

Medical Compliance Services

July 2016

OFFICE OF BILLING COMPLIANCE PROFESSIONAL COMPONENT

Anesthesia Medical Direction Rules

Preoperative Evaluation

The anesthesiologist must document that he/she examined the patient and his/her individual assessment. One does not need to repeat a previous evaluation and can note the resident's, CRNA's, AA's, or PA's information, but writing "agree with above" is not sufficient. The anesthesiologist must also document his/her anesthetic care plan.

Have a Question?

Call us at 305-243-5842 or email
officeofbillingcompliance@med.miami.edu

Example:

- (for Cholecystectomy) Patient examined. Above noted. 43 yo woman, ASA II for HTN and obesity. Plan GA with ETT.

Intraoperative Presence and Direction

CMS requires documentation of availability throughout the case and presence for critical portions of the anesthesia, including induction and emergence. You can document availability in the anesthesia record with a note, such as "available throughout."

For documenting intraoperative monitoring of the course of anesthesia, the anesthesiologist should note the time and initial to document his/her presence. This may simply be documentation of "VSS" or may be more detailed if a significant event is occurring.

On the anesthesia record, the documentation should show documentation of induction, emergence, and postoperative notes. Also, additional notes for other events, e.g., transfer of care, intraoperative monitoring, line placements, or other intraoperative events are to be documented. These notes should document the anesthesiologist's presence and medical direction, but should not include the words "supervise" or "supervised" to avoid confusion.

Examples:

Induction-Specific Notes:

"Present for induction, ...

- ...Smooth mask induction, IV placed, intubation without problem"
- ...IV induction, intubation as noted, present for positioning"
- ...Spinal placed at L2-3 without difficulty"

Emergence-Specific Notes:

"Present for emergence, ...

- ... Awake, extubated"
- ... and extubation"

The medical direction requirement is to provide indicated post-anesthesia care. For a patient with an uncomplicated course, this indicated care might simply entail an examination of the patient in a recovery area and note no apparent anesthetic complications. Similarly, if patient is taken to ICU from the OR, the indicated care may be in the report given to ICU team.

Example:

- for PACU patient: "Patient examined. Awake. VSS, no apparent complications from anesthesia"
- for ICU patient: "VSS, Report given to ICU Staff"

- for ICU patient: “patient ready for transfer, Report given to ICU Staff”

Transparency in Health Care Summary of the Florida Senate House Bill (HB) 1175

Effective July 1, 2016, Hospitals and ASCs are required to provide access to the searchable service bundles on their website. Consumers will be presented with the estimated average payment received, excluding Medicaid and Medicare, and estimated payment ranges for each service bundle, by facility, facilities within geographic boundaries, and nationally. The facility must disclose that this information is an estimate of costs and that actual costs will be based on services actually provided to the patient. Additionally, the facility must disclose the facility’s financial assistance policies and collection procedures.

The hospital and ASC must notify prospective patients that other health care providers may provide services in the facility and bill separately from the facility. Furthermore, the prospective patient must be informed that these healthcare providers may or may not participate with the same health insurers or health maintenance organizations (HMOs) as the facility. Patients should contact the practitioners to determine the health insurers and HMOs the practitioners participates as a network or preferred provider. The facility must provide contact information for the practitioners.

Patients may request personalized good faith estimates of charges for non-emergency medical services from hospitals, ASCs, and health care practitioners relating to medical services provided in the hospital or ASC. These good faith estimates must be provided to the patient within 7 days after the patient’s request. The bill provides for a daily fine for non-compliance by facilities and health care practitioners. The personalized estimate must also inform the patient about the health care provider’s financial assistance policies and collection procedures.

A patient may also request an itemized bill or statement from the hospital and ASC, after discharge. The requested itemized bill or statement must be provided within 7 days and be specific, written in plain language, and identify all services provided by the facility and any facility fees, as well as rates charged, amounts due, and the payment status. The itemized bill or statement must inform the patient to contact his or her insurer regarding the patient’s share of costs. The facility must provide records to verify the bill or statement within 10 days after a request and respond to questions concerning the statement or bill.

Each diagnostic-imaging center operated by a hospital but not located on the hospital grounds is required to post in the reception area prices charged to uninsured persons for the 50 most frequently provided services.

National Health Care Fraud Takedown-\$900 Million in False Billing, Largest Alleged Loss Amount in Strike Force History

This coordinated takedown is the largest in history, both in terms of the number of defendants charged and loss amount.

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare and Medicaid for treatments that were medically unnecessary and often never provided. In many cases, patient recruiters, Medicare beneficiaries and other co-conspirators were allegedly paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could then submit fraudulent bills to Medicare for services that were medically unnecessary or never performed.

Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of submitting a total of approximately \$900 million in fraudulent billing.

This takedown reflects an unprecedented nationwide sweep led by the Medicare Fraud Strike Force in 36 federal districts, resulting in criminal and civil charges against 301 individuals, including 61 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$900 million in false billings.

Among the alleged fraud uncovered:

- A Texas doctor certified patients for home health care that was not necessary; then home health care companies billed Medicare for \$23.3 million based on those certifications.
- A California physician who performed unnecessary vein ablation procedures was charged with \$12 million in fraudulent billing.
- In Florida, the owner of clinics that deliver infusion drugs was accused of submitting reimbursement claims for expensive drugs that were never purchased or given to patients.
- In Michigan, owners of two physical therapy clinics were accused of submitting claims to Medicare after patients had died and fabricating imaging reports to build a false medical case for prescribing painkillers and physical therapy visits.

More than 60 people were charged with fraud related to the prescription drug benefit portion of Medicare.

Overlapping Surgeries

Under the new guidelines for overlapping surgeries, effective July 1, 2016, surgeons will need to be informed of the different types of qualified medical providers that will participate in their surgery and who might be performing some of the non-critical portions of the operation. If an urgent situation arises that requires the primary surgeon to leave the operating room unexpectedly, the patient should be subsequently informed.

Two Overlapping Surgeries: Teaching Surgeons may bill Medicare for two, but not more than two, overlapping procedures provided that the Teaching Surgeon is physically present for the key portions of both procedures.

When all key portions of the initial procedure have been completed, the Teaching Surgeon may begin to become involved in a second procedure. It is critical that the teaching surgeon personally document the key portions of both procedures.

The Teaching Physician must document the name of the physician (not a resident) who will be immediately available for the non-key portions of the first procedure. The designee must be a physician who is not personally involved in, or immediately available for, any other surgical procedure.

Under the new guidelines for Overlapping Surgeries, effective July 1, 2016, the surgeon must inform the patients prior to the performance of the procedure, and agree to the procedure, discuss with the patient about what "critical portion of the operation" means and who might be performing some of the noncritical portions of the operation.

Three or More Overlapping Surgeries: In the case of three or more overlapping surgical procedures, the Teaching Surgeon's role in each of the cases would be classified as supervisory and therefore, not reimbursable under Medicare Part B.

July Update to the 2016 Medicare Physician Fee Schedule Database

Indicator Changes

- **G0296** Multiple surgery = 0; diagnostic imaging family indicator = 99
- **G9678** Procedure status = C (effective for services on or after July 1, 2016)
- **10036** Multiple surgery indicator = 0
- **37188** Multiple surgery indicator = 0
- **45346** Endo base code = 45330
- **61651** Multiple surgery indicator = 0
- **65855** Bilateral indicator = 1
- **69209** PC/TC indicator = 3

New Procedure Codes (procedure status=E, no relative value units [RVUs])

- **Q5102** (effective April 5, 2016)
- **Q9981-Q9983** (effective July 1, 2016)

Other New Codes (procedure status=C, no RVUs)

0437T, 0438T, 0440T, 0441T, 0442T, 0439T, 0443T, 0444T, 0445T

Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, however, they will adjust claims that you bring to their attention.

More information is available in [MLN Matters® article MM9633](#)

Emergency Department Visits (Codes 99281 - 99288)

Physician billing for emergency department services provided to patient by both the patient's personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.

If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

Medical Policies: Botulinum Toxins-Revision to the Part A and Part B Local Coverage Determination

(LCD)

LCD L33274 for botulinum toxins was revised to add ICD-10-CM code range G81.11-G81.14 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J0588. These codes were inadvertently missed when the FDA approved indication, upper limb spasticity in adult patient, was added to the LCD for incobotulinumtoxinA (Xeomin®).

In addition, the LCD was revised based on LCD reconsideration requests to include additional ICD-10-CM diagnosis codes for the FDA approved indication, upper limb spasticity in adult patient, for abobotulinumtoxinA (Dysport™) and incobotulinumtoxinA (Xeomin®). ICD-10-CM codes G80.0, G80.1, G80.2, G82.53, G82.54, G83.0*, and ICD-10-CM code ranges G83.21-G83.24*, I69.031-I69.034, I69.051-I69.054, I69.131-I69.134, I69.151-I69.154, I69.231-I69.234, I69.251-I69.254, I69.331-I69.334, I69.351-I69.354, I69.831-I69.834, and I69.851-I69.854 were added under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes J0586 and J0588. Language clarifying the asterisked diagnoses was also added to this section.

Additionally, "spasticity of the arm in patients following a stroke" was removed from the "Off-label Indications" section for Dysport™.

This LCD revision to add code range G81.11-G81.14 for procedure code J0588 is effective for claims processed **on or after June 09, 2016**, for services rendered **on or after December 22, 2015**. The LCD revision to include additional diagnosis codes for upper limb spasticity for procedure codes J0586 and J0588 is effective for services rendered **on or after June 09, 2016**.

Billing News: CMS Issues Advisory for Billing of Tests for Zika Virus

The Centers for Medicare & Medicaid Services issued an advisory reminding providers that Medicare covers Zika virus testing under Medicare Part B, as long as the clinical diagnostic laboratory test is reasonable and necessary for the diagnosis or treatment of a person's illness or injury.

More information is available at medicare.fcso.com/Billing_news/0345046.asp

Clinical Lab

The Centers for Medicare & Medicaid Services (CMS) recently updated the lists of Current Procedural Terminology (CPT®) codes that are subject to billing instructions associated with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests.

The CPT codes added to the list must have the modifier QW to be recognized as a waived test. CMS changes the CPT® codes covered under CLIA (and thus requiring certification) each year.

More information is available at medicare.fcso.com/Clinical_lab/0345050.asp

Special Histochemical Stains and Immunohistochemical Stains

Please click on the link below for information on the new LCD for special histochemical stains and immunohistochemical stains.

More information is available at cms.gov/medicare-coverage-database

Tips on Inquiries, Denials and RUCs

Preventing Duplicate Claim Denials

Providers are responsible for all claims submitted to Medicare under their provider number. Preventable duplicate claims are counterproductive and costly, and continued submission to Medicare may lead to program integrity action.

Enhanced duplicate claim edits include pending and same claim details in history review of duplicate procedures and services. Bill correctly the first time to avoid duplicate denials.

More information is available at medicare.fcso.com/Inquiries_and_denials/255391.asp

Provider Enrollment News: Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D

The Centers for Medicare & Medicaid Services (CMS) finalized new rules requiring physicians and professionals who write prescriptions for Part D drugs to be enrolled in an approved status or have a valid opt-out affidavit for their prescriptions to be covered by Medicare. CMS revised this article October 20, 2015, to change the enforcement of the Part D prescriber enrollment requirement to June 1, 2016.

Phase 2 edits for ordered/referred items and services The Centers for Medicare & Medicaid Services (CMS) revised this article September 24, 2015, and October 21, 2015, to update the link to the ordering referring report on the CMS website and to clarify legislative changes affecting providers who file Medicare opt-out affidavits with Medicare contractors.

External Ocular Photography-Revision to the Part B LCD ID number: L33819

The LCD for external ocular photography was revised based on a reconsideration request to include ICD-10-CM diagnosis code D49.2 (Neoplasm of unspecified behavior of bone, soft tissue, and skin) under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 92285 (External ocular photography with interpretation and report for documentation of medical progress). In addition, the "Sources of Information and Basis for Decisions" section of the LCD was updated.

This LCD revision is effective for claims processed on or after June 23, 2016, for services rendered on or after October 1, 2015.

"New Data on Physician Financial Relationships" Sunshine Act

On June 30, CMS added 2015 data to the Open Payments website, which displays payments and transfers of value made by group purchasing organizations and drug/device manufacturers to physicians and teaching hospitals. Based on reports filed by manufacturers, CMS counted and publicized approximately 11.9 million records of financial transactions attributed to 618,931 physicians and 1,116 teaching hospitals, worth \$7.52 billion in total payments.

The 2015 Open Payment Program data set is the second full year of data available on the CMS Open Payments website. Additionally, CMS updated data from 2013 and 2014 that was newly submitted. Physicians and teaching hospitals had the opportunity to review and dispute the data reported by drug and device manufacturers before the data was published. CMS is scheduled to refresh the Open Payments data in early 2017 to reflect additional updates to the data that have been made since this publication.

The Open Payments Program is a national transparency program aimed at spotlighting financial relationships between physicians, teaching hospitals, and drug/device manufacturers.

CMS proposes 90-Day Meaningful Use Reporting Period in 2016

After a strong advocacy effort by MGMA and other provider organizations, the Centers for Medicare & Medicaid Services (CMS) has proposed shortening the Meaningful Use reporting period for all eligible professionals, eligible hospitals, and Critical Access Hospitals to any continuous 90-day period between Jan. 1 and Dec. 31, 2016. CMS included this provision in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System [proposed rule](#). Currently, providers are required to report Meaningful Use measures for the full calendar year for returning participants. This proposed change will increase reporting flexibility and lower the reporting burden for all providers. The OPPS final rule is expected later this fall.

Florida Medicaid New Oral Metoclopramide Safe Dosing Limitations

Metoclopramide carries a black box warning regarding the risk of tardive dyskinesia, which may be irreversible. The risk of developing tardive dyskinesia increases with duration of treatment and total cumulative dose. Treatment with metoclopramide for longer than 12 weeks should be avoided in all but rare cases where therapeutic benefit is thought to outweigh the risk of developing tardive dyskinesia.

Beginning October 2016, the Agency for Health Care Administration (Agency) will be implementing the following limitations for oral metoclopramide:

- A maximum limit of 40 mg per day for recipients under the age of 18 years
- A maximum limit of 60 mg per day for recipients ages 18 and older
- A maximum of 12 continuous weeks of therapy for recipients of all ages

Providers prescribing oral metoclopramide in excess of the limits specified above will be required to submit a prior authorization request to Magellan Medicaid Administration, Inc. if the recipient is receiving services through the fee-for-service delivery system.

For recipients enrolled in a health plan, prescribers should contact the health plan directly for prior authorization requirements for this drug.

Physician Fee Schedule: Proposed CY 2017 Changes

Medicare also expands the Diabetes Prevention Program

On July 7, CMS proposed changes to the Physician Fee Schedule to transform how Medicare pays for primary care through a

new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the Diabetes Prevention Program within Medicare starting January 1, 2018.

The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in calendar year 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning
- Care for patients with mobility-related impairments

For More Information:

- [Proposed Rule](#) (CMS-1654-P): Comments due no later than 5 pm on September 6, 2016
- [Fact Sheet](#)
- [Diabetes Prevention Program](#)

See the full text of this excerpted [CMS press release](#) (issued July 7).

Hospital and ASC: Proposed OPPS Changes for CY 2017

On July 6, CMS proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers.

Proposed changes include:

- Addressing physicians' concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology
- Emphasizing health outcomes that matter to the patient

CMS estimates that the updates in the proposed rule would increase OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

For More Information:

- [Proposed Rule](#) (CMS-1656-P): Comments due no later than 5 pm on September 6, 2016
- [Fact Sheet](#)

See the full text of this excerpted [CMS press release](#) (issued July 6).

AMBULATORY SURGICAL CENTERS (ASC)

Ambulatory Surgical Center (ASC) Fee Schedule Update

Please click on the link below to view the 2016 Medicare Part B ASC fee schedule for July 1, 2016

[2016 Medicare Part B ASC Fee Schedule](#)

OFFICE OF BILLING COMPLIANCE HOSPITAL COMPONENT

Medicare's Proposed Site-Neutral Payment Policy

President Obama's administration plans to eliminate their Medicare payments for services at new off-campus outpatient departments, saying it ignores the intent of Congress and will limit access to care.

Under an outpatient payment rule proposed last week for 2017, Medicare would not pay hospitals for most services provided at off-campus departments that started billing Medicare after Nov. 2, 2015. Instead, physicians would be paid for services there at an enhanced rate. And off-campus departments that were already billing Medicare as of that date would not be paid for any services they add. They also would be cut off from all payments if the facility is relocated or expanded.

Congress called for the so-called site-neutral payments in the Bipartisan Budget Act of 2015. But the hospital organizations say the way the CMS plans to carry out the provision violates what the law actually says. The legislation states that new off-campus departments should be paid "under the applicable payment system." While some analysts thought it was possible the CMS might interpret that to mean the physician fee schedule, they also thought the agency might choose the fee schedule Medicare uses for ambulatory surgery centers.

The policy was adopted by Congress in response to a 2013 Medicare Payment Advisory Commission report that found Medicare was paying 141% more for a Level 2 echocardiogram in an outpatient setting than the program paid for one performed in a physician's office.

It is expected hospitals will lobby Congress and the CMS to modify the site-neutral payment policy for outpatient services. Consumer advocates and lawmakers argued that the higher payments weren't justified and pushed hospitals to buy physician practices. The AHA countered that hospitals have higher cost structures than physician offices because they have emergency departments and trauma capacities.

Lawmakers have already responded to one concern of the hospital industry. Last month the House passed a bill that would exempt hospital outpatient departments from the new site-neutral payments if the provider had an agreement for construction of the facility before Nov. 2, 2015.

JW Modifier

The Centers for Medicare & Medicaid Services (CMS) issued CR 9603 to alert MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals.

Effective January 1, 2017, providers are required to:

- Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals) and
- Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded

Off-Campus Provider Based Department "PO" Modifier

If an item or service is being provided by an applicable provider and is being paid through the OPPS (Outpatient Prospective Payment System), then the PO modifier should be applied.

Remember: The PO modifier only applies to services paid under the OPPS. Accordingly, therapy services that are billed under the PFS and have an OPPS status indicator of "A" do not require the PO modifier. The status indicator identifies whether the services described by the HCPCS code is paid under the OPPS, and whether the payment is to be made separately or packaged.

NOTE: The Medicare Claims Processing Manual Chapter 4 20.6.11 was updated in July 2015 to read: "This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department and hospital."

Drugs or laboratory services: In order for the PO modifier to be applied for drugs or laboratory services, we need to know whether the item or service is being paid through the OPPS. For instance, a drug with an OPPS status indicator of "K" or a laboratory test that is packaged into an OPPS service should have the PO modifier applied. The Medicare status indicator K is for non-pass through drugs, biological agent and radiopharmaceutical agents, and is paid an APC (ambulatory Payment classification) based fee. If a service is not paid through the OPPS, such as a laboratory test paid separately through the Clinical Laboratory Fee Schedule, it should not have the PO modifier applied.

For laboratory services, billing personnel will need to determine if the given test(s) will be packaged for the given claim. This is not a straightforward process. See the "Q4" status indicator that indicates when a laboratory test might be packaged. To see which tests are conditionally packaged, go to Addendum B and the using the Excel format, sort the CPT®/HCPCS codes by status indicator. Billing personnel will then need to check to see if the given laboratory test(s) are packaged for the particular claim and then attach the PO modifier as appropriate. Note that the packaging of the laboratory tests is at the claim level not necessarily by date-of-service.

“Billing personnel will need to fully understand the “Q4” status indicator and how it is used by the APC Grouper.” Q4 status indicator refers to conditionally packed laboratory tests, and is paid under OPSS. a single hospital outpatient claim (Type of Bill 13X) could have HCPCS codes with the PO modifier and HCPCS without the PO modifier (e.g., a patient is treated at an off-campus PBD and the on-campus hospital on the same day). The services provided at off-campus dialysis facilities are billed under the ESRD PPS and, therefore, do not require the PO modifier.

The PO modifier does not apply to:

- Off-campus provider based departments (PBDs) of Critical Access Hospitals (CAHs) because CAHs are not paid through the OPSS
- Services provided through Medicare Advantage
- Services physically provided at remote hospital locations of the applicable main hospital or on the campus of a remote location of the applicable main hospital
- Items or services provided in either Type A or Type B Emergency Departments
- Any facility that does not meet the definition of provider-based.

Hospitals will need to CHECK any unusual situations such as an off-campus ED or a provider-based urgent-care clinic that might be deemed as a dedicated emergency department. For these unusual situations the Medicare MAC in our jurisdiction may be consulted.

Infliximab (Remicade™)-Revision to the Part A LCD ID Number: L33704

The LCD for infliximab (Remicade™) has been revised within the “Limitations” and “Documentation Requirements” sections of the LCD to clarify requirements for the indication of aortic arch syndrome (Takayasu). In addition, based on change request (CR) 9633 (Quarterly Update to the MPFSDB – July CY 2016), CR 9636 (Quarterly HCPCS Drug/Biological Code Changes), CR 9658 (July 2016 Update to the Hospital OPSS), CR 9661 (July 2016 I/OCE Specifications), and CR 9668 (July 2016 Update of the ASC Payment System), the “CPT/HCPCS codes” section of the LCD was revised to add HCPCS code Q5102 and modifier ZB.

The LCD revision related to aortic arch syndrome (Takayasu) is effective for claims processed on or after July 14, 2016. The LCD revision related to the addition of HCPCS code Q5102 and modifier ZB is effective for claims processed on or after July 5, 2016, for services rendered on or after April 5, 2016, for HCPCS code Q5102, and on or after April 1, 2016, for modifier ZB.

July 2016 Update of the Hospital Outpatient Prospective Payment System

Change request 9658 describes the following key changes to be implemented in the July 2016 outpatient prospective payment system (OPSS) update:

- Billing instructions for intensity modulated radiation therapy planning
- Upper eyelid blepharoplasty and blepharoptosis repair
- Revised status indicators for pathology CPT® codes
- Reporting for certain outpatient department services
- Category III CPT® codes effective July 1, 2016
- Drugs, biologicals, and radiopharmaceuticals
- Addition of C1713 and C1817 to the list of devices allowed for the device intensive procedure edit
- Coverage determinations

More information is available in [MLN Matters® article MM9658](#).

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RESEARCH BILLING COMPLIANCE

Research Billing: Medicare Claims Processing Manual, Chapter 32

Type of Study	Hospital Charges (UB-04) Inpatient Claims	Hospital Charges (UB-04) Outpatient Claims	Professional Charges (CMS-1500)
Medicare Clinical Trial Policy	ICD-10 diagnosis code Z00.6 as the secondary diagnosis code for trial participation	ICD-10 diagnosis code Z00.6 as the secondary diagnosis code for trial participation	ICD-10 diagnosis code Z00.6 as the secondary diagnosis code for trial participation
Instructions apply to conventional care, including treatment of complications	ICD-10 diagnosis code Z00.6 as the primary diagnosis code for healthy controls only	ICD-10 diagnosis code Z00.6 as the primary diagnosis code for healthy controls only	ICD-10 diagnosis code Z00.6 as the primary diagnosis code for healthy controls only
Billing provider must include in the medical record the following information: trial name, trial sponsor, and sponsor-assigned protocol number	Condition Code 30 (qualifying clinical trial) reported at the claim level for both trial participants and healthy controls	Condition Code 30 (qualifying clinical trial) reported at the claim level for both trial participants and healthy controls	Q1 Modifier- for both participants and healthy controls- apply to each service identified as conventional care only on line items related to the clinical trial
	Include Z 00.6 and Condition Code 30 regardless of whether all services on the claim are related to the clinical trial or not	Include Z 00.6 and Condition Code 30 regardless of whether all services on the claim are related to the clinical trial or not	Q0 Modifier- for each service identified as investigational
	NCT #- required as of January 1, 2014	Q1 Modifier- for both participants and healthy controls- apply to each service identified as conventional care only on line items related to the clinical trial	NCT # preceded by "CT" required as of January 1, 2014
		Q0 Modifier- for each service identified as investigational	
		NCT #- required as of January 1, 2014	

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ANNOUNCEMENTS & TRAININGS OFFICE OF BILLING COMPLIANCE

Announcements

This is a reminder that all CMS, RAC, AHCA, Cert, Zip and Managed Care audit requests, overpayment requests or any request for medical records correspondence should be forwarded to the attention of Osmany Rodriguez, Manager of External/Special Audits at the Office of Billing Compliance. Should you need to contact him, he can be reached via email at ORodriguez5@med.miami.edu or at 305-243-5842.

Trainings

The Office of Billing Compliance **2016 Live Coding, Billing and Documentation Educational Sessions** will begin on April 6, 2016. For more information, please contact our office at 305-243-5842. Date are listed below and are posted on our website, obc.med.miami.edu/Live-Sessions

Upcoming 2016 Live Coding, Billing and Documentation Educational sessions:

- August 24, 2016 at 7:30am SCCC 1301-**Medicine-Gastroenterology & Hepatology**
- August 24, 2016 at 6:00pm Retter Auditorium-**Ophthalmology**
- August 25, 2016 at 6:45am RMSB 3rd Floor-**Anesthesiology**
- August 25, 2016 at 8:00am LPLC 7th Floor-**Neurological Surgery**
- August 25, 2016 at 5:00pm Mailman 8th Floor Auditorium-**Orthopaedics**
- September 12, 2016 at 4:00pm DRI 1000-**Medicine-Endocrinology**
- September 13, 2016 at 9:00am Mailman 8th Floor Auditorium-**Surgery**
- September 13, 2016 at 5:00pm Mailman 8th Floor Auditorium-**Psychiatry**
- September 21, 2016 at 7:00am JMH West Wing Room 279-**Diagnostic Radiology**
- September 21, 2016 at 12:00pm TBA-**Neurology**
- September 21, 2016 at 6:00pm Mailman 8th Floor Auditorium-**Surgery**
- September 22, 2016 at 7:00am RMSB 5th Floor-**OB GYN**
- September 22, 2016 at 12:00pm SCCC 1537-**Radiation Oncology**
- September 22, 2016 at 5:30pm SCCC 1301-**Medicine-General, Internal, Geriatric and CHDS**
- September 26, 2016 at 7:00am JMH West Wing Room 279-**Diagnostic Radiology**
- September 26, 2016 at 12:00pm SCCC 1537-**Radiation Oncology**
- September 26, 2016 at 5:00pm Mailman 8th Floor Auditorium-**Medicine-Pulmonary**

Online Training

The Office of Billing Compliance has an on-line learning module to promote the prevention, detection and correction of Fraud, Waste and Abuse. All UHealth/Miller School of Medicine faculty and staff are required to complete it annually.

The required computer-based learning (CBL) module is titled **Fraud, Waste and Abuse** and is accessed by logging in to **ULearn**, the University's learning management system.

Please follow the steps below to access the Fraud, Waste and Abuse CBL:

1. Click <http://ulearn.miami.edu/> to log in to ULearn
2. Click on "Transcript"
3. Locate the "Fraud, Waste and Abuse" CBL and click "Launch"

MEDICAL COMPLIANCE SERVICES

Who are we?

- Helenmarie Blake, ESQ. Interim AVP Medical Compliance and Chief Privacy Officer
- Iliana De La Cruz, Executive Director, Professional Billing Compliance
- Maria Suarez, Executive Director, Hospital Billing Compliance

Where are we?

- Don Soffer Clinical Research Center
1120 NW 14 Street, 12th Floor, Suite 1289, Miami, FL 33136 (Locator D-24)

How do you reach us?

- Tel: 305-243-5842
- Fax: 305-243-6487
- Email: officeofbillingcompliance@med.miami.edu
- Web: <http://obc.med.miami.edu/>
- To make a report, visit the 'Cane Watch website at www.canewatch.ethicspoint.com or call toll free 877-415-4357



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