UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

BILLING COMPLIANCE

UHealth System

Fraud, Waste and Abuse Training

You are the key to the integrity of our institution and your daily commitment to avoid and prevent fraud, waste and abuse is the foundation for protecting our institution's values. As with all strong programs, it starts with communication and training. All University of Miami UHealth/Miller School of Medicine faculty and employees are required to complete the mandatory Fraud Waste and Abuse (FWA) training annually. The deadline to complete the 2016 Fraud, Waste and Abuse training has been extended until February 15, 2017.

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Fraud, Waste and Abuse UHealth Compliance 2016

Thank you for being an integral part of the UHEALTH compliance effort! It is the responsibility of the University of Miami UHealth/Miller School of Medicine to comply with Federal and State laws, regulations and requirements. The University of Miami and the UHealth/Miller School of Medicine are committed to uphold the highest ethical standards in the conduct of its business. You are the key to the integrity of our institution and your daily commitment to avoid and prevent fraud, waste and abuse is the foundation for protecting our institution's values. As with all strong programs, it starts with communication and training.

All University of Miami UHealth/Miller School of Medicine faculty and employees are required to complete the mandatory **Fraud Waste and Abuse (FWA)** annually.

The deadline to complete the mandatory online module titled, **"UHealth Fraud Waste and Abuse 2016"** has been extended until **February 15, 2017** and is available via ULearn.

- Download a step-by-step guide to accessing and completing this mandatory online training requirement:
- Click here to log in to ULearn.

The module should take about **30 minutes to complete**

- For difficulty accessing ULearn or the module, please contact UMIT at 305-243-5999.
- If you have questions about this mandatory training requirement or questions of its contents, please contact the Office of Billing Compliance by emailing, officeofbillingcompliance@med.miami.edu or by calling 305-243-5842.

Thank you for your effort and dedication to transforming lives at the U. It is because of you that we can build a strong ethical foundation, one person at a time.

Having trouble viewing the presentation? Below are a few pointers that may help:

- Press Ctrl and click on the link simultaneously.
- Try using a different browser, for example Internet Explorer.
- Make sure that your pop up blockers have been disabled. Please refer to the following step-by-step guide.

Helenemarie Blake-Leger, JD
Chief Privacy & Data Security Officer
Interim Associate Vice President Medical Compliance
Iliana De La Cruz, CPCO, RMC
Executive Director/Office of Billing Compliance (Professional)
Maria C. Suarez, JD
Executive Director/Office of Billing Compliance (Hospital)

Medicare Finalizes New Physician Payment System

The Centers for Medicare & Medicaid Services (CMS) released a final rule implementing a new Medicare physician payment system, which replaces the sustainable growth rate (SGR) formula and marks the most significant change to Medicare physician reimbursement in 20 years. Beginning in 2017, physician practices can choose between two payment options.

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Beginning in 2017, physician practices can **choose between two payment options:**

1. Merit-Based Incentive Payment System **(MIPS)** and;
2. Risk-based alternative payment models **(APMs)**

At the outset, there are relatively few APM opportunities, and CMS estimates that more than 90% of physicians will participate in MIPS, making it the default method.

MIPS increases or decreases physician Medicare reimbursement rates based on performance on measures in four categories:

- quality,
- cost,
- EHR use, and;
- clinical practice improvement activities (CPIA)

Payments in 2019 will be adjusted based on 2017 performance, and the cost category will not be counted in 2017. The year 2017 will be a transition year and physician practices will have four options for engaging in MIPS:

1. Report all required measures for at least 90 consecutive days and be eligible for a bonus payment;
2. Report more than one quality measure, more than one improvement activity, and the required EHR measures for at least 90 consecutive days and be eligible for a small bonus payment;
3. Report one quality measure, one improvement activity, or the required EHR measures and avoid a penalty; or
4. Do nothing and receive a 4% payment penalty in 2019.

Observation Services

“Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short- term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

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Section 20.6, Chapter 6 of the Medicare Benefit Policy Manual (MBPM) (Pub. 100–02)

Outpatient observation services are not to be used as a substitute for medically necessary inpatient admissions.

It is also important to remember that observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law, and hospital staff bylaws, to admit patients to the hospital or to order outpatient services.

Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, or patient's families, or while awaiting placement to another facility.

Calculating Observation Time

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour.

Observation time ends when all medically necessary services *related to observation* care are completed.

Observation services <u>should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours).</u>

Additionally, there must be medical necessity for observation beyond the usual recovery period (4 to 6 hours) of the usual recovery time associated with procedures are reimbursed as part of the procedure.

The medical necessity for observation services must be documented in the medical record.

<u>Observation is not to be used as a substitute for recovery room services. The need for observation care should be determined by the patient's condition during the postoperative recovery period, not prior to surgery. General standing orders for observation services following all outpatient surgery are not recognized.</u>

Patients must be in the care of a physician during the period of observation, as documented in the medical record. The medical record must also include documentation of Physician assessment of the need for continued observation care or determination of inpatient admission or discharge after the first 24 hours of observation and again at 48 hours of observation care.

The following are **NOT considered Observation services:**

✓ Recovery from outpatient surgery or procedure

✓ Chemotherapy

✓ Blood transfusion

✓ Short stays for in-patient only procedures

New Physician Specialty Code for Hospitalist

Effective **April 1, 2017**, a new physician specialty code for hospitalist will be implemented. When enrolling in Medicare, physicians self-designate their Medicare physician specialty on the Medicare enrollment application or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). The new physician specialty code C6 has been designated for hospitalist. Additional information is available in MLN Matters® article MM9716

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9716.pdf

2017 Hospital Outpatient and ASC Prospective Payment System Highlights

2017 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Highlights

On November 1, 2016, CMS released its final 2017 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System rule implementing site-neutral payment provisions of the Bipartisan Budget Act of 2015.

Site-neutral payment provisions

CMS is implementing Section 603 of the Bipartisan Budget Act of 2015. Under this section, certain off-campus provider-based departments (PBD) that began billing under the OPPS on or after Nov. 2, 2015, will no longer be paid for most services under the OPPS. Instead, beginning Jan. 1, 2017, these facilities will be paid under the physician fee schedule. However, services provided in a dedicated emergency department will continue to be paid under the OPPS.

Under the final rule, CMS put certain restrictions on off-campus PBDs that began billing under the OPPS prior to Nov. 2, 2015. The agency finalized a proposal requiring these departments to provide services and bill from the same physical address as they did Nov. 2, 2015, to be exempt from the site-neutral payment provisions.

However, there are still certain proposals that CMS has not finalized. For instance, the agency is still working on a proposal that would allow off-campus PBDs to maintain excepted status if the hospital is sold and the new owner accepts the existing Medicare provider agreement.

Payment update

CMS will increase OPPS rates by 1.65 percent in 2017. CMS arrived at the rate increase through the following updates: a positive 2.7 percent market basket update, a negative 0.3 percent update for a productivity adjustment and a negative 0.75 percent update for cuts under the ACA. After considering all other policy changes included in the final rule, CMS estimates OPPS payments will increase by 1.7 percent in 2017.

Hospital Outpatient Quality Reporting Program

For 2017, CMS is adding seven measures to the Hospital Outpatient Quality Reporting Program for the 2020 payment determination and subsequent years.

Moderate Sedation and Endoscopic Services

For CY 2017, CMS unbundled moderate sedation for some endoscopic services and will require sedation to be separately billed using designated CPT code(s), when provided. Click here to view the list of the impacted codes and the new RVUs for these services.
http://obc.med.miami.edu/documents/CMS-1654-F_Moderate_Sedation_Work_Values_Table.pdf

2017 Office of Inspector General Work Plan Hospital Initiatives

Each fall, the Department of Health and Human Services Office of Inspector General (OIG) publishes its Work Plan for the upcoming fiscal year to summarize new and ongoing OIG reviews and initiatives. On November 10, 2016, the OIG's2017 Work Plan was posted to its website.

The OIG's Work Plan sets forth its initiatives and priorities for the 2017 federal fiscal year (FFY), which the OIG will pursue through audits, investigations, inspections, industry guidance (including advisory opinions) and enforcement actions (including actions to impose civil monetary penalties, assessments and administrative sanctions, such as exclusions). The 2017 OIG Work Plan includes the audits begun in years past that will continue into FFY2017 as well as new audits scheduled to begin in FFY2017.

There are a number of new starts for OIG audits and other reviews included in the 2017 OIG Work Plan. Below are some of the initiatives affecting hospitals.

Incorrect medical assistance days claimed by hospitals

To address the risk of overpayment under the Medicare disproportionate share hospital payments, OIG will determine whether, with respect to Medicaid patient days, Medicare administrative contractors properly settled Medicare cost reports in accordance with federal requirements.

Comparison of provider-based and freestanding clinics

The OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures. The OIG will also assess the potential impact on Medicare and beneficiaries of hospitals' claiming provider-based status for such facilities. This review was also included in the 2016 OIG Work Plan and has not been revised.

Hyperbaric Oxygen Therapy in Outpatient Setting

OIG previously expressed concerns regarding the appropriateness of and the existence of supporting documentation for hyperbaric oxygen therapy treatment for Medicare beneficiaries. In its 2017 Work Plan, the OIG announced it will review whether Medicare payments related to hyperbaric oxygen therapy outpatient claims were reimbursable. Hospitals should review services and the supporting documentation to ensure Medicare beneficiaries satisfied the covered conditions for reimbursement.

Inpatient rehabilitation hospital patients not suited for intensive therapy

The OIG will assess a sample of rehabilitation hospital admissions to look at whether the Medicare beneficiaries at issue participated in and benefited from intensive therapy.

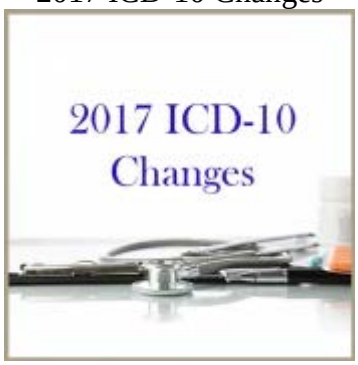
Inpatient rehabilitation facility payment system requirements

The OIG, based on prior reviews of individual inpatient rehabilitation facilities indicating possible Medicare overpayments, intends to review rehabilitation facilities nationally regarding compliance with Medicare documentation and coverage requirements. In particular, the OIG will look at whether facilities are specifically documenting in the medical record, at the time of admission, support for a reasonable expectation that the patient needs multiple intensive therapies, is able to actively participate and demonstrate measurable improvement, and requires supervision by a rehabilitation physician to assess and modify the course of treatment to maximize the benefit of the rehabilitation process.

Inpatient psychiatric facility outlier payments

Citing a significant increase in the number of claims with outlier payments, the OIG intends to look at inpatient psychiatric facilities nationally for compliance with Medicare documentation, coverage, and coding requirements relating to outlier payments.

2017 ICD-10 Changes



Below is the 2017 update to the ICD-10-CM diagnosis coding structure is effective for services rendered on or after October 1, 2016. The list also shows the Local Coverage Determinations (LCDs) affected as a result of these changes.

2017 ICD-10 Update

https://medicare.fcso.com/Coverage_News/0358851.asp

2017 Medicare Physician Fee Schedule (MPFS)

Select from the links below to view the disclosure report for your locality.

- Florida locality 03 2017 Florida Locality 03
- Florida locality 04 2017 Florida Locality 04
- Florida locality 99 2017 Florida Locality 99
- Anesthesia conversion factors Anesthesia conversion factors

https://medicare.fcso.com/data_files/0362638.pdf
https://medicare.fcso.com/data_files/0362639.pdf
https://medicare.fcso.com/data_files/0362640.pdf
https://medicare.fcso.com/include/license.asp

The Importance of the Medicare Coverage Analysis in Clinical Trials

To ensure appropriate reimbursement for the services provided to a patient in a clinical trial, research sites must develop a budget for each trial. One important step in developing a clinical trial budget is conducting a Medicare Coverage Analysis, sometimes referred to as an MCA. This identifies the services for which Medicare will pay under the Medicare Clinical Trial Policy. A methodical analysis also helps avoid compliance pitfalls with regard to inappropriate billing or double billing.

Non-compliant billing is subject to severe penalties, as well as civil and criminal actions. Determining the eligibility of a clinical study's related tests, procedures or interventions for Medicare coverage requires a detailed review of the clinical events specified in the protocol to determine which can be reimbursed. This sometimes cumbersome and time-consuming process is essential.

The first step is to determine whether the trial qualifies for coverage. To qualify, a trial should meet these criteria:

- The purpose of the trial must be to evaluate an item or service that falls within a Medicare benefit category. For example, physicians' services, durable medical equipment and diagnostic tests would be covered; cosmetic surgery would not.
- The trial must have a therapeutic intent. Does it potentially improve the participants' health outcomes?
- The trial will enroll patients with a diagnosed disease, rather than healthy volunteers.

Private insurance

Starting in 2014, private insurance companies are required to pay for routine costs of care delivered in clinical trials. The Patient Protection and Affordable Care Act describes "routine patient costs" in clinical trials that health insurers must cover as "all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial." This includes items such as hospital visits, imaging or laboratory tests and medication.

False Claims Act Settlement

False Claims Act Settlements December 7, 2016; U.S. Attorney; Southern District of Florida

South Miami Hospital, a not-for-profit regional hospital located in South Miami, Florida has agreed to pay the United States approximately $12 million to settle allegations that it violated the False Claims Act by submitting false claims to federal healthcare programs for medically unnecessary electrophysiology studies and other procedures allegedly performed by John R. Dylewski, M.D., at South Miami Hospital.

For more information, please refer to the full article: South Miami Hospital Agrees to Pay the United States $12 Million to Settle False Claims Act Allegations

https://www.justice.gov/usao-sdfl/pr/south-miami-hospital-agrees-pay-united-states-12-million-settle-false-claims-act

What Is The Minimum Required Documentation When Billing For A Split/Shared Visit?

What is the minimum required documentation by the Attending Physician when billing for a split/shared visit?

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and
2. The physician personally documents, in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.
3. An Attestation alone, by the Attending Physician, is not acceptable as Physician Documentation. The Teaching Physician Rule does not apply to NPPs (Nurse Practitioners or PAs).

- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.
- The NPP MUST be an employee (or leased) to bill a shared visit. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician unless it's only the ROS and PMFS Hx.