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OFFICE OF AUDIT, COMPLIANCE & ETHICS

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Target Areas in the 2015 OIG Work Plan

The U.S. Department of Health and Human Services Office of Inspector General (OIG) has released the 2015 Work Plan to provide information on the areas it will concentrate work to assure compliance with federal health care regulations. As in past years, the work will be devoted to assure appropriate payments, eligibility, medical necessity, and information security/privacy.

HIPAA security and privacy compliance will be a focus this year. The OIG will be looking at hospital policies and plans for contingency /disaster planning requirements, implementation of electronic health records (EHR) and security of EHR technology. Selected audits will review relationships with business associated, with specific mention of cloud service providers, to assure that electronic health information is adequately protected.

The Work Plan also brings the microscope to processes for privileging/credentialing, sanction-checking and assuring medical necessity to assure proper oversight by the health care entity. Meaningful Use incentive payments to eligible providers and hospitals will receive scrutiny also.

In addition, hospitals will continue to have coding, billing, payment and quality items on the Work Plan. Risk areas for non-compliance will be a special focus, and the OIG has identified appropriate level of care decisions (inpatient vs outpatient), the two-midnight rule for inpatient admissions, appropriate coding including diagnosis coding for kwashiorkor, sleep testing and cardiac procedures for targeted reviews. Oversight of pharmaceutical compounding continues on the 2015 Work Plan - this follows the 2012 meningitis outbreak from contaminated injections. Professional services including those of anesthesia providers, sleep-testing physicians, ophthalmologists, and dentists are also targets for review.

As in past years, the Work Plan emphasizes benefits of education and training (available on the OIG website), use of Provider Self-Disclosure, and risks of Civil Monetary Penalties. The Office of Audit, Compliance and Ethics is working with senior leaders to address risks, internal controls and compliance monitoring for items on the Work Plan that are significant to the business of UConn Health. To learn more about the 2015 OIG Work Plan, please see this link https://oig.hhs.gov/reports-and-publications/workplan/

For questions, please contact Margaret DeMeo, Associate Compliance Officer at 860-679-1226 or Demeo@uchc.edu

Paper Documents with PHI? - Use Caution When Handling

Per the new UConn Health policy #2014-09 Handling Paper Communications About Patients including PHI—Assuring Proper Identity of the Patient staff are expected to use two data points of patient identity to assure they are mailing, faxing or handing the correct paper documents to the correct person. Pages of each document must be initialed by the responsible staff member when processing any paper communication.

As a reminder, the Privacy Office also requests that staff dealing directly with patients and their PHI review these additional policies, as they are helpful to guide staff when handling these types of communications about patients to individuals who may need the patient's PHI.

2003-23 Faxing of PHI
2003-20 Verification of Individuals or Entities Requesting Disclosure of PHI
2012-01 Email Communication with Patients/Research Participants

For questions, please contact Iris Mauriello, Compliance Integrity/Privacy Officer at 860-679-3501 or mauriello@uchc.edu

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2015 Brings a New Link Between Physician and Hospital Medicare Payments

The Centers for Medicare and Medicaid Services (CMS) recently issued Transmittal 541 giving its' auditing entities the authority to deny payment for claims "related" to an inpatient admission when the admission is considered medically unnecessary. CMS has determined that claims are related when "documentation associated with one claim can be used to validate another claim."(1) For example, when an inpatient surgical admission is determined to be medically unnecessary and the inpatient hospital payment is denied, the auditors may also deny the surgeon's procedure payment.

Related claim reviews are considered automated reviews. As such, auditors will make a determination whether to approve or deny both the inpatient admission and the associated professional services based solely upon the documentation contained in the hospital's medical record. Auditors are not required to review the physician's office notes. For the first time, documentation in the physician's office notes supporting the inpatient procedure must also be included in the hospital's medical record. This will be a significant undertaking but is necessary for both the hospital and physician to obtain payment and avoid subsequent audit denials.

Currently, Transmittal 541 gives both Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs) the authority to deny related claims. However, CMS is expected to also grant denial authority to Recovery Audit Contractors (RACs).

Implementation of related claim reviews is expected to begin in April of 2015 when auditors start reviewing inpatient stays under the two midnight rule regulations. As always, commercial insurance companies will be monitoring CMS's success rate with related claim denials and will be evaluating whether to follow suit.

(1)*CMS Manual System, Transmittal 541 issued September 12, 2014*

For questions or additional information about this article to Kim Bailot, Associate Compliance Officer, x4746 KBailot@uchc.edu

Modifier 59 Changes in 2015

On 01/01/2015 CMS introduced a new subset of Modifier 59 Distinct Procedural Service. Based on CMS audits, Modifier 59 is the most applied and misused modifier currently being utilized. Even though the errors may be unintentional, the improper use of this modifier leads to claims being paid incorrectly. This new subset of modifiers will give CMS a clearer picture of services being provided.

The new subset modifiers are:

- Modifier XE: Separate Encounter. A service that is distinct because it occurred during a separate patient/provider encounter. *An example would be the exact same procedure code performed twice on the same day i.e. EKG*
- Modifier XS: Separate Structure. A service that is distinct because it was performed on a separate organ/structure. *An example would be destruction of lesion on right leg and skin biopsy of left arm*.
- Modifier XP: Separate Practitioner. A service that is distinct because it was performed by a different practitioner. *An example would be if a patient has surgery in the morning by a general surgeon and then goes back to the OR in the afternoon for surgery by a cardiologist.*
- Modifier XU: Unusual Non-Overlapping Service. The use of a service that is distinct because it does not overlap usual components of the main service. *An example would be the excision of a lesion of the upper thigh and excision of the lower leg.*

As a default, at this time CMS will initially accept either a 59 modifier or a more selective X {E, P, S, U} modifier as correct coding although the expectation is that providers will migrate to the more selective modifiers quickly.

For more information please refer to CMS Transmittal 1422, Change Request 8863: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

For additional questions or concerns, please contact Janice McDonnell, Compliance Specialist at X4093 or jmcdonnell@uchc.edu