient's presenting problem.

It becomes harder to determine what the provider addressed during the visit because the note contains a laundry list of the patient's chronic and acute conditions. The structural integrity of the note, which is intended to represent what happened during that specific visit, becomes compromised.

On contradictions, it is one of the biggest ways that cloned elements of notes are revealed. Because the information from previous notes is often brought forward by ancillary staff before the encounter, the provider will sometimes add contradictory information. The ROS might indicate negative for a headache which is then contradicted by an HPI of severe headaches.

Just do it very carefully, and know that CMS and their auditors are going to be looking closely to make sure there is variety in your notes that reflect the documentation needs of a specific encounter.

Compliance Quiz

Would you like to win a free coffee mug? Please read the newsletter, take the quiz below and email your answers to shen.wang@ttuhsc.edu! Individuals who correctly answer the questions will be entered into a drawing for prizes! The last day to submit your answers is May 11, 2018.

1. At TTUHSC, all PHI are stored electronically. (page 2)

   A. True B. False

2. The 2018 CPT code set adds 93792 and 93793 to replace 99363 and 99364. (page 4)

   A. True B. False

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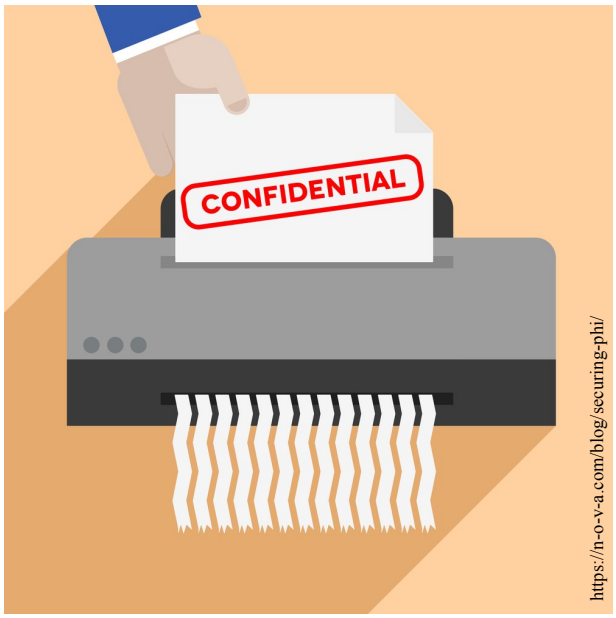
Safeguarding Paper with PHI/PII

Sensitive information on paper is the same as sensitive information on a computer. Both need to be protected from unauthorized access and should be treated with caution and discretion. In particular, protected health information (PHI) in all forms (e.g., verbal, fax, paper, electronic) is covered by the HIPAA privacy regulations. Electronic PHI (ePHI) is specifically covered by the HIPAA security regulations. In addition, personally identifiable information (PII) should be protected from inappropriate access, use, and disclosure. PII refers to information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.



https://n-o-v-a.com/blog/securing-phi/

Even though much of the PHI/PII is stored electronically now, there is still plenty of paper that contains PHI/PII found throughout our building. Sometimes we even forget that we have paper with PHI/PII stashed in various places, so it is important to think carefully about where we keep our PHI/PII, and take precautions when clearing out an area, as well as storing and transporting paper with PHI/PII. Some things to consider include:

- When exchanging office furniture, make sure you do not mistakenly leave paper with PHI/PII in the drawers or cabinets. You should have a process that your staff follows whenever such furniture is leaving the department that ensures no paper will be left behind. Desks and filing cabinets are at particularly high risk of having paper PHI/PII left in them.
- When transporting paper, enclose it in an envelope or covered container if practical. Be careful about setting paper down in a public area to perform another task, even momentarily. You would be surprised how many times paper PHI is found by or in a bathroom!
- Avoid bringing any paper with PHI/PII home, and don't keep paper PHI/PII in your car.
- Keep printouts of sensitive information such as medical records in a secure location, such as a locked desk, locked filing cabinet or a safe. Avoid leaving sensitive documents unattended, especially in high traffic areas.
- When mailing documents to a patient or patient's representative, make sure the addressee matches the name on the paperwork you are placing in the envelope.
- Paperwork of multiple patients can become mixed up in a busy work space. That is why we have to go through EACH piece of paper to ensure RIGHT PAPERWORK goes to the RIGHT PATIENT.

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Billing Compliance Education: Queries

The Golden Rule of Documentation:

"If it's not documented by the physician/provider, it didn't happen."

A query can be a powerful communication tool used to clarify documentation in the health record and achieve accurate code assignments.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

Queries are deemed appropriate when documentation in the patient's record fail to meet the following criteria:

www.allalliedhealthschools.com/medical-billing-coding/medical-billing-and-coding-terminology/

- Clarity — Diagnosis listed without statement of cause or suspected cause. Procedures not clearly documented to the suggestive documentation implied by CPT lay descriptions.
- Completeness — Entries to the patient record that do not correlate with clinical indicators or diagnostic tests.
- Consistency — Information documented that is conflicting, or not substantiated.
- Correctness — Instances when clinical reports suggest a need for more specific documentation.
- Legibility — Illegible handwritten notes where the data cannot be assessed for coding.

Queries should not be used to question a provider's clinical judgment, and may only be used to clarify documentation when it fails to meet criterion. Providers should only be queried when documentation is conflicting, ambiguous or incomplete regarding any significant reportable diagnosis or procedure.

Providers are expected to follow policies/ procedures and assist in providing documentation indicated by the query policies and procedures. Timely response with documentation that is complete and specific is required.

Coding staff performing the query function are expected to follow policies relating to documentation, querying, coding and compliance. A query should not be performed for every discrepancy in the medical record, insignificant and irrelevant findings do not require a query, and the value of collecting information for improved data is the primary objective of the query process.

Queries are initiated for all payor types regardless of the impact on reimbursement. Coders should not perform unnecessary queries. The practice of repetitive querying or overuse of the query process should be monitored internally.

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INR Monitoring Codes Changes For 2018

If you code for anticoagulant management, you need to get a handle on some changes when CPT® 2018 took effect on Jan. 1, 2018.

In 2018, CPT deleted codes 99363 and 99364 and replaced them with codes 93792 and 93793:

- 93792: Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's caregiver's ability to perform testing and report results.
- 93793: Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test (s), when performed. This code has work RVUs, recognizing that it is physician/NP/PA work to interpret the lab results, make dosing adjustment if needed, and schedule additional tests, again if needed. The dosage does not need to be changed in order to report 93793. It is for a new test result.

There are two important things to know about this:

First, the new codes are not a one-to-one replacement, but describe services for patients on anticoagulation therapy. Second, these new codes have an active status in the Medicare Fee Schedule. That is, Medicare has assigned Relative Value Units (RVUs) to the codes and will pay for them.

Can these be performed on the same day as an E/M service?

The CPT Handbook indicates that a separately identifiable E/M service may be reported on the same day as 93792, instructions and training for a patient who will start home INR monitoring.

The CPT Handbook indicates "Do not report 93793 on the same day as an E/M service". So, if the INR is done on the day of the visit and the physician/NP/PA interprets the result and gives the patient dosage instructions, do not report 93793 in addition to the E/M.

Billing Compliance Training is Coming!

This year for the live training we have combined two of the required compliance trainings into ONE presentation. Now you can complete the Annual Billing Compliance training and the CMS General Compliance training at once during live training. Want to know when there is a live training near you? Ask your clinic administrator or call the Compliance office. If you are not able to attend live training, you may still complete the training online. A General Compliance Training pamphlet has been developed that you may also use as training.

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Enforcement Update

Bipartisan Budget Bill Increases Civil Monetary Penalties for Health Care Fraud

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018, which affects health care providers by drastically increasing potential penalties for acts of fraud, waste, and abuse related to federal health care programs.

The Civil Monetary Penalties Law (CMPL), codified at 42 U.S.C. § 1320a-7a, imposes civil monetary penalties and assessments for various types of conduct, including, among other things, filing certain improper claims, accepting or paying kickbacks, offering beneficiary inducements, and arranging or contracting with excluded persons. Under the 2018 Budget Act, the penalties available to the government under the CMPL have now more than doubled. For example, conduct that used to be punishable by up to $10,000 per violation under the CMPL (for example, for knowingly filing an improper claim) is now punishable by CMPs of up to $20,000 per violation.

The 2018 Budget Act also amends the AKS, codified at 42 U.S.C. § 1320a-7b(b), which makes it a felony to knowingly and willfully solicit, receive, offer, or pay remuneration in exchange for federal health care program referrals. Specifically, the Budget Act increases the maximum penalty under the AKS from $25,000 to $100,000 per violation, and increases the maximum term of imprisonment from five to ten years.

UNTHSC to Pay $13 Million to Settle Claims Related to Federal Grants

The University of North Texas Health Science Center (UNTHSC) is a recipient of National Institutes of Health (NIH) Federal research grant funding. The settlement results from a self-disclosure by UNTHSC to the United States that from January 2011 through February 2016, UNTHSC failed to ensure that its time and effort reports related to certain federally-funded grants were accurately and timely certified.

UNTHSC, as a recipient of NIH grant funds, is responsible for accurately reporting and certifying time and effort spent on these grants. Under these obligations, UNTHSC was required to demonstrate accuracy through records that accurately reflect the work performed and an appropriate system of internal controls. UNTHSC failed to meet these requirements, and as a result, received payments for inaccurately and untimely time and effort certifications and received salary payments when the correlating payments did not match the accompanying time and effort reports. The United States contends that this conduct resulted in false claims being submitted to the government.

UNTHSC has agreed to pay the United States $13,073,000.00 to settle claims that it inaccurately measured, tracked and paid researchers for effort spent on certain NIH-sponsored research grants on February 16, 2018.